THE DEVELOPMENT OF BEST PRACTICE GUIDELINES FOR THE CONTINGENCY
MANAGEMENT OF HEALTH-RELATED ABSENTEEISM
IN THE MOTOR MANUFACTURING INDUSTRY

By

AMANDA WERNER

Thesis presented in fulfillment of the requirements for the Degree:

DOCTOR TECHNOLOGIAE: HUMAN RESOURCES MANAGEMENT

in the Faculty of Business and Economic Sciences
at the Nelson Mandela Metropolitan University

PROMOTOR: Prof. N. Kemp

JANUARY 2005
The financial assistance of the National Research Foundation towards this research is acknowledged. Opinions expressed in this thesis and conclusions arrived at, are those of the author and are not necessarily to be attributed to the National Research Foundation.
DECLARATION

“I, Amanda Werner, hereby declare that:

• the work in this thesis is my own original work;
• all sources used or referred to have been documented and recognised; and
• this thesis has not been previously submitted in full or partial fulfillment of the requirements for an equivalent or higher qualification at any other recognised education institution.”

------------------------
AMANDA WERNER          DATE
THE DEVELOPMENT OF BEST PRACTICE GUIDELINES FOR THE
CONTINGENCY MANAGEMENT OF HEALTH-RELATED ABSENTEEISM
IN THE MOTOR MANUFACTURING INDUSTRY

BY

AMANDA WERNER

DEGREE: DOCTOR TECHNOLOGIAE
(HUMAN RESOURCES MANAGEMENT)

FACULTY: MANAGEMENT

PROMOTOR: PROF. N. KEMP

ABSTRACT

The research problem in this study was to identify best practices for the contingency management of health-related absenteeism. To achieve this goal, the following actions were taken:

• A literature study was conducted to identify the scope and impact of health-related absenteeism on organisations and the legal parameters within which health-related absenteeism should be managed.

• A literature study was also conducted to identify strategies to prevent and reduce health-related absenteeism and strategies to ensure the continuous provision of products and services in periods of high absenteeism. The theoretical study focused on the management of absenteeism, wellness, ill-health/mental problems and HIV/AIDS, as well as contingency strategies aimed at maintaining production and service provision.
• The findings from the literature study were integrated into a model of best practices for the contingency management of health-related absenteeism.

• This model was used as a basis for the development of a survey questionnaire to determine whether senior human resources practitioners, occupational health practitioners or line managers, who were responsible for the management of health-related absenteeism in organisations, agreed with the best practice guidelines developed in the study. The survey was conducted in the motor and motor component industry in the Nelson Mandela Metropolitan Municipality and Buffalo City Metropole.

The empirical results from the study showed a strong concurrence with the best practices guidelines developed in the study, with the exception of the strategies aimed at maintaining undisrupted production and service provision during periods of high absenteeism. In particular, disagreement was shown with regard to alternative work arrangements such as flexible work-hours, a compressed work-week, telecommuting and job-sharing.

Absenteeism, in general, is an issue that organisations are challenged with on a daily basis. The proliferation of various diseases, specifically HIV/AIDS, is contributing to this problem. An integrated and strategic approach is required to deal effectively and constructively with the immediate and expected future impact of health-related issues on absenteeism. Organisations could use the best practices guidelines, identified in this study, as a mechanism to benchmark how well they manage health-related absenteeism.
ACKNOWLEDGEMENTS

• Prof. Norman Kemp, my research supervisor, for his encouragement and professional guidance during the study.

• Prof. Graham Stead, for assisting with the statistical analysis.

• Prof. Dave Berry, Head-of-Department, Human Resources Management, Nelson Mandela Metropolitan University, for his continuous support and encouragement throughout this study.

• Prof. N.J. Dorfling, Dean for the Faculty of Business and Economic Sciences, Nelson Mandela Metropolitan University, for his interest and encouragement.

• My colleagues in the Faculty of Business and Economic Sciences, Nelson Mandela Metropolitan University, for their interest, support and encouragement.

• The respondents of the study who supplied empirical data.

• My family and friends, for their encouragement, support and love.

• Marcelle Werner, for her professional assistance with the editing and layout of the thesis.
TABLE OF CONTENTS

DECLARATION i
ABSTRACT ii
ACKNOWLEDGEMENTS iv
TABLE OF CONTENTS v
LIST OF CHARTS x
LIST OF GRAPHS xi
LIST OF FIGURES xii
LIST OF TABLES xiii
LIST OF APPENDICES xviii

CHAPTER 1
INTRODUCTION, PROBLEM STATEMENT AND OUTLINE OF RESEARCH PROJECT

1.1 PROBLEM STATEMENT 2
1.2 KEY CONCEPTS 9
1.3 DELIMITATION OF THE STUDY 11
1.4 SIGNIFICANCE OF THE STUDY 11
1.5 OBJECTIVES OF THE STUDY 14
1.6 RESEARCH METHODOLOGY 15
1.7 ORGANISATION OF THE REMAINDER OF THE STUDY 18
CHAPTER 2
THE SCOPE AND IMPACT OF HEALTH-RELATED ABSENTEEISM ON ORGANISATIONS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>INTRODUCTION</td>
<td>22</td>
</tr>
<tr>
<td>2.2</td>
<td>HEALTH-RELATED ABSENTEEISM CONTEXTUALISED</td>
<td>23</td>
</tr>
<tr>
<td>2.3</td>
<td>THE EXTENT AND NATURE OF HEALTH-RELATED ABSENTEEISM IN SOUTH AFRICAN ORGANISATIONS</td>
<td>29</td>
</tr>
<tr>
<td>2.4</td>
<td>THE IMPACT OF ABSENTEEISM ON THE PRODUCTIVITY LEVELS OF EMPLOYEES</td>
<td>63</td>
</tr>
<tr>
<td>2.5</td>
<td>THE FINANCIAL IMPLICATIONS OF ILL-HEALTH AND ASSOCIATED ABSENTEEISM</td>
<td>67</td>
</tr>
<tr>
<td>2.6</td>
<td>LEGAL PARAMETERS FOR THE MANAGEMENT OF HEALTH-RELATED ABSENTEEISM</td>
<td>72</td>
</tr>
<tr>
<td>2.7</td>
<td>THE MERITS OF ADOPTING A CONTINGENCY APPROACH TO THE MANAGEMENT OF HEALTH-RELATED ABSENTEEISM</td>
<td>82</td>
</tr>
</tbody>
</table>

CHAPTER 3
CONTINGENCY MANAGEMENT STRATEGIES AIMED AT PROMOTING A HEALTHY WORKFORCE AND REDUCING HEALTH-RELATED ABSENTEEISM

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>INTRODUCTION</td>
<td>87</td>
</tr>
<tr>
<td>3.2</td>
<td>WORK-PLACE POLICIES PERTAINING TO ABSENTEEISM AND HEALTH-RELATED ISSUES</td>
<td>89</td>
</tr>
<tr>
<td>3.3</td>
<td>THE RECORDING, MEASUREMENT AND ANALYSIS OF HEALTH-RELATED ABSENTEEISM</td>
<td>109</td>
</tr>
<tr>
<td>3.4</td>
<td>A HOLISTIC APPROACH TO HEALTH IN THE WORKPLACE</td>
<td>128</td>
</tr>
<tr>
<td>3.5</td>
<td>THE MANAGEMENT OF HIV/AIDS IN THE WORKPLACE</td>
<td>154</td>
</tr>
<tr>
<td>3.6</td>
<td>ERGONOMICS</td>
<td>168</td>
</tr>
<tr>
<td>3.7</td>
<td>DEALING WITH INCAPACITY</td>
<td>169</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>3.8</td>
<td>A CONTINGENCY MANAGEMENT PLAN AIMED AT PROMOTING A HEALTHY WORKFORCE AND REDUCING HEALTH-RELATED ABSENTEEISM</td>
<td>171</td>
</tr>
<tr>
<td>3.9</td>
<td>CONCLUSION</td>
<td>173</td>
</tr>
<tr>
<td><strong>CHAPTER FOUR</strong></td>
<td><strong>CONTINGENCY MANAGEMENT STRATEGIES AIMED AT ENSURING THE CONTINUITY OF PRODUCTION AND SERVICES IN THE FACE OF ABSENTEEISM</strong></td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>INTRODUCTION</td>
<td>176</td>
</tr>
<tr>
<td>4.2</td>
<td>DESIGNING A FLEXIBLE ORGANISATION</td>
<td>180</td>
</tr>
<tr>
<td>4.3</td>
<td>MANAGING FLUCTUATING STAFF LEVELS THROUGH HUMAN RESOURCES PLANNING</td>
<td>183</td>
</tr>
<tr>
<td>4.4</td>
<td>ENSURING THE OPTIMAL USE OF AVAILABLE TALENT</td>
<td>188</td>
</tr>
<tr>
<td>4.5</td>
<td>ENSURING AN ADEQUATE SKILLS SUPPLY THROUGH TRAINING AND DEVELOPMENT</td>
<td>192</td>
</tr>
<tr>
<td>4.6</td>
<td>ENSURING AN ADEQUATE SKILLS SUPPLY THROUGH ALTERNATIVE WORK ARRANGEMENTS</td>
<td>195</td>
</tr>
<tr>
<td>4.7</td>
<td>ENSURING AN ADEQUATE SKILLS SUPPLY THROUGH ALTERNATIVE EMPLOYMENT PRACTICES</td>
<td>203</td>
</tr>
<tr>
<td>4.8</td>
<td>REDUCING THE IMPACT OF ABSENTEEISM THROUGH CAREFUL CONSIDERATION OF PRODUCTION AND SERVICE PROCESSES</td>
<td>207</td>
</tr>
<tr>
<td>4.9</td>
<td>CONTINGENCY MANAGEMENT STRATEGIES AIMED AT ENSURING THE CONTINUITY OF PRODUCTION AND SERVICE DELIVERY IN THE FACE OF ABSENTEEISM</td>
<td>214</td>
</tr>
<tr>
<td>4.10</td>
<td>CONCLUSION</td>
<td>215</td>
</tr>
</tbody>
</table>
# CHAPTER 5

DEVELOPMENT OF BEST PRACTICES FOR THE CONTINGENCY MANAGEMENT OF HEALTH-RELATED ABSENTEEISM

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>INTRODUCTION</td>
<td>218</td>
</tr>
<tr>
<td>5.2</td>
<td>BEST PRACTICES</td>
<td>219</td>
</tr>
<tr>
<td>5.3</td>
<td>PRESENTATION OF BEST PRACTICES FOR THE CONTINGENCY MANAGEMENT OF HEALTH-RELATED ABSENTEEISM</td>
<td>221</td>
</tr>
<tr>
<td>5.4</td>
<td>CONCLUSION</td>
<td>231</td>
</tr>
</tbody>
</table>

# CHAPTER 6

RESEARCH METHODOLOGY

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>INTRODUCTION</td>
<td>234</td>
</tr>
<tr>
<td>6.2</td>
<td>PROFESSIONAL RESEARCH DESIGN</td>
<td>235</td>
</tr>
<tr>
<td>6.3</td>
<td>THE EMPIRICAL STUDY</td>
<td>237</td>
</tr>
<tr>
<td>6.4</td>
<td>PRESENTATION AND ANALYSIS OF THE BIOGRAPHICAL INFORMATION</td>
<td>251</td>
</tr>
<tr>
<td>6.5</td>
<td>CONCLUSION</td>
<td>265</td>
</tr>
</tbody>
</table>

# CHAPTER 7

ANALYSIS AND INTERPRETATION OF RESULTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>INTRODUCTION</td>
<td>268</td>
</tr>
<tr>
<td>7.2</td>
<td>QUANTITATIVE ANALYSIS OF RESULTS</td>
<td>269</td>
</tr>
<tr>
<td>7.3</td>
<td>REVIEW OF QUANTITATIVE ANALYSIS</td>
<td>325</td>
</tr>
<tr>
<td>7.3</td>
<td>CONCLUSION</td>
<td>333</td>
</tr>
</tbody>
</table>
CHAPTER 8

SUMMARY, RECOMMENDATIONS AND CONCLUSION

8.1 INTRODUCTION 336
8.2 SUMMARY OF THE STUDY 336
8.3 RECOMMENDATIONS 340
8.4 PROBLEMS AND LIMITATIONS 343
8.5 CONCLUSION 343

REFERENCES 345
<table>
<thead>
<tr>
<th>Chart</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chart 6.1</td>
<td>Number of companies surveyed</td>
<td>249</td>
</tr>
<tr>
<td>Chart 6.2</td>
<td>Organisational size</td>
<td>252</td>
</tr>
<tr>
<td>Chart 6.3</td>
<td>Responses with regard to operational focus</td>
<td>253</td>
</tr>
<tr>
<td>Chart 6.4</td>
<td>Responses with regard to functional area employed in</td>
<td>254</td>
</tr>
<tr>
<td>Chart 6.5</td>
<td>Responses with regard to gender</td>
<td>256</td>
</tr>
<tr>
<td>Chart 6.6</td>
<td>Responses with regard to home language</td>
<td>257</td>
</tr>
<tr>
<td>Chart 6.7</td>
<td>Gross Absence Rate</td>
<td>259</td>
</tr>
<tr>
<td>Chart 6.8</td>
<td>Percentage absenteeism attributed to genuine ill-health</td>
<td>261</td>
</tr>
<tr>
<td>Graph 6.1</td>
<td>Training programmes/workshops presented in the previous twelve months</td>
<td>258</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Graph 6.2 (a)</td>
<td>Health-related organisational policies</td>
<td>263</td>
</tr>
<tr>
<td>Graph 6.2 (b)</td>
<td>Health-related organisational policies</td>
<td>264</td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Overall health risks and sick-day status</td>
<td>47</td>
</tr>
<tr>
<td>2.2</td>
<td>Breakdown of HIV/AIDS prevalence in South Africa by age group: 1999</td>
<td>53</td>
</tr>
<tr>
<td>2.3</td>
<td>The impact of HIV/AIDS in organisations</td>
<td>54</td>
</tr>
<tr>
<td>2.4</td>
<td>Conceptual business cost curves of responses to HIV/AIDS</td>
<td>62</td>
</tr>
<tr>
<td>2.5</td>
<td>A model for estimating absenteeism</td>
<td>69</td>
</tr>
<tr>
<td>3.1</td>
<td>Factors influencing absenteeism and return-to-work barriers</td>
<td>98</td>
</tr>
<tr>
<td>3.2</td>
<td>Opportunities for health management</td>
<td>137</td>
</tr>
<tr>
<td>4.1</td>
<td>A model for flexibility, uncertainty and human resources management</td>
<td>178</td>
</tr>
<tr>
<td>4.2</td>
<td>A sample replacement chart</td>
<td>186</td>
</tr>
<tr>
<td>4.3</td>
<td>Flexitime work schedules</td>
<td>197</td>
</tr>
<tr>
<td>4.4</td>
<td>Flexible sub-assembly process</td>
<td>211</td>
</tr>
<tr>
<td>5.1</td>
<td>Model of best practices for the contingency management of health-related absenteeism</td>
<td>222</td>
</tr>
</tbody>
</table>
LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 2.1</td>
<td>Five major categories of absenteeism as identified by various surveys</td>
<td>24</td>
</tr>
<tr>
<td>Table 2.2</td>
<td>The prevalence of TB in South Africa</td>
<td>39</td>
</tr>
<tr>
<td>Table 2.3</td>
<td>Health risks/behaviours and associated criteria</td>
<td>46</td>
</tr>
<tr>
<td>Table 2.4</td>
<td>The different stages of HIV and its transformation into AIDS</td>
<td>50</td>
</tr>
<tr>
<td>Table 2.5</td>
<td>The dual impact of HIV/AIDS</td>
<td>57</td>
</tr>
<tr>
<td>Table 3.1</td>
<td>A no-fault absenteeism policy</td>
<td>93</td>
</tr>
<tr>
<td>Table 3.2</td>
<td>Proof of illness</td>
<td>111</td>
</tr>
<tr>
<td>Table 3.3</td>
<td>Time lost index figure from a South African study</td>
<td>119</td>
</tr>
<tr>
<td>Table 3.4</td>
<td>The time lost index figures derived from international companies</td>
<td>120</td>
</tr>
<tr>
<td>Table 3.5</td>
<td>Actions taken by organisations to minimise the medical costs of HIV/AIDS</td>
<td>132</td>
</tr>
<tr>
<td>Table 3.6</td>
<td>Average absenteeism levels at organisation with and without HIV interventions</td>
<td>156</td>
</tr>
<tr>
<td>Table 3.7</td>
<td>The percentage of club members utilising various HIV/AIDS best practices</td>
<td>157</td>
</tr>
<tr>
<td>Table 6.1</td>
<td>Number of companies surveyed</td>
<td>249</td>
</tr>
<tr>
<td>Table 6.2</td>
<td>Number of responses received on or before due date</td>
<td>250</td>
</tr>
<tr>
<td>Table 6.3</td>
<td>Total number of responses received after second follow-up</td>
<td>250</td>
</tr>
<tr>
<td>Table 6.4</td>
<td>Responses with regard to organisational size</td>
<td>252</td>
</tr>
<tr>
<td>Table 6.5</td>
<td>Responses with regard to operational focus</td>
<td>253</td>
</tr>
<tr>
<td>Table 6.6</td>
<td>Responses with regard to functional area employed in</td>
<td>254</td>
</tr>
<tr>
<td>Table 6.7</td>
<td>Responses with regard to gender</td>
<td>255</td>
</tr>
<tr>
<td>Table 6.8</td>
<td>Responses with regard to home language</td>
<td>256</td>
</tr>
</tbody>
</table>
Table 6.9  Training programmes/workshops presented in previous twelve months 258
Table 6.10  Gross absence rate 259
Table 6.11  Percentage absenteeism attributed to genuine ill-health 261
Table 6.12  Health-related organisational policies 263
Table 7.1  Means and standard deviations of scores for Section B 271
Table 7.2  Correlations of scores for Section B with all other Sections 272
Table 7.3  Corrected item means, correlations and internal consistency coefficients of Section B (12 items) 273
Table 7.4  Means and standard deviations of scores for Section C1 274
Table 7.5  Correlations of scores for Section C1 with all other sections 275
Table 7.6  Corrected item means, correlations and internal consistency coefficients of Section C1 (6 items) 276
Table 7.7  Means and standard deviations of scores for Section C2 277
Table 7.8  Correlations of scores for Section C2 with all other Sections 278
Table 7.9  Corrected item means, correlations and internal consistency coefficients of Section C2 (7 items) 279
Table 7.10  Means and standard deviations of scores for Section C3 280
Table 7.11  Correlations of scores for Section C3 with all other sections 281
Table 7.12  Corrected item means, correlations and internal consistency coefficients of Section C3 (6 items) 281
Table 7.13  Means and standard deviations of scores for Section C4 282
Table 7.14  Correlations of scores for Section C4 with all the other sections 283
Table 7.15  Corrected item means, correlations and internal consistency coefficients of Section C4 (7 items) 284
Table 7.16  Means and standard deviations of scores for Section D 285
| Table 7.17 | Correlations of scores for Section D with all other sections | 287 |
| Table 7.18 | Corrected item means, correlations and internal consistency coefficients of Section D (16 items) | 288 |
| Table 7.19 | Number of responses according to organisational size | 290 |
| Table 7.20 | Homogeneity of variances for small and large organisations' total scores for each section of the questionnaire | 291 |
| Table 7.21 | Descriptive statistics for section total scores for small and large organisations | 292 |
| Table 7.22 | Analysis of variance for group total mean scores for Sections B1 and D1 for small and large organisations | 293 |
| Table 7.23 | Number of responses according to GAR | 294 |
| Table 7.24 | Homogeneity of variances for organisations with a low and high GAR for totals for each section of the questionnaire | 295 |
| Table 7.25 | Descriptive statistics of section total scores for organisations according to GAR | 296 |
| Table 7.26 | Analysis of variance for group total mean scores for Sections B1 to D1 for organisations with a low and high GAR | 297 |
| Table 7.27 | Number of responses according to GARSick | 298 |
| Table 7.28 | Homogeneity of variances for organisations with a low and high GARSick for totals for each section of the questionnaire | 299 |
| Table 7.29 | Descriptive statistics of total scores for organisations according to GARSick | 299 |
| Table 7.30 | Analysis of variance for group total mean scores for Sections B1 to D1 for organisations with a low and high GARSick | 300 |
| Table 7.31 | Number of responses according to HIV/AIDS policy | 301 |
| Table 7.32 | Homogeneity of variances for organisations with and without an HIV/AIDS policy for totals for each section of the questionnaire | 302 |
Table 7.33  Descriptive statistics of total scores for organisations without (NO) or with (YES) an HIV/AIDS policy  303
Table 7.34  Analysis of variance for group total mean scores for Sections B1 to D1 for organisations with and without an HIV/AIDS policy  304
Table 7.35  Effects and main effect of the relationship between GAR, GARSick and totals for B1 (Absence)  306
Table 7.36  Means and standard deviations for total scores for B1 (Absence) for GAR and GARSick  306
Table 7.37  Effects and main effect of the relationship between GAR, GARSick and totals for C1 (Wellness)  308
Table 7.38  Means and standard deviations for total scores for C1 (Wellness) for GAR and GARSick  308
Table 7.39  Effects and main effect of the relationship between GAR, GARSick and totals for C2 (Ill-health)  310
Table 7.40  Means and standard deviations for total scores for C2 (Ill-health) for GAR and GARSick  310
Table 7.41  Effects and main effect of the relationship between GAR, GARSick and total scores for C3 (HIV/AIDS)  311
Table 7.42  Means and standard deviations for total scores for C3 (HIV/AIDS) for GAR and GARSick  312
Table 7.43  Effects and main effect of the relationship between GAR, GARSick and total scores for C4 (Success factors)  313
Table 7.44  Means and standard deviations for total scores for C4 (Success factors) for GAR and GARSick  313
Table 7.45  Effects and main effect of the relationship between GAR, GARSick and total scores for D (Contingency strategies)  315
Table 7.46  Means and standard deviations for total scores for D (Contingency strategies) for GAR and GARSick  315
Table 7.47  Standardised Discriminant Function Coefficients for Section scores for organisational size  318
Table 7.48  Standardised Discriminant Function Coefficients for Section scores for GAR  320
<table>
<thead>
<tr>
<th>Table 7.49</th>
<th>Standardised Discriminant Function Coefficients for Section scores for GARSick</th>
<th>321</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 7.50</td>
<td>Descriptive statistics of total scores for C4 for organisations according to GARSick</td>
<td>323</td>
</tr>
<tr>
<td>Table 7.51</td>
<td>Standardised Discriminant Function Coefficients for Section scores for HIV/AIDS policy</td>
<td>324</td>
</tr>
</tbody>
</table>
# LIST OF APPENDICES

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1</td>
<td>Covering letter for survey</td>
<td>367</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Survey questionnaire</td>
<td>368</td>
</tr>
</tbody>
</table>
CHAPTER ONE

INTRODUCTION, PROBLEM STATEMENT
AND OUTLINE OF RESEARCH PROBLEM

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>PROBLEM STATEMENT</td>
<td>2</td>
</tr>
<tr>
<td>1.2</td>
<td>KEY CONCEPTS</td>
<td>9</td>
</tr>
<tr>
<td>1.2.1</td>
<td>Absenteeism</td>
<td>9</td>
</tr>
<tr>
<td>1.2.2</td>
<td>Sick-absence</td>
<td>10</td>
</tr>
<tr>
<td>1.2.3</td>
<td>Health-related absenteeism</td>
<td>10</td>
</tr>
<tr>
<td>1.2.4</td>
<td>Presenteeism</td>
<td>10</td>
</tr>
<tr>
<td>1.2.5</td>
<td>Contingency management</td>
<td>10</td>
</tr>
<tr>
<td>1.3</td>
<td>DELIMITATION OF THE STUDY</td>
<td>11</td>
</tr>
<tr>
<td>1.4</td>
<td>SIGNIFICANCE OF THE STUDY</td>
<td>11</td>
</tr>
<tr>
<td>1.5</td>
<td>OBJECTIVES OF THE STUDY</td>
<td>14</td>
</tr>
<tr>
<td>1.6</td>
<td>RESEARCH METHODOLOGY</td>
<td>15</td>
</tr>
<tr>
<td>1.6.1</td>
<td>Literature study</td>
<td>15</td>
</tr>
<tr>
<td>1.6.2</td>
<td>Best practice guidelines for the contingency management of health-related absenteeism</td>
<td>16</td>
</tr>
<tr>
<td>1.6.3</td>
<td>Empirical study</td>
<td>17</td>
</tr>
<tr>
<td>1.6.4</td>
<td>Population</td>
<td>18</td>
</tr>
<tr>
<td>1.6.5</td>
<td>Statistical analysis</td>
<td>18</td>
</tr>
<tr>
<td>1.7</td>
<td>ORGANISATION OF THE REMAINDER OF THE STUDY</td>
<td>18</td>
</tr>
</tbody>
</table>
CHAPTER ONE

INTRODUCTION, PROBLEM STATEMENT AND OUTLINE OF RESEARCH PROJECT

1.1 PROBLEM STATEMENT

South African businesses are recording a remarkable increase of absenteeism in the workplace (Gilchrist, 2003: 7). Hamilton-Atwell (2003: 56-61) and Finnemore and Weiss (1996: 27-29) are of the opinion that the years of isolation and lack of global competitiveness have made South African organisations complacent towards the high levels and costliness of absenteeism. The absence of an employee, whether due to illness or any other reason, is costly and disruptive, and a loss to the organisation. Actual cost can be calculated by considering all related expenses, such as temporary replacement and loss of productivity, and then adding 10 to 20 per cent to the calculated figure, depending on the skill level of the employee. The international norm for acceptable levels of absenteeism is three per cent of working time lost, but in a very competitive environment, which is driven by world standards, organisations should not be content with an average position. According to Hamilton-Atwell (2003: 58-59), a recent study done in South Africa, in which 14 major organisations participated, revealed absenteeism rates of between 5.1 and 21.6 per cent. Hamilton-Atwell attributed these variations to differences in absenteeism policies. She labelled levels of absenteeism of less than six per cent as excellent, and between six and 11 per
cent as reasonable, even though these levels are still above the international norm. The use of these alternative norms to evaluate absenteeism can be attributed to the impact of the South African labour legislation, which allows employees to take ample legitimate sick-leave. The financial consequences of absenteeism clearly indicate that it is imperative to take appropriate action to reduce legislation’s impact on absenteeism (Markowich & Eckberg, 1996: 115-120).

Many organisations diligently record absenteeism, but do not utilise the information as an analytical tool in solving problems. A statistic, often quoted by the IBM Corporation in New York, indicates that the average organisation uses only two to four per cent of the data that resides in its system. The paradox is that, although many managers do not use the information at their disposal, responses to a number of surveys have rated the improved monitoring and provision of absenteeism statistics to line managers as two of the most important factors in absenteeism control (Greengard, 1999: 103; Seccombe, 1995a: 1).

Annual absenteeism surveys conducted in Britain by the Confederation of British Industry (CBI) highlight the fact that absenteeism levels may differ according to region, industry, and the size of the business. Traditionally, absenteeism is worse in the public sector than in the private sectors, while small businesses report the lowest rates of absenteeism. A considerable variation was found among different regions (CBI absenteeism survey, 2001).

Absenteeism is a problem that has increasingly affected businesses in the Port Elizabeth-Uitenhage region (now called the Nelson Mandela Metropolitan
Municipality) and it is expected that the HIV/AIDS pandemic will aggravate this situation (Gilham, 2000: 17). The Port Elizabeth Regional Chamber of Commerce and Industry (PERCCI) has recently organised workshops and discussions in order to assist their members in the management of absenteeism (Marx, 2001). Delta, a motor manufacturing concern, reported an increase in family responsibility leave and unpaid leave, while Volkswagen South Africa (VWSA) indicated dissatisfaction with an absenteeism rate of 3.4 per cent during a time of the year in which low levels of absenteeism are normally experienced (Gilchrist, 2003: 9).

Traditionally, absenteeism has been regarded as a controllable behaviour that can be reduced to acceptable levels through accurate monitoring and corrective action. Van der Merwe and Miller (1988: 5) state that excessive absenteeism is regarded as withdrawal and delinquent behaviour. The implication is that employees want to withdraw physically and emotionally from the workplace due to work-related stress, and therefore abuse the absenteeism system of the organisation. This type of absenteeism can be controlled through adapting the organisational culture, management style and job design of employees.

Cole (2002: 7-8) highlights the following actions as best practices for addressing absenteeism:

- Work to get employer and employee buy-in;
- Design flexible work arrangements and/or telecommuting arrangements;
- Implement improved technology systems in order to capture appropriate absenteeism data;
• Create programmes that enable employees to manage their health and the health of their dependents;
• Administer ergonomic and/or safety programmes;
• Promote awareness of the importance of absenteeism programmes;
• Work with unions to develop mutually beneficial policies and programmes;
• Provide adequate, timely data and effective reporting of absenteeism;
• Publish consistent policies; and
• Increase supervisor involvement in return-to-work issues.

Considering human vulnerability to illness, a zero level of absenteeism is highly unlikely. The proliferation of diseases such as human immune virus/acquired immune deficiency syndrome (HIV/AIDS), cholera, tuberculosis (TB), cancer, malaria, flu, and mental diseases such as stress and depression is challenging the perception that absenteeism is completely controllable. In a country like South Africa, where sickness and recuperation are aggravated by extreme poverty levels, organisations are increasingly faced with staff shortages, productivity interruptions and inefficiencies due to lost labour that is the result of caring for families, attending funerals and providing child-care. It would, therefore, be in the interest of organisations to adopt meaningful and workable contingency strategies in order to maintain a stable and reliable workforce, and provide uninterrupted production and service provision. A report by the World Economic Forum presented at the Economic Summit in Durban on June 21, 2000 stated that businesses were playing down the effect of HIV/AIDS, and that they considered it more as a problem for the employee than for the organisation
The paradigm that exists is that HIV/AIDS is a humanitarian or public health issue rather than an issue which impacts on the bottom-line (Breuer, 2000: 52-55). A pandemic such as HIV/AIDS does not only affect sick-leave, but also authorised and unauthorised leave, such as in the situation when employees have to care for sick family members or attend funerals. A study done at a motor manufacturing concern in Port Elizabeth revealed that an absenteeism level of approximately 15 per cent and the lack of a workable contingency plan resulted in poor quality and low schedule attainment (Gie, 2000). Most businesses have no HIV/AIDS strategy in place, and ad-hoc education, awareness and treatment programmes are implemented without any impact analysis, stakeholder consultation, culture alignment, study of socio-economic conditions or plan to measure the results (Gibson, 2004).

The financial burden that comes with the management of HIV/AIDS is a major concern for business. In this regard, Taylor (2001: 42) states that much less strain will be placed on disability insurance funds if the health of an employee is maintained for as long as possible through medical science intervention. In this way, the individual can continue to function as an employee, in society and as co-contributor to his/her benefit package. According to Taylor, the health recovery prognosis for blue-collar employees might be lower, as they often are not able to afford the comprehensive benefits of a 100 per cent medical aid scheme and are therefore excluded from professional medical intervention.

In a quest to manage absenteeism and physical incapacity more constructively, many new intervention trends are emerging. These strategies include an emphasis on counselling (rather than discipline), flexible work arrangements,
wellness programmes, return-to-work rehabilitation programmes for sick employees, disease educational programmes, alternative leave provisions, and the provision of health-care. Taylor (2001: 44) proposes that organisations adopt innovative solutions to meet staff needs, while keeping costs within desirable limits.

In addition, many organisations embark on alternative labour provision strategies, such as subcontracting and outsourcing, as a means to reduce human resource management responsibilities and ensure a stable labour supply. Strategies such as these might pose implications for industrial relations and human rights issues (Taylor, 2000: 44). Another contingency measure, the parallel training of technical staff, is recommended for maintaining an undisturbed workflow during periods of absenteeism due to health-related issues (Breuer, 2000). Parallel training implies multi-skilling to ensure that employees are more interchangeable.

Organisational strategists must take cognizance of legislation that lays the foundation for any strategy aimed at managing uncontrollable absenteeism and maintaining a stable workforce. There are a number of laws and codes of good practice that employers must abide by. The Basic Conditions of Employment Act (No 75 of 1997) regulates work hours and leave, including sick-leave, maternity leave and family responsibility leave. The Employment Equity Act (No 55 of 1998) promotes equity and non-discrimination (Sono & Werner, 2004: 171). The Government has also published a Code of Good Practice on HIV/AIDS and Employment. This code provides parameters for organisations in terms of the strategies that they can utilise in the general and contingency management of HIV/AIDS-related absenteeism (Government Gazette, April 2000).
This introduction offers the basis for the exploration of the main problem of this proposed study:

**What contingency strategies can be utilised by organisations to manage health-related absenteeism?**

An analysis of the main problem allows identification of the following sub-problems:

**SUB-PROBLEM 1**

What is the impact of health-related issues and absenteeism on organisations?

**SUB-PROBLEM 2**

Which contingency management strategies can be utilised by organisations in order to reduce health-related absenteeism?

**SUB-PROBLEM 3**

Which contingency management strategies can be utilised by organisations to maintain undisrupted production and provision of services in the face of absenteeism?
SUB-PROBLEM 4

To what extent do organisations utilise effective contingency strategies to reduce health-related absenteeism?

SUB-PROBLEM 5

To what extent do organisations utilise effective contingency strategies to maintain undisrupted production and provision of services?

The main focus of this study was on the contingency strategies utilised by organisations to reduce the immediate and emerging disruptive effect of health-related absenteeism in the workplace.

1.2 KEY CONCEPTS

For clarification, the main concepts used in this study are defined. The rationale behind these concepts are explained in paragraph 2.2 in Chapter two.

1.2.1 Absenteeism

Absenteeism is defined as non-attendance when an employee is scheduled to work, regardless of the reason for absence (Van der Merwe & Miller, 1988: 3).
1.2.2 Sick-absence

Sick-absence is any unscheduled and reported absence that is attributed to physical illness, disease or injury, whether real, imagined or feigned.

1.2.3 Health-related absenteeism

Health-related absenteeism refers to any unscheduled and reported absence that is the result of genuine physical illness, condition, disease or injury.

1.2.4 Presenteeism

Presenteeism refers to when employees are present at work, but do not perform to optimal levels.

1.2.5 Contingency management

A contingency is defined as any event that could or could not happen in the future (Oxford Advanced Learner’s Guide, n.d.). Contingency management involves the consideration of, and planning for, an event that could or could not happen in the future.
1.3 DELIMITATION OF THE STUDY

The theoretical component of the study was restricted to health-related absenteeism. Delinquent absenteeism due to dissatisfaction in the workplace was excluded as it does not form part of the scope of this study.

The empirical component of the study was restricted to organisations in the automobile and automobile component industry in the following areas:

- The Nelson Mandela Metropolitan Municipality; and
- Buffalo City Metropole.

Both these areas fall within the Eastern Cape Province of the Republic of South Africa.

1.4 SIGNIFICANCE OF THE STUDY

Absenteeism in the workplace is not a new problem. It has been researched, written about and has appeared in articles in journals many times, over many decades. Various factors necessitate the ongoing research of this phenomenon:

- Historical studies mainly consider the causes of delinquent absenteeism and corrective or disciplinary strategies that can be used to reduce it. The contingent management of health-related absenteeism, focussing on maintaining undisrupted production and service provision and/or retaining the skills and abilities of a sick employee as far as possible, has been neglected.
• Various sources (Gilchrist, 2003: 7; Hamilton-Atwell, 2003: 58-59; Werner, 2004: 548) indicate that absenteeism is still a prevalent problem, not only internationally, but also locally. The Port Elizabeth Regional Chamber of Commerce and Industry (PERCCI) presents workshops for its members in a continuous quest to find workable solutions to this problem (Marx, 2001). PERCCI has also formed an absenteeism forum to deal with health-related absenteeism.

• Companies operate in a changing political, social, economic and technological environment. These changes are, amongst others, reflected in the Basic Conditions of Employment Act (No 75 of 1997), which makes provision for basic rights in terms of leave and the Code of Good Practice on the Employment of People with Disabilities. Renewed emphasis placed on work-life balance and flexibility in employment practices challenges traditional absenteeism policies. According to Levine Associates (2000: 3), the challenge is to create fair policies that take employees’ changing needs, with regard to their personal and family life, into account.

• Absenteeism is set to increase as a result of the HIV/AIDS pandemic and other related illnesses. This could lead to reduced work performance and lower productivity. Statistics made available by the Health Department show that as much as 20 per cent of South Africa’s economically active population may be HIV-positive (Gilham, 2000: 17). In 2000, 12 138 new cases of TB were diagnosed in Gauteng alone (Gauteng Health Department, 2001). Bruton, of Tendline Dynamics, a leading motor business analyst, has suggested that the automotive industry should tackle the HIV/AIDS issue. Bruton highlighted the direct costs of
HIV/AIDS, as well as systemic costs, such as the loss of workplace cohesion and the effect on workforce performance and experience (New initiatives to tackle AIDS in the South African Motor Industry, 2001). The Government has published a Code of Good Practice on Key Aspects of HIV/AIDS, which provides parameters for organisations in terms of the strategies that they can utilise in the management of HIV/AIDS-related absenteeism (Government Gazette, 2000). Organisations have to adopt workable solutions to manage the consequences that are attached to HIV/AIDS. The parameters set in the above-mentioned code can be explored as a means to find guidelines for the general management of health-related absenteeism.

- An overview of the related literature revealed a lack of integrated information on organisational policies, specifically regarding the contingency management of health-related absenteeism with the aim of maintaining an undisrupted workflow. Organisational policies are often fragmented and contradictory (Moodley, 2003).

The above points illustrate the need for research into health-related absenteeism management strategies. They also emphasise the contribution that this study can make towards identifying practices that can reduce unnecessary absenteeism and that are aimed at maintaining desirable workforce strengths to ensure undisrupted production and service provision. The results may also have implications for strategies utilised to maintain a stable workforce in the event of high labour turnover as a result of illness.
The results of this study may be used by:

- Line managers responsible for manufacturing, production, sales or services;
- Human resource practitioners responsible for the overall organisational absenteeism management strategy and the implementation thereof;
- Labour relations practitioners in negotiating agreements with trade unions and employee representatives;
- The government, in its quest to ensure fair labour practices and preserve economic strength; and
- Others, such as financial and medical institutions, who are involved in developing broad strategies related to the management of HIV/AIDS and other health-related problems on a personal and organisational level.

1.5 OBJECTIVES OF THE STUDY

The study was aimed at achieving the following objectives:

OBJECTIVE 1

To determine the extent to which organisations experienced health-related absenteeism.
OBJECTIVE 2

To develop a theoretical framework for the contingency management of health-related absenteeism in the workplace, that can be utilised as a model for assessing the current strategies employed by organisations to maintain a stable supply of productive labour and undisrupted production and provision of services.

OBJECTIVE 3

To determine the extent to which organisations follow the theoretical guidelines for maintaining a stable workforce supply in the face of high levels of absenteeism.

1.6 RESEARCH METHODOLOGY

The following procedure was followed in order to achieve the goals of the research:

1.6.1 Literature study

A literature study of published, unpublished and electronic texts and studies that were relevant to the topic was undertaken. The purpose of the literature study was to research contemporary thinking regarding the contingency management of health-related absenteeism in organisations. The researcher found that little attention was given to health-related absenteeism in existing literature, especially
in comparison to delinquent absenteeism. As a result of this discovery, the researcher had to explore additional and alternative means of finding information and therefore attended seminars, workshops and meetings where issues applicable to the study were discussed. The researcher also had personal communications with a number of experts in the fields of medicine, human resource management and law.

1.6.2 Best practice guidelines for the contingency management of health-related absenteeism

Best practice guidelines for the contingency management of health-related absenteeism were developed through a synthesis of existing theory. The development of these best practice guidelines were based on:

- The identification of the key elements of a contingency approach to management;
- The identification of key features of an absenteeism recording and monitoring system that is aimed at the provision of accurate and timely information to management with regard to the nature and scope of absenteeism in the organisation;
- The comparison of available absenteeism statistics in order to indicate the prevalence of health-related absenteeism;
- The identification of current and future health risks which may impact on absenteeism levels in the organisation;
• The verification of the legal parameters pertaining to the contingency management of health-related absenteeism within which organisations are restricted;
• The identification of the key features of a contingency management strategy aimed at reducing absenteeism levels by focussing on the health and well-being of employees; and
• The identification of the key features of a contingency management strategy aimed at ensuring the continuation of undisrupted production and service provision in the face of increased health-related absenteeism.

1.6.3 Empirical study

Empirical data required to achieve the research objectives was obtained by means of a scientifically developed questionnaire that was administered to senior human resources practitioners in organisations in the automobile and automobile component industry.

The questionnaire was subdivided into four sections:

• Biographical data;
• The management of health-related absenteeism;
• The promotion of corporate health to prevent absenteeism; and
• The continuity of production and service provision in the face of increasing absenteeism.
1.6.4 Population

The population consisted of all automobile and automobile component companies in the Nelson Mandela Metropolitan Municipality and the Buffalo City Metropole that employed more than fifty employees. A total of seventy companies met the criteria for the study. The questionnaire was administered to one senior human resources practitioner in each company.

1.6.5 Statistical analysis

Descriptive and cross-classification comparative statistical methods were used for the analysis and interpretation of the data contained in the questionnaire.

1.7 ORGANISATION OF THE REMAINDER OF THE STUDY

In Chapter one, the problem statement, delimitation of research area, significance, study objectives and research methodology of the study were stated. Chapter two explores the impact of health-related issues and health-related absenteeism on organisations. The legal parameters for managing this phenomenon are investigated and the importance of a contingency approach is considered.

Chapter three is dedicated to a discussion of the contingency management approaches aimed at controlling absenteeism levels and promoting a healthy
workforce. Specific issues that receive attention are work-place policies, health benefits, rehabilitation, return-to-work and employment assistance programmes.

Chapter four focuses on contingency management approaches aimed at ensuring continuity of production and service provision. The necessity of careful manpower planning is indicated and various alternative skill supply strategies are investigated. Attention is also given to maintaining undisrupted production and service provision in the face of increasing absenteeism levels.

Chapter five contains a strategic model for the contingency management of health-related absenteeism based on the data presented in Chapters two, three and four. In Chapter six, the design of the field study is discussed and in Chapter seven the results of the study are presented and analysed, and in Chapter eight, final conclusions and recommendations are offered.
# CHAPTER TWO

THE SCOPE AND IMPACT OF HEALTH-RELATED ABSENTEEISM ON ORGANISATIONS

## 2.1 INTRODUCTION

## 2.2 HEALTH-RELATED ABSENTEEISM CONTEXTUALISED

## 2.3 THE EXTENT AND NATURE OF HEALTH-RELATED ABSENTEEISM IN SOUTH AFRICAN ORGANISATIONS

2.3.1 Mental-health diseases / stress

2.3.2 Trauma

2.3.3 Substance abuse

2.3.4 Tuberculosis (TB)

2.3.5 Malaria

2.3.6 Respiratory diseases

2.3.7 Injury/musculoskeletal conditions

2.3.8 Cancer

2.3.9 Health risk factors

2.3.10 HIV/AIDS

2.3.10.1 The prevalence of HIV/AIDS in South Africa

2.3.10.2 The general impact of HIV/AIDS on the economy and on organisations

## 2.4 THE IMPACT OF ABSENTEEISM ON THE PRODUCTIVY LEVELS OF EMPLOYEES

## 2.5 THE FINANCIAL IMPLICATIONS OF ILL-HEALTH AND ASSOCIATED ABSENTEEISM

## 2.6 LEGAL PARAMETERS FOR THE MANAGEMENT OF HEALTH-RELATED ABSENTEEISM

2.6.1 Basic Conditions of Employment Act (No 75 of 1997)

2.6.2 Employment Equity Act (No 55 of 1998)

2.6.3 Labour Relations Act (No 66 of 1995)

2.6.4 Code of Good Practice on the Employment of People with Disabilities

2.6.5 Occupational Health and Safety Act (No 85 of 1993)
2.6.6 Legal and contractual boundaries for the Employee Assistance Programme (EAP) 79
2.6.7 Code of Good Practice on HIV/AIDS and Employment 80

2.7 THE MERITS OF ADOPTING A CONTINGENCY APPROACH TO THE MANAGEMENT OF HEALTH-RELATED ABSENTEEISM 82
CHAPTER TWO

THE SCOPE OF AND IMPACT OF HEALTH-RELATED ABSENTEEISM ON ORGANISATIONS

2.1 INTRODUCTION

Chapter one provided an overview of the study through a presentation of the problem statement, delimitation of the research area, discussion of the significance of the study, study objectives and research design. In the problem statement, it was indicated that the proliferation of various diseases is expected to have an escalating effect on absenteeism levels in organisations and that organisations will have to adopt meaningful contingency strategies in order to combat the negative effects on production and service provision. The objective of this study is to determine the impact of health-related absenteeism on organisations, and to explore the extent to which organisations engage in meaningful contingency management approaches aimed at maintaining a healthy workforce and ensuring undisrupted production and service provision.

In this chapter, the scope and impact of health-related absenteeism will be explored. The extent of the problem, as well as its effect on production and service provision, will be elaborated on as contained in the literature dealing with absenteeism. Attention will be given to the financial implications of health-related
absenteeism, as well as the legal parameters within which this phenomenon should be managed. The discussion will conclude with a presentation of the merits of adopting a contingency approach in the management of health-related absenteeism.

2.2 HEALTH-RELATED ABSENTEEISM CONTEXTUALISED

The aim of this section is to consider the merits of distinguishing health-related absenteeism from other forms of absenteeism. From the discussion, it will become evident that, with regard to the management of absenteeism, most authors focus on delinquent absenteeism and measures aimed at dealing with delinquent absenteeism only. Authors such as Levine Associates (2000: 2-4), Mathis and Jackson (2000: 91) and van der Merwe and Miller (1988: 10) treat absenteeism mostly as withdrawal behaviour and a symptom of job dissatisfaction rather than the result of genuine illness. Subsequently, the corrective actions proposed by these authors focus on control and disciplinary action and not the management of health-related matters. While the abovementioned authors focus mostly on absenteeism as withdrawal or delinquent behaviour which requires discipline and control, little or no attention is given to the contingency management of health-related absenteeism. The researcher aimed at addressing this deficiency with this study.

Levine Associates (2000: 2) define an absence as any time that an employee is not on the job during scheduled working hours. They exclude granted leave of absence, holiday or vacation time from the definition, as these incidents cover
situations where an employee is not scheduled to report for duty. Levine Associates (2000: 2) do not encourage organisations to distinguish between various absenteeism categories such as sick-absence, authorised absence and unexcused absence, as it unnecessarily complicates administration and monitoring. They consider an absence as an absence regardless of the reason and suggest that once an employee has exceeded the number of days allowed for absenteeism, his/her services are to be terminated. This no-nonsense approach to the management of absenteeism is generally known as a no-fault policy. Levine Associates refer to studies that have identified the main causes of absenteeism according to five different categories although they do not indicate the source of their statistics (refer to Table 2.1).

**Table 2.1:** Five major categories of absenteeism as identified by various surveys

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness</td>
<td>45%</td>
<td>21%</td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td>Family issues</td>
<td>27%</td>
<td>25%</td>
<td>64%</td>
<td></td>
</tr>
<tr>
<td>Personal needs</td>
<td>13%</td>
<td>20%</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>Feel entitled</td>
<td>9%</td>
<td>17%</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Stress</td>
<td>6%</td>
<td>17%</td>
<td>11%</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** CCH, 2003; Levine Associates, 2000: 4; Mathis and Jackson, 2000:91
These authors’ approach to the management of absenteeism is based on the notion that 50 per cent of all absenteeism is due to reasons other than genuine illness, and that most of those who report absent due to “genuine illness” stay away as a result of poor physical working conditions and poor supervision. They pay no attention whatsoever to the management of absenteeism related to genuine health-related matters or to the impact of work-related stress. This line of thinking is similar to that of most other authors.

Mathis and Jackson (2000: 91) do not define the word “absenteeism” as such, but utilise the term “unscheduled absences”, which emphasises the disruptive nature of absenteeism. These authors distinguish between voluntary and involuntary absenteeism. Involuntary absenteeism refers to genuine illness and family issues that make it impossible for employees to attend, while voluntary, unscheduled absenteeism refers to delinquent absenteeism. Mathis and Jackson (2000: 91) provide various strategies to deal with voluntary absenteeism, including discipline and positive reinforcement, but do not provide any guidelines for dealing with genuine illness that prevents the employee from assuming his/her normal duties in the normal way. They cite absence categories from a study, which covered more than 400 firms in the United States of America (USA), conducted in 1998 by CCH Incorporated (CCH), an employment law and human resources software provider – refer to Table 2.1. These absence categories are the same as those indicated by Levine Associates. In a similar study done by CCH in 2001 and 2002, illness accounted for 32 and 33 per cent of all absence, an increase of respectively 11 and 12 per cent from the 1998 survey (CCH, 2001a; CCH, 2002). Reasons, other than personal illnesses,
indicated in the 2002 survey were family issues (24%), personal needs (21%), stress (12%) and entitlement mentality (10%). Entitlement mentality refers to employees perceiving sick-leave as an employment benefit that should be used. In 2003, absenteeism levels in the USA dropped to an all-time low average of 1.9 per cent, while family issues as a reason for absence have increased. The decline in absenteeism levels is attributed to a tougher economic climate in the USA (CCH, 2003).

Although these studies were conducted in the USA, it can be argued that they are relevant in a South African context as they illustrate the reality that people are absent from work as a result of delinquent and health-related issues such as illness and stress, amongst others. Knowing the reason for absenteeism could assist an organisation in identifying suitable strategies for dealing with it.

Table 2.1 provides an example of how absenteeism can be categorised. However, there are other ways of categorising absenteeism which are explored below. According to van der Merwe and Miller (1988: 10), sick-absence is seldom well-defined in studies, but would normally include all genuine health-related absences for which an organisation would require a medical certificate and for which an employee could claim benefits. It could also include one- or two-day absences for which employees may not be required to submit medical certificates. These authors acknowledge that sickness may be feigned or imagined in order for the employee to withdraw from an unpleasant work environment. They distinguish between sick-absence, authorised absence and unexcused absence. Authorised absence is any absence not related to the health of the employee, that is allowed by management, while unexcused
absence is any absence for which the employee did not provide an excuse, or, if the employee did provide an excuse, it was rejected. Making a distinction between the different categories of absence provides the basis for the analysis and control of absenteeism. It allows the administrator to pinpoint the problem areas and to identify delineating trends. Although these authors recommend that organisations should verify whether or not sick-absence is caused by the physical work environment, they give no other recommendations for dealing specifically with employees who are prevented from attending work as a consequence of genuine health-related issues. They merely suggest medical certificates be examined, the employee briefly interviewed to obtain relevant information and the medical certificate filed.

Burton (1999: 1) distinguishes between absenteeism (scattered absences), short-term disability (absenteeism of a longer duration) and presenteeism (being at work, but not performing up to standard). The distinction between scattered absences and short-term disability is important, as it has implications for the way in which absenteeism is measured. Paragraph 3.3.2 deals with the measurement of absenteeism, and the reader will notice that the absence frequency rate (AFR) is used to measure the disruptiveness of absenteeism. Scattered absences are regarded as more disruptive than short-term disability, as the former requires more contingency management. Presenteeism is also important to the study of absenteeism and wellness in an organisation, as it could indicate future absenteeism. Low job performance could be the result of poor physical strength which precludes the identification of an illness.
Cunningham and James (2000) note that, from both an academic and practical perspective, current literature pays little attention to the management of genuine injury and sick-absence. They also mention that a Labour Force Survey done by the USA government during the period 1987-1991 revealed that 42 per cent of most recent incidents or spells of absenteeism were of more than six-days’ duration and that 32 per cent were of more than two-weeks’ duration. These statistics imply that most days that were lost, were due to lengthy spells of absence, which are normally, although not exclusively, related to genuine illness. In addition, Cunningham and James (2000) note that, because a large proportion of short incidents or spells of absenteeism are also due to genuine illness, management’s corrective action, normally carried out from a disciplinary perspective, is misdirected. Van der Merwe and Miller (1988: 24) are of the opinion that delinquent absences are recognisable as they mostly occur in a recognisable pattern, while absences due to genuine illness appear randomly and are often of a longer duration. This notion, that shorter absences are mostly delinquent, is challenged by Zeelie (2003), who is of the opinion that HIV/AIDS will impact on the normal nature and occurrence of absenteeism, and that as a result, more absences of a shorter duration can be expected in the coming years in South Africa.

The European Report on health and safety in the workplace argues that, although ill-health is the main cause of workplace absenteeism, relatively few organisations address the issue systematically. This is despite the fact that employers, as well as employees, are increasingly confronted with the cost of workplace absenteeism and work incapacity (European Report, 1998).
In conclusion, most studies that address absenteeism, address it from the perspective that absenteeism is mostly a delinquent behaviour and that corrective measures should be developed from a disciplinary and monitoring perspective. Sick-absence is mostly considered as a smokescreen to escape from an unsatisfying work environment. Little or no attention is given to genuine illness or the impact of stress on attendance levels. The purpose of this study is to overcome this deficiency in current literature and research.

*Health-related absenteeism*, for the purpose of this study, is defined as any unscheduled and reported absence that is attributed to genuine physical or mental illness, condition, disease or injury. The focus of this study is therefore on genuine health-related matters that cause absenteeism and not the abuse of the sick-leave system.

The distinction between various categories of absenteeism allows the organisation to pinpoint problems and trends. In the case of health-related absenteeism, it allows the organisation to monitor the absence of employees due to health-related matters, so that appropriate corrective actions and contingency plans can be developed.

### 2.3 THE EXTENT AND NATURE OF HEALTH-RELATED ABSENTEEISM IN SOUTH AFRICAN ORGANISATIONS

The purpose of this section is to present a realistic scenario of the state of health of the South African workforce and the impact that it has on absenteeism and the
continuous delivery of products and services. Leads were taken from various South African and international sources to determine which health issues are relevant and regarded as having a significant impact on absenteeism levels in organisations.

Makgoba (2001), previously president of the Medical Research Council (MRC) of South Africa, described HIV/AIDS, tuberculosis, telemedicine, malaria, crime violence and injury as “national priorities”.

According to Zeelie (2003), many organisations are currently experiencing high levels of absenteeism as a result of stress. A CBI (Confederation of British Industry) absenteeism survey showed that while long-term physical illness is more associated with manual employees, stress and recurring illness are more associated with non-manual employees (CBI, 2001).

Moodaley (2003), a private medical practitioner, confirms that stress, substance abuse and respiratory diseases are major health factors that impact negatively on attendance in organisations. Moodley is of the opinion that psychological counselling, substance abuse programmes and the following up of patients at work by a professional nurse are the best ways to curb health-related absenteeism in organisations.

According to Blott (2003), a medical practitioner and consultant to 22 companies in the Nelson Mandela Metropole, the most reported reasons for absenteeism are flu, backache, stress/depression and gastro. Blott is of the opinion that the high levels of absenteeism are due to employees who abuse sick-leave
provisions and that companies who exert stricter control experience lower levels of absenteeism. However, at the same time, he indicated that the effects of HIV/AIDS on attendance levels are becoming more and more evident in organisations in the Nelson Mandela Metropole.

A study conducted by Bank One and the Medical Research Unit of the University of Michigan in the USA revealed typical health problems that lead to absenteeism in organisations. The study investigated the effect of the following diseases/conditions on absenteeism, short-term disability and presenteeism: digestive diseases, mental-health diseases, respiratory diseases, injury, musculoskeletal conditions and cancer. In addition, it was found that health risks such as smoking, lack of exercise, failure to wear a seatbelt, exposure to violence, psychological distress, diabetes, high blood pressure, high cholesterol and elevated body mass index (obesity) also increased absenteeism in organisations (Burton, 1999). Although this study was conducted in the USA, the findings could be relevant to the South African situation as many of these conditions such as diabetes, high blood pressure, high cholesterol, stress and exposure to violence also receive prominent attention in South Africa. The main findings of this study are discussed in paragraph 2.4.

In Chapter one, it was mentioned that, even though HIV/AIDS has been labelled as the biggest health threat to organisations, many businesses are still in denial and do not actively respond to this challenge. Daly (2000) states that it is essential to make organisations aware of the severity of the impact of HIV/AIDS on business in order for them to respond effectively. A more detailed discussion
of health-related issues, which impact on absenteeism levels in organisations, is presented below.

2.3.1 Mental-health diseases / stress

Stress is defined as a physical and psychological reaction to stressors in the internal and external environment. Although a certain level of stress is considered as positive for creativity and achievement (eustress), prolonged stress (distress) can result in negative physical, emotional, cognitive and behavioural consequences for the individual (Bergh & Theron, 2003: 398, 433). Cardiovascular disease is one of the leading causes of death in South Africa and is related to, amongst others, high levels of anxiety, anger and hostility, as well as high strain jobs (Bergh & Theron, 2003: 404).

Stress is not only a South African, but also an international problem. For this reason, international studies could contribute to understanding the general nature of stress and finding suitable remedies. According to the CCH Unscheduled Absence Survey conducted in the USA, stress has seen an increase of 316 per cent as a reason for unscheduled absenteeism (CCH, 2003). These high levels of stress are linked to high productivity demands, and the significantly less vacation leave available to US employees in comparison to employees in other countries (Lippman, 2001; Putting brakes on employee absenteeism, 2000). A Canadian organisation that specialises in employee benefits reports that emotional factors account for 61 per cent of time lost through absenteeism and considering that 15 per cent of the workforce causes 90 per cent of all absenteeism, this problem could be brought under control (Benefits Interface
Incorporated, n.d). A Canadian webportal reports a national absenteeism average of four per cent and attributes most absenteeism to stress as a result of downsizing and family problems. Families face more stress in an economic reality of dual-career couples (Absenteeism on the job: what are companies doing about it?, 2003).

A study conducted on sick-absence and health in the national health sector in England indicated that the two most often reported reasons for sick-absence among nurses were increased pressure of work/stress and organisational change. The study indicated that the most widely recognised strategy for reducing absenteeism was seen as internal organisational control, that is taking a corrective or disciplinary approach to the problem (Seccombe, 1995b: 6-8).

According to Vinassa (2003: 21), a South African author, occupational health statistics indicate that approximately 80 per cent of doctor’s visits are for stress-related conditions, while 50 per cent of illnesses are lifestyle-related.

Stress has also become characteristic of the South African workforce. Rabe (2001: 48) cites research that indicated that 30 per cent of absenteeism problems were due to bad relationships within families while mental and emotional issues accounted for 23 per cent of sick-leave reasons (Rabe, 2001: 48).

Vinassa (2003: 20) identified the following key stressors in South African organisations:

- The perpetual pressure for change and reorganisation in the workplace;
- Interpersonal relations among workers, especially as a consequence of
restructuring, and flatter organisational structures;

- Critical incidents such as crime and natural disasters; and
- Family-related problems.

Gilchrist (2003: 20) supports this view by indicating downsizing, operational pressures and poorly thought through decisions regarding placements and promotions, as major causes of stress in South African organisations. Hamilton-Atwell (2003: 58) states that organisational restructuring results in an initial reduction of absenteeism, as people try to prove that they are indispensable, but as soon as they settle in the new structure of the organisation, absenteeism increases again.

One study drew attention to the possible effect of change and reorganisation in the workplace on stress and subsequently absenteeism levels. According to this study, absenteeism levels of 15 per cent per day were evident in an organisation that switched to a team-based system. This study was conducted at a motor manufacturing concern in the Nelson Mandela Metropole. The high absenteeism levels had serious implications for quality and schedule attainment (Gie, 2000: 95).

In conclusion, employees in South Africa are increasingly exposed to various stressors in and outside the work environment. Stress results in physical, cognitive, emotional and behavioural consequences for the individual. Absenteeism is a behavioural consequence which affects productivity and continuity in the workplace. It is therefore necessary for management to consider the sources of stress in the workplace and provide mechanisms to deal with it.
2.3.2 Trauma

Freeman (2004b: 8) defines trauma as physical and psychological damage that results from injury. General trauma includes events such as death, suicide, violent crime, rape, sexual assault and harassment, HIV/AIDS, road accidents, divorce, miscarriage and natural disasters. Examples of workplace trauma include shooting incidents, industrial accidents, robberies, road accidents and distressing sights, bullying and sounds or orders that trigger an emotional response. Trauma results in a broad range of physical, emotional, cognitive and behavioural consequences.

Freeman (2004b: 5) provides the following statistics related to loss and trauma in South Africa:

- Approximately 70 000 South Africans are killed traumatically every year with 3.5 million seeking health-care as a result of trauma;
- One in every 15 South Africans will get injured;
- One in every 63 South Africans will become victims of violent crime;
- Eighty per cent of trauma patients resort to substance abuse in some form;
- Thirty-one South Africans die from firearm wounds every day; and
- Violence is cited as the reason for proceedings in forty per cent of divorce cases.

There is currently an increased demand for proactive crime prevention workshops in South African, which includes anti-hijacking, rape prevention and
coping with rape modules (Vinassa, 2003: 21). Post-traumatic stress disorder occurs during, immediately after, or some time after a stressful situation such as a rape or a robbery. Absenteeism could be a behavioural indication of burnout, a term that implies post-traumatic stress (Bergh & Theron, 2003: 405, 433).

It is therefore evident that trauma is characteristic of the South African situation. Trauma results in a wide range of physical and emotional symptoms and subsequently increases absenteeism in the workplace.

### 2.3.3 Substance abuse

Substance abuse is defined as the use of illegal substances or the misuse of controlled substances, alcohol, or other drugs (Mathis & Jackson, 2000: 552). Freeman (2004a: 5) provides the following statistics regarding substance abuse in South Africa:

- Sixty per cent of substance abusers are employed;
- Substance abusers are five times more likely to claim workman’s compensation;
- Substance abusers incur 300 per cent more health costs;
- Almost half of male prisoners reported that they used alcohol or drugs just before committing the offence for which they are imprisoned;
- A third of alcohol consumers engage in risky alcohol consumption during weekends;
- Half of all fatal and traumatic injuries in South Africa are alcohol-related; and
• White females older than 30 years are the most frequent abusers of over-the-counter-drugs.

According to Schultz (2004a: 295), alcoholism is a serious and widespread disease. Freeman (2004a: 25) states that no occupational or demographical group is immune to the abuse of drugs and alcohol. Substance abuse results in physical, emotional, cognitive and behavioural consequences, including workplace violence, accidents and absenteeism. Substance abuse is also linked to stress in the workplace (Bergh & Theron, 2003: 408).

Freeman (2004a:25) highlights the following consequences of substance abuse in the workplace:

• Health-related problems;
• Higher absenteeism and excessive use of sick-leave;
• A loss of productivity;
• Workplace accidents; and
• Increased costs due to employee replacements and treatment of the disease.

It is therefore clear that substance abuse is a problem faced by organisations in South Africa. It is a health-related issue that is not only affecting absenteeism and productivity in the workplace, but also the financial resources of an organisation. Organisations should not only focus on rehabilitation, but also the prevention of substance abuse.
2.3.4 Tuberculosis (TB)

TB is a disease that is spread through the air by a person with tuberculosis of the lung. Small droplets of infected sputum are coughed into the air and breathed in by other people. The symptoms of TB may include a persistent cough of more than 3 weeks, feeling weak or sick, weight loss, night sweats, chest pain or coughing up blood (Patrick, 2003). TB is very contagious, and the potential of transmission of the disease in the workplace is very high. However, once a person is on treatment, he/she can no longer infect others. Deferred treatment results in escalating costs and a slower recovery (Gauteng Health Department, 2001).

A major problem experienced with TB patients is that at least three people are infected before treatment is commenced and that those who do not adhere to the medication regimen, can infect up to ten others (Patrick, 2003). It is imperative that infected people follow through with treatment, as the effectiveness of the bacterial strains of the medicine is reduced by non-adherence to treatment procedure.

MRC statistics indicate that 362 out of every 100 000 South Africans are diagnosed with TB. Not all areas in South Africa are evenly affected. Table 2.2 shows the prevalence of TB infection in South Africa. As can be derived from the table, people in Kwa-Zulu Natal and Mpumulanga are most affected by this disease. The prevalence of TB in the Eastern Cape area is 20.4 per cent. In areas where there is a greater prevalence of TB, more intensive interventions are required.
Table 2.2: The prevalence of TB in South Africa

<table>
<thead>
<tr>
<th>Provinces</th>
<th>TB incidence per 100 000 people</th>
<th>Estimated TB cases</th>
<th>Proportion of TB cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>504</td>
<td>34 371</td>
<td>20.4%</td>
</tr>
<tr>
<td>Free State</td>
<td>282</td>
<td>8 272</td>
<td>32.1%</td>
</tr>
<tr>
<td>Gauteng</td>
<td>375</td>
<td>26 378</td>
<td>25.2%</td>
</tr>
<tr>
<td>Kwa-Zulu Natal</td>
<td>381</td>
<td>34 178</td>
<td>45.0%</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>286</td>
<td>8 716</td>
<td>39.5%</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>340</td>
<td>2 675</td>
<td>13.6%</td>
</tr>
<tr>
<td>Northern Province</td>
<td>260</td>
<td>13 927</td>
<td>16.7%</td>
</tr>
<tr>
<td>North West</td>
<td>271</td>
<td>9 557</td>
<td>25.9%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>559</td>
<td>20 615</td>
<td>12.0%</td>
</tr>
<tr>
<td>South Africa</td>
<td>362</td>
<td>158 689</td>
<td>27.0%</td>
</tr>
</tbody>
</table>

Source: Medical Research Council of South Africa, 1997

About three quarters of TB victims are in the most economically active group – 15 to 54 years old (Maher, Boldrini, Pathania, Alli, Gabriel, Kisting & Norval, 2003: 7, 35-36). TB is a workplace issue as it affects productivity through the loss of skills and experience, absenteeism, disrupted production and service provision and escalating costs. A publication by the World Health Organisation (WHO) and the International Labour Organisation (ILO) on TB uses a South African case study to illustrate the benefits of a TB workplace programme. According to this publication, prior to the implementation of a TB control programme, TB had cost AngloGold US$ 2775 per case, with a further US$ 410 per lost shift due to absenteeism. After the introduction of a TB control
programme, the cost was reduced to only US$ 90 per employee per year and a US$ 150 saving was made through the prevention of active TB among HIV-positive employees (Maher, Boldrini, Pathania, Alli, Gabriel, Kisting & Norval, 2003: 7, 35-36).

Although HIV/AIDS is comprehensively discussed in paragraph 2.3.10, it is important to note that TB and HIV/AIDS are considered as an explosive combination. HIV/AIDS reduces a person’s immunity and therefore makes him/her more susceptible to TB (Gauteng Health Department 2001). It is for this reason that companies, such as AngloGold, have introduced their TB management programme in tandem with their HIV/AIDS management programme.

Considering that the largest proportion of TB sufferers are from the most economically active group (15 – 45 years old), and that approximately 27 per cent of people are infected (refer to Table 2.2) with TB, it clearly becomes a workplace issue. Early diagnosis and regular treatment will reduce the affect this disease has on absenteeism levels in organisations.

2.3.5 Malaria

According to the MRC of South Africa, malaria is, alongside TB and HIV/AIDS, one of the main death causing diseases in Africa (MRC of South Africa, 2001). Approximately 300 to 500 million people are annually treated for malaria. Ninety per cent of these cases occur in sub-Saharan Africa. Malaria is a disease caused mainly by the parasite Plasmodium falciparum. The parasite is
transmitted to humans by the female anopheles mosquito. The main areas in South Africa that are exposed to malaria include Mpumalanga, Northern Province and the northeastern parts of Kwa-Zulu Natal. Malaria transmission in South Africa is seasonal with the greatest number of cases occurring between October and May. With the advent of malaria drug resistance, prompt diagnosis is a crucial component of malaria control and patient management. Women are four times more likely to die of malaria than men.

Malaria is not a problem in all areas of South Africa. The Eastern Cape, for example, is not affected by malaria. Education about this disease should therefore be aimed at employees who need or want to travel to malaria areas. However, malaria could affect the levels of absenteeism in organisations that are exposed to this disease.

2.3.6 Respiratory diseases

Respiratory diseases include diseases such as asthma, bronchitus and flu. Asthma is a chronic disease of the lungs and airways that can cause wheezing, chest tightness and difficulty in breathing. Asthma attacks are triggered by allergies, pollution, physical exercise (especially in cold weather), a viral cold or flu, emotions and drugs. Research evidence indicates a significant increase of asthma attacks among people from all races in South Africa. Asthma has also been linked to a Western lifestyle and migration from rural to urban and peri-urban areas (Jeena, Luyt & Morris, 2004). In the USA, it is estimated that eight million workdays were lost in 1994 due to asthma alone. The poor management of asthma in employees and their dependants leads to unintended absenteeism and unnecessary health expenses. Approximately 25 per cent of newly
diagnosed cases of asthma and the aggravation of previously treated asthma in adults are work-related. Chemicals, airborne matter from production and tobacco smoke are the main culprits (Williams, 2001: 1-2). Rees (2004) defines occupational asthma as asthma caused by substances inhaled in the workplace. Continued exposure to asthma sensitisers can result in permanent damage and disability.

The Occupational Health and Safety Act, discussed in paragraph 2.6.5, requires organisations, amongst others, to do risk assessments, provide a safe work environment, educate employees about health risks, monitor the health of employees, and keep medical records and medical surveillance records for 30 years (Rees, 2004).

Asthma is an example of a respiratory disease that could lead to an increase in absenteeism in the workplace. It is clear that proactively dealing with potential asthma triggers in the workplace could reduce its impact on absenteeism.

2.3.7 Injury / musculoskeletal conditions

According to Rhys Edwards, managing director (MD) of international employee benefits and human resources consultancy Aon, insurance industry statistics show that musculo-skeletal injuries are the leading cause of disability, both globally and in South Africa (Myers, 2001: 2).

The Soma Institute, which deals with absenteeism, disability and health management, found that 60 per cent of work-related claims are due to repetitive
strain, while 90 per cent of back injuries are related to sprain. Employees at the Volkswagen factory in Uitenhage, for example, suffered from increased lower back pain as a result of working on equipment that had been built for Japanese employees, who are on average shorter than their South African counterparts (Myers, 2001: 2). The subsequent ergonomical modification of the equipment rectified the problem.

It is not only factory workers who suffer discomfort from ergonomic problems. Due to the technological age, many employees are required to spend a considerable part of the day behind a computer. Injuries resulting from the use of office furniture and computers may appear to be minor at the time, but could eventually lead to occupational disability. The most expensive musculoskeletal disorder suffered by employees is carpal tunnel syndrome. Carpal tunnel syndrome is a result of inflammation of the soft tissue in the wrists and hands, which then affects nerves and reduces blood flow through the veins. The American Bureau of Labour Statistics reports that a median of 25 workdays are lost as a result of carpal tunnel syndrome, which is more than the time lost due to fractures or amputations (Intracorp’s new carpal tunnel program helps employees reduce lost workdays and medical costs, 2000).

It is evident that the work environment itself can be a major cause of injury and musculoskeletal conditions which result in absenteeism. The Occupational Health and Safety Act (No 85 of 1993), discussed in paragraph 2.6.5, requires of employers to ensure a safe and healthy environment.

2.3.8 Cancer
It is predicted that, while the incidence of cancer will remain the same for developed countries, it will increase rapidly in developing countries, mainly due to the adoption of a Western lifestyle linked with urbanisation. The most common kind of cancer in Africa is Kaposi’s sarcoma, which is strongly associated with HIV/AIDS. Ten thousand new cases of Kaposi’s sarcoma are expected in South Africa every year. Whereas most types of cancer appear in one place in the body and then may spread to other parts, Kaposi’s sarcoma can appear in several parts of the body at the same time. This type of cancer appears mostly on the skin, but may also affect internal organs, especially the lymph nodes, the lungs and parts of the digestive system (Cancerbackup, 2003). It is mainly diagnosed in people in their thirties, an age in which HIV/AIDS is most prevalent (CANSA, 2003).

The MRC of South Africa (2001) reports that the leading cause of cancer deaths in South Africa is trachea/bronchi/lung cancer, which affects males twice as much as females. For women, the leading cause of death is cervix and breast cancer, with trachea/bronchi/lung cancer in third place. Smoking is a major factor in the development of cancer. It causes more than 90 per cent of lung cancer and is considered a major contributor to cancer of the larynx, mouth, esophagus, bladder, kidney and pancreas. The affect of smoking as a health risk factor is discussed in paragraph 2.3.9.

Spelten, Sprangers and Verbeek (2002: 1) state that the increased survival rate of cancer patients justifies attention to the problems survivors may encounter when they return to work. These authors cite a meta-analysis of 14 studies that indicated that a non-supportive work environment and physical labour are
negatively associated with the return-to-work likelihood of cancer victims. Head and neck cancer victims were the least likely type of cancer victims to return to the workplace.

Cancer patients are subjected to various medical regimes, but can, with the necessary support in the workplace, continue to make a valuable contribution to the organisation. By adjusting the work environment and the content of the task, the early return to work of employees who have cancer can be facilitated. This is especially relevant in the case of employees with scarce cognitive competencies. The role of return-to-work policies in the management of absenteeism is discussed in paragraph 3.2.2.

### 2.3.9 Health risk factors

A study conducted on the impact of ill-health on productivity, which is discussed in more detail in paragraph 2.4, concluded that it made business sense to pay attention to the health risk factors among employees in organisations. The study showed that even though it was crucial for employee health programmes to target the sickest employees and those responsible for the highest direct and indirect health costs, it was equally important to assist the rest of the employees, who were at a low risk, to maintain their health (Burton, 1999: 1-3).

The Medical Research Centre of the University of Michigan has identified various health risks/behaviours that put individuals’ health at risk and increase absenteeism in the workplace (Edington, 2002: 6). Individuals exhibiting two or
less of these risks/behaviours are at low risk and unlikely to take excessive sick-leave; those exhibiting three to four behaviours are at medium risk, while those exhibiting five or more behaviours are at high risk and most likely to take excessive sick-leave. Table 2.3 presents these health risks/behaviours and the criteria that indicate risk. Figure 2.1, on the other hand, shows the relation between overall health risk appraisal and sick-day status as measured in a specific organisation.

**Table 2.3:** Health risks/behaviours and associated criteria

<table>
<thead>
<tr>
<th>Health risks/behaviours</th>
<th>High risk criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>More than 14 drinks a week</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Systolic&gt;139 mmHg or diastolic &gt;89mmHg</td>
</tr>
<tr>
<td>Body Mass Index</td>
<td>27.8 for men and 27.3 for women</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>&gt;239 mg/dl</td>
</tr>
<tr>
<td>Existing medical problem</td>
<td>heart, cancer, diabetes and stroke</td>
</tr>
<tr>
<td>Illness days</td>
<td>&gt;5 days previous year</td>
</tr>
<tr>
<td>Job satisfaction</td>
<td>Partly or not satisfied</td>
</tr>
<tr>
<td>Life satisfaction</td>
<td>Partly or not satisfied</td>
</tr>
<tr>
<td>Perception of health</td>
<td>Fair or poor</td>
</tr>
<tr>
<td>Physical activity</td>
<td>Less than once a week</td>
</tr>
<tr>
<td>Safety belt usage</td>
<td>Using safety belt less than 90% of the time</td>
</tr>
<tr>
<td>Smoking</td>
<td>Current smoker</td>
</tr>
<tr>
<td>Stress</td>
<td>High</td>
</tr>
<tr>
<td>Use of drugs for relaxation</td>
<td>Few times a month or more</td>
</tr>
</tbody>
</table>

**Source:** Edington, 2002: 6

The health risks indicated in Table 2.3 can guide organisations in identifying and addressing the type of issues that could possibly impact on the health and safety of their employees, and consequently the absenteeism levels in the organisation. At the same time, it provides guidelines for the development of
interventions, such as wellness programmes, aimed at preventing and reducing absenteeism. Wellness programmes are discussed in paragraph 3.4.3.2.

Figure 2.1 illustrates the relationship between overall health risk appraisal and sick-day status as measured in a specific organisation. As can be seen from this figure, the average number of days lost per year increases as the health risk increases. Employees with a low risk (0-1 health risk) were absent for an average of 0.8 days a year. The number of days absent increased to 1.8 per year if the employee had 2-3 health risks, and 4.4 per year if the employee had four or more health risks. This clearly shows that, should the health risks of employees be reduced, absenteeism levels will be reduced as well.

**Figure 2.1:** Overall health risk and sick-day status

![Overall health risk and sick-day status](image)

**Source:** Edington, 2002: 27

A study in which 300 employees participated (100 former smokers, 100 current smokers and 100 non-smokers) showed that current smokers had significantly more absenteeism than non-smokers, while former smokers had intermediate
absenteeism values. Former smokers showed a significant decline in absenteeism in the years following cessation. The productivity levels (objectively measured) showed that the production levels of former smokers declined during the first year after cessation to levels lower than those of current smokers, but then increased again to above those of current smokers after the first year of cessation. Subjective assessment values of “productivity evaluation by others” and “personal life satisfaction” were highest for non-smokers, lowest for smokers and intermediate for former smokers (Halpern, Shikiar, Rentz, & Khan, 2001: 1-2). This study illustrates the negative impact of smoking on performance, attendance and life satisfaction. It confirms smoking as a risk factor that should be addressed in wellness programmes.

Although the above health risks and their relation to absenteeism were researched in the USA, they are also relevant to South Africa. It has already been indicated that South Africans are affected by some of these health risks such as alcohol and drug abuse, accidents (here related to the use of safety belts), smoking, stress, as well as medical conditions such as cancer. It is therefore reasonable to deduce that in South Africa these same health risks could impact on absenteeism levels in organisations. Bradshaw, Bourne, Schneider and Sayed (1995: 5-8) state that South Africans are subjected to chronic diseases of lifestyle as a result of smoking, unhealthy eating patterns, a typical Western diet and a sedentary lifestyle. A community syndrome of hypertension, atherosclerosis and diabetes, together with cancer, was responsible for 28.5 per cent of deaths in the 35 to 64 year old age group in South Africa in 1988. Considering that the latter is the most economically
productive sector of the population, it can be concluded that the mentioned life risks will have an impact on absenteeism in organisations.

In conclusion, health risks do impact on absenteeism levels in organisations and it is therefore important for organisations to introduce wellness programmes. The purpose of wellness programmes is to educate employees about their health, and secondly to assist employees with unhealthy lifestyles to reduce the risks to which they are exposed.

2.3.10 HIV/AIDS

There is no dispute that HIV/AIDS is a topical and actual issue in South Africa. The Bureau for Economic Research states that most businesses in South Africa fail to respond to the HIV/AIDS epidemic despite the fact that it affects profits adversely (Shevel, 2004: 5). HIV/AIDS received prominent attention in this study for the following reasons:

- It is currently considered as the biggest health threat to the people of South Africa;
- It is expected to affect the economy, businesses, families and individuals (a macro and micro economic impact); and
- It is expected to have a major impact on absenteeism levels in organisations.

According to the Bureau for Economic Research, the manufacturing sector has been worst hit by lower profitability as a result of HIV/AIDS (Shevel, 2004: 5). White (2001: 11) highlights the impact that HIV/AIDS could have on the
automotive industry and the Eastern Cape as a whole. While it lies outside the scope of this study to present a medical perspective of HIV/AIDS, organisations need to understand that the HIV/AIDS virus is latent for a considerable period and that its effects are not immediately evident in the organisation (Ballard, 2002: 2). Table 2.4 illustrates the different stages of HIV and its transformation into AIDS.

**Table 2.4:** The different stages of HIV and its transformation into AIDS

<table>
<thead>
<tr>
<th>Stage</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV Infection</td>
<td>Initial infection with HIV</td>
</tr>
<tr>
<td>2. Window Period</td>
<td>HIV infection with no symptoms of disease and no detectable antibodies. An HIV antibody test will be negative although the virus is present. Lasts 2-12 weeks but may last several months</td>
</tr>
<tr>
<td>3. Seroconversion</td>
<td>The development of antibodies, often accompanied by a few days of flu-like illness</td>
</tr>
<tr>
<td>4. Asymptomatic HIV Infection</td>
<td>Antibody tests are positive but there are no apparent symptoms of illness. This period may last from a few months to many years</td>
</tr>
<tr>
<td>5. HIV/AIDS related illnesses</td>
<td>Symptoms of diseases increase as HIV damages the immune system (e.g. diarrhoea, swollen glands, night sweats). Symptoms are not yet life threatening. Period may continue for months or years, but infections become more persistent and serious</td>
</tr>
<tr>
<td>6. AIDS</td>
<td>Life threatening infections occur as immune system weakens. Life expectancy dependent on nature of infections and availability of treatment</td>
</tr>
</tbody>
</table>

**Source:** Ballard, 2002: 3

The implication of the information presented in Table 2.4 is that absenteeism (and labour turnover as a consequence of permanent incapacity and death) can
become a serious or critical problem during stages five and six. During stage five, the person has not yet developed full-blown AIDS. Although the person may experience an array of HIV/AIDS-related illnesses from time to time, these illnesses are not life-threatening.

2.3.10.1 The prevalence of HIV/AIDS in South Africa

Various statistics on the prevalence of HIV/AIDS in South Africa are available, and the validity of these statistics, as well as the data on which they are based, is often questioned. Regardless of this, most statistics sketch a bleak picture of the HIV/AIDS situation in Southern Africa and South Africa.

The MRC of South Africa estimates that between five- and seven-million South Africans will die from HIV/AIDS between 2001 and 2011. The following facts were stated in the 2000/1 report published by the MRC:

- Half of the deaths in people between 15 and 49 years old are due to HIV/AIDS;
- Adult death registration increased from 50 per cent in 1990 to 90 per cent in 1999;
• Mortality rates of women between the ages of 25 and 29 years are three times higher than a decade ago; and

• Mortality rates for men are spread out over an older and wider range, a consequence of the tendency of older men to have sex with younger women.

(Medical Research Council of South Africa, 2001a)

In an Old Mutual health care survey, eighty-three per cent of the respondents believed that their medical scheme would be severely affected in the future by the cost of providing HIV/AIDS benefits. It was estimated that 7.5 per cent of the medical scheme population was already HIV-positive. This was equal to approximately 525 000 medical scheme members (Old Mutual Health Care Survey, 2001: 14-15).

Figure 2.2 below shows the age distribution of new HIV infections in South Africa. It is clear that the majority of people who become infected are in the age group of 15 to 39 years old, the period in which people make a significant contribution to the economy.
At DaimlerChrysler South Africa (DCSA), 450 employees in the company are living with HIV/AIDS. Of those, 180 were registered with a medical aid, and 85 received anti-retroviral drugs (AIDS programme goes step closer, 2003). In the analysis of a self-report study conducted at Volkswagen South Africa (VWSA) it was reported that about 98 people at the company were infected with HIV/AIDS, which was much less than the predicted numbers of 487 for the year 2001. However, eight per cent of the employees who participated in the study indicated that they have lost family members, and 16.5 per cent indicated that they have lost friends to the epidemic (White, 2001: 95). The possibility exists that people might not answer honestly in self-report questionnaires due to the fear of victimisation.
The above discussion indicates that HIV/AIDS is a serious problem in South Africa, but also that it is hard to get reliable statistics on the actual situation. Paragraph 3.5.1 deals specifically with HIV/AIDS prevalence and impact studies.

2.3.10.2 The general impact of HIV/AIDS on the economy and on organisations

HIV/AIDS has a direct impact on the macro economic environment and on individual organisations. The impact of HIV/AIDS on organisations is illustrated in Figure 2.3.

**Figure 2.3:** The impact of HIV/AIDS in organisations

**Source:** Daly, 2000: 15
It is evident from Figure 2.3 that HIV/AIDS ultimately results in a decline of profits due to increased medical expenses and declining productivity. These result in less money being reinvested into the organisation and the inability of the organisation to maintain reliable services and products. Figure 2.3 also illustrates major issues that need to be addressed for the contingency management of absenteeism, namely health costs, absenteeism itself and the continuity of the delivery of products and services. These issues are addressed in Chapters three and four.

(a) The macro economic impact

HIV/AIDS will have a considerable impact on organisations through its influence on markets, savings, investment, services and education (Daly, 2000, 13).

The King 2 Report on Corporate Governance for South Africa (Temkin, 2002) was released on 26 March 2002 in Sandton, Johannesburg. It highlights areas of the economy which could possibly be affected by HIV/AIDS. These include:

- Decreased productivity through death, compassionate and sick-leave;
- Increased overhead costs such as health-care and insurance;
- Reduction in the available skills base;
- A contracting consumer base and changes in consumer spending patterns; and
- Reduced profitability and diminished investor confidence.

The King 2 Report also states that there is little evidence to suggest that organisations are taking appropriate measures to promote sustainability in the
face of this pandemic. The report emphasises the importance of planning when dealing with the impact of HIV/AIDS, and stresses that the regular monitoring and measuring of performance, through the use of established indicators, should form part of the process. The report also recommends that companies report at least once a year on issues such as HIV/AIDS, adherence to environmental standards and black economic empowerment – the concept of triple bottom line reporting, which implies meeting financial, environmental and social objectives. (Temkin, 2002).

In the Eastern Cape Benchmarking Club Newsletter (Ballard, 2002: 5) the following macro-economic consequences of the HIV/AIDS pandemic, which are similar to those identified by the King 2 Report, were highlighted:

- HIV/AIDS deaths result in the reduction of the number of workers available, especially those in their most productive years. As these employees will then be replaced by younger, less experienced people, productivity is affected;
- A shortage of skills leads to higher production costs and a subsequent loss of international competitiveness;
- Lower government revenues and reduced private savings (due to an increase in health-care costs and a loss of income for workers) will slow down job creation in the formal sector. Employees will be forced to find jobs in the lower paying, informal sector;
- The management of HIV/AIDS is costly. Costs include increased expenditure associated with the monitoring of high-risk groups, the establishment of prevention strategies and provision of health-care and welfare; and
- Increased pressure will be placed on social security systems, such as life insurance and pension funds, which are important sources of capital for both the government and private sector.

HIV/AIDS affects the broader economy and is therefore a national problem that will require constructive efforts from all those involved.

(b) The impact on the individual organisation

The impact of HIV/AIDS on the macro-environment has direct implications for organisations. The impact will vary depending on factors such as the nature of the company or industry, the nature of the labour market and the policies adopted by the company. Daly (2000: 14) identifies two broad areas in which HIV/AIDS impacts on individual business operations, namely productivity and increased costs. This dual impact is illustrated in Table 2.5.

Table 2.5: The dual impact of HIV/AIDS

<table>
<thead>
<tr>
<th>Productivity impact</th>
<th>Cost impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness</td>
<td>Life insurance</td>
</tr>
<tr>
<td>Absenteeism</td>
<td>Medical aid</td>
</tr>
<tr>
<td>Early retirement</td>
<td>Death benefits</td>
</tr>
<tr>
<td>Compassionate leave</td>
<td>Training and recruitment</td>
</tr>
<tr>
<td>Labour turnover</td>
<td>Administrative</td>
</tr>
</tbody>
</table>

Source: Eastern Cape Benchmarking Club Newsletter, 2002: 6
The implication of Table 2.5 is that organisations have to manage the financial cost of HIV/AIDS, as well as the impact it may have on productivity levels. Productivity levels are mostly affected through absenteeism and disruption, which are discussed in more detail below.

- Absenteeism

Daly (2000: 15) states that absenteeism, as a result of HIV/AIDS, is one of the most fundamental observable indicators of costs and lower productivity in business. This is mostly brought about by the disruption of the production cycle, the under-utilisation of equipment and the use of temporary staff. He mentions the effect of absenteeism on the quality control of products and service, which ultimately affects a company’s image and the loyalty of its customers.

On the other hand, an analysis of the attendance of 884 employed patients, who had previously formed part of a time-oriented health outcome study, suggested that there was no significant difference between the ability of people without HIV and people with HIV to be able to work. However, in a study conducted by Leigh, Lubeck, Farnham and Fried (1997), employed people with AIDS were reported to be unable to work for approximately 5.1 (one week) more days out of the previous three months than the groups with or without HIV. The implication of this study is that if people who are HIV-positive can be protected from opportunistic diseases, they can continue to live a productive life. However, once AIDS sets in, the effect on absenteeism will be significant.
In addition to sick-leave as a result of genuine ailments, employees will require compassionate leave to care for sick family members and to attend funerals of friends and family (Ballard, 2002: 5). This exacerbates the amount of absenteeism resulting from the HIV/AIDS pandemic.

- Disruption

The following factors contribute to disruption in the workplace as a result of HIV/AIDS:

Morbidity: Employees will require time off due to illness, use their maximum allowable sick-leave before being dismissed or before they resign due to incapacity. Morale is affected by the loss of colleagues, relatives and friends, discrimination and suspicion, and the disruption of work activities.

Mortality: Labour turnover as a result of incapacity and death results in a loss of skill and loss of tacit knowledge (collective knowledge gained from both the work and the organisational environment).

According to Daly (2000: 16), it is difficult to calculate the cost of loss of knowledge and skill. However, the loss of intellectual capital has dire consequences for organisational value and progress. It takes years to build up this type of knowledge, and it is not easily transferable to other people. For this reason, the availability of a large pool of labour does not solve the problem. As HIV/AIDS mostly affects people in their most productive years, these knowledgeable and skilled employees will probably be replaced with less experienced
ones. This will have implications for training efforts and costs in organisations.

Replacement and training of labour: Employment and training are costly processes. The cost implications will be affected by the labour intensiveness of a specific operation, the level of skill, and the general availability of labour (Ballard, 2002: 5).

HIV/AIDS affects individual organisations in two broad areas, namely productivity and increased costs. Absenteeism and disruption are major influences on productivity.

(c) Cost implications in terms of absenteeism and related issues

HIV/AIDS increases costs associated with employee absenteeism in a number of ways (Daly, 2000: 16):

- Production costs: Rising production costs as a result of disruption and lost time. The South African Business Coalition on HIV and AIDS reports that the manufacturing sector is worst hit by the pandemic (Shevel, 2004: 5).

- Recruitment and training: Absenteeism results in staff fluctuations. Strategies to deal with these fluctuations, such as multi-skilling and extensive human resource monitoring can be costly. It may also result in higher demands for wages and salaries.

- Insurance cover and pensions: Pension fund and life insurance premiums rise as a result of early retirement due to incapacity or death.
• Health management: In the 2001 Old Mutual health-care survey, in which 60 key South African companies participated, cost control, HIV/AIDS and pensioner pre-funding surfaced as the three top strategic issues that employers were going to face over the next five years (Old Mutual Health Care Survey, 2001: 14 - 15). The rising cost of health-care services will ultimately limit the extent to which organisations can give employees access to these services. Daly (2000: 16) refers to a study of a commercial agro-estate in Kenya that showed that they experienced an increase of 400 per cent in medical expenses as a result of HIV/AIDS.

It is evident that HIV/AIDS has broad financial implications for organisations and that it is therefore necessary to respond to this challenge in a strategic and rational manner.

(d) The danger of not responding to HIV/AIDS

Daly (2000: 18) indicates that one of the most important lessons learned from the reaction of business to HIV/AIDS is the consequence of inactivity or denial. A comprehensive education and prevention programme in Senegal has lead to one of the lowest infection rates in sub-Saharan Africa. Figure 2.4 indicates how the costs of HIV/AIDS escalate when organisations do not react immediately.
Figure 2.4 Conceptual business cost curves of responses to HIV/AIDS

Source: Daly, 2000: 18

Figure 2.4 shows that early intervention can provide desirable results. Eskom in South Africa is hailed by various prominent international organisations as a leader in the management of HIV/AIDS. A voluntary HIV/AIDS surveillance survey conducted at Eskom in 1999, which covered 15 per cent of the workforce, showed that education and awareness training resulted in a lower prevalence rate than earlier predicted (Daly, 2000, 18). This has direct consequences for future absenteeism levels in the organisation.

Daly (2000, 18) refers to a survey commissioned by UNAIDS in 1997 and supported by The Prince of Wales Business Leaders Forum and the Global Business Council on HIV and AIDS, which covered 203 companies in 14 countries. This survey revealed that among the most important reasons that companies responded to HIV/AIDS, included a concern for the welfare of
employees (46% response rate), the protection and safety of employees (34%), legal implications (24%) and the escalation of health-care costs (16%). Eight percent of the respondents indicated that they responded due to the threat of absenteeism. It is noted that these question items did not include any direct reference to real business reasons, such as a threat to competitiveness, which could necessitate a response to the HIV/AIDS crisis. Daly, however, mentions that companies located in countries with a high HIV/AIDS prevalence rate, such as South Africa, mainly respond to HIV/AIDS in order to minimise its impact on business operations and employees.

The above discussion illustrates the impact of HIV/AIDS on the economy and individual organisations and highlights the fact that early intervention will reduce the financial impact of this pandemic.

2.4 THE IMPACT OF ABSENTEEISM ON THE PRODUCTIVITY LEVELS OF EMPLOYEES

Absenteeism is more disruptive and costly in a manufacturing environment than an administration environment due to operational demands. Downsizing and lean manufacturing have left organisations with a smaller workforce, and the absence of team members is thus more disruptive (Carrell, Elbert, Hatfield, Grobler, Marx, & Van der Schyf, 1998: 570).

A study, in which the impact of ill-health on productivity was quantified by taking absenteeism, short-term disability and presenteeism into account, was
conducted at a bank in the USA, and specifically in their credit card section, where a telephone-based customer-care service was offered (Burton, 1999: 1-3). The company used a computerised system to track the exact time spent on various aspects of the job, such as the time spent on various aspects of a call, the time between calls to complete transactions and the time logged off the system. This system made it easy to calculate presenteeism. In this study, a Worker Productivity Index (WPI) was developed to measure the impact of employees’ health on job performance. Three factors were considered in calculating the total lost time due to ill-health:

- Absenteeism (the sum of scattered absences);
- Short-term disability; and
- Presenteeism (productivity loss as a result of people not functioning fully while on the job).

The total time lost based on these three factors was then converted into a WPI. The WPI was calculated as follows:

(a) Firstly, a productivity standard that most employees would reach was determined.

(b) Time lost due to absenteeism, short-term disability and presenteeism was determined.

(c) The total time lost per week was expressed as a percentage (for example twenty per cent).

(d) This percentage was subtracted from 100 to obtain a measurement of the productivity level (if 20 per cent of the scheduled time was lost, then productivity is at 80 per cent).
The index was applied to more than 500 customer-care workers. An average WPI of 89 per cent per employee was calculated. The employees at this organisation were also given the opportunity to complete periodic health risk appraisals (HRAs). The results of these HRAs were stored in a database, along with other information, such as the worker’s age, medical coverage, claims history, test results, participation in wellness programmes, and days lost due to short-term disability and absenteeism. Only employees who completed HRAs were included in this study. Using the average WPI as a baseline, the researchers determined to what extent various health conditions and health risks impacted on employees’ average productivity.

Conclusions drawn from this study were:

- Employees with no or only one health risk (refer to paragraph 2.3.9) exceeded the average WPI by 3 points;
- Employees with three or more health risks scored three points below the average WPI;
- Of the employees who took short-term disability during the study year, those with digestive disease and mental-health diseases had the lowest WPI scores;
- Employees with digestive problems were less likely to go on disability, but more likely to suffer from presenteeism (not performing while on the job);
- Employees with mental problems tended to perform well when at work, but lost time due to disability;
• Smokers and employees with a sedentary lifestyle had a higher than average WPI (although the researchers warn that the ill effects of such a lifestyle might only realise at a later age as the subjects in the study had an average age of 33);

• The three risk factors mostly associated with low levels of productivity were diabetes, self-reported distress and elevated body mass index; and

• Of the people who suffered from various diseases taken into account for this study, those with cancer came closest to the average with a WPI of 84 per cent.

The final conclusion drawn by the researchers was that it was important to give consideration to the general health of all employees (Burton, 1999: 1-3). Absenteeism levels were highest for those employees who had mental-health diseases, respiratory diseases and musculoskeletal conditions (0.74 or 0.75 hours lost per week). Time lost due to short-term disability was highest for people with mental-health diseases (8.72 h), injury (6.12 h), digestive diseases (5.66 h) and cancer (5.54 h). Taking absenteeism, short-term disability and presenteeism into account collectively, digestive disease and mental-health problems were the biggest health threats to productivity, while cancer was the least of the problems. Diabetes and high cholesterol were mostly associated with absenteeism, while high blood pressure and high cholesterol were mostly associated with short-term disability.

It is evident that ill-health results in absenteeism and low productivity. It is also evident that by focusing on the health of all employees, absenteeism can be
reduced and productivity improved. Wellness programmes (refer to paragraph 3.4.3.4) should therefore not be aimed only at those employees who are often absent, but should also serve as a general preventative function.

2.5 THE FINANCIAL IMPLICATIONS OF ILL-HEALTH AND ASSOCIATED ABSENTEEISM

Health-related absenteeism, and absenteeism in general, results in direct and indirect costs for the organisation, as well as the employee. Direct costs refer to the medical expenses and indirect costs refer to the value of work lost due to the illness or diminished productivity while a person is recovering from an illness.

Hamilton-Atwell (2003: 59) indicates the following direct costs of absenteeism for the organisation:

- Sick- or leave-pay to the absent employee;
- Fringe benefits of the absent employee;
- Overtime to pay staff where work could not be completed;
- Overstaffing – staffing for absenteeism, recruitment, hiring orientation and training of extra employees; and
- Payment of wages to temporary employees.

Organisations should periodically compute the cost of absenteeism and identify trends to determine the severity of the problem and the impact on profits (Carrell et al, 1998: 570).
Hamilton-Atwell (2003: 59) suggests the following formula to determine the direct cost of absenteeism, even though she agrees that it does not provide a perfect figure:

\[
\frac{\text{Total days absent} \times \text{remuneration of employees}}{\text{Total number of employees}}
\]

This formula converts the absence of employees into an actual amount based on the average number of employees. It represents the average cost per employee absent.

Pauly, Nicholson, Xu, Polsky, Danzon, Murray and Berger (2002: 221-231) used a mathematical model to prove that the indirect financial impact of absenteeism is influenced by the size of the company, the production function, the nature of the product and the competitiveness of the labour market. The model indicates that the cost of lost time increases when perfect substitutes are not available to replace absent employees, when there is team production, or when there is a penalty for not meeting a target. The researchers concluded that the productivity gains of health programmes benefit workers in the long-term, and that employers, who implement work-loss reduction programmes, reap the financial benefits thereof. Swanepoel, Erasmus, Van Wyk and Schenk (2003: 776) also present a model that can be used to calculate the cost of absenteeism. This model is presented in Figure 2.5.
Figure 2.5: A model for estimating the cost of absenteeism

Source: Swanepoel, Erasmus, Van Wyk and Schenk, 2003: 776
The above model makes provision for direct costs (salary and benefits), indirect costs (supervisory involvement in the management of the absence) and any other costs associated with absenteeism (overtime premiums, casual employment, machine downtime, etcetera). This model is flexible in the sense that it allows for situations where employees are being paid while they are absent, as well as for situations where they are not being paid during absence. Step nine also allows organisations to include company specific costs related to absenteeism.

According to Mathis and Jackson (2000: 91), absenteeism in the USA costs $505 per employee per year and 7.2 days per employee are lost annually due to absenteeism. The CCH Unscheduled Absence Survey revealed that the average absenteeism rate in the USA was 2.2 per cent in 2001 and 2.1 per cent in 2002. While absenteeism rates have gone down, the cost of absenteeism has increased. The survey polled approximately 230 human resources professionals employed in US companies and organisations with a total of more than 1.3-million employees. The report states that the average per-employee cost of absenteeism rose from $610 per year in 2000 to $755 in 2001 to $789 in 2002. The direct costs of unscheduled absences increased by 24 per cent. The report also states that personal illness remains the single most common reason (33%) for last-minute absences (CCH, 2001b; CCH, 2002). George and Jones (2002: 93) indicate that absenteeism costs companies in the US approximately $40-billion a year.
It was indicated in the South African parliament that the absenteeism of public servants in the 12 months leading to September 30, 2000, cost the state R632-million. More than 4.3-million workdays in this period were lost due to sick-leave. The highest incidence of sick-leave was reported for “frontline” public servants, such as teachers, police, nurses and welfare officers. (Sick leave costs state R632m, 2002).

The Soma Institute, which deals with absenteeism, disability and health management in South Africa, estimates that worker disability in 1999 cost the economy in excess of R2-billion. This figure is nearly double the amount for 1998, which was R1.1-billion (Myers, 2001).

A study which incorporated 11 telecommunication companies, with a total of 710 000 employees, revealed that lost productivity, associated with sick-leave and disability, costs employers three times more than those organisations who have group health and disability programmes (Gemignani, 2000).

In conclusion, it is evident that absenteeism has a direct impact on the bottom line of organisations and that it should be addressed strategically. However, organisations in South Africa have to consider the requirements of various laws that govern the management of health-related absenteeism.
2.6 LEGAL PARAMETERS FOR THE MANAGEMENT OF HEALTH-RELATED ABSENTEEISM

To ensure compliance with the law, it is important to develop a good understanding of the legislation that governs and affects absenteeism management and health-related issues in the workplace.

2.6.1 Basic Conditions of Employment Act (No 75 of 1997)

The Basic Conditions of Employment Act (No 75 of 1997) (BCEA) applies to the public and private sectors. The basic conditions of this Act form an integral part of all employment contracts, unless replaced, varied or excluded in accordance with the Act, or unless the employee, in his/her own capacity, or via a bargaining council agreement, contracted more favourable terms of employment. The Act compels employers to arrange the working time of employees in such a way as not to endanger their health and safety, and with due regard to family responsibilities (Nel, 2004: 86).

In terms of absenteeism, the act provides for sick-leave, maternity leave and family responsibility leave.

Sick leave (Section 22 of the BCEA)

During every sick-leave cycle, an employee is entitled to paid sick-leave equal to the number of days the employee would normally work during six weeks. A sick -
leave cycle implies a period of 36 months of employment with the same employer which starts immediately after employment or the completion of the employee's prior sick-leave cycle. During the first six months of employment an employee is entitled to only one day’s paid leave for every twenty-six days worked. These days may be subtracted from those allowed during the first sick-leave cycle. An employer must pay an employee for a day of sick-leave the wage he/she would normally get, and it should be paid on the employee’s normal payday. An employee’s daily pay for sick-leave may be reduced by agreement, provided that the number of days sick-leave is increased. The pay may not be reduced below 75 per cent of ordinary pay.

**Proof of incapacity (Section 23 of the BCEA)**

An employer does not have to pay an employee in terms of Section 22 if the employee is absent for more than two consecutive days or more than two occasions during an eight-week period and, on request of the employer, does not submit a medical certificate proving that the employee was sick or injured during the time of absence. The medical certificate must be signed by a medical practitioner or a person who is certified to diagnose and treat the patient and who is registered with a professional council. If an employee who lives on the premises of the employer is not able to obtain a medical certificate, payment may not be withheld, unless the employer can prove that he/she has provided reasonable assistance to the employee to obtain such a certificate.

Section 24 of the BCEA states that section 22 and 23 do not apply to employees who are unable to work due to an accident or occupational disease as defined by
the Compensation for Injuries and Diseases Act (No 130 of 1993) or the Occupational Diseases in Mines and Works Act (No 78 of 1973), except for any period for which the person is not entitled to compensation according to these acts.

**Maternity leave**

The BCEA lays down restrictions for the management of absenteeism related to pregnancy and birth. Maternity leave would normally not be included in absenteeism figures, as it is of a long duration and would distort absenteeism figures. However, a discussion of maternity leave is included here, because pregnancy can be considered as a health-related condition that could result in unscheduled absenteeism, and also because the manager is required to make contingency plans to replace the absent employee. Furthermore, unfavourable working conditions might complicate pregnancies and result in an increase in absenteeism. Although the BCEA limits the extent to which this type of absence can be managed in the organisation, it does allow for some flexibility.

According to the BCEA, a pregnant employee is entitled to four months maternity leave, which may begin four weeks before the date of birth, unless otherwise agreed upon or, if required by the employee for health reasons. An employer may not require an employee to return to work for at least six weeks after the birth of a child. However, an employee might willingly agree to return to work if certified as fit to do so by a doctor or midwife. An employee who experienced a stillbirth or miscarriage during the third trimester of a pregnancy, is still entitled to six weeks leave maternity leave, or for longer, if a doctor certifies it as necessary.
due to health reasons. The employer is required to provide alternative employment to an employee who works at night, or whose work might endanger her health or the safety of her child. Payment of maternity leave is subjected to the provisions of the Unemployment Insurance Act (No 30 of 1966).

Family responsibility leave (Section 3)

Family responsibility leave does not relate to the health condition of the employee, but to that of his/her immediate family, as described by the BCEA. It has become especially relevant due to HIV/AIDS, as many authors such as Ballard (2002: 5) and Shevel (2004:5) expect an increase in family responsibility leave as a result of this pandemic.

According to the BCEA, employees who have been in employment with an employer for longer than four months, and who work at least four days a week for that employer, are entitled, on request of the employee, to three days paid leave to take when

- The employee’s child is born;
- The employee’s child is sick; and
- The employee’s spouse or life partner, or parent, adopted parent, grandparent, child, adopted child, grandchild or sibling dies.

An employer may require reasonable proof that the abovementioned events, for which leave was requested, did occur. Leave, in terms of this Section, lapses at the end of the annual leave cycle in which it accrues. The number of days and
the circumstances under which leave is granted, in terms of this Section, may vary according to a collective agreement.

2.6.2 Employment Equity Act (No 55 of 1998)

The major aims of the Employment Equity Act are to promote equal opportunity and fair treatment in employment through the elimination of unfair discrimination and to redress the disadvantages in employment experienced by designated groups, in order to ensure their equitable representation in all occupational categories and levels in the workplace (Nel, 2004: 170).

In terms of the contingency management of health-related absenteeism, this Act compels organisations to treat all employees that are challenged by health-related issues equitably and not to discriminate on the basis of a whole range of grounds, including race, gender and disability. The anti-discriminatory part of this Act applies to all employers, and requires employers to scrutinise all human resources policies, practices and procedures in order to rid them of any potential discrimination.

2.6.3 Labour Relations Act (No 66 of 1995)

The Labour Relations Act regulates the relationship between employers and employees, and employee representatives. The Act includes guidelines for the handling of discipline and the fair dismissal of employees. In the context of current employment law, discipline is regarded as corrective rather than punitive.
Employers are encouraged to correct employees’ behaviour by means of a graduated disciplinary system that makes provision for counselling and warnings (Nel, 2004: 91). Schedule eight of the Labour Relations Act contains the Code of Good Practice: Dismissal which provides guidelines for dismissal due to misconduct (Section 7), incapacity due to poor performance (Section 8 & 9) and incapacity due to ill-health or injury (Section 10 & 11).

An employee can only be dismissed if the employer can prove that

- The reason for dismissal was fair, and related to the employee’s conduct or capacity and the employer’s operational requirements; and
- The dismissal was effected in accordance with a fair procedure.

2.6.4 Code of Good Practice on the Employment of People with Disabilities

The Code of Good Practice on the Employment of People with Disabilities was published in August 2002. According to Stelzner (2003: 1-2), a practicing attorney in labour law, employers in South Africa should examine their approach to disability in order to address problems proactively and avoid legal action against them at a later stage. Employers have to understand the difference between disability and incapacity. An employee who is injured (whether on duty or not) or becomes ill, and who is frequently absent from work or cannot perform his/her duties to the same standard as before, might be perceived as not having the capacity to continue employment, and subsequently be dismissed according to the Code of Good Practice on Dismissal, as scheduled to the Labour Relations
Act. However, the injury or illness might amount to a disability, and subsequently the employee is entitled to be treated on an affirmative-action basis.

The Code defines a disability as a long-term or recurring physical or mental impairment which substantially limits the employee's prospects of entry into, or advancement in, employment. In this case, the employer is obliged to determine whether a reasonable opportunity exists to accommodate the disabled employee in order to retain his/her services. Only in situations where the business would suffer unjustifiably by retaining the services of the employee, would dismissal due to incapacity become acceptable. The Code also suggests that, while the same performance standards would apply to people with or without disabilities, the manner in which performance is evaluated might have to be adapted in the case of a person with a disability, depending on the nature of the disability.

The Code prohibits any medical testing, except in limited and exceptional circumstances. Indiscriminate testing is strictly illegal. Where testing is justifiable, only relevant facts such as whether or not the employee can still safely perform his/her duties, or whether reasonable accommodation can be applied, should be ascertained. Employees with disabilities may also not be excluded from any benefits on the basis of their disability. On the contrary, employers have the duty to inform employees of the benefits that they are entitled to as a result of their disability and how to apply for them.
2.6.5 Occupational Health and Safety Act (No 85 of 1993)

The Occupational Health and Safety Act covers everybody in South Africa, except those in the mining industry and merchant shipping, who are separately legislated. This Act compels both the employer and the employee to create and maintain a safe and healthy workplace. Specific duties of the employer include, among others:

- To create a workplace free of safety and health hazards;
- To provide the necessary information, instruction, training, supervision; and
- To provide facilities, assistance and training to health and safety representatives.

(Schultz, 2004a: 301)

2.6.6 Legal and contractual boundaries for the Employee Assistance Programme (EAP)

EAPs are programmes designed to deal with a broad range of stress-related problems, including behavioural and emotional difficulties, substance abuse, family and marital discord, HIV/AIDS and other personal problems. (Schultz, 2004a: 294). Legal and contractual boundaries related to EAPs pertain to the eligibility of entry into the programme, referral circumstances, the obligation of the employer to utilise the EAP before resorting to disciplinary action, informed consent, the impartial role of the EAP provider, the competency level of the provider and the service, the safekeeping of records, and the parameters of professional liability. The EAP is also subjected to the Employment Equity Act,
especially in terms of the prohibition of discrimination, and the fact that the onus is on employers to provide poor performers and those with ill-health a “reasonable opportunity to improve”. The EAP is considered as a reasonable opportunity (Moodley, 2003).

2.6.7 Code of Good Practice on HIV/AIDS and Employment

The Minister of Labour has published the Code of Good Practice on key aspects of HIV/AIDS. The Code acknowledges the impact that HIV/AIDS will have on the workplace in terms of prolonged staff illness, absenteeism, and death impacting on productivity, employee benefits, occupational health and safety, production costs and workplace morale. The aim of the Code is to provide employers, trade unions and employees with guidelines on how to develop non-discriminatory workplace policies and programmes. The Code does not impose any additional legal obligations other than those already imposed by existing legislation, including the BCEA, EEA, LRA, Occupational Health and Safety Act (No 85 of 1993), Mine Health and Safety Act (No 29 of 1996), Compensation and Occupational Injuries and Diseases Act (No 130 of 1993), Medical Schemes Act (No 131 of 1998) and the common law and Constitution of South Africa Act (No 108 of 1996) (Government Gazette, 2000).

The following list contains the main aspects of the Code of Good Practice on HIV/AIDS, which impact on the contingency management of absenteeism in the workplace:

- The prevention of unfair discrimination against an applicant or employee on the basis of his/her HIV/AIDS status;
• The promotion of a non-discriminatory work environment through the development of policies and programmes, awareness, education and training, and support for employees infected by HIV/AIDS;

• Testing to ascertain an employee’s HIV-status is illegal, unless authorized by the Labour Court, in which case it is subjected to stringent rules in terms of the provision of pre- and post-test counselling, confidentiality and voluntary, informed consent;

• Employees have a legal right not to disclose their HIV-status, but should a person voluntary discloses his/her HIV-status, the information may under no circumstances be disclosed to others without the person’s express consent;

• A culture of openness, acceptance and support should be created for those who voluntary disclose their HIV-status;

• A safe working environment should be promoted;

• Employees who occupationally acquired HIV/AIDS should be assisted in applying for compensation claims;

• Infected employees may not be unfairly discriminated against in the allocation of employee benefits;

• Employees may not be dismissed based on their HIV/AIDS status;

• Should an employee become too ill to work, the employer is obliged to follow accepted guidelines regarding dismissals due to incapacity, which includes adapting the employee’s duties, accommodating the employee’s disability and to finding alternative employment for the employee; and
The development of a specific HIV/AIDS policy and the management of employees who are HIV-positive.

The development of an HIV/AIDS policy, HIV/AIDS awareness, training and education and the management of employees who are HIV-positive will be explored further in Chapter three.

In summary, due to recent changes in South African labour law, it would be advisable for employers to continuously audit their policies and practices in the field of absenteeism, health and safety, disability and HIV/AIDS management to ensure that they adhere to the law. The LRA takes precedence over all other acts, except the Constitution, and in the case of conflict between the LRA and any other act, priority will be given to the provisions in the LRA (Nel, 2001: 103).

2.7 THE MERITS OF ADOPTING A CONTINGENCY APPROACH TO THE MANAGEMENT OF HEALTH-RELATED ABSENTEEISM

Kepner and Tregoe (1981: 140-150) perceive the purpose of “potential problem analysis” as the reduction of the future to manageable proportions. It enables a walk into the future, and then a return to the present to take action proactively. Kepner and Tregoe identify four basic activities that provide the framework for potential problem analysis:

- Identifying the vulnerable areas of an undertaking;
• Identifying specific potential problems within these vulnerable areas that could have a sufficiently negative impact on the operation in order to merit taking action now;
• Identifying the likely causes of these potential problems and identifying action that would prevent them from occurring; and
• Identifying the contingent actions that can be taken if preventative actions fail, or if preventative action is impossible.

The above framework is relevant for the contingency management of health-related absenteeism. Health-related absenteeism renders organisations vulnerable, and therefore should be prevented. In addition, when preventative measures do not attain the desired affect, organisations should consider contingency strategies to ensure that production and service provision are not disrupted.

The operational areas of an organisation are vulnerable to excessive absenteeism, especially in a lean manufacturing environment. In this chapter, it was illustrated how various health-related issues, including HIV/AIDS, can make organisations more vulnerable as a result of their impact on absenteeism levels.

Jelley (2003: 8) states that HIV/AIDS is often perceived as a social or community problem rather than a company-specific risk, while it actually poses a risk similar to that of asset security or exchange rate volatility. Jelley suggests a multi-dimensional approach to managing HIV/AIDS as a business risk:

• HIV/AIDS should be identified, measured and managed. It should be placed on the top of board agendas;
• The risk should be managed by senior executives who are specifically appointed for this purpose; and
• Management structures and interventions should be evaluated regularly.

Lifeworks, a company specialising in HIV/AIDS management in organisations, suggest the following four steps in managing HIV/AIDS as a risk:

• Recognise the risk;
• Define the risk;
• Measure the risk; and
• Manage the risk.

(Lifeworks, n.d.)

In conclusion, in this chapter the scope and impact of health-related absenteeism on organisations were discussed. Various diseases and conditions that impact on acceptable levels of absenteeism were discussed. It is evident that a high rate of absenteeism will affect the competitiveness of an organisation, and that a contingency approach should be followed to maintain undisrupted production and service provision. In the next chapter, specific attention is given to strategies that can be adopted to prevent, control and reduce health-related absenteeism, while Chapter four focuses on strategies that can be adopted to ensure the continuity of production and service provision in the face of absenteeism.
Calculate total employee hours lost as a result of absenteeism for the same time period.

Calculate weighted average salary per hour of absent employees.

Calculate the cost of employee benefits per hour per employee.

Remuneration lost per hour per absent employee = salary + benefits.

Are absent employees paid?

Remuneration lost per hour per absent employee = benefits only.

Calculate total remuneration lost with absent employees (1 x 4a or 4b).

Estimate total supervisor hours lost with employee absence.

Calculate average hourly supervisor salary and benefits.

Estimate total supervisor remuneration lost with the handling of absenteeism problems (6 x 7).

Estimate all other costs associated with absenteeism.

Estimate total cost of absenteeism (5 + 8 + 9).

Estimate total cost of absenteeism per employee (10 ÷ total number of employees).

Figure 2.4: A model for estimating the cost of absenteeism

Source: Swanepoel, Erasmus, Van Wyk and Schenk, 2003: 776
CHAPTER THREE

CONTINGENCY MANAGEMENT STRATEGIES AIMED AT
PROMOTING A HEALTHY WORKFORCE AND REDUCING
HEALTH-RELATED ABSENTEEISM

3.1 INTRODUCTION 87

3.2 WORKPLACE POLICIES PERTAINING TO ABSENTEEISM
AND HEALTH-RELATED ISSUES 89

3.2.1 Absenteeism policy 90

3.2.1.1 No-fault absenteeism policy 93
3.2.1.2 Paid time-off (PTO) 95

3.2.2 Return-to-work policy 96
3.2.3 Disability policy 100
3.2.4 Corporate wellness policy 100
3.2.5 Employee Assistance Programme (EAP) policy 102
3.2.6 Substance abuse policy 104
3.2.7 Stress and trauma as integrated parts of the EAP policy 105
3.2.8 HIV/AIDS policy 106

3.3 THE RECORDING, MEASUREMENT AND ANALYSIS
OF HEALTH-RELATED ABSENTEEISM 109

3.3.1 Recording of absenteeism 110

3.3.1.1 Proof of illness 111
3.3.1.2 Counselling 115
3.3.1.3 Alternative work arrangements 117
3.3.1.4 Dismissal due to incapacity 117

3.3.2 Measuring absenteeism 118
3.3.3 The analysis of absenteeism 123
3.3.4 Reporting of absenteeism rates 126
3.3.5 Benchmarking 126

3.4 A HOLISTIC APPROACH TO HEALTH IN THE WORKPLACE 128
3.4.1 Prevalence studies
3.4.2 The provision of health benefits
3.4.2.1 Medical aid schemes
3.4.2.2 Sick funds
3.4.2.3 Medication
3.4.3 INTERGREGATED OCCUPATIONAL HEALTH-CARE PROGRAMMES
3.4.3.1 Occupational health-care services
3.4.3.2 Health risk appraisals and wellness Programmes
3.4.3.3 Disease-specific education and case management
3.4.3.4 Employee Assistance Programmes (EAPs)

3.5 THE MANAGEMENT OF HIV/AIDS IN THE WORKPLACE
3.5.1 Prevalence and impact studies
3.5.2 Policy development
3.5.3 Awareness and education programmes
3.5.4 Case management
3.5.5 Community networking
3.5.6 Continuous research and evaluation

3.6 ERGONOMICS

3.7 DEALING WITH INCAPACITY

3.8 A CONTINGENCY MANAGEMENT PLAN AIMED AT PROMOTING A HEALTHY WORKFORCE AND REDUCING HEALTH-RELATED ABSENTEEISM

3.9 CONCLUSION
CHAPTER THREE

CONTINGENCY MANAGEMENT STRATEGIES AIMED AT
PROMOTING A HEALTHY WORKFORCE AND REDUCING
HEALTH-RELATED ABSENTEEISM

3.1 INTRODUCTION

In Chapter two, the scope and impact of health-related absenteeism in organisations were presented. Various diseases and health conditions that are relevant to the South African situation and the impact of these diseases and health conditions on absenteeism in organisations were discussed and emphasised. The negative consequences that absenteeism holds for the continuity of productivity and customer services were also highlighted and the legal parameters for the contingent management of health-related absenteeism were demarcated. A business case was then made for adopting a contingency approach to the management of health-related absenteeism.

The aim of this chapter is to provide an overview of contingency management strategies aimed at promoting a healthy workforce and reducing health-related absenteeism, while Chapter four is dedicated to contingency management
approaches aimed at ensuring the continuity of production and service provision in the face of absenteeism.

An example of a contingency approach to the management of absenteeism is presented below to illustrate the main aspects of such an approach. A study conducted by the European Foundation (1997) identified the following key aspects of a model of good practice when managing health-related absenteeism in the workplace:

- A systematic and comprehensive approach, aimed at improving the health of the workforce, which includes preparation of the project, an investigation of health problems, organising solutions before interventions are carried out and an evaluation of the impact;
- A committed co-ordinating project team that has a clear brief to manage and implement the project;
- Formal or informal agreement about the scope, needed resources and tasks and responsibilities of the project team and other stakeholders;
- Higher management involvement to facilitate the identity of the project in the organisation, decision-making, implementation and the co-operation of middle management and employees;
- Active worker participation;
- Good information and communication;
- Active incorporation of human resources management, occupational health-service and external guidance;
- Involvement of workplace forums, health and safety committees, and trade unions;
• Procedural measures, which include more comprehensive absence reporting mechanisms and preventative measures that focus on the person and the work, to raise the absenteeism barrier;
• Integrative measures aimed at lowering the reintegration barrier and facilitate return-to-work of the sick employee; and
• The treatment of absenteeism related to health as a normal phenomenon and integrating absenteeism and ill-health management into organisational policy and practice.

This example of a contingency approach to managing absenteeism shows that it is extensive and involves the whole organisation.

In this chapter, specific attention is given to the development of appropriate policies that guide decisions relating to absenteeism and other health-related issues, the recording and monitoring of absenteeism, the provision of health benefits and an integrated corporate health-care programme. In the next section, the development of various workplace policies that support the contingent management of health-related absenteeism, are discussed.

3.2 WORKPLACE POLICIES PERTAINING TO ABSENTEEISM AND HEALTH-RELATED ISSUES

In comparison to procedures and rules that are situation-specific, workplace policies act as general guidelines to focus organisational behaviours. Policies are general in nature and guide organisational decision-making. Organisations
should guard against policy proliferation, and also regularly review and update policies when situational changes occur. A well-designed policy should be consistent, necessary, applicable, understandable, reasonable, distributed and communicated (Mathis & Jackson, 2000: 586).

It is a concern that organisations struggle to integrate policies, and that fragmented policies, which are contradictory and difficult to interpret and follow, are the result. According to Moodley (2003), an advocate, work-life professional and expert on employee assistance programmes (EAPs) and South African law, a possible solution is to develop one overall “corporate health policy”, but continue to have separate policies for various aspects such as absenteeism, HIV/AIDS and EAPs. It is imperative that all the workplace policies are integrated in order to ensure a comprehensive approach to the contingency management of health-related absenteeism, and to prevent discrepancies and ambiguity, in terms of responsibility and desired action.

The development of policies is subject to many legal requirements. The legal parameters for the contingency management of health-related absenteeism have been discussed in Chapter two.

3.2.1 Absenteeism policy

A properly developed absenteeism policy is a valuable management tool. Any absenteeism policy should be negotiated with employees, or employee representatives where applicable, in order to foster a sense of ownership, loyalty
and commitment to the prevention of absenteeism. Policies should be aligned with specific circumstances, make use of language suitable for the target group, and should be distributed and communicated to all employees. Absenteeism policies should also be applied consistently. In comparison to traditional policies, modern absenteeism management procedures have to comply with strict legal prescriptions and make provision for counselling and rehabilitation programmes in order to assist recuperating employees to return to work (Hamilton-Atwell, 2003: 59).

Levine Associates (2000: 3) suggest the following steps in the development of an absenteeism policy:

(a) First analyse the organisational needs: This includes a consideration of cost, control, time, absence tracking methods and resources.

(b) Identify solutions: Determine the most effective policy for the organisation's needs.

(c) Develop the process: Develop and finalise the policy and detail the managerial roles and responsibilities in the attendance programme.

(d) Implement the process.

(e) Follow up and review: Review the implementation and adherence to the process. Set attendance goals and monitor attainment of these goals.

Levine Associates do not specifically mention the involvement of employees and employee representatives in the process of policy development. Levine Associates state that an absenteeism policy should indicate the following:

- The importance of attendance as expressed in the employment contract;
• Punctuality requirements;
• Notification and documentation procedures;
• Circumstances considered “voluntary termination”, absence without leave and reason for counselling, suspension or termination;
• To whom the policy is applicable;
• When it will come into effect;
• Compensation arrangements for days absent;
• Number of sick-days granted and the reasons that are allowable (ill-health, family leave, excused absenteeism, etc);
• When a medical certificate will be required;
• The consequences of non-compliance;
• Late-coming procedure and implications for sick record; and
• Whom to contact for further clarification of the policy.

Levine Associates (2000: 3) mention that policies are generally stricter for businesses where both the presence and punctuality of employees are required, such as in the case of self-managed work teams or service teams, and less strict for professional workers, for whom the emphasis is on goal attainment. In the section below examples of various types of policies are presented. The discussion around these policies is normative in nature, as organisations can use their discretion in terms of the policies they introduce with the purpose of managing of absenteeism, and the wording of these policies.
3.2.1.1 No-fault absenteeism policy

The no-fault absenteeism policy was developed out of the need to “beat” employees who “beat” the absenteeism system. In a no-fault policy, any absence is considered as an absence regardless of the reason (Carrell et al, 1998: 572). It takes the discretion of whether an absence excuse is acceptable or not, away from the supervisor. Management decides how many days can be tolerated (taking legal requirements into account), and once an employee has exceeded the maximum number, his/her services are terminated. Organisations utilising a no-fault absenteeism policy often make use of a point system to measure absenteeism. Table 3.1 provides an example of a no-fault absenteeism policy.

Table 3.1: A no-fault absenteeism policy

<table>
<thead>
<tr>
<th><strong>ABSENTEEISM POLICY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>As a result of excessive absenteeism and/or tardiness, disciplinary action may be required and will be based on frequency of occurrences in accordance with the following:</td>
</tr>
<tr>
<td>• Absenteeism is defined as being absent from work on any scheduled workday, whether the absence is excused or unexcused.</td>
</tr>
<tr>
<td>• Each period of consecutive absences will be recorded as “one occurrence” regardless of the number of days’ duration.</td>
</tr>
<tr>
<td>• Tardiness will be considered reporting to work within ten (10) minutes of the scheduled starting time. One occasion of tardiness will be charged as one quarter (¼) occurrence of absenteeism.</td>
</tr>
<tr>
<td>• Employees who report to work late, as provided for in the reporting regulations, or who leave before the end of the shift (with management’s permission) will be charged with one-half (½) of an absence occurrence.</td>
</tr>
<tr>
<td>• Employees who are absent without call-in will be charged with two occurrences of absence for that occasion.</td>
</tr>
<tr>
<td>• Absence due to Funeral Leave or Union Businesses (each as defined by the Contract), and further including hospital confinement and work-incurred injury will not be recorded as an occurrence of absence for purpose of disciplinary action.</td>
</tr>
</tbody>
</table>
For each calendar month of perfect attendance, an employee with an absence record will have one occurrence deducted from his/her absentee record.

Absence records will be maintained for a consecutive twelve-month period, starting with the employee’s first occurrence of absence. All absence records and warning slips that are one year old, or older, shall not be considered for purposes of disciplinary action under this policy.

Corrective discipline will be administered according to the following:

- Three occurrences, or “points”, within a twelve-month period – oral warning.
- Five occurrences, or “points”, within a twelve-month period – written warning.
- Seven occurrences, or “points”, within a twelve-month period – second written warning.
- Twelve occurrences, or “points”, within a twelve-month period – discharge.

The above policy is in addition to action that may be taken when cumulative time lost from work for any reason substantially reduces the employee’s services to the company, or as may be related to provisions in the contract.

Source: Carrel, Elbert, Hatfield, Grobler, Marx & van der Schyf, 1996: 573

As can be seen in Table 3.1, the emphasis is on the time lost due to absenteeism and not the reason for absenteeism. Provision is also made for tardiness. This is a more structured way in which to deal with absenteeism, which leaves little room for subjective interpretation.

In a no-fault absenteeism system, the supervisor’s role is simply to record the days or number of points that the employee has used, and to give continuous feedback to the employee. Provision is made for warnings, and private counselling in order to cater for situations where factors outside the control of the employee are responsible for excessive absenteeism (Levine Associates, 2000: 1-4). The no-fault absenteeism policy makes administration easier, as the supervisor does not have to inquire about the reason for absence, or decide whether “excused” absence is acceptable or not. However, if absenteeism due
to ill-health, or other reasons, is not recorded and medical certificates are not presented, it is impossible to use the absenteeism recording system as a mechanism to anticipate the development of trends, or as the basis for a disease prevalence study in the organisation. For example, if a number of employees are regularly absent as a result of backache and it is not recorded as such, it becomes impossible to identify the problem and develop strategies to prevent or reduce it. For this reason, the no-fault absenteeism policy is not recommended as suitable for the contingency management of health-related absenteeism.

3.2.1.2 Paid time-off (PTO)

The paid time-off policy is an alternative to the no-fault absenteeism policy. In this case vacation leave and public holidays are also taken into account. As specified in a paid time-off (PTO) policy (also called paid leave banks), all vacation leave, holidays and sick-leave for each employee are kept in a PTO account. PTO can be used for any leave, but if it is exhausted, the employee is not paid in the case of any absenteeism. The PTO system reduces one-day absences, but employees tend to utilise all the allowed time off by taking unused days for vacation. The different categories of absenteeism are not used for the recording of absenteeism, which makes it impossible to use this system to anticipate trends in health-related absenteeism or to use it as a basis for disease prevalence studies. The 2002 CCH Unscheduled Absence Survey reports that paid leave banks continue to be ranked as the most effective absence control programme in the USA. However, fewer than half of the organisations that participated in the survey, utilised paid leave banks (CCH, 2002).
The above policy could give employees more flexibility to manage their own health-related absenteeism. According to this policy, whether the employee him/herself is sick, or whether he/she wants to tend to a sick family member, is of no relevance. The employee gets a fixed total number of days, including vacation and public holidays, to use towards time-off. Whereas an employee would previously be “forced” to take leave on a public holiday, the employee could now choose to work on the day of the public holiday, and rather take the time off when required for health-related purposes. This policy encourages employees to save traditional vacation leave and public holiday leave for health-related purposes. A negative aspect of this policy is that healthy employees could utilise all their days for non-health-related matters.

While the PTO system allows employees greater flexibility in managing their health-related problems, it does not facilitate the comprehensive recording of absenteeism, which forms the basis for the analysis and management of absenteeism. It is therefore not recommended as suitable for the contingency management of health-related absenteeism.

### 3.2.2 Return-to-work policy

The aim of a return-to-work policy is to facilitate a speedy return of a sick or injured employee to his/her normal position. The careful monitoring of absenteeism facilitates early return to work. If an intervention is initiated within the first six weeks of absenteeism, the likelihood of an employee returning to work is increased by 80 per cent (Myers, 2001). Return-to-work programmes
include modified work, job redesign and alternative job placement (Business Times Survey, 1999).

The Labour Relations Act (No 66 of 1995) and the Employment Equity Act (No 75 of 1997) compel employers to reasonably accommodate an injured or disabled employee in the workplace. A return-to-work policy aims for more than simply accommodating an employee. It can reduce health-related costs related to medical intervention and also increase productivity levels in the organisation.

The European Foundation’s report (European Foundation, 1997: 20) explains the process of becoming ill, being absent, recovering and resuming work in terms of a lack of balance between the person and the environment. This imbalance, which can result in health problems, is the consequence of a discrepancy between the work demands and the capacity of the employee. For example, a job might require strenuous physical movements, while the employee is of slight build and runs the risk of developing muscle strain. The effects of this is illustrated in Figure 3.1. An absenteeism barrier (forces that prevent absenteeism) is formed by pressures to continue working despite developing health problems, while a reintegration barrier (factors that restrain reintegration) is formed by a totality of factors that affect the course of the illness and return to work. If a person has been absent for a lengthy period, effort is required on the part of the employee to return to work and assume normal productivity. Factors related to the individual, such as a lack of motivation, or to the workplace, such as demanding working conditions, could increase resistance to reintegration within the organisation. In addition, societal factors, such as family members who encourage the person to stay at home longer, also create resistance to
reintegration. The purpose of return-to-work policies and programmes are to lower the reintegration barrier and assist the person in settling down in his/her job.

**Figure 3.1:** Factors influencing absenteeism and return-to-work barriers

![Diagram of factors influencing absenteeism and return-to-work barriers]

**Source:** European Foundation, 1997: 20

It is therefore clear that it should not be left up to the individual employee to craft his/her own return to the workplace, but that a structure should be in place, in the form of return-to-work policies and procedures, to facilitate the process. These policies and procedures relate to the involvement of professionals, such as medical insurance or rehabilitation organisations and the way their involvement is structured.
Considering the direct and indirect costs of absenteeism, which were discussed in Chapter two, there is a strong business case for the implementation of effective return-to-work policies and procedures. However, Myshko (2003: 1-2) cautions that it is not merely enough to get the person back to work, but that the person should be empowered to engage in meaningful and productive work. A person might be physically incapable of certain tasks, while possessing excellent cognitive skills which could be applied in the training of other employees. Myshko is of the opinion that light duty is not an effective way to re-engage people in their jobs. It merely results in presenteeism, a state where an employee is at work, but not productive.

Myshko also reasons that company policy often disables people more than the injury itself, as policies are often ambiguous. Organisations should formulate clear return-to-work policies that provide guidelines to managers, supervisors and employees.

A return-to-work policy stresses the commitment of the organisation to facilitate return-to-work, as it benefits both the employer and the employee. The return-to-work procedure should clarify who is responsible for the management of the programme, who is eligible to enter the programme, the process to be followed, compensation arrangements while the person is on the programme, and its duration. It should also indicate the consequences of a person’s unwillingness to participate in the programme.

With the proliferation of HIV/AIDS and applicable legislation in South Africa, return-to-work strategies are receiving more attention. DaimlerChrysler South
Africa (DCSA) includes a section in its policy on HIV/AIDS in the workplace that states that the company “makes efforts to reasonably accommodate an employee in another position in line with existing legislation and company policies”, if the employee is not able to perform current duties as a result of his/her medical condition.

A return-to-work policy has the potential to prevent and reduce unnecessary absenteeism as it allows employees to return to work earlier and stay productive. For this reason it is advocated as a useful strategy in the contingency management of health-related absenteeism.

### 3.2.3 Disability policy

South African labour law, discussed in Chapter two, makes provision for the fair treatment and equitable representation of people with physical and psychological disabilities, in the workplace. In South Africa, it is obligatory to employ a certain number of disabled people and companies will have to ensure that they do formulate a policy on disability. Employers are also obliged to “reasonably” accommodate the disability of the employee and to provide opportunities for the retraining and development of employees with disabilities.

### 3.2.4 Corporate wellness policy

Wellness focuses on the employee’s physical and mental-health. The assumption is that prevention is better than cure, and that a holistic approach is
best when taking care of the broader social and domestic dynamics of employees. Wellness programmes aim at identifying and correcting specific health problems, health hazards, or negative health habits, such as smoking, poor diet, stress and lack of exercise. According to Moodley (2003), organisations should develop an overall corporate wellness policy in order to integrate various health-related policies such as the EAP, HIV/AIDS, substance abuse, stress and trauma and smoking policy.

Matlala (1999: 22-25) suggests that organisations include wellness in their overall strategy and in the culture of the organisations, involve all role players, and develop and implement health promotion policies, such as EAPs, a smoking policy and a HIV/AIDS policy. He states that organisations who ignore the promotion of health cannot be considered as learning organisations and that such an attitude will reflect in a high rate of absenteeism and low rate of productivity.

In Chapter two (refer to paragraph 2.4), it was mentioned that employees who carried a low health risk were more productive and less absent. Wellness programmes are aimed at optimising health by reducing health risks among employees. In the case of HIV/AIDS, attention to the general health of a person might prevent or postpone the onset of full-blown AIDS and could result in the person’s prolonged productivity. By implication, wellness programmes could have a direct impact on absenteeism levels in organisations, and therefore form an important strategy in the contingency management of health-related absenteeism.
3.2.5 Employee Assistance Programme (EAP) policy

An EAP is a structured intervention that offers a broad range of services aimed at identifying certain individual problems (notably substance abuse and financial, relationship and mental problems) that adversely affect job performance. An EAP is implemented with the objective to empower the employee to constructively deal with these problems and return to making a full contribution to the organisation and attaining full functioning in his/her personal life (Arnold, Cooper & Robertson, 1998: 447; Bergh & Theron, 2003: 440-441).

When a new EAP service is introduced, it is crucial that employees are consulted (through the trade union, where applicable) and that the service is incorporated into the employment contract. Management should also receive adequate training as to their role in the EAP (Moodley, 2003).

The purpose of an EAP policy is to formalise and document EAP service standards. Moodley (2003) provides the following guidelines for the development of an EAP policy:

- A consistent and qualitative service should be provided by developing a programme that clearly defines eligibility, services offered, and referral;
- The relationship between the organisation and the EAP provider (internal or external) should be clearly defined;
• The accountability and parameters for the administration of the EAP should be clarified;

• The policy document should be compatible with other policies. For example, it should be decided whether employees' participation in the EAP for rehabilitation falls under annual or sick-leave, or whether it does not constitute as absenteeism;

• The EAP policy, procedure and services should fit the specific needs of the employees and the working environment;

• An internal EAP provider should be distinguished from any external providers;

• Confidentiality, as applicable to the whole EAP provider group, should be spelled out. The disclosure of information should only take place with the employees’ express written consent, in terms of the agreed upon policies, and according to strict requirements in terms of referral sources and statements (content, circumstances and receiver);

• Substance abuse should be acknowledged as an illness and the EAP should play a rehabilitative, counselling, educational and supportive role;

• The EAP’s role in stress management should be clarified. Provision should be made for guidance, advice and training, and a protocol for the management of occupational stress;

• Provision should also be made for the management of loss and trauma in the workplace; and
• Even though separate policies are provided for HIV/AIDS and disability, the role of EAP in the management of HIV/AIDS should be described.

In conclusion, an EAP policy provides a structured strategy in the prevention and reduction of absenteeism in the workplace. It is, however, important to ensure that the EAP meets the necessary requirements of legitimacy and quality to maximise its contribution to the contingency management of absenteeism.

3.2.6 Substance abuse policy

In paragraph 2.3.3, it was shown that substance abuse is a serious problem in South Africa and that this abuse has a major impact on attendance in the workplace. In addition, employees who attend work while under the influence of alcohol or drugs pose a serious safety risk to themselves and their co-workers. Ideally, the substance abuse policy should be integrated with the EAP policy. However, because substance abuse is a major problem to many people and organisations, it is discussed separately from the EAP policy. Important aspects, specifically related to a substance abuse policy, are discussed in this paragraph.

According to Schultz (2004a: 295), a formal written policy on substance abuse should be developed and communicated to all employees. The policy should:

• State management’s philosophy and position on the use and possession of illegal drugs and alcohol;
• Set standards for appropriate conduct both on and off the job;
• List the methods that might be used to determine the causes of poor performance; and

• State the organisation’s views on rehabilitation, including specific penalties for policy violations.

It is therefore evident that substance abuse is a problem in South African organisations that should be addressed. Substance abuse is not only a health-related matter, but also a disciplinary matter. In order to reduce the effect of substance abuse on absenteeism levels in organisations, a professional approach should be followed.

3.2.7 Stress and trauma as integrated parts of the EAP policy

The impact of stress and trauma on levels of absenteeism and productivity was discussed in paragraph 2.3.2. It is evident that stress and trauma are currently major problems in South Africa, and therefore also in South African organisations. According to Moodley (2003), trauma does not have to be contained in a separate policy, but could be included in other policies such as the EAP or health and safety policy. Whether in a separate or integrated policy, the purpose of such a policy should be, firstly, to demonstrate the company’s commitment to addressing these problems, and secondly, to provide a constructive manner in which to deal with stress and traumatic experiences in the workplace.

Although stress and trauma are implicated as issues that could be addressed by the EAP, and therefore, by implication, also covered in the EAP policy, it is
currently posing a threat to attendance levels in organisations and, as such, also to organisational productivity. Due to the magnitude of the problem in South Africa and South African business, as discussed in paragraph 2.3.2, it justifies special attention.

3.2.8 HIV/AIDS policy

The Code of Good Practice on HIV/AIDS and Employment, which was discussed in Chapter two, recommends that every workplace develops a specific HIV/AIDS policy to ensure that employees are not unfairly discriminated against in employment policies and practices.

The code provides the following guidelines for the development of a workplace policy on HIV/AIDS:

- The organisation’s position on HIV/AIDS;
- An outline of the HIV/AIDS programme;
- Details on employment policies (e.g. position regarding HIV testing, employee benefits and performance management);
- Express standards of behaviour expected of employers and employees;
- Set out the means of communication within the organisation on HIV/AIDS issues;
- Details of employee assistance available to persons affected by HIV/AIDS;
- Details of implementation responsibilities; and
• Monitoring and evaluation mechanism.

(Government Gazette, 2000)

The code also recommends that all policies be developed in collaboration with key stakeholders in the workplace including trade unions, employee representatives, occupational health staff and the human resources department. It also recommends that the policy should reflect the nature and needs of the particular workplace.

DaimlerChrysler South Africa (DCSA) has received world acclaim for its HIV/AIDS programme (Fayo, 2004: 10). It is therefore useful to consider what the company’s policy on HIV/AIDS entails. In its HIV/AIDS policy, the DCSA has committed itself to:

• The development and implementation of an HIV/AIDS policy in consultation with employees at all levels;
• Fair treatment of all employees living with HIV/AIDS;
• Keeping personal information confidential;
• Compliance to relevant legislation and the South African Development Conference (SADC) Code on HIV/AIDS and Employment;
• Providing a non-discriminatory and caring workplace environment;
• A comprehensive health-care approach to HIV/AIDS;
• Continuous education and awareness services for employees and their families;
• Minimising the impact of HIV/AIDS on the company’s ability to do
business; and

- Co-operation with and support for organisations involved in community-based HIV/AIDS initiatives and advocacy.

(DCSA Star Flash, 18 June 2001)

Positive aspects of this policy include the involvement of employees in policy development and implementation, compliance to legislation, the extension of services to the family of employees, co-operation with community-based organisations and emphasis on the company’s ability to do business. DaimlerChrysler SA claims that, since the start of their workplace programme, the survival rate for those affected had risen to 90 per cent, and that not one baby born to a mother who was part of the programme, has been infected with HIV (Fayo, 2004: 9).

An HIV/AIDS policy gives direction to the management of the HIV/AIDS pandemic within an organisation and should be developed according to legal and situational requirements.

The above discussion focused on the policies that are important to the contingency management of health-related absenteeism. Space does not permit the provision of examples of these policies.
3.3 THE RECORDING, MEASUREMENT AND ANALYSIS OF ABSENTEEISM

There is no literature that disputes the fact that accurate record-keeping is a fundamental first step in any successful absenteeism management programme. The recording of absenteeism does not only provide a basis for the management of individual absenteeism, but also a basis for the measurement of group absenteeism and organisational absenteeism, and subsequently, the analysis of absenteeism levels in an organisation. A survey done by PricewaterhouseCoopers in 2003, in which 1056 organisations in 47 countries participated (25 from South Africa), revealed that in comparison to 61 per cent of global organisations, only 31 per cent of South African organisations tracked absenteeism (Mathews, 2003: 2). According to Werner (2004: 550), the recording and measurement of absenteeism has no value if it is not utilised in effective management decision-making.

The Soma Initiative, a company that specialises in health-related absenteeism, return-to-work and rehabilitation programmes highlights the following as the main components of an effective absenteeism management strategy that specifically aims at containing health-related absenteeism:

- A comprehensive employee database;
- Daily registration of absenteeism;
- Early selection of potential long-term absenteeism cases;
- Referral of selected cases to an occupational doctor for a specified medical report;
• Determining of the occupational capacity and earliest return-to-work date;
• Monitoring of the reintegration process and return to work;
• Forwarding of any relevant information to an insurer;
• Comprehensive reporting to the employer regarding the health status of the absent employee and his/her progress;
• Management of information and statistical analysis of sick-leave data; and
• Sorting of the data according to employee, department or the entire company.

(The Soma Initiative, n.d.b)

It is clear that these guidelines address the recording, measurement and analysis of health-related absenteeism.

3.3.1 Recording of absenteeism

The most basic information required to record absenteeism is the employee’s name and employee number, days absent, and reason for absence. Human resources software makes it easy to record absenteeism, and often provides for individual, as well as group records. Group records are important when identifying absenteeism trends in the organisation. For the sake of determining the extent of health-related absenteeism in the organisation, absences can be divided into three categories: sick-absences, authorised absences and
unexcused absences (Werner, 2004: 549). Figure 3.2 illustrates some of the options offered by a software programme for the analysis of absenteeism.

**Table 3.2:** Options offered by an absenteeism management software programme

<table>
<thead>
<tr>
<th>GROUP TRENDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department/section</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Gender and race</td>
</tr>
<tr>
<td>Marital status</td>
</tr>
</tbody>
</table>

**Source:** Nel, van Dyk, Haasbroek, Schultz, Sono and Werner, 2004: 551

As can be seen from the above table, absenteeism-related information, such as department, age, gender, race of the absentee, can be recorded. These types of information can assist organisations in making a careful analysis of the causes and nature of absenteeism, and subsequently assist in the development of strategies for the management of absenteeism that are tailor-made for each situation. Important issues that surface during the recording of absenteeism are proof of illness, counselling, alternative work arrangements and dismissal due to incapacity. These issues are discussed below.

### 3.3.1.1 Proof of illness

The conflict between an employer’s need for information and an employee’s right to privacy is seldom better demonstrated than in situations where personal medical information is required. The issue is even more complicated when
diseases or conditions are stigmatised, such as in the case of HIV/AIDS, or in the case of stress or other mental illnesses. One assumes that unions will strongly object to an effort by management to inquire too deeply into the nature of an employee’s illness.

Lapere (2004), medical practitioner and expert in Labour Law in South Africa, noted that the ethical guidelines for medical certification used by the Health Professions Council of South Africa (HPCSA) are in fact stricter than the requirements for medical certificates prescribed by law in the Basic Conditions of Employment Act (No 75 of 1997). According to Lapere, organisations in the Nelson Mandela Metropole are increasingly unwilling to pay employees for days absent if medical certificates are unclear, incomplete or invalid. He encouraged doctors to act ethically when issuing medical certificates, as the stroke of the pen affects the remuneration of the employee, his/her job, as well as the productivity of the organisation. The indiscriminate issuing of medical certificates brings the medical profession into disrepute.

In terms of medical certificates and reports, the Health Professions Council of South Africa (HPCSA) recommends the following:

- A practitioner shall only grant a certificate of illness if such certificate contains the following information, namely:
  
  (a) The name, address and qualification of the practitioner;
  
  (b) The name of the patient;
  
  (c) The employment number of the patient (if applicable);
  
  (d) The date and time of the examination;
  
  (e) Whether the certificate is being issued as a result of personal
observations by the practitioner during an examination, or as the result of information received from the patient, and whether it is based on acceptable medical grounds;

(f) A description of the illness, disorder or malady in layman's terminology with the informed consent of the patient: If the patient is not prepared to give such consent, the medical practitioner or dentist shall merely specify that, in his/her opinion, based on an examination of the patient, the patient is unfit to work;

(g) Whether the patient is totally indisposed for duty or whether the patient is able to perform less strenuous duties in the work situation;

(h) The exact period of recommended sick-leave;

(i) The date of issuing the certificate of illness; and

(j) A clear indication of the identity of the practitioner who issued the certificate. It shall be personally and originally signed by him/her next to his/her initials and surname in printed letters.

- If preprinted stationery is used, a practitioner shall delete words which are irrelevant.

(Health Professional Council of South Africa, 2004)

The Basic Conditions of Employment Act (BCEA) requires that a medical certificate contains proof that the employee was sick or injured during the time of absence and that it be signed by a medical practitioner or a person who is certified to diagnose and treat a patient and who is registered with a professional council.
The following general guidelines in terms of proof of illness have been developed over time from existing jurisprudence (Guidelines for absenteeism control: http://www.benefits.org/interface/cost/absent.2.htm):

- The employee has the right to privacy unless the employer can demonstrate that it is its legitimate business interest to obtain more information;
- When intrusion is justified, it should be limited to what is absolutely necessary;
- The employee has the duty to inform the employer of an intended absence, the cause and expected duration to allow the employer to make alternative arrangements for the continuation of production or service provision;
- The absent employee has to inform the employer of any change in his/her condition;
- It is unreasonable to expect proof for every illness if the absence does not create a problem, as in the case of a single occurrence;
- A mere assertion by the person claiming to be sick is not satisfactory proof;
- An employer can refuse to accept a medical certificate if it contains insufficient information, such as if an indication of date of return to work is not indicated;
- Non-production of a certificate can result in the employer withholding pay until it is produced;
- Rejection of a certificate by the employer must be explained to the employee;
• Where reasonable, the employer can require proof of fitness; and
• When unusual circumstances raise reasonable suspicion that an employee has abused the system, the employer may demand more information, such as whether an employee was confined to his/her bed or home, or did he/she engage in outside activities;

A study of the organisational culture, the relationship between the employer and employee, and the design of the employee’s job lies outside the scope of this study, but it should nevertheless be noted that these factors do influence the diligence and honesty with which employees report absences, and whether they use legitimate sick-leave as a mechanism to withdraw from the work situation or not.

3.3.1.2 Counselling

The process of counselling is interdependant on record keeping, and therefore is discussed in the same section as record keeping. Van der Merwe and Miller (1988: 17) suggest that the situation when a returning employee is required to submit a medical certificate and/or explain his/her absence, provides a good opportunity to examine the individual’s records, caution the employee and stress the importance of attendance. Absenteeism records determine whether counselling is necessary, and what form the counselling should take. In Chapter two, the legal requirements with regard to counselling were discussed (refer to paragraph 2.6.3). Employers are encouraged to correct employees’ behaviour by means of a graduated disciplinary system that makes provision for counselling
and warnings. Counselling is aimed at identifying problems and finding constructive solutions. The proper recording of absenteeism will reveal the need for counselling. As soon as a problem has been identified, the employer interviews the employee to communicate attendance requirements, and to offer assistance. If absences are intermittent, the employer meets with the employee every time he/she returns to work. If the absence is prolonged, the employer keeps in touch with the employee and stays updated with his/her condition. The employee may be required to provide the employer with regular medical assessments. These assist the employer in anticipating whether the employee is likely to be able to return to work or not.

Finnemore and Weiss (1996: 27-29) highlight the following advantages of positive counselling:

- It makes the employee aware that his/her attendance is valued;
- It allows an opportunity to emphasise the absenteeism policy and the consequences of non-attendance;
- Genuine problems such as alcoholism, family problems and job dissatisfaction may be addressed; and
- It provides the union with an opportunity to solve problems rather than to defend a person during disciplinary hearings.

The recording of absenteeism provides the first step in the management of absenteeism and provides the opportunity to start counselling before a problem escalates. Counselling provides an opportunity for an employee to be referred to the Employee Assistance Programme (EAP) officer who could assist an
employee in managing his/her health better. The EAP as a practice in the contingency management of absenteeism is discussed in paragraph 3.4.3.4.

3.3.1.3 Alternative work arrangements

One of the decisions that is dependant on the individual absenteeism record of an employee, is whether alternative work should be arranged or not. As discussed in the previous chapter, South African Labour Law requires the employer to make reasonable attempts to accommodate the employee who experiences health-related problems by offering an alternative position, or by means of alternative job requirements.

3.3.1.4 Dismissal due to incapacity

Another decision that is dependant on the individual absenteeism record of an employee, is whether he/she should be dismissed as a result of incapacity. It is evident that accurate and up-to-date information is required in order to make such a decision according to legal requirements. When an employee is unable to provide his/her services on a continuous basis, the person has been counselled and supported, and alternative work arrangements have proved unsuccessful, his/her services may be terminated. The procedure to follow in such a case is discussed in paragraph 3.7.
3.3.2 Measuring absenteeism

The purpose of measuring absenteeism is to determine the extent and nature of absenteeism in the organisation. The two measurements that are commonly used are the total time lost and absence frequency (Cherrington, 1995: 71; Hamilton-Atwell, 2003: 59; Werner, 2004: 550). The total time lost is also called the gross absence rate (GAR). These measurements can be used to determine the overall time lost and the absence frequency rate for the organisation as a whole, as well as for every separate group in the organisation. The creation of these groups should be based on logical differential criteria, such as nature of the job, level in organisation, skill level, gender and department. This enables management to identify absenteeism trends in the organisation, as well as absenteeism problems that are unique to a specific group, with a view to find constructive solutions to these problems. Jollife (2000) states that the evaluation of absenteeism should be based on a thorough assessment of valid, accurate data, with a view to determine severity (the number of hours/days lost), frequency (number of episodes), concentration (many absent occasionally or few absent frequently) and a search for patterns (such as specific departments and times of the year).

The total time lost index (or GAR) gives an indication of the percentage of time lost due to absenteeism. The total time lost is calculated as follows:

\[
\text{GAR} = \left( \frac{\text{Total no of days lost over period}}{\text{Total possible man-days over period}} \right) \times 100
\]


The internationally acceptable norm for absenteeism is three per cent. Considering the impact of absenteeism on production and service provision, and the issue of global competitiveness, the question is raised whether organisations should be content with an absenteeism rate of three per cent. Table 3.3 shows the time lost index figures (here called GAR) as derived from a study in which 14 major South African organisations participated. The exact date of the study was not indicated, but it was described as a ‘recent’ study. The letters of the alphabet represent the different organisations.

Table 3.3: Time lost index figures (here called GAR) from a South African study

Source: Hamilton-Atwell, 2003: 58

It is evident from Table 3.3 that all of these South African organisations had lost more than three per cent of the scheduled work time, and therefore that none of them had met the international standard of three per cent or less. The lowest scheduled work time lost is 5.1 per cent, while the highest is 21.6 per cent. The average time lost is 11.6 per cent. Table 3.3 can be compared to table 3.4,
which presents the time lost index figures for a few international countries, over different periods.

**Table 3.4:** The time lost index figures derived from international companies

<table>
<thead>
<tr>
<th>Country</th>
<th>Rate</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>3.0%</td>
<td>1997</td>
</tr>
<tr>
<td>Denmark</td>
<td>3.5%</td>
<td>1995</td>
</tr>
<tr>
<td>Netherlands</td>
<td>8.3%</td>
<td>1993</td>
</tr>
<tr>
<td>USA</td>
<td>2.7%</td>
<td>1994</td>
</tr>
<tr>
<td>Australia</td>
<td>2.7%</td>
<td>1998</td>
</tr>
<tr>
<td>Belgium</td>
<td>7.0%</td>
<td>1995</td>
</tr>
<tr>
<td>Portugal</td>
<td>8.0%</td>
<td>1995</td>
</tr>
</tbody>
</table>

**Source:** Hamilton-Atwell, 2003: 58

In comparison to these international countries, South African companies have a high absenteeism rate, which could comprise their ability to compete globally.

Rabe (2001: 48) notices that if South African employees were to use all the sick-leave they are entitled to according to the BCEA, the absenteeism rate would be about four per cent. Though most employers would be content with four per cent, it cannot be considered as acceptable. The Pareto principle implies that 20 per cent of employees are responsible for 80 per cent of absenteeism. This means that if employers focus on the 20 per cent causing the problem, they could bring absenteeism under control.

Whereas the total time lost index gives an indication of the total time lost due to absenteeism, the absence frequency rate is used to give an indication of the nature or causes of absenteeism. The absence frequency rate reflects the
number of incidents per employee per month. An incident of absenteeism is defined as one spell of absence, irrespective of the number of days involved, as long as the days run consecutively. The absence frequency rate is based on absenteeism information collected over a month and is expressed as a ratio.

The absence frequency rate is calculated as follows:

\[
\frac{\text{Number of absence incidents over period}}{\text{Total number of employees}}
\]

A high absence frequency ratio indicates the prevalence of shorter, more disruptive incidents of absenteeism, while a lower frequency rate indicates longer, but less disruptive incidents. It is easier and less costly to make contingency arrangements when it is known that an employee will be absent for a longer period than for multiple shorter incidents of absenteeism, as they are predictable.

The total time lost index and frequency rate are determined for every group of employees and for every category of absence, namely sick-absence, authorised absence and unexcused absence.

In addition to the above mentioned indices, the short duration absence frequency rate (SDAFR) and long duration absence frequency rate (LDAFR) can be used to determine the disruptiveness of absenteeism of a short and long duration. The SDAFR is calculated for incidents consisting of one or two days, while the
LDAFR is calculated for incidents consisting of three or more days (Hamilton-Atwell, 2003: 59).

The SDAFR is calculated as follows:

<table>
<thead>
<tr>
<th>One- or two-day absence incidents over period</th>
<th>Average number of employees</th>
</tr>
</thead>
</table>

The LDAFR is calculated as follows:

<table>
<thead>
<tr>
<th>Three-day or longer absence incidents over period</th>
<th>Average number of employees</th>
</tr>
</thead>
</table>

The SDAFR and another measure, the worst days absence frequency rate (WDAFR) are normally aimed at evaluating the extent of sick-leave abuse. The worst days absence frequency rate takes into account traditional “bad” days for absenteeism, such as Monday/Friday and payday absences.

The WDAFR is calculated as follows:

<table>
<thead>
<tr>
<th>Monday/Friday leave incidents over period</th>
<th>Average number of employees</th>
</tr>
</thead>
</table>

Most authors refer to the time lost index and absence frequency rate only. However, the use of these various measurements could assist organisations in tracking trends in absenteeism and enable them to benchmark against similar
organisations. The next paragraph illustrates how absenteeism measurements assist in the analysis of absenteeism problems.

3.3.3 The analysis of absenteeism

According to Werner (2004: 550), the recording and measurement of absenteeism has no value if the data is not interpreted and used as a diagnostic tool to identify and rectify problems.

The total time lost index gives an indication of the percentage of work-days lost due to absenteeism. This total should be compared to the international norm of three per cent and a decision should be made whether it needs improvement or not. The percentage time lost can also be benchmarked against the industry or regional average, if these figures are available. By comparing different departments/groups, problems within the organisation can be located. Trends over time within a specific group can also be followed for early identification of absenteeism problems.

The percentage time lost due to illness is specifically relevant to the purpose of this study. It is normally agreed that if the total time lost due to illness is high, and is coupled with a high absence frequency rate, the company is plagued by shorter incidents of absences, which are considered as more disruptive. This is also often interpreted as an indication that the sick-leave system is abused (Van der Merwe and Miller, 1998: 23-24; Werner, 2004: 550). Shorter absences could be an indication of delinquent behaviour, as people could make use of legitimate
sick-leave to withdraw from an unpleasant work situation. A study of the reasons and remedies for withdrawal behaviour lies outside the scope of this study, as it often relates to wrong selection and placement, unmet expectations, and the person-work relationship. However, withdrawal behaviour is also linked to stress, whether it is consciously experienced as such or not.

If the percentage time lost due to illness is high and coupled with a low absence frequency rate, it is a clear indication that people are genuinely ill, and that the illnesses are more serious in nature (Van der Merwe and Miller, 1998: 23-24). However, Zeelie (2003) challenges this perception, stating that the situation could be different in the case of HIV/AIDS. According to him, employees in the late-phase of HIV will occasionally take a day or half of a day off to visit a clinic or hospital. Once these employees develop AIDS, they become prone to various infections of a less serious nature, such as flu, and will take short periods of leave (two to three days). Zeelie is of the opinion that employers can easily misinterpret the shorter periods of illness as delinquent behaviour and react without empathy. The time needed to recuperate from these infections will increase with time as the immune system continuously weakens. This situation will continue until people are so often absent due to tiredness, lethargy, illnesses and mental problems, such as stress, that a stage of incapacity is reached.

According to Zeelie (2003), employees who are not infected, but have family members who are infected, will also show a higher tendency for absenteeism, as they attend to sick family members. Due to the stigmatisation of people affected by HIV/AIDS, they are less likely to be honest about the real reason for their absence, and are more likely to fake personal illness.
Considering the prevalence of HIV/AIDS in South Africa, companies could expect an increase in family responsibility leave, as employees might request time off to attend to sick family members and to attend funerals. Organisations might want to calculate the percentage of time lost due to family leave, if it appears to become a major concern. The following formula could be used to calculate time lost due to family leave:

\[
\text{Days lost due to family responsibility leave} \times 100 \quad \text{X Total possible man-days}
\]

The percentage derived from this calculation should not be compared to the absence norm of three per cent, as it is only a sub-category of the total absenteeism rate. However, it will allow the organisation to follow trends in absenteeism.

A high percentage of work-time lost due to unexcused absenteeism normally results in disciplinary action. A discussion of unexcused absenteeism and the necessary corrective action falls outside the scope of this study as it is not regarded as health-related absenteeism, although certain aspects of it have been addressed in section 3.2.1.1.

In conclusion, the recording, measuring and analysis of absenteeism are important to determine the extent and nature of absenteeism in the organisation. Employers should be careful not to always attribute shorter incidents of
absenteeism to delinquent behaviour, but should verify the underlying causes that are behind a high percentage time lost due to sick-leave.

One way in which this can be done is through prevalence studies, which are discussed in paragraph 3.4.

### 3.3.4 Reporting of absenteeism rates

Various stakeholder groups, such as employees, trade unions, management and the human resources management department could potentially be exposed to absenteeism reports. Respondents to a number of surveys have rated the improved monitoring of absenteeism and dissemination of absenteeism statistics to line managers as two of the most important factors in absenteeism control (Greengard, 1999: 103; Seccombe, 1995a).

### 3.3.5 Benchmarking

According to Thor (1995: 1), benchmarking is the systematic comparison of elements of performance in an organisation against those of other organisations, usually with the aim of improving the situation.

According to Johns (1997), a world authority on employee absenteeism, research shows that few companies benchmark absenteeism figures, which reflects their failure to manage it strategically by linking it to performance levels. Benchmarking the level of health-related absenteeism with those experienced by
similar organisations, as well as the contingency approaches utilised by these organisations to manage health-related absenteeism, could direct organisations towards managing health-related absenteeism more scientifically.

In order for benchmarking to be useful, comparative data should be used. Organisations should agree on what to measure and how to measure it. Havergal (1996: 30-31) calls for the use of similar data and uniform indicators in the benchmarking process. For example, if maternity leave is excluded from absenteeism figures, it should be excluded from all statistics. She also suggests that it is preferable, in the calculation of absenteeism, to use days or shifts lost rather than hours lost. The number of employees in a group should also be noted to make comparisons useful, as a ten per cent absenteeism rate for a group of 100 employees is much more costly than a ten per cent rate for a group of ten employees.

In conclusion, the recording, and the measurement and analysis of absenteeism, forms the basis of managing absenteeism as these activities allow organisations to determine the extent and nature of the problem, and guide effective decision-making with regard to dealing with the situation.

The rest of this chapter focuses on the maintenance and management of health in the workplace. Firstly, a holistic approach to the management of health is discussed, after which the focus shifts to health benefits and integrated occupational health-care programmes. Due to the threat of HIV/AIDS to the survival of organisations, a discussion of strategies aimed at managing this pandemic receives a focal position in the discussion. The focus then shifts to
ergonomics, and lastly, to dealing with incapacity. Although care has been taken to avoid it, some duplication is inevitable, as most aspects linked to the management of health are interrelated.

3.4 A HOLISTIC APPROACH TO HEALTH IN THE WORKPLACE

According to Schultz (2004a: 293), organisations are starting to adopt a proactive and holistic approach to health issues in the workplace. This implies not only dealing with apparent health problems, but also giving attention to the general physical and mental wellness of employees.

Considering the impact of HIV/AIDS on the organisation and absenteeism levels within the organisation, which was discussed in Chapter two, it is inevitable that the management of HIV/AIDS will feature prominently in a discussion of health-related issues in an organisation. However, as also seen in the discussion in Chapter two, many other health issues, such as stress, trauma and substance abuse, also contribute to absenteeism. An important aspect to consider is that the guidelines offered for the management of HIV/AIDS in the workplace, can also be used as a framework for dealing with other health-related issues. In addition, because DaimlerChrysler South Africa (DCSA) has received acclaim, both in South Africa and internationally, for the manner in which they deal with the HIV/AIDS pandemic, reference will be made to how they apply some of the best practices associated with the management of HIV/AIDS in the workplace.

In this section, attention is given to strategies that are aimed at the management of general health in the workplace, and the assumption is that these strategies
assist organisations in managing various health-related issues. Although reference will be made to the management of HIV/AIDS, this issue is discussed in more detail in paragraph 3.5 and focuses on strategies that are specifically aimed at the management of HIV/AIDS in the workplace. Therefore a certain amount of duplication is inevitable.

3.4.1 Prevalence studies

The purpose of a prevalence study is to determine the occurrence of a variable, such as smoking, in a group or various groups. In medical terms, “prevalence” refers to statistics that indicate the total number of people in a population who have a certain condition or disease. The use of prevalence studies as a means to determine the occurrence of diseases and illnesses in an organisation has received prominent attention with the spread of, and consequent efforts to manage, HIV/AIDS. Prevalence studies aimed at determining the impact of HIV/AIDS on the organisation will receive more attention in paragraph 3.5 during a more detailed discussion of HIV/AIDS. In 2002, AngloGold introduced symptom and radiological screening to determine the prevalence of TB in the organisation. The organisation has its own workplace laboratory for sputum collection and testing, as well as its own X-ray facility, for screening and diagnosis. Schultz (2004a: 292) mentions that organisations could use attitude surveys to determine the extent and nature of stress in an organisation. Such a survey could also be regarded as a prevalence study. General health risk assessments, as part of a wellness programme, also reveal the prevalence of health conditions and health risk factors within the organisation.
From a contingency management point of view, prevalence studies can be used to determine the extent to which a health condition exists in a specific workplace so that the necessary steps can be taken to manage the situation.

3.4.2 The provision of health benefits

The offering of health benefits is one strategy used by organisations to attract and retain employees. A study done to compare the health outcomes of individuals with and without health insurance, which included people suffering from illnesses such as cancer, diabetes, cardiovascular diseases, HIV/AIDS and mental illness, found that those without coverage had a 25 per cent greater chance of dying than those with private health insurance (Stolz, 2002).

As the cost of medical benefits soars, employers are forced to consider alternative strategies to maintain medical health coverage for employees. The following options are typically considered:

- An increase in employee contributions;
- New health-benefit options and pricing structures;
- New delivery and purchasing models;
- Disease management and health improvement plans;
- Re-evaluation of the total strategy and approach to health-care costs and cost-sharing;
- Voluntary employee-paid supplemental insurance products; and
Critical illness policies which are built on a life-insurance benefit model, rather than a medical-indemnity benefit model. If the policyholder contracts a major disease, the company pays out a fixed amount. (Stolz, 2002: 1-8)

Johnson (2003), director of Algoa Insurance Company Limited (AIC), in Port Elizabeth, suggests that organisations take a long-term strategic view towards the provision of health benefits, and seek assistance from experts in the field to compile a package that caters for specific needs of the employee and the organisation.

DaimlerChrysler South Africa (DCSA) continually reviews the benefits it offers to employees to cater for the impact of HIV/AIDS. Health-related employee benefits include insured death and disability benefits, funeral cover, and a company medical aid scheme (DCSA Star Flash, 2001: 3).

Old Mutual has conducted a survey to determine, amongst others things, what actions organisations took to minimise the financial impact of medical costs in the face of HIV/AIDS. Some of the findings from this survey are presented in Table 3.5.
Table 3.5: Actions taken by organisations to minimise the medical costs of HIV/AIDS

<table>
<thead>
<tr>
<th>Actions taken to minimise medical costs due to HIV/AIDS</th>
<th>1999</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education and awareness</td>
<td>85%</td>
<td>83%</td>
</tr>
<tr>
<td>Nothing</td>
<td>23%</td>
<td>10%</td>
</tr>
<tr>
<td>Case management</td>
<td>17%</td>
<td>48%</td>
</tr>
<tr>
<td>Additional HIV/AIDS benefit</td>
<td>15%</td>
<td>2%</td>
</tr>
<tr>
<td>Restrict HIV/AIDS benefit</td>
<td>11%</td>
<td>17%</td>
</tr>
<tr>
<td>Reinsured HIV/AIDS risk</td>
<td>9%</td>
<td>3%</td>
</tr>
<tr>
<td>Create a separate fund for HIV/AIDS</td>
<td>4%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Source: Old Mutual Healthcare, 2001: 15

The results of this study illustrate that the number of organisations who did nothing to reduce medical costs, decreased from 23 per cent to ten per cent between 1999 and 2001. Fewer organisations made provision for an additional HIV/AIDS benefit, while the number of companies that restricted their HIV/AIDS benefit increased by six per cent. There was an increase of 31 per cent in companies that made use of case management, and a nine per cent increase in companies that created a separate fund for HIV/AIDS. From a contingency management point of view, the two most adopted strategies to cap or reduce the escalating costs of HIV/AIDS in 2001 were education and awareness (83%) and case management (58%). Awareness and training are mostly preventative in nature, while case management is aimed at employees who are infected with the virus and who show negative symptoms.

Myslik (in Bennett, 2002b), head of NMG-Levy’s HIV/AIDS consultancy division, states that organisations go through definite stages in their approach to HIV/AIDS, which range from denial to holistic strategies. These stages are:
• Denial and avoidance by excluding HIV/AIDS treatment from the medical aid package. However, this practice was stopped by the Medical Schemes Act;
• The provision of employee benefit packages to limit the impact of HIV/AIDS;
• The offering of wellness and educational packages;
• The provision of anti-retrovirals; and
• The formation of corporate alliances with non-governmental organisations to obtain donor subsidies before launching more holistic programmes.

It is the view of Old Mutual that, while education and awareness might help change the behaviour of the next generation, much more will be required to deal with the current generation. According to the report, it is evident that case management interventions are perceived as helpful in reducing the financial costs related to medical treatment (Old Mutual Healthcare, 2001: 15).

Health benefits include medical aid, sick funds and provision of medication. Each is briefly discussed below.

3.4.2.1 Medical aid schemes

Medical aid schemes provide medical coverage for employees and their dependants. Basic medical aid plans usually make provision for a limited number of services, or full services with a percentage levy paid by members,
while general plans provide for the full cost of prolonged treatment for more serious conditions (Schultz, 2004a: 280).

### 3.4.2.2 Sick funds

Old Mutual Healthcare (2001:15) suggests that employers should not rely solely on medical aid schemes to deal with the financial implications of HIV/AIDS, but that they also consider the establishment of an additional fund. The costs of such a fund are to be offset by the benefits of retaining the productivity of employees for as long as possible, as well as the cost associated with employing new people.

In 2002, Delta (now General Motors), a large motor manufacturing company in South Africa, and its trade union agreed to establish a sick fund to cater for extended sick pay provided in terms of a new absenteeism policy. The employer, as well as employees, would contribute to the sick fund. The purpose of the fund was to supplement employees' income during sick-leave. The company and trade union agreed that employees would only receive 75 per cent of their normal pay during the first two days of absence (Delta absenteeism policy, 2002). This policy deters employees from taking short, unscheduled leave, while both employee and employer carry the financial burden of extended sick leave due to genuine illness.
3.4.2.3 Medication

The provisioning of anti-retroviral treatment (ART) for HIV/AIDS has lately received some attention in the media as companies such as DaimlerChrysler South Africa (DCSA) have given employees access to such treatment through the company’s medical aid scheme. The Old Mutual Healthcare Survey presents a positive case for administering ART (Old Mutual Healthcare, 2001). The Old Mutual Healthcare Model suggests that the use of ART reduces the number of AIDS sicknesses and deaths over time. It prolongs and improves the quality of the lives of infected employees, allowing them to stay productive for much longer, and resulting in organisations having to spend less on the replacement and re-training of new employees, as well as on death and disability benefits.

DaimlerChrysler South Africa (DMSA) has pledged ongoing commitment to increase access to anti-retroviral drugs, treatment according to standard protocols and appropriate treatment of opportunistic infections within the framework of the company medical aid scheme. Since 1999 the company has provided treatment for HIV/AIDS-related illnesses and access to anti-retroviral treatment for HIV-infected members that are in need of such treatment (DCSA Star Flash, 18 June 2001).

Jelly (2000: 8), on the other hand, suggests that the key to an economically viable HIV/AIDS programme does not lie so much in the provision of ART, but in the early diagnosis and the provision of proactive medical care to all employees.
who are HIV-positive. For this reason, it is important to encourage employees to
determine their HIV-status.

One area in which organisations make a positive contribution to the health of
their employees, is through the administration of medication for tuberculosis (TB).
As discussed in Chapter two, TB is strongly associated with HIV/AIDS. Non-
adherence to the medical regimen decreases the effectiveness of it, aggravates
the contagious nature of the disease, and makes people more vulnerable to
HIV/AIDS. By administering TB medication to infected employees, organisations
actively reduce illness and absenteeism levels in the organisation.

In conclusion, the provision of health benefits places employees in a better
position to manage their health and increase their attendance levels. The nature
and extent of the health benefits depends on what organisations can afford, and
the needs of employees.

### 3.4.3 Integrated occupational health-care programmes

An integrated occupational health-care programme is a programme supported by
top management, which utilises resources inside and outside the organisation. It
aims to holistically deal with the health of employees, in order to promote
wellness and reduce ill-health, which could impact on absenteeism and
productivity in the organisation. Daly (2000) perceives health management as
not just a cost, but also as an investment. Health management has a positive
effect on the reduction of absenteeism, as it decreases illness and health risks.
Daly is of the opinion that this is specifically relevant in countries where public health-care provision is limited and private health-care expensive, as is the case in South Africa.

Burton (1999: 1) stresses that, although it is crucial to target those employees who are the sickest and most responsible for direct and indirect health costs, it is equally important to assist the rest of the employees to maintain a low health risk.

Figure 3.2 shows opportunities that arise for health management in the organisation. The process includes screening, preventative services, lifestyle interventions aimed at low risk maintenance and risk reduction, and disease case management.

**Figure 3.2:** Opportunities for health management

![Opportunities for health management diagram](image)

**Source:** Edington, 2002
From Figure 3.2 it is evident that health management is aimed at both healthy and unhealthy employees. Screening is done to determine the risk employees carry of developing diseases. Employees at low risk are exposed to interventions to maintain a low risk, while those who are at high risk are exposed to interventions aimed at reducing the risk. Early signs or symptoms are detected to prevent the development of diseases. However, once employees have developed a disease, each specific case is managed to attain the best possible results, that is, to keep the employee as productive as possible and to keep absenteeism as low as possible.

Consequent to the introduction of a health-care programme at their subsidiary in Mechelen, Belgium in 1998, the US chemicals company, Du Pont, reduced absenteeism levels to two per cent, which compared favourably to the national average of seven per cent. The company saved ECU (European Currency Unit) one-million (European Report, 1998). The integrated health-care programme introduced by Du Pont to one of their Belgium subsidiaries provided for:

- Advice;
- Health questionnaires;
- Health education;
- Provisioning of a health-care center;
- Sporting activities;
- Risk evaluation;
- Medical examinations (which focused on occupational risks such as noise, handling of insolvents, etc); and
- Employee input.
It is evident from the above that education, the evaluation of risk, access to resources and wellness are included in Du Pont’s approach to health-care. It confirms, from a contingency management perspective, that it is important to create a culture that is focused on good health rather than on ill-health. It is also evident that the programme was developed with the involvement of employees, which increases its acceptance and utilisation.

According to the European Report on health and safety in the workplace (1998), the success of a workplace programme aimed at reducing absenteeism and ill-health depends on:

- Adopting a systematic approach;
- Building a committed project team which has a clear brief to manage and implement the project;
- Active support from senior and line management;
- Involvement of the human resources department, company medical service or external guidance;
- Active worker participation, as workers have first-hand knowledge of their work and work environment;
- Good communications within an organisation;
- A balanced approach to ensure that reporting in is not too simple; and
- Preventative measures focusing on the person and the work.

An important aspect derived from the above is the participation of various stakeholders such as employees, managers, the human resources department
and medical experts. Other aspects include the careful planning and implementation of the health programme by a project team, interventions aimed at both the employee and the work, good communication and top management support.

According to Seccombe (1995: 9b), a review of effectiveness of health promotion in the workplace suggests five key factors:

- Visible, enthusiastic support and involvement of senior managers;
- Involvement of employees at all levels in the planning and implementation of programmes;
- Use of corporate wide policies that promote healthy environments, as well as more intensive individual and group-oriented approaches;
- Targeting of activities for specific groups at risk and focusing on priority issues for particular groups; and
- Efforts to involve those groups least likely to participate.

In conclusion, it is evident that an integrated occupational health-care programme can only be successful if it is supported by top management and provides for employee input, networking with other institutions, continuous research and continuous evaluation. In this section, attention is given to the main components of an integrated health-care programme as a vehicle to assist employees. These components include occupational health-care services, health risk appraisals and wellness programmes, disease-management and the Employee Assistance Programme (EAP).

3.4.3.1 Occupational health-care services
In order to deal with sick employees and unnecessary health-related absenteeism, many organisations have established on-site health clinics. These clinics are normally manned by occupational health-care nurses and are, by agreement, visited by a medical practitioner on specific days. In a survey done by the Eastern Cape Benchmarking Club, 85 per cent of the club members indicated that they offered occupational health services (Eastern Cape Benchmarking Club Newsletter, 12 September 2003: 1).

Occupational Care South Africa (OCSA) is an organisation that provides strategic nurse-based occupational health services to organisations. The purpose is to ensure legal compliance, provide basic health-care to employees, reduce absenteeism and increase productivity. According to OCSA, occupational health refers to the legal obligation employers have to ensure that the health of employees are not compromised by their jobs. Services include monitoring the health of employees to determine fitness, emergency care on-site and compensation of injury on duty (COID) management. OCSA has a productivity programme aimed at managing the unproductive employee and absenteeism trends (Occupational Care South Africa, http://www.ocsa.co.za).

The on-site clinic caters for the general health of employees, minor injuries, TB treatment, and executes basic hearing and eyesight tests. In some organisations, the occupational nurse visits sick employees at home in order to monitor their condition. A textile company in Grahamstown reports an increase in its rate of absenteeism during the cold winter months of July and August
(Gilchrist 2003: 8). For this reason, some organisations provide flu injections to their employees as a measure to reduce absenteeism.

From a contingency perspective, the provision of occupational health-care services to employees could prevent absenteeism by identifying health-related problems before they escalate, providing basic health-care on the company premises and providing management with information about the health of employees.

### 3.4.3.2 Health risk appraisals and wellness programmes

In this section, the utilisation of health risk appraisals is discussed. Thereafter, the discussion moves to wellness programmes, the key elements of a wellness programme and areas of wellness that are addressed by organisations.

The purpose of a health risk appraisal is to assess the health of employees in order to detect health-related conditions that could lead to illness or death, such as diabetes or hypertension, and to identify risk factors, such as smoking or obesity, that could compromise the health of an employee in the future. Health risks that impact on attendance levels were discussed in Chapter two, paragraph 2.3.9.

Vinassa (2003: 21) reports that a South African company, whose innovative approach to health risk management includes leading-edge technology, represents a first of its kind worldwide. The company, Body iQ, provides
organisations with a comprehensive risk appraisal of the health status of its employees and an indication of their readiness to change. Relevant lifestyle information and key health measurements are assessed on-site during a corporate health day. The company also offers a more comprehensive medical and lifestyle assessment aimed at high net-worth individuals, which is conducted by an accredited medical center. Employees receive personalised and confidential feedback reports and the employer receives a comprehensive report, profiling the group’s health-risk profile together with recommended intervention strategies.

By doing a basic eye test, many other health conditions, such as diabetes, hypertension, cholesterol and retinal migraines, can be detected. Middle-aged people often want to retain an image of being young, and therefore postpone going for regular medical examinations, including regular eye tests. Presbyopia is an eye condition that typically sets in during middle-age. In addition to the effects of age, the increasing use of computers also puts strain on people’s eyes and a condition called computer vision syndrome can develop. This condition affects older people, as well as young people (Presenteeism vs Absenteeism, 2000).

Health risk appraisals often form the basis of wellness programmes. Wellness programmes focus on the improvement of the emotional, physical and spiritual wellness of employees. Potgieter (2003: 219) defines emotional wellness as a stage of complete well-being. Wellness management refers to a conscious behavioural strategy that aims at optimising all areas of an employee’s life, including work, family, self, intellectual and social domains. This is in contrast
with the mere absence of symptomatic behaviour of employees as an indication of their wellness.

According to Vinassa (2003: 20) corporate wellness programmes are slowly finding a place in the human resources strategies of a growing number of best practice companies. These include EAPs, on-site gyms, masseurs and yoga sessions, biokinetic and nutrition programmes, employee well-being programmes, such as hijack and rape prevention, attendance management, trauma counselling, performance and incapacity management.

Research results from various medical studies presented at various international scientific meetings between 2000 and 2002 illustrated the positive clinical effects of corporate cardiovascular disease risk reduction programmes for people with abnormal health baseline values. In one of these studies, the average six-month health-care claims per employee increased by 10.3 per cent for employees who did not participate in the programme, while it decreased by 14.3 per cent for those employees who did participate in the programme. Another study demonstrated that these positive results could be obtained whether the programme was offered on-site or remotely, from a call center using the telephone and Internet as delivery method (Abstract listing: 2002).

Matlala (1999: 24) provides the following guidelines for developing a wellness programme in an organisation:

- Incorporating employee wellness or health promotion into the overall strategy of the organisation;
- Adopting employee wellness into the culture of the organisation;
Involvement and support from all the role players, such as labour representatives, management and others; and

The development and implementation of health promotion policies, such as an EAP, smoking and HIV/AIDS policy.

Matlala’s views are supported by Schmottlach and Dodson (1998), who believe that wellness activities have the best opportunity to achieve their goal when multiple interventions are offered, when they are continuous and when they are supported over an extended period of time. Schmottlach and Dodson (1998) therefore advocate the need to integrate wellness activities into the mission of an organisation. Positive outcomes of integration include an actual change in the organisational culture, a clear message to the organisation’s stakeholders that wellness is important, better changes for funding from inside and outside the organisation, programme ownership and increased involvement in policy formation. Schmottlach and Dodson (1998) identify the following key activities in the integration of wellness into the organisational mission:

- Assess the organisational culture;
- Identify a wellness advocate;
- Assess supportive entities that are internal and external to the organisation;
- Understand the organisational mission, goal and objectives and the link between wellness and the mission, goals and objectives;
- Establish wellness prominently in the organisational structure;
- Develop a well-planned action plan;
• Develop ownership of the programme by involving people, groups and constituencies within the organisation;
• Develop an ongoing data collection plan;
• Acquire a permanent budget; and
• Develop a systemic view of wellness to enhance a cultural change within the organisation.

From the above, it is evident that wellness management should not be seen as an intervention that stands on its own, but that it should be integrated into the organisational culture through a collaborative, organisation-wide, systematically planned and well-executed effort.

DaimlerChrysler International has won several awards for its wellness programme. Key features of their programme include:

• A partnership with the union and health-care providers;
• A wellness advisory council;
• Focus on awareness, education, maintenance and assessment;
• Flexibility based on employees’ needs; and
• Extensive evaluation of the results.

(Hutchins, 2001: 50-52)

From the above, one can determine best practices for the introduction of a wellness programme into the organisation. These include involvement of all stakeholders, a team that takes ownership of wellness in the organisation, a
comprehensive wellness programme that is tailor-made to the needs of employees and continuous evaluation of results.

Du Pont is also an organisation that has received attention for its emphasis on health and safety. A subsidiary of the US company Du Pont, which is located in Belgium, reported a two per cent drop in absenteeism after monitoring the weight and blood pressure of employees, and discouraging smoking. It also introduced stress management and fitness training. The success of the programme was credited to establishing a committed project team and to obtaining worker participation. Safety and health are key values of this organisation (European Report, 1998).

A Canadian portal (Wage war on absenteeism, n.d.) for management and workplace resources suggests that the following could be included in a wellness programme:

- **Smoking cessation programmes:** Smoking is not only linked to cancer, emphysema, and heart disease, but also increases the risk of hypertension, ulcers and strokes. It lowers health costs and absenteeism;

- **Physical exercise:** Physical exercise results in lower blood pressure, stable blood sugar, stable body weight, lower cholesterol and less perceived stress levels. Employees who regularly exercise miss fewer workdays;

- **Weight management:** High fat and sugar diets are associated with increased breast and colon cancer, coronary artery disease, obesity, hypertension, diabetes and arthritis:
• Substance abuse management: Alcohol and drug abuse affect the person’s health, as well as proneness to accidents and injury. Substance abuse leads to hypertension, liver disease or death, as well as moral and social deterioration in the workplace; and

• Stress management: Increasing headaches, neck and back pains, asthma and depression, which are caused by high stress levels, result in poor work performance.

The above-mentioned aspects provide examples of interventions that could be included into a wellness programme. A careful analysis of the current health of employees will reveal which of these interventions are necessary in a specific organisation.

Old Mutual is considered as the first major employer in South Africa to embark on a pilot programme to assist employees in managing their weight. The programme is run by Old Mutual Healthcare (OMHc) and aims at educating employees about obesity, which is commonly associated with the onset of hypertension, diabetes, elevated cholesterol levels, osteoarthritis and other conditions, and helping employees to control their weight. The programme was developed by OMHc medical advisors and a pharmaceutical company. The programme includes educational sessions and a series of evaluations, including blood pressure, cholesterol, weight, Body Mass Index (BMI) and body fat percentage tests, done by a wellness programme provider. Participants received a personalised diet and exercise regime, and their exercise, diet compliance and weight was evaluated on a monthly basis. Counselling and psychological support was also provided.
Potgieter (2003: 218) refers to a South African study where a R2-million improvement in bottom-line production was attained after employees from a construction camp were exposed to a six-month project that focused on changing their lifestyles. The programme was offered by a multi-disciplinary team of nurses and biokineticians, who introduced fitness programmes, healthy diets, and HIV/AIDS and lifestyle education.

3.4.3.3 Disease-specific education and case management

Wellness programmes are aimed at enhancing the general mental and physical wellness of all employees. On the other hand, some employees’ abilities could be affected by a specific disease or condition, which is pre-existing, that decreases their productivity or attendance. For these employees, disease-specific education and case management are introduced. A rehabilitation programme is developed and integrated with an absenteeism and return-to-work programme. The Soma Institute, an organisation that specialises in absenteeism, disability and rehabilitation programmes, perceives the main components of a rehabilitation programme, which is normally provided by an outsourced organisation, to be as follows:

- Selection of cases that can be rehabilitated;
- Referral of specific cases for an early return-to-work assessment to determine occupational capacity and specific restrictions;
- Rehabilitation services or any other appropriate intervention;
- Execution of a cost-profit analysis;
• Request for authorisation of the selected rehabilitation services either from the employer or insurer, as applicable;
• Tracking of referral approved cases to service providers;
• Guideline and protocol-driven rehabilitation of individuals at accredited return-to-work centers;
• Monitoring of the entire rehabilitation and reintegration process; and
• Processing the claims of specific service providers and directing applicable payments to the relevant debtors.

(The Soma Initiative, n.d.b)

It is evident from the above that professionals in the field of rehabilitation should be involved in order to speed up recovery and assist employees in returning to work as soon as possible. A cost-profit analysis will reveal the cost of medical intervention in comparison to the benefit of keeping the employee on the payroll.

An example of a health condition that could be better controlled through disease-specific education is asthma. The goals of an asthma management programme are to prevent and control symptoms, maintain normal or near normal activity levels and lung function, minimise emergency room visits and maintain optimal medication use with the fewest adverse side effects (Williams, 2001: 1-2).
3.4.3.4 Employee Assistance Programmes (EAPs)

In paragraph 3.2.5, the development of an EAP policy in the organisation was discussed. In this section, attention shifts to the way in which an EAP can assist organisations in managing absenteeism in the workplace.

An EAP can be considered as a mechanism that is used to attain the goals of an integrated health-care programme. An EAP is a strategic and professional service aimed at improving performance and productivity. It is designed to identify and resolve productivity problems associated with employees who are impaired by personal concerns. The main focus areas of an EAP are HIV/AIDS, disability, addiction, stress and trauma. Professional assistance is provided in a broad range of human relation’s problems including alcohol or substance abuse, emotional or behavioural disorders, financial and legal problems, child-care and elderly care, family and marital discord, work-related problems and abusive relationships. An EAP should fulfill a multifunctional and strategic role, while supporting the organisation in its legislative obligations (Moodley, 2003).

O’Hara (1995: 207) cites a study that used two objective measures, namely health-care costs and absenteeism for a multi-year period, as dependent variables to analyse the cost-benefit of an EAP. The results showed a 4:1 return on investment, after the costs of operating the EAP was deducted. O’Hara points out that this study covered a three-year period, included approximately 5000 employees, and involved the use of acceptable statistical and scientific methods.
Steddon (1990) identified the following main components of an EAP system:

- Policy decision and programme design;
- Training and orientation of key staff;
- Communication to all employees and their families;
- Counselling and referral service; and
- Programme evaluation.

These main components identified by Steddon shows that the EAP should be professionally developed and designed, administered by well-trained people, marketed to its target groups and evaluated for quality and results.

Moodley (2003) expands on these components and lists the core activities of an EAP as follows:

- Consultation;
- Training of suitable employees in the identification and resolution of job performance issues related to employees' personal concerns and difficulties;
- Confidential, appropriate, relevant and timely problem assessment services;
- Appropriate and relevant referrals for diagnosis, treatment and assistance;
- The establishment of co-operation between the on-site EAP, community resources and other professionals;
- The provision of follow-up services for employees who utilise the services;
• On-site interviewing services offered by trained, registered auxiliary social workers who receive regular in-service training and supervision by an EAP practitioner;

• On-site counselling services intervention by the EAP practitioner with follow-up within 24 hours; and

• Referral to off-site counselling, with adequate time-off arrangements, where needed.

Sappi, a South African organisation, utilises the assistance of out-sourced organisations for their EAP. The company utilises the services of FAMSA on site twice a month to counsel and offer professional support to employees and their families as part of an overall strategy to reduce and control absenteeism (Gilchrist, 2003: 9).

Services offered by an EAP should not only be made available to employees, but also to their families, worker union representatives, supervisors/managers and the organisation as a whole. Confidentiality should be guaranteed, except in cases where the employee and employer have entered into a voluntary participation agreement, in which the employer withholds disciplinary action as a result of the employee participating in the programme. However, information volunteered will only relate to the employee’s compliance or non-compliance to the programme. The EAP is subjected to professional, legal and ethical standards. Moodley (2003) indicates that the EAP practitioner should be a trained and registered social worker or counselling psychologist with at least one year’s EAP training and experience. Administrative staff should be professional and sensitive to confidential and ethical issues.
Managers and supervisors should realise that they play an important role in the EAP. They should be trained in constructive confrontation techniques in order to ensure that they accept responsibility for employee performance and that they do not cover up personal difficulties of employees.

From a contingency management perspective, the EAP can be used to identify problems that could impair employees’ ability to attend work. Through professional intervention, these problems can be addressed and the employee can resume his/her duties in a productive manner. The best scenario is one in which the EAP is used to assist and support employees so that they do not have to take leave to attend to or escape from their problems.

3.5 THE MANAGEMENT OF HIV/AIDS IN THE WORKPLACE

The involvement of business in HIV/AIDS strategies and programmes is prompted by legal obligation, business consequences and social responsibility. The Code of Good Practice on HIV/AIDS and Employment provides the following recommendations in terms of a workplace HIV/AIDS programme:

- A workplace programme should be aimed towards preventing new infections, providing care and support for employees who are infected or affected, and managing the impact of the epidemic on the organisation; and
- The nature and extent of the programme should be guided by the needs and capacity of each individual workplace, but the following are recommended:
- regular HIV/AIDS awareness programmes;
- education and training;
- condom distribution and recommendations of use;
- the enhancement of health seeking behaviour for sexually transmitted diseases;
- a wellness programme for employees affected by HIV/AIDS;
- the enforcement of universal infection control measures;
- an environment that is conducive to openness, disclosure and acceptance among all staff;
- access to counselling and other social support for people affected by HIV/AIDS; and
- the regular monitoring, evaluation and review of the programme by all parties.

(Government Gazette, 2000)

A survey done by the Eastern Cape Benchmarking Club revealed a positive relation between HIV/AIDS management and absenteeism, although it could not be validated as a direct causal one, as a lower level of absenteeism could also be indicative of a general caring attitude by management (Eastern Cape Benchmarking Club Newsletter, 12 September 2003: 6). Table 3.6 compares the average absenteeism rates of organisations with and without HIV infection interventions.
Table 3.6: Average absenteeism levels at organisations with and without HIV interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Ave Absenteeism</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS Plan (n=23)</td>
<td>3.88%</td>
</tr>
<tr>
<td>No HIV/AIDS Plan (n=11)</td>
<td>4.25%</td>
</tr>
<tr>
<td>Focal HIV/AIDS Person (n=19)</td>
<td>3.70%</td>
</tr>
<tr>
<td>No Focal HIV/AIDS Person (n=16)</td>
<td>4.30%</td>
</tr>
<tr>
<td>Peer Education Programmes (n=14)</td>
<td>3.70%</td>
</tr>
<tr>
<td>No Peer Education Programme (n=20)</td>
<td>4.20%</td>
</tr>
<tr>
<td>Management Awareness Programme (n=16)</td>
<td>3.70%</td>
</tr>
<tr>
<td>No Management Awareness Programme (n=19)</td>
<td>4.28%</td>
</tr>
<tr>
<td>STD Awareness Programme (n=17)</td>
<td>3.54%</td>
</tr>
<tr>
<td>No STD Awareness Programme (n=18)</td>
<td>4.46%</td>
</tr>
<tr>
<td>Condom Distribution (n=32)</td>
<td>3.92%</td>
</tr>
<tr>
<td>No Condom Distribution (n=3)</td>
<td>5.10%</td>
</tr>
<tr>
<td>Occupational health services (n=30)</td>
<td>3.90%</td>
</tr>
<tr>
<td>No occupational health services (n=5)</td>
<td>4.70%</td>
</tr>
<tr>
<td>Community Support Programme (n=9)</td>
<td>3.88%</td>
</tr>
<tr>
<td>No Community Support Programme (n=26)</td>
<td>4.06%</td>
</tr>
</tbody>
</table>

Source: Eastern Cape Benchmarking Club Newsletter, 12 September 2003: 6

Table 3.6 provides strong evidence that managing HIV/AIDS has an impact on absenteeism levels in organisations. Organisations would be wise to incorporate such a strategy as part of their contingency plans in managing absenteeism.

The Eastern Cape Benchmarking Club Newsletter (2003: 6-7) highlighted the following as critical aspects of a successful HIV/AIDS strategy and vision:

- A long term perspective;
- A realisation that it makes business sense;
- A conviction that it will save lives;
- The commitment of time and resources;
- A holistic and multi-strategic approach;
• Creative, inexpensive interventions, but full commitment to making them work; and
• The evaluation of effectiveness of interventions.

A real concern pointed out in the newsletter was that, although many companies had structures in place to deal with HIV/AIDS, an impression was created that these structures had not been utilised for a considerable period of time, and in some cases, had not been utilised for years. Table 3.7 indicates responses from two surveys done by the Eastern Cape Benchmarking Club, one in 2002 and the other in 2003, that illustrate the percentage of club members involved in various best practice interventions. The 2002 survey included 26 members while the 2003 survey included 40 members.

Table 3.7: The percentage of club members utilising various HIV/AIDS best practices

<table>
<thead>
<tr>
<th>Best practice interventions</th>
<th>% Club members with interventions in place</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2002 survey</td>
</tr>
<tr>
<td>Formalised HIV/AIDS policy</td>
<td>55.6</td>
</tr>
<tr>
<td>Focal HIV/AIDS person</td>
<td>55.6</td>
</tr>
<tr>
<td>Peer education programme</td>
<td>55.6</td>
</tr>
<tr>
<td>Management awareness programme</td>
<td>61.1</td>
</tr>
<tr>
<td>STD awareness programme</td>
<td>61.1</td>
</tr>
<tr>
<td>Condom distribution</td>
<td>72.2</td>
</tr>
<tr>
<td>Occupational health services</td>
<td>77.8</td>
</tr>
<tr>
<td>Community support programme</td>
<td>38.9</td>
</tr>
</tbody>
</table>

Source: Eastern Cape Benchmarking Club Newsletter, April 2002: 6; September 2003: 6
From the above table, it is evident that condom distribution is the most popular activity, while a community support programme is least utilised. A decline in peer education, as well as management awareness training, is notable. Once again, it is indicative of organisations who feel they have done their duty by training their employees, without realising that long-term intervention is needed.

In 2000, DaimlerChrysler South Africa (DCSA) decided to develop a world-class, comprehensive and needs-oriented approach to all aspects of HIV/AIDS. The strategy had three goals: to prevent further infection, ensure the best care for those already infected and reduce the impact on the company to ensure its growth and development (DCSA Star Flash, 18 June 2001).

Eskom is an organisation that has experienced positive results from its HIV/AIDS workplace programme. Bennett (2002a) reports that Eskom experienced a decline in the infection rate among staff due to a comprehensive programme that cost the company around R180-million a year. Eskom indicated that the rate of infection was 9 per cent in comparison to 12 per cent in 1995.

The next few paragraphs focus on activities related to the main aspects of a strategic HIV/AIDS management programme, as revealed by the literature.

3.5.1 Prevalence and impact studies

In paragraph 3.4.1, prevalence studies were discussed as a component in a holistic approach to the management of health in the organisation. In this paragraph, specific attention is given to prevalence and impact studies aimed at
determining the extent to which organisations are affected by the HIV/AIDS pandemic.

As HIV/AIDS is a highly emotive issue, it is not easy to determine its prevalence in the organisation. The purpose of a HIV/AIDS prevalence study is to determine the occurrence of HIV/AIDS among employees in order to determine the impact on the organisation and to develop tailor-made strategies to deal with it. Daly (2000) states that the impact of absenteeism, as a result of HIV/AIDS, in organisations depends on the flexibility of the production systems, the actual levels of absenteeism as determined by the prevailing socio-cultural norms, the quality and quantity of health-care provision and the general economy. Van Niftrik (2003: 34-35) reasons that, in order to get a comprehensive picture of the impact of HIV/AIDS, actuarial, epidemiological and financial models should be used. The impact on organisations varies according to employee demographics, organisational dependence on human labour, the geographical location of the organisation, place of residence of employees, the state health-care infrastructure, availability of access to affordable pro-active medical management and the nature of the organisation.

The King 2 Report emphasised the importance of planning in dealing with the impact of HIV/AIDS, and stressed that the regular monitoring and measuring of performance, through the use of established indicators, should form part of the process. The report also recommended that organisations report at least once a year on HIV/AIDS, and other social issues in their financial reports (King 2 applies to all: 37).
Various approaches can be used to estimate the prevalence of HIV/AIDS. It is suggested that either actuarial-based studies (non-evasive), surveillance testing, or a combination of the two methods, be used. Surveillance methods include salivary, blood or urine tests. Based on these figures, the financial impact of HIV/AIDS on the organisation should be determined (Lifeworks, http://www.lifeworks.co.za/html/4steps.htm). Considering the laws pertaining to the management of HIV/AIDS in the workplace, which were discussed in Chapter two, a prevalence study should not compromise the confidentiality or the HIV-status of individuals and should be done in consultation with employees and employee representatives.

Tests performed on pregnant women attending antenatal clinics often form the basis of actuarial-based studies. This approach is suitable for a heterosexually driven epidemic where it is evident that the general population has become infected in significant numbers, such as is the case with HIV/AIDS in South Africa (UNAIDS, 2004).

Various computer-based medical and financial risk management programmes are available to quantify the likely impact of HIV/AIDS on company performance. An example is HealthInSite, a Johnnic Publishing Group company, which has launched AIDSInSite, a comprehensive HIV/AIDS management tool that enables a company to compile a specific HIV/AIDS risk profile and make effective decisions in terms of how to manage it. The programme costs from R1 500 a month, and gives access to education and training support through a variety of media (Kahn 2002: 1-2).
DaimlerChrysler South Africa (DCSA) reports that it conducts a periodic HIV/AIDS risk assessment of the organisation, its employees, and their families. It includes prevalence and impact studies, without compromising confidentiality of the HIV-status of individuals (DCSA Star Flash, 18 June 2001).

It is evident that prevalence and impact studies form the basis for the development of a strategy in dealing with HIV/AIDS in the workplace. Due to the impact of HIV/AIDS on absenteeism levels in organisations, these kinds of studies should be included in a contingency strategy for the management of absenteeism.

3.5.2 Policy development

The development of an HIV/AIDS policy was discussed in paragraph 3.2.8. In a survey conducted among 26 members of the Eastern Cape Benchmarking Club, only 55.6 per cent of the respondents indicated that they had a formalised HIV/AIDS policy in place (Eastern Cape Benchmarking Club Newsletter, 2002: 6). A follow-up survey, involving 40 organisations, revealed a slight increase, with two-thirds (66%) of club members indicating that they had a formalised HIV/AIDS plan in place. However, participating members indicated an average effectiveness rating of 54.7 per cent for their HIV/AIDS plans. (Eastern Cape Benchmarking Club Newsletter, 2003). In a similar study conducted by Old Mutual, 58 per cent of the participants in the study did not believe that the actions taken by their companies were sufficient in dealing with the HIV/AIDS crisis (Old Mutual health care survey, 2001: 14-15).
A policy provides guidelines for the management of HIV/AIDS in the workplace. However, it is evident that a policy alone is not enough and that organisations should carefully consider the content of their policies, and commit themselves to strategies that are developed for the management of this pandemic in the workplace.

### 3.5.3 Awareness and education programmes

In this section, awareness and education programmes, specifically concerning HIV/AIDS, are discussed. Attention is given to the importance of such programmes, the media, and strategies that can be used for awareness and education initiatives.

In an Old Mutual Health Care survey, in which 60 key South African companies participated, education and awareness programmes where indicated as the most popular strategies taken by employers to reduce the financial risk presented by this disease. One of the conclusions drawn from this study, which were also stated in paragraph 3.4.2, was that employers should not rely solely on education and awareness initiatives to manage HIV/AIDS, but that more meaningful solutions should be sought (Old Mutual Health Care survey, 2001: 14-15).

The Eastern Cape Benchmarking Club Newsletter (12 September 2003: 7) suggests that awareness programmes could be launched through various media,
such as peer education, work team discussions, presentations by management, theatre, guest speakers, videos, posters, pamphlets and email.

The HIV/AIDS education and awareness programme offered by DaimlerChrysler South Africa (DCSA) includes the following:

- The dissemination of relevant and credible information via company publications, Intranet and Internet, workplace-based computer “touch screen” HIV/AIDS information kiosks, informative publications, referral to the National HIV/AIDS help-line, and other support and information services;
- The appointment, training and ongoing support of peer educators in the workplace;
- Health promotion campaigns, including promotion of voluntary counselling, testing and proper condom use; and
- Co-operation and partnership with community-based HIV/AIDS initiatives.

(DCSA Star Flash, 18 June 2001)

It is evident that various strategies, media and resources can be used to make employees aware of and to educate them about HIV/AIDS.
3.5.4 Case management

In paragraph 3.4.3.3, disease-specific education and case management were discussed. In this paragraph, attention is specifically focused on the management of HIV/AIDS cases.

The greatest obstacle in the effective medical management of HIV/AIDS is that most HIV-positive people only learn of their HIV-status during the onset of AIDS, which occurs about six to seven years after infection. For an HIV/AIDS programme to be medically and economically viable, pro-active treatment of healthy HIV-positive people is imperative (Jelley, 2003: 8). With proper nutrition, lifestyle education and general medical care for unrelated and inter-current diseases employees can stay healthy and productive, and at the same time increase the economic benefits of a HIV/AIDS programme. According to Jelley (2003: 8), about 90 per cent of all employees living with HIV/AIDS are still healthy in the asymptomatic pre-AIDS stages.

The Code of Good Practice on HIV/AIDS and Employment (Government Gazette, 2000), which was discussed in Chapter two, provides the following guidelines for managing HIV-positive employees:

- HIV-infected employees should continue to work under normal conditions in their current employment for as long as they are medically fit to do so;
- Employers should work to maximise the performance of all employees. This includes reasonable accommodation for employees
who develop conditions as a result of HIV/AIDS in order to help ensure that they maintain their employment for as long as possible;

- Employees with HIV/AIDS have the same rights to sick-leave as any other employees, and a joint investigation by the employer and employee should be undertaken to consider alternative sick-leave allocations, in accordance with the BCEA; and

- Employers should take all reasonable steps to assist employees with referrals to appropriate health, welfare and psycho-social facilities within the community, if such services are not provided at the workplace.

(Government Gazette, 2000)

The Old Mutual Health Report (2001: 14-15), which was referred to in paragraph 3.4.2, indicated that 48 per cent of the respondents found clinical case management of HIV/AIDS patients as a useful intervention in organisational HIV/AIDS management. The Eastern Cape Benchmarking Club Newsletter (12 September 2003: 7) identified the provision of health-care facilities, the effective distribution of condoms (as opposed to just making them available), the promotion of good health to prevent opportunistic diseases and the facilitation of access to proper medical treatment as important company interventions.

DaimlerChrysler South Africa (DCSA) has committed itself to the provision of anti-retroviral drugs, treatment and serological monitoring (according to standardised procedures), and the treatment of opportunistic infections within the framework of their medical aid scheme. The health-care service works in
partnership with the employees’ family doctors, and other health-care providers (DCSA Star Flash, 18 June 2001, 3).

Many employees will get sick as a result of HIV/AIDS. However, if these employees have access to professional services that can help them to manage symptoms related to HIV/AIDS, they can stay healthier longer and continue to make a productive contribution to the organisation. The contingency management of health-related absenteeism should therefore involve strategies that are aimed at assisting employees in the management of their illness.

3.5.5 Community networking

Disease prevention, health promotion and community involvement involve a paradigm shift for most manufacturing organisations. The HIV/AIDS pandemic forces non-traditional alliances between organisations and communities, which include the sharing of scarce resources and joint HIV/AIDS initiatives. DaimlerChrysler South Africa (DCSA) has extended its HIV/AIDS programme to the community by an educational campaign, involvement of families of employees, the training of peer educators from the community, community activities, and increased communication between DCSA’s Occupational Health Services, private community practitioners and community health services (DCSA Star Flash 18 June 2001: 3).
Many organisations do not have the resources, knowledge or facilities to deal with HIV/AIDS. Collaboration with non-governmental and other organisations in the community could assist in the adoption of a more holistic approach to the management of HIV/AIDS. In terms of absenteeism, it could lead to a reduction of unscheduled loss of work-time if employees were, on a wider front, encouraged to manage their own health and stay productive for as long as possible.

### 3.5.6 Continuous research and evaluation

Continuous research and evaluation are important for any HIV/AIDS strategy to be successful. DCSA has commissioned a survey of the current knowledge, perceptions and behaviour of employees at all levels to ensure that awareness initiatives and material were based on actual needs and requirements. They have also embarked on a formal audit of their current in-house occupational health services (DCSA Star Flash, 18 June 2001: 4).

In conclusion, many organisations are taking positive action in dealing with the HIV/AIDS pandemic. However, it is necessary to keep the momentum, regularly evaluate the processes and employ creative solutions to deal with the situation in a constructive, yet cost-effective manner. In the next, section ergonomics as a strategy to deal with injury in the workplace is considered.
3.6 ERGONOMICS

Ergonomics is a study of the relation between the employee and the physical work environment aimed at creating a safe and comfortable working environment, and enhancing productivity (Schultz, 2004a: 204).

Intracorp, a leading US organisation that specialises in disability management, uses a pro-active strategy to deal with carpal tunnel syndrome, which can be expanded to other frequently experienced injuries in the workplace (Intracorp’s new carpal tunnel program helps employees reduce lost workdays and medical costs, 2000). Carpal tunnel syndrome is a repetitive strain injury of the wrist frequently encountered by computer, office and shop floor operators (Bergh & Theron, 2003: 60). The programme addresses both the risk factors and the management of the injury. The programme consists of:

- A structured pre-injury plan: this includes an analysis of potential risk factors and a pre-planned procedure to prevent or minimise lost time should an injury occur;

- Injury and return-to-work management: should an injury occur, qualified physicians are identified, the physician is provided with transitional duty options to facilitate decision-making, employees are focused on returning to work and transitional duty assignments are arranged; and

- Post-injury management: the returning worker progresses through the transitional work duties identified in the pre-injury stage, risk factors are minimised and outcomes are benchmarked.
The company uses software to manage injuries and maintain a database, which sorts return-to-work options by industry, type of job and physical demands in order to help the case manager immediately determine potential transitional duties. These jobs are jobs that employees are physically able to do and that are productive and meaningful to the employer. The company claims that it has reduced lost time with 20 to 30 per cent and corresponding medical costs by 15 to 20 per cent due to its case management programme. The data is based on an analysis of approximately 100,000 employees’ compensation claims during 2002.

In paragraph 2.3.7, it was indicated that injury in the workplace has a significant impact on absenteeism levels in the organisation. As part of a contingency management strategy to reduce absenteeism, attention should be given to preventing injury in the workplace and to assisting injured employees in recovering and resuming their normal duties as soon as possible.

### 3.7 DEALING WITH INCAPACITY

At some point (as stated in the absenteeism policy) the employer’s right to expect the employee to be at work, as required in the employment contract, outweighs the employee’s right to be sick. If reasonable efforts were made to accommodate the employee, as required by South African Labour Law, and they proved unsuccessful, it will become necessary to terminate the services of the employee. The policy from a company in the motor manufacturing sector reads as follows: “Employees who have already exceeded their 36-day sick-leave entitlement, will be issued with final warnings for their incapacity to carry out their contractual obligations. Should these employees incur a further one incident of
sick-absence within the current sick-absence cycle, they will be subjected to an enquiry."

This procedure for termination is as follows:

- Formal meetings in which verbal warnings are given. These meetings should be documented. It is during this time that medical assessments may be requested, and alternative employment options are considered and exercised;
- If absenteeism continues to be a problem, a letter of concern is handed to the employee. A second letter of concern will be worded in a stronger manner, and it will warn the employee that if attendance does not improve the employee’s services are to be terminated.
- Discharge.

An arbitrator will consider the following in ruling whether a discharge due to incapacity was justified or not:

- Has the employee done everything to regain his/her health and return to work?
- Has the employer provided every assistance possible to promote recovery, such as time-off, support and counselling?
- Has the employer informed the employee of the unworkable situation resulting from his/her ill-health?
- Has the employer made reasonable efforts to accommodate the employee by offering a suitable alternative position, or a reduction in hours?
• Has enough time elapsed to allow for every possible chance of recovery?
• Has the employer treated the employee in an equitable manner?

In addition, the company should be able to prove that absences are excessive and disruptive, and that the employee will be unable to provide his/her services on a continuing basis as required (Guidelines for absenteeism control: http://www.benefits.org/interface/cost/absent2.htm).

The purpose of a contingency strategy for the management of absenteeism is to reduce and manage absenteeism in the workplace in order to ensure that the company stays profitable. Should an employee, regardless of efforts made to reduce absenteeism, still not be able to contribute to the organisation in an economically viable manner, the company should make the decision to terminate the services of the employee. However, legal requirements in this regard should guide this process.

3.8 A CONTINGENCY MANAGEMENT PLAN AIMED AT PROMOTING A HEALTHY WORKFORCE AND REDUCING HEALTH-RELATED ABSENTEEISM

In paragraph 2.7, the merits of adopting a contingency approach to the management of health-related absenteeism were discussed. In this chapter, Chapter three, contingency strategies aimed at promoting a healthy workforce and reducing health-related absenteeism were explored and discussed. Main aspects that should be contained in a contingency strategy for the management of absenteeism, revealed in the literature study, are the following:
• The development and integration of various workplace policies aimed at managing absenteeism and promoting the health of employees. These include absenteeism, return-to-work, disability, corporate wellness, employee assistance programme (EAP), substance abuse, stress and trauma, and HIV/AIDS policies;

• The development and maintenance of an absenteeism management system that includes the accurate recording, measuring, analysing and benchmarking of absenteeism. The recording of absenteeism provides an opportunity to deal with individual health-related cases by means of counselling, alternative work arrangements and, in the case of incapacity, dismissal;

• The development of a holistic approach, based on prevalence studies, to the management of health in the workplace through the strategic planning and provision of health benefits, such as medical aid, sick funds and access to medication, and the development of integrated occupational health-care programmes, such as occupational health-care services, health risk appraisals, wellness programmes, disease-specific education, case management and employee assistance programmes (EAPs);

• Highlighting the development of a strategy, based on prevalence and impact studies, for the management of HIV/AIDS in the workplace. This includes policy development, appointing a HIV/AIDS task team, awareness and education, the management of individual cases, community networking and continuous research; and

• Continuous evaluation of the effectiveness of the strategies utilised for the contingency management of health-related absenteeism for adjustment to policies and contingency management interventions.
3.9 CONCLUSION

In conclusion, various workplace policies provide guidelines to management for promoting a healthy workforce and reducing health-related absenteeism. It is imperative that these policies be integrated in order to provide consistency and to address health-related absenteeism in a co-ordinated manner. The basis of any absenteeism programme lies in the accurate recording, measurement, analysis and reporting of absenteeism. Benchmarking allows comparison with similar units, organisations and industries, both on a local and international level. A holistic approach to promoting health in the workplace includes regular prevalence studies or audits, strategically planned health benefits and an integrated occupational health-care programme that maintains and promotes the general health of employees and addresses ill-health in a constructive and cost-efficient manner. Although HIV/AIDS is also addressed within these structures, special attention was given to the management of this pandemic. Due to the impact of workplace injury on absenteeism levels, a short description and overview of ergonomics was presented. Pro-active action is better than retro-active cure. Lastly, there will always be cases where an employee is, due to ill-health, absent too often and incapable of performing a task and where it no longer makes business sense to retain the services of the employee. In these cases, the action taken by management to terminate the services of the employee is subjected to the requirements set out by the Labour Law.

In Chapter four, contingency management strategies, aimed at ensuring the continuity of production and service provision in the face of absenteeism, are discussed.
## CHAPTER FOUR

### CONTINGENCY MANAGEMENT STRATEGIES AIMED AT ENSURING THE CONTINUITY OF PRODUCTION AND SERVICES IN THE FACE OF ABSENTEEISM

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>INTRODUCTION</td>
<td>176</td>
</tr>
<tr>
<td>4.2</td>
<td>DESIGNING A FLEXIBLE ORGANISATION</td>
<td>180</td>
</tr>
<tr>
<td>4.3</td>
<td>MANAGING FLUCTUATING STAFF LEVELS THROUGH HUMAN RESOURCES PLANNING</td>
<td>183</td>
</tr>
<tr>
<td>4.3.1</td>
<td>The talent forecast</td>
<td>184</td>
</tr>
<tr>
<td>4.3.2</td>
<td>Talent action plans</td>
<td>187</td>
</tr>
<tr>
<td>4.3.3</td>
<td>The integration plan</td>
<td>188</td>
</tr>
<tr>
<td>4.4</td>
<td>ENSURING THE OPTIMAL USE OF AVAILABLE SKILL</td>
<td>188</td>
</tr>
<tr>
<td>4.5</td>
<td>ENSURING AN ADEQUATE SKILLS SUPPLY THROUGH TRAINING AND DEVELOPMENT</td>
<td>192</td>
</tr>
<tr>
<td>4.5.1</td>
<td>Pre-need hiring and training</td>
<td>192</td>
</tr>
<tr>
<td>4.5.2</td>
<td>Multi-skilling</td>
<td>193</td>
</tr>
<tr>
<td>4.6</td>
<td>ENSURING AN ADEQUATE SKILL SUPPLY THROUGH ALTERNATIVE WORK ARRANGEMENTS</td>
<td>195</td>
</tr>
<tr>
<td>4.6.1</td>
<td>Flexitime</td>
<td>196</td>
</tr>
<tr>
<td>4.6.2</td>
<td>Job-sharing</td>
<td>199</td>
</tr>
<tr>
<td>4.6.3</td>
<td>Telecommuting</td>
<td>200</td>
</tr>
<tr>
<td>4.6.4</td>
<td>Compressed work-weeks</td>
<td>201</td>
</tr>
<tr>
<td>4.7</td>
<td>ENSURING AN ADEQUATE SKILL SUPPLY THROUGH ALTERNATIVE EMPLOYMENT PRACTICES</td>
<td>203</td>
</tr>
<tr>
<td>4.7.1</td>
<td>Contingent workers</td>
<td>205</td>
</tr>
<tr>
<td>4.7.2</td>
<td>Subcontracting or outsourcing</td>
<td>206</td>
</tr>
<tr>
<td>4.8</td>
<td>REDUCING THE IMPACT OF ABSENTEEISM THROUGH CAREFUL CONSIDERATION OF PRODUCTION AND SERVICE PROCESSES</td>
<td>207</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>4.8.1</td>
<td>Lean manufacturing and absenteeism</td>
<td>208</td>
</tr>
<tr>
<td>4.8.2</td>
<td>Automation</td>
<td>213</td>
</tr>
<tr>
<td>4.9</td>
<td>CONTINGENCY MANAGEMENT STRATEGIES AIMED AT ENSURING THE CONTINUITY OF PRODUCTION AND SERVICE DELIVERY IN THE FACE OF ABSENTEEISM</td>
<td>214</td>
</tr>
<tr>
<td>4.10</td>
<td>CONCLUSION</td>
<td>215</td>
</tr>
</tbody>
</table>
CHAPTER FOUR

CONTINGENCY MANAGEMENT STRATEGIES AIMED AT
ENSURING THE CONTINUITY OF PRODUCTION AND
SERVICES IN THE FACE OF ABSENTEEISM

4.1 INTRODUCTION

Chapter three provided an overview of contingency management strategies directed at promoting a healthy workforce and reducing health-related absenteeism. This chapter is dedicated to contingency management approaches aimed at ensuring the continuity of production and service provision in the face of absenteeism. It focuses on the design of a flexible organisation through flexible social processes, human resources planning and management, flexible working arrangements and employment practices, and lastly, flexible operating processes, to ensure the minimum disruption due to unscheduled absenteeism.

As discussed in chapter two, many diseases and illnesses pose a threat to the continuity of production and service provision as a result of their impact on the attendance levels of employees. When considering the impact of, for example, HIV/AIDS and stress in the workplace, it is a fait accompli that an increasing number of employees will get sick and be absent from the workplace. The challenge facing organisations is to find ways in which to maintain a steady
supply of competent and skilled labourers in order to accommodate fluctuating attendance levels and fluctuating customer demands.

During the course of this study, the researcher noticed that, in terms of the management of HIV/AIDS, little or no attention is given to strategies aimed at ensuring continuous production and service provision in the face of increasing levels of absenteeism. Some organisations try to deal with the HIV/AIDS crisis by switching from one medical insurance broker to another. This is perceived as a short-sighted approach and it is suggested that organisations, in addition to conducting impact studies, adapt their recruitment, personnel maintenance and training strategies to deal with the HIV/AIDS challenge (Van Wyk, 2001).

The Institute for Employment Studies (Brewster, Carey, Dowling, Grobler, Holland & Warnich, 2003: 115) developed a model for flexibility, uncertainty and human resources management that was used as a basis for developing the structure of this chapter. The model originated from a post-Fordism period, in which employers were increasingly frustrated by the low motivation and high absenteeism levels in organisations, seen as a by-product of mass-production and the fragmentation of jobs on the assembly-line (Beardwell & Holden, 2001: 202). The model is presented in Figure 4.1.
Figure 4.1: A model for flexibility, uncertainty and human resources management

Source: Brewster, Carey, Dowling, Grobler, Holland & Warnich, 2003: 115

The purpose of the model is to closely match human resources with work demand in order to increase the efficiency of human resources utilisation while
catering for market fluctuations. Instead of traditional hierarchical and bureaucratic structures, the model redefines the organisation into two distinct segments – the core and periphery. The core consists of permanent, highly skilled employees who provide for functional flexibility. The core is responsible for firm-specific tasks and jobs. The peripheral workforce (peripheral group 1 in Figure 4.1) provides for quantitative or numerical flexibility. The peripheral group is responsible for what are described as ‘plug-in’ jobs and could include clerical, supervisory, component and testing occupations. In addition, both the core and peripheral workforce can be supplemented through part-time, temporary or sub-contracted work (peripheral group 2 in Figure 4.1). The outer circle in Figure 4.1 represents people, groups or organisations that are not considered as employees but who enter the organisation to deliver a service or perform a task such as in the case of consultants who are considered as self-employed. In this case, minimal organisational commitment or disruption takes place. Training takes a central role in the flexible organisation as it ensures the availability of skills. Training is provided to core and peripheral employees, as well as people who enter the company with the purpose of gaining skills and experience, such as public subsidy trainees and trainees not in employing bodies (this group could possibly include students who participate in co-operative learning programmes). This model was developed in the United Kingdom, but could be adapted to the South African situation. For example, instead of only considering public subsidy trainees, South African organisations could also utilise learnerships for a flexible labour strategy, as well as other training and development opportunities sprouting from the Skills Development Act (Act No 97 of 1998). It is recommended that organisations wishing to implement contingency management strategies aimed as ensuring the continuity of production and services in the face
of absenteeism should consider adopting this model of human resources management.

4.2 DESIGNING A FLEXIBLE ORGANISATION

The focus of this chapter is on strategies that will ensure the continuous provision of products and services in situations where organisations are faced with high levels of absenteeism. Beardwell and Holden (2001: 109) note that empirical research in the late 1980s and early 1990s in Britain showed that one of the main reasons for the development of a flexible organisation was to accommodate absenteeism among permanent employees.

Carrell et al (1998: 124) and Brewster et al (2003:103-105) identify various types of flexibility that can be used to create a flexible organisation and that illustrates the magnitude of this approach:

- **Functional flexibility:** the adaptability and mobility of employees to exercise a range of tasks, including multi-skilling and job rotation. This implies that, in the event of an employee being absent, other employees have already pro-actively been trained to take over his/her function and that no extra training is required;

- **Numerical flexibility:** varying the size and structure of the workforce in response to changes in the level and pattern of demand. This implies that in the event of absent employees, additional employees will be available to ensure that production or service demands are met;
• Temporal flexibility (also called work-time flexibility or internal-numerical flexibility): varying the patterns of work hours, shift systems, part-time work, home working and temporary work. This allows the employee more control over his/her time to attend to personal issues without disrupting production and service delivery.

• Flexitime: the generic word for flexible scheduling formats permitting flexible hours within the limits set by the employer and still requiring a standard number of hours. This implies that employees will be able to attend to private affairs such as doctor’s visits and the care of sick family members during non-scheduled working time with minimum disruption to the delivery of products and services;

• Job sharing: one job shared between two workers through split day, split week or alternating weeks. This results in both functional and numerical flexibility so that, in the event of one employee being absent, the other can take over with little or no disruption to the work process;

• Financial flexibility: a shift towards new pay and remuneration systems that facilitate numerical and functional flexibility, such as assessment-based pay systems in stead of rate-for-the-job payment;

• Procedural and regulatory flexibility: the establishment of consultative mechanisms to introduce variations in work practices. This is especially important in a country such as South Africa, where labour markets are highly regulated. Strategies aimed at ensuring the continuity of production and service delivery in the event of absenteeism should be implemented in collaboration with employees and employee representatives;
• Mobility, or location flexibility: a shift in the nature of work, or a career change within the same organisation. This includes telecommuting and virtual work arrangements. These alternative work arrangements imply that employees who are physically challenged due to ill-health could continue to deliver essential services to the organisation through the use of collaborative computer systems should the nature of their tasks allow them to do so;

• Cognitive flexibility: a paradigm shift to adopt a new psychological contract between the employer and employee. This includes the acceptance of life-long learning, multi-skilling, boundary management and result-based compensation. Alternative work arrangements aimed at preventing disruption caused by absenteeism can only be implemented if employees buy into the concept and process of flexibility; and

• Organisational flexibility: the explicit willingness of management to develop and integrate multiple forms of flexibility by changing the structure and design of the organisation. This implies that management should commit itself to finding alternative ways to dealing with absenteeism in the workplace. Schultz (2003: 232) describes a flexible organisation as being organic, one consisting of networks of multi-talented individuals who perform a variety of tasks and which is never static but changes continuously according to the demands of the situation.

The contingency management of health-related absenteeism is facilitated by the introduction of flexible staffing practices and work arrangements. The next
section deals with strategic manpower planning as the basis of a strategic management process for dealing with fluctuating labour supply and demand, and high absenteeism levels in the organisation.

4.3 MANAGING FLUCTUATING STAFF LEVELS THROUGH HUMAN RESOURCES PLANNING

Schultz (2004b: 214) defines human resources planning as a systematic, fully integrated organisational process that is based on pro-actively planning ahead in order to ensure that appropriate quantity and quality of talent is available. In order to compete in a global and competitive environment, organisations must attract and retain employees who have abilities and aptitudes that add value to the company. Considering the current and anticipated impact of health-related issues on absenteeism levels in organisations, it will become increasingly difficult to achieve this goal as absenteeism results in fluctuating staff levels. It is expected that HIV/AIDS will impact increasingly on staffing levels and create a shortage of skilled staff. From a contingency perspective, organisations should determine the impact of absenteeism on staff levels, estimate the future need of skill or talent caused by absenteeism and develop strategies to ensure that the necessary talent will be available for the continuity of production and service delivery. Swanepoel et al (2003: 235) believe that the impact of excessive turnover rates and absenteeism levels can be reduced if human resources planning is carried out properly.
Human resources planning consists of three main areas, namely talent forecast, talent action plans, and the integration process (Schultz, 2004b: 214-215; Bowin & Harvey, 2002: 71-73).

4.3.1 The talent forecast

The purpose of talent forecasting is to predict changes in the demand and supply of talent. A high level of absenteeism affects labour supply and could result in a shortage of essential skill. It would therefore be necessary to determine the impact of absenteeism on the availability of skill in the organisation as part of the talent forecasting process (Greif, 1991: 182).

The first step in human resources planning is to estimate the number and type of employees that may be needed in the future. Many sophisticated software programmes exist that assist organisations in their planning. Two types of forecasting techniques can be utilised:

- Quantitative techniques; and
- Qualitative techniques.

Quantitative techniques rely heavily on numerical data from the past (Schultz, 2004b: 216). Examples of quantitative techniques are the moving average, linear programming and actuarial models. Qualitative techniques, on the other hand, require subjective input from experts in the organisation, such as senior management, who understand the demand of the operational side of the business. Qualitative techniques are flexible, and allow the incorporation of
factors and conditions that the expert feels should be considered. Examples of qualitative techniques are the Delphi and Nominal Group Techniques.

The time lost index and absence frequency rate, which were discussed in paragraph 3.3.2, are examples of quantitative techniques that are used to determine the impact of absenteeism on staff levels. By studying trends in absenteeism, future staff needs arising from absenteeism, can be identified. In essence, HIV/AIDS prevalence and impact studies are also quantitative measures that reveal how the pandemic is expected to affect absenteeism levels and the supply of labour, both within the organisation and in the external environment. Decenzo and Robbins (2002: 133) also suggest the use of probability statistics (actuarial studies which are quantitative in nature) as a means to estimate the occurrence of situations, such as death or illness, which are normally difficult to predict.

The second step in human resources planning is to estimate the consistency of availability of both the internal and external labour supply that could be utilised to meet the labour needs of the organisation. In terms of absenteeism, this would imply the availability of replacement personnel for those employees who are absent. This process normally starts with assessing the availability of skills within the organisation. Such information is obtained through skills inventories and management inventories. Typical information provided by a skills inventory include biographical data, education and qualifications, service record (including significant work experiences), results of performance assessments, language skills, training and development programmes attended, community and industrial leadership responsibilities, disciplinary actions, awards received and career
prospects. A replacement chart could also assist in the contingency management of health-related absenteeism as it indicates the skills and competencies of a given employee and also indicates possible replacements for the person in the event of sickness, termination of employment as a result of health-related issues or any other reason.

Decenzo and Robbins (2002: 131) describe a replacement chart as a typical organisational chart indicating positions that may become vacant in the near future and the individuals who could fill them. Replacement charts are normally used for succession planning for higher-level employees, but could be extended to all other levels to indicate functional flexibility in the organisation. Figure 4.2 provides an example of a replacement chart.

**Figure 4.2:** A sample replacement chart

![Replacement Chart Example](image-url)
Swanepoel et al (2001: 244) perceive replacement charts as a more short-term and flexible technique than succession planning, as it indicates how one employee can replace another as soon as the need arises.

In manufacturing organisations, both skills inventories and replacements charts could be useful in identifying employees who are able to stand in for those who are absent. In the same way, it could be used to redeploy staff to production areas where bottlenecks are experienced. In both cases, the continuity of production or service delivery is ensured.

Health-absenteeism affects both the supply and demand of human resources in the organisation and as such absenteeism figures provide valuable data in determining talent needs.

4.3.2 Talent action plans

Talent action plans outline the action that should be taken to attract, retain, re-deploy, and develop the talent that a company needs in order to meet the forecasted quantity and quality of employees (Schultz, 2004b: 215). In terms of the contingency management of absenteeism, talent action plans could ensure that the necessary skills are available to the organisation when employees are absent so that production and service delivery can continue without disruption.

Talent action plans involve:

- Sourcing and recruitment of an adequate supply of key talent;
- Identifying talent within the organisation and developing it further; and
Ongoing evaluation of the gap between talent needs and availability.

Schultz (2004b: 217) suggests the following plans or strategies could be used to boost the supply of talent in the organisation:

- Use of overtime;
- Use of part-timers or temporary workers;
- Sub-contracting;
- Recruitment from outside;
- Promotion from within;
- Succession planning; and
- Training or retraining.

The above strategies can be used to ensure that the necessary skill is available in the event of short- or long-term absenteeism.

4.3.3 The integration plan

In order to meet the staffing needs of the organisation, action plans should be fully implemented and monitored. According to Schultz (2004b: 215), it is also important to identify support for and resistance to talent action plans.

4.4 ENSURING THE OPTIMAL USE OF AVAILABLE TALENT

Due to the impact of HIV/AIDS, organisations stand to experience an increase in absenteeism and loss of key personnel. Considering the expected shortage of
skilled labour supply as a result of the HIV/AIDS pandemic, it becomes necessary for organisations to use the full potential of available talent, that is, of employees who are healthy and not prone to absenteeism, in the organisation.

A new concept that encompasses the full use of available talent in the organisation is engagement. Engaged employees care about the future of their organisation, are proud to work for the organisation, experience a sense of personal accomplishment, see the organisation as a preferred employer, feel inspired to deliver their best, understand how their role relates to the organisational goals and objectives, feel personally motivated to help the organisation succeed, and are willing to put a great deal of effort in, beyond what is normally expected (Perrin, 2003: 5). The study conducted by Perrin revealed a positive link between engagement and the retention of key personnel in the organisation. Engaged employees bring value to an organisation, because they are psychologically involved with their jobs and perceive high performance as important to their self-worth. This is similar to the concept of job involvement as described by Bergh and Theron (2004: 172).

Perrin (2003: 20) found ten elements that contribute to the engagement of employees, presented here in order of importance, as identified through research:

1. Senior management interest in employee well-being;
2. Challenging work;
3. Decision-making authority;
4. Customer orientation;
5. Career advancement opportunities;
6. Company reputation;
7. Collaboration with co-workers;
8. Resources to get the job done;
9. Input into decision making; and
10. Senior management vision.

Both the first and last element, that is, senior-management interest in employees and senior management vision, emphasise the role senior management plays in job engagement. According to Perrin (2003: 15), customer focus is an important element to engagement because employees know that it is central to the success of the organisation, and confidence is derived from a purpose-driven organisation. It is significant that traditional monetary rewards have not been identified as a key element in employee engagement. This would, however, be in line with the motivational theory of Herzberg, which states that a perceived low salary or wage will result in dissatisfaction but that, when an employee receives an equitable or adequate income, the person will neither be satisfied nor dissatisfied. Satisfaction is derived from factors such as a challenging job, opportunities to grow and develop, responsibility, recognition and achievement (Bergh & Theron, 2004: 152).

Various authors (Gwilliam, 2002; Luthans and Peterson, 2001: 376-387; Paditporn & Verma, 2003) emphasise the role of the manager in fostering engagement in the workplace. Kemp (2002: 6-7) states that bad management is the leading cause of active disengagement in the workplace. He criticises organisations for venerating employees in their mission statement as the most valued asset while in practice not developing the two most important factors that
contribute to engagement, namely the self-esteem and self-confidence of employees. According to Kemp (2002:6-7), employees need attention in the workplace, and he equates attention with, amongst other things, direction, encouragement, training, guidance, motivation and upholding the dignity of employees. Engaged employees demonstrate self-efficacy by taking initiative, thinking independently, solving problems.

A survey by Gallup Organisation found that 17 per cent of the US workforce was actively disengaged from their jobs and using more sick-leave (Ray, 2003). This is in line with the study done by Perrin, who found that 19 per cent of the sample in his study indicated low engagement. Perrin (2003: 6-7) found that 17 per cent of employees were highly engaged while the remaining “massive middle” achieved moderate and varying scores on the items included in the study. To optimally utilise existing talent in the organisation, an environment should be created where employees fully engage with their jobs and the organisation. Without proper training and development employers cannot expect job engagement.

Engagement is important to the contingency management of health-related absenteeism, as it is one strategy that can be used by organisations to ensure that, while some employees are absent, others who are at work are committed to meeting production and service goals.
4.5 ENSURING AN ADEQUATE SKILLS SUPPLY THROUGH TRAINING AND DEVELOPMENT

The emphasis on a flexible organisation highlights the need for a more flexible workforce, not only in terms of numerical flexibility but also functional flexibility. As was discussed in paragraph 4.2, numerical flexibility refers to the ability to change the size and structure of staff in the organisation in accordance with the human resources needs. Functional flexibility implies the availability of staff that can apply themselves in more than one function through multi-skilling and job rotation. The aim of flexible working is not only to reach greater efficiencies in an uncertain work environment, but also to eliminate rigid employment practices. Carefully planned training and development is a prerequisite for creating flexibility in the workplace (McGoldrick, 1996: 259). Pre-need hiring and training, and multi-skilling are strategies that could prevent disruption in production and service provision. Pre-need hiring implies employing a person a month or two before the person is actually required and training the person to the required level of competency. According to Schultz (2004: 217), pre-need hiring ensures that production and service delivery are not delayed due to a shortage of talent, especially in cases where the required skill is a scarce commodity.

4.5.1 Pre-need hiring and training

Although pre-need hiring and training may be regarded as a costly exercise, it may be justified under certain circumstances. The replacement of skill depends on the labour intensiveness of a specific task, the level of skills employed and the general availability of labour. Schultz (2004b: 217) suggests that organisations
make use of pre-need hiring and training to overcome delays caused by the employment process and the slow learning curve. It could prove to be more cost-effective than hiring a person only when a position becomes vacant. It is especially relevant in organisations that require highly skilled people that are difficult to source. Pre-need hiring and training indicates a pro-active approach to managing fluctuating staff levels. Many businesses would probably argue that pre-need hiring is a costly exercise. However, in a case where it is known that an employee’s health is deteriorating and that dismissal due to incapacity is a necessity, pre-need hiring will ensure that a replacement is found in time and that this person is trained to the necessary level of competency so that disruption to the production process or service delivery is either avoided or kept to the minimum. It would be costly to apply pre-need hiring indiscriminately but in the case of key personnel who have specialised skills, this strategy might prove to be useful.

4.5.2 Multi-skilling

Replacing an absent employee is difficult when the absent employee is the only one who knows what the job entails, or when he/she is the only one with the necessary skills to execute the task. This problem can be overcome with multi-skilling. Multi-skilling implies functional flexibility, meaning that workers are trained to execute a variety of jobs so that their skills can be applied according to the organisational needs. Multi-skilling is also recommended for areas in the manufacturing process that are characterised by bottlenecks, or where a few key
individuals normally handle a specific function (Whiteside and Barnett, http://www.ssd.u-bordeaux2.fr/sas/notes_sida/uk/manufacturing.htm).

Multi-skilling is a pre-requisite for a flexible organisation. Breuer (2000, 52-55) mentions parallel training as a technique to ensure that specialised technical skill is available in organisations. Parallel training implies training more than one employee for a designated technical job so that in the case of absenteeism or even labour turnover, production or service delivery will not be disrupted due to a lack of skill (Breuer, 2000: 52-55). Parallel training is similar to multi-skilling but is focused on a specialised task or function.

Womack and Jones (1996: 264) suggest that employees should not only learn job-related operational skills but that they should also be able to think horizontally about the total flow of value in the organisation. Employees should understand how various jobs relate to each other, and how they interrelate with all activities in the organisation.

One of the main strategies in the contingency management of health-related absenteeism is to ensure that the necessary skills are available to the organisation so that production and service delivery will not be disrupted. The training and development of new and existing employees is an important part of such a strategy.
4.6 ENSURING AN ADEQUATE SKILL SUPPLY THROUGH ALTERNATIVE WORK ARRANGEMENTS

Economic volatility, competitiveness, advanced technology and internationalisation are the main drivers of alternative work arrangements, such as flexitime and telecommuting. The need for more flexible work arrangements forces the human resources management department to adopt a strategic approach to the management of an organisation’s human resources. One of the benefits of flexible working arrangements is a decrease in absenteeism, labour turnover and overtime. (Brewster et al, 2003: 102; Gordon, 2002: 476). Flexible working arrangements contribute to a decrease in absenteeism as employees are provided with more control over their work schedules without compromising organisational needs.

Various authors (Carrel et al, 1998: 124; Schultz, 2004b: 225-226) perceive flexitime, job-sharing, telecommuting and compressed work-weeks as alternative work arrangements that provide greater flexibility in the workplace. Flexitime entails changing the quantity and timing of labour input while keeping employee numbers stable, job-sharing is when a job is split between two employees, telecommuting is working electronically from any location the employee chooses and a compressed work-week is reducing the number of workdays by extending the number of work hours worked on other days (Brewster et al, 2003: 13, 104; Schultz, 2004b: 226). Both the 2001 and 2002 CCH Unscheduled Absence Survey reports indicate flexibility in the workplace as a vital key in combating the problem of unscheduled absences. The 2002 CCH Unscheduled Absence
Survey indicated that US employers perceived alternative work arrangements, a compressed work-week and telecommuting as the most effective strategies to combat unscheduled absenteeism (CCH, 2001a and 2002: Unscheduled Absence Survey).

DaimlerChrysler Germany has adopted various flexible working arrangements in order to efficiently meet fluctuations in product demand. These include adjusting employee numbers (workforce flexibility) and employees’ working hours (working-time flexibility) to actual requirements by means of flexi-pools, working-time accounts, new shift models, working-time budgets and the use of temporary workers in the holiday season (http://daimlerchrysler.com).

According to Brewster et al (2003: 109), flexible work patterns are well established in Europe and Asia, and are rapidly developing in Australia. In comparison, South Africa still displays a highly traditional employment structure, with almost 90 per cent of employees categorised as permanent full-time, and 78 per cent of employees working a standard work-week.

In the next few paragraphs, the various types of alternative work arrangements will be discussed in more detail.

4.6.1 Flexitime

The traditional business schedule is usually from eight in the morning to five in the afternoon, the conventional starting and finishing time for employees. A variation of this schedule is flexitime or flexible working hours. With flexitime, the
employer determines a core period in which all employees must be present. Two flexible bands of time for arrival and departure are also established. Employees can choose their arrival and departure times within these bands to schedule an eight-hour work-day (Carrel et al, 1998: 127; Mathis & Jackson, 2000: 53).

Figure 4.3 illustrates flexitime work schedules.

**Figure 4.3  Flexitime work schedules**

<table>
<thead>
<tr>
<th>Downtown retail</th>
<th>7h00</th>
<th>10h30</th>
<th>13h00</th>
<th>21h00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial institution (½ hour lunch; 7-hour day)</td>
<td>8h00</td>
<td>11h30</td>
<td>13h00</td>
<td>18h00</td>
</tr>
<tr>
<td>Suburban retail</td>
<td>10h00</td>
<td>11h00</td>
<td>13h00</td>
<td>17h00</td>
</tr>
</tbody>
</table>

**Source:** Carrell, Elbert, Hatfield, Grobler, Marx & Van der Schyf, 1998: 127

As can be seen in Figure 4.3, the downtown retail company has established a core time between 10h30 and 13h00. During this time all employees have to be present. Employees can arrive at work from 7h00 to 10h30 and depart from 13h00 to 21h00, as long as they have been at work the required period of eight
hours and the full core period. The financial institution has a core period between 11h30 and 13h00, and requires employees to work a seven-hour work day with half an hour lunch taken outside the core period. It appears that employees would also have to agree with each other when they take their lunch time so that it is staggered and service to the clientele is not disrupted. In the suburban retail organisation two core periods exist. Employees will be scheduled to either work during core period one or core period two.

Employers in the textile and clothing industry perceive flexibility as essential in order to compete on a global level. This industry makes use of predominately female workers, who struggle to fulfil both work and family roles. Employers in the textile industry in the Western Cape indicated that they require a 24-hour work-day, seven days a week, with an optimum of 360 days a year to achieve greater output with lowered costs. It would imply more shifts, and hence, greater employment opportunities. These employers are not resisting paying full wages and benefits to contract employees, but complain that they are not allowed to employ contract workers for a period of more than three months, which hinders flexibility. A survey among these employers revealed an absenteeism rate of between four and 18 per cent (Bhorat, 1998: 1-7).

Kempske (1998: 1-4) indicates workplace flexibility as one of the top ten predicted characteristics of future organisations. He states that creative employment contracts will support more time off, flexibility in hours and work location, technological job aids and more risk-based pay arrangements, with built-in opportunities to increase income. Employees will have more and more choices about work arrangements, which will allow them to meet their individual
needs. Work-hours scheduling will become less important, as performance and results are emphasised. Employees will also demand more flexibility in order to pursue life interests. Kempske (1998: 1-4) makes it clear that future global business will strongly emphasise workforce development and lifelong learning.

According to Berry (1998: 483) and George and Jones (2002: 306), flexitime does not improve or impair performance on the job, but reduces absenteeism. Flexitime provides the employee with an opportunity to manage his/her personal and family commitments better, and makes commuting easier.

Carrell et al (1998: 126) report that almost every survey shows that companies experience more advantages than disadvantages as a result of introducing flexitime. These authors specifically mention decreases in labour turnover, absenteeism and tardiness. Mathis and Jackson (2000: 53) confirm these findings.

4.6.2 Job-sharing

Job-sharing involves dividing full-time jobs into two or more part-time positions, without particular regard for how it is divided. Two individuals are, as a team, jointly responsible for the tasks related to a position, or responsible for only half of the tasks related to the position. Carrell et al (1998: 126) state that job-sharing can lead to higher productivity, a greater pool of qualified applicants and reduced costs. They cite research done in a mass-assembly department, which showed that productivity increased by seven per cent as a result of job-sharing and that
the scrap ratio was reduced by 12 per cent. Job-sharing reduces the cost of training, hiring temporary workers and overtime. However, problems relating to communication and accountability may arise. Job sharing could be useful to the contingency management of absenteeism as it allows flexibility. Should an employee get sick, he/she could make an arrangement with the other member of the team to stand in for him/her so that the job can be executed without disruption to production or service delivery.

4.6.3 Telecommuting

Telecommuting has been made a reality through new technological developments such as email and networking. Telecommuting implies that employees can perform some or all of their duties from home, or any other location. However, telecommuting is not viable for all kinds of jobs. Mathis and Jackson (2000: 54) define telecommuting as going to work by means of electronic computing and telecommunications equipment. According to George and Jones (2002: 306), telecommuting results in less time lost due to absences. Decenzo and Robbins (2002: 23) state that telecommuting gives an employer the option to move work to an area that is more cost-effective.

According to Johns, a professor in management at Concordia University in Montreal, Canada, and a world expert in absenteeism management, telecommuting may be the only workable solution for family-related stress and absenteeism. He mentions that Alvin Toffler describes commuting to work as the
most unproductive activity, while Peter Drucker describes it as an obsolete activity (http://www.workplace.ca/secure/manbehav/0009.html).

Other concepts related to telecommuting are *hoteling*, which describes a situation where an employee occasionally uses a small central office and equipment for a limited period, as required, and the *virtual office*, which describes an employee who carries his “office” with him/her in the form of a cellular phone, laptop and business cards (Mathis and Jackson, 2000: 54).

Decenzo and Robbins (2002: 24) warn that an increase in telecommuting poses new human resource management challenges. This view is supported by Carrell et al (1998: 125), who warn that telecommuting should be introduced with care, as not all people can work independently, and could lead to feelings of isolation. It also requires a different type of management control. However, telecommuting could reduce the impact of absenteeism by allowing disabled and unhealthy employees, who might not be able to go to work, to work from home. Telecommuting also offers employees the opportunity to schedule their work time according to their personal needs. Telecommuting places the focus on the attainment of work-related goals attained and not actual hours spent at work.

### 4.6.4 Compressed work-weeks

A compressed work-week implies a shorter work-week than the traditional five work-days a week, while maintaining the same number of hours as before. The advantages of a compressed work-week are time off to attend to personal and family issues, reduced transport costs and better utilisation of equipment. A
Gallup Organisation survey in the USA revealed that two-thirds of working adults would prefer a compressed work-week (Heizer & Render, 1999: 368). Employers in South Africa have to avail themselves of the requirements of the Basic Conditions of Employment Act (No 75 of 1997), in terms of limitations on the number of work-hours per day, before changing employees’ working times (Carrell et al, 1998: 126). The Basic Conditions of Employment Act states that, through negotiation, the daily hours of work may be increased to allow for a compressed work-week, provided that the weekly limits apply and employees do not work for more than five days a week. In addition, through a collective agreement it can be decided that the hours of work be averaged over a period of up to four months (Nel, 2004: 87).

Gordon (2002: 475) cautions that a compressed work-week might lead to fatigue, and suggests that two-week block compressed work-weeks, rather than one-week blocks, should be considered. An example of this would be working for four days, followed by a four-day break, and then working for four more days, followed by a normal two-day weekend break.

This concludes the discussion of alternative work arrangements. Pettinger (in Brewster et al, 2003: 119) notes that the successful implementation of flexible work patterns requires a long-term commitment to creating a conducive environment that is supported by top management, a long-term view of the results desired and a long-term commitment to developing the required skills, knowledge, attitudes, behaviour and expertise, including training programmes.
4.7 ENSURING AN ADEQUATE SKILLS SUPPLY THROUGH ALTERNATIVE EMPLOYMENT PRACTICES

Paragraph 4.6 considered alternative work arrangements as a strategy to ensure that adequate skill levels are maintained in the organisation for production and service delivery to continue during periods of absenteeism. These practices are not always useful to all employers but where possible, they should be considered. This paragraph considers alternative employment practices, such as the employment of contingent workers and the sub-contracting or outsourcing of non-core functions as a strategy for the contingency management of absenteeism. Non-core functions are those functions that are peripheral to an organisation's main line of business. For example, in a chicken processing concern, the vaccination of chickens and washing of overalls are considered as peripheral functions. Although most organisations use some kind of alternative employment practice, it is often done in a haphazard manner rather than as part of a comprehensive staffing strategy, managed and administered by human resources professionals. An important aspect of such a strategy is attention to human aspects, which include morale, training and development, and team spirit, and which affect productivity (Greble, 1997). Alternative employment arrangements have advantages and disadvantages, which can be considered from an operational, financial and legal perspective. These advantages and disadvantages are discussed next.
Operational considerations

An optimum employment solution is one that results in the provision of the correct number of qualified workers for the job in the most cost-effective manner. Any change in staffing strategy should be carefully planned and executed as not to affect production or service provision negatively (Greble, 1997). An advantage of alternative employment arrangements is that it could save organisations money, as they would only pay the minimum number of people according to requirements. However, if alternative arrangements are not well-managed, it might result in underqualified people being employed at short notice, with a resultant drop in the quality of production or service delivery.

Financial considerations

Each staffing option is priced differently and all of them have direct and indirect costs. Greble (1997) warns that, although the use of traditional temporary employees, who are paid by the hour, seems to be a cheaper option, it might be a more expensive option due to higher training costs, absenteeism, interrupted workflow and impaired productivity. Organisations should carefully analyse the cost of maintaining a permanent workforce versus employing contingency staff, without compromising quality or time. Alternative work arrangements could prove to be cheaper in terms of remuneration as employees who work under these arrangements often do not enjoy benefits such as medical aid but more expensive in terms of quality or the time in which production or service delivery goals are attained.
Legal considerations

Each employment alternative brings with it unique legal implications and potential liabilities. The legal implications affect both the relationship between the organisation and the provider of the alternative staff, and the organisation and the temporary employees. It might be an advantage to shift the organisation's legal responsibility for its employees to a sub-contracting firm so that this company can deal with issues such as employment, remuneration and dismissals. However, sub-contracting to outside organisations requires careful consideration of contractual agreements with each company to ensure that organisational needs are met.

Two types of alternative work arrangements, namely the employment of contingency workers and sub-contracting or outsourcing, are discussed below.

4.7.1 Contingent workers

In South Africa, organisations are increasingly making use of non-standard employment practices to curb the escalating costs of labour and to meet the needs of employees who require more time-off to care for personal needs (Carrell et al, 1998: 125). Non-standard employment includes part-time employment, temporary employment, employment supplied by agencies, casual employment and the use of workers engaged under a sub-contractual relationship.
According to Mathis and Jackson (2000: 92), absenteeism levels are lowest in retail/wholesale firms and highest in governmental agencies, utilities and manufacturing concerns. They are of the opinion that this is the result of the retail/wholesale industry employing a large percentage of part-time workers. Bowin and Harvey (2001: 111) also perceive temporary employment as a strategy to deal with labour shortages, to create greater flexibility and to gain access to a quick source of experienced labour. In the case of absenteeism, an absent employee can be replaced in a short period of time without disruption to production or service delivery.

Employee leasing is also a form of temporary employment. A leasing company handles recruitment, employment, training, compensation and evaluating (Bowin and Harvey, 2001: 112; Decenzo and Robbins, 2002: 164). In this case, the employee is registered with and paid by the leasing company but according to contract, spends much longer periods with the client company than most contingent employees. In terms of the contingency management of health-related absenteeism, a leased employee might be required to stand in for an employee who needs a considerable time to recover from a health-related condition, such as major surgery or a stroke.

4.7.2 Sub-contracting or outsourcing

Organisations are increasingly relying on outsourcing to meet their labour force requirements and achieve greater flexibility in staffing levels. Independent contractors are required to do specific work for an organisation, either at the
premises or from a distant station. As such an individual is not regarded as an employee and does not enjoy the same benefits as permanent employees, costs are saved (Decenzo & Robbins, 2002: 164).

Baron and Kreps (1999: 466-467) warn that organisations should not simply adopt outsourcing to avoid legal liabilities, but that it should be aimed at allowing the organisation to focus on its core tasks.

Despite the controversy surrounding alternative work arrangements and employment practices, the growing need for and utilisation of these strategies cannot be ignored. This needs arises from the strong competition organisations face, the need to rationalise and reduce expenses and the need to become lean. The development of contemporary work and employment arrangements requires a participative/consensual management style and constructive relationships with all stakeholders. Alternative work arrangements and employment practices allow organisations to achieve greater flexibility. This enables the organisation to react faster and more efficiently to high levels of absenteeism in order to ensure that production and service processes can continue as planned.

4.8 REDUCING THE IMPACT OF ABSENTEEISM THROUGH CAREFUL CONSIDERATION OF PRODUCTION AND SERVICE PROCESSES

The size of a company, its production function, the nature of the product and competitiveness of the labour market influence the financial impact of
absenteeism on organisations. Daly (2000) states that the impact of absenteeism in organisations as a result of HIV/AIDS depends on, amongst others, the flexibility of the organisation’s production systems. Two production and service processes are discussed below, namely lean manufacturing and automation.

4.8.1 Lean manufacturing and absenteeism

To stay competitive, organisations must adopt lean and agile manufacturing environments and processes that allow for lower inventory levels and quicker response times (Liker, 1998: 11-13).

General literature on global manufacturing and lean manufacturing considered for the purpose of this study revealed that very little or no attention is given to absenteeism. However, by implication, global manufacturing and lean manufacturing do not leave room for absenteeism, as they are focused on effective and efficient goal-attainment, clarified expectations, a common purpose and accountability. The assumption is that if every team member has a clearly defined and significant role to play, there will be no need for delinquent absenteeism. On the other hand, Chapter two presented a realistic scenario of the health-related issues that are currently challenging South African organisations. Based on this scenario, it is a valid conclusion that even in a lean manufacturing system employees, as a result of health-related issues, will need to take leave from work. Two approaches can be adopted to counteract the negative effects of absenteeism in a lean manufacturing environment:
• Multi-skilling, to ensure that every employee can be replaced by another on short notice; and
• Adapting the manufacturing process to accommodate absenteeism and high labour turnover.

High levels of labour turnover and absenteeism could cause a lean and agile production system to fail. Quintana (1998: 452-469) conducted research at a company on the USA/Mexican border that proved that a recursive, pull-type production control system, which meets daily quota and minimises inventory, could be advantageous in an organisation plagued by high labour turnover and absenteeism levels. A pull-type production system is characterised by a lower amount of work-in-process (WIP) and a lower inventory of finished goods, in other words, an application of the just-in-time (JIT) concept. The product being pulled away by the customer or a downstream manufacturing operation creates demand on the production line. US companies have established maquiladora or twin-plant companies, on the USA/Mexican border, which is a marriage between the “professional rich” US and the “labour rich” Mexico. The US/Mexican region has traditionally been inundated by high labour turnover and absenteeism, which results in higher variability in production rates, lower product quality and lower throughput rates. To overcome these deficiencies, an adapted JIT production control system (AJITPCS) was suggested. In such a system, only the first workstation is allowed to pull as much raw material as it needs. All other downstream workstations are restricted to pulling the number of parts being passed to it from the pivotal (first) workstation. In this way, excess capacity is created at the first workstation, which can be redeployed elsewhere should absenteeism or labour turnover make it necessary. The research conducted by
Quintana proved that an AJITPC could accommodate variance experienced due to an unstable supply of labour. One important fact emphasised in the study conducted by Quintana (1998) is that the quality of the line influences the lean system, as the lower the quality of production, the more raw material has to be released for rework, which is contrary to the goals of a lean and agile manufacturing system. Training and development is an integral requirement in a lean manufacturing environment to ensure quality, continuous improvement and zero waste. Lean manufacturing implies employing less but highly qualified people. Absenteeism in this environment will have a more marked effect. It becomes a challenge to the organisation to carefully determine and balance the need for an adequate supply of employees in the face of possible absenteeism and the needs of lean manufacturing. The lessons learned from these twin-plant or maquiladora companies on the USA/Mexican border can be drawn to other developing countries. South Africa is regarded as a developing country, one that is characterised by modern technology, a shortage of skilled labour and high absenteeism levels.

Lean manufacturing creates a more flexible organisation that allows organisations to satisfy customer needs faster and more efficiently. McGoldrick (1996: 263) illustrates how an organisation can be changed from a single product mass assembly line to a flexible work organisation. This change will allow an organisation to adapt to stiffer competition in the market, move away from Taylor-like specialisation, and deal with absenteeism and late-coming, which compound the inflexibility of the traditional assembly line. In McGoldrick’s case study, employees, who regularly attended, were dissatisfied about being moved to jobs, which they did not know well, at short notice, in order to stand in for absent
employees. According to McGoldrick, a combination of high absenteeism, lateness and low morale due to payment grievances, in addition to the lack of flexible labour, were social factors that resulted in diseconomies of scale in the mass-production process. By moving from a traditional assembly line setup to a system of lean manufacturing that is more flexible, absenteeism could be managed more effectively. Figure 4.4 illustrates one of the two sub-assembly processes created in the place of the traditional mass-assembly line.

**Figure 4.4:** Flexible sub-assembly process

![Flexible sub-assembly process](image)

**Source:** McGoldrick, 1996: 266

As can be seen in Figure 4.2, the single, traditional assembly line has been replaced by two distinct processes, indicated as sub-assembly one (I) and two (II). Most of the routine, simple assembly tasks are undertaken on these sub-assembly lines. At these sub-assembly lines, each operator, through the process
of job rotation, learns all the skills required on the line. Should one of these employees be absent, any one of the other employees would be able to perform the absent employee’s function due to acquired functional flexibility. From the sub-assembly lines, semi-finished products are delivered to one of six round-tables, which are each manned by a single operator who rotates each task on the round-table by means of a foot pedal. The single operator at each of these tables completes all the tasks necessary to assemble a complete product, whether it involves welding, wiring or soldering. Each operator is able to complete a different product. The round-table operators are carefully selected and receive three months training to reach the required competency level. This new setup that incorporates lean manufacturing and flexibility has distinct advantages:

- A broader range of products can be produced;
- Employees, who are now more flexible, can be moved along the sub-assembly lines to prevent bottlenecks;
- Due to multi-skilling, employees can stand in for absentees with the minimum disruption; and
- A huge increase in productivity results.

It is not suggested that the above mentioned systems are the ultimate way in dealing with absenteeism-related problems, but illustrate that organisations could reconsider their production processes and service systems to ensure continuous delivery of production and service provision as demanded by customers. Flexible production systems, in conjunction with flexible work arrangements and employment practices, present a strategy for dealing with fluctuating staff levels as a result of absenteeism.
In conclusion, manufacturing processes can be adjusted to create more flexibility. A more flexible production system can accommodate absenteeism more effectively. However, the implication is that the work line should be well-skilled, not only in terms of the tasks that they perform, but also in terms of the basic concepts of continuous improvement and lean thinking. Cross-training and multi-skilling are important, as every member of the work line or cell should ultimately be able to operate every process in that line or cell.

4.7.2 Automation

Automation results in greater efficiency and reduced costs and is introduced in many organisations to replace human beings. Office automation involves the use of sophisticated computer hardware and software to store, analyse, and present information. It also improves time management and communication, and open up opportunities for telecommuting. Automation excludes the need for human resources and is therefore an option in the management of health-related absenteeism.

Automation of the manufacturing sector should be considered in situations where labour supply is a serious constraint. However, if an organisation is achieving a competitive advantage through using labour, which, according to international standards, is considered as cheap, automation might not be an option. Automation implies that the organisation has to rely to a greater extent on a smaller number of skilled employees (Barnett, Fellow and Whiteside, n.d.).
Absenteeism may have a more marked effect in this case. In conclusion, automation is a strategy that could be used to reduce the effect of absenteeism but should be carefully considered.

4.8 CONTINGENCY MANAGEMENT STRATEGIES AIMED AT ENSURING THE CONTINUITY OF PRODUCTION AND SERVICE DELIVERY IN THE FACE OF ABSENTEEISM

In this chapter, contingency strategies aimed at ensuring the continuity of production and service delivery in the face of absenteeism were discussed. The main aspects that should be contained in a contingency strategy for the management of absenteeism, revealed in the literature study presented in this chapter, are the following:

- In general, the development of a flexible organisation that is able to react timeously to changes in staff levels and market demands;
- More specifically, the management of fluctuating staff levels through estimating the talent needs that are created by absenteeism and developing talent action plans to ensure that the required talent is available to the organisation to ensure that production and service delivery processes are not disrupted;
- The training and development of employees as part of a talent action plan to ensure that the required level of skill is available to the organisation. This could include pre-need hiring and training, and multi-skilling;
• The introduction of alternative work arrangements, such as flexitime, job-sharing, telecommuting and compressed work-weeks, to give employees more control over their time and to allow them time to attend to personal matters. Telecommuting provides unwell and physically challenged employees the opportunity to be productive while staying at home;

• The introduction of alternative employment practices, such as the employment of contingency workers and the sub-contracting or outsourcing of non-core functions to other organisations, in order to ensure greater flexibility in staffing levels, to reduce cost; and to ensure that the focus is on the delivery of products and services rather than on employment and absenteeism, and

• The consideration and adjustment of current production and service delivery processes to ensure that they are not hampered by absenteeism. This could also include the automation of processes and service delivery.

4.10 CONCLUSION

Organisations need to consider strategies in order to ensure undisrupted production and service provision in the face of increasing levels of absenteeism. A strategic approach includes making the organisation more flexible by introducing flexible work arrangements and alternative employment practices through careful manpower planning and training, and through adopting flexible processes for production and service provision.
In Chapter five, the theoretical and empirical research findings presented in Chapter two, three and four, are integrated into a model of best practices which will be utilised for assessing the extent to which organisations in the motor manufacturing industry agree that these best practices are useful for the contingency management of health-related absenteeism.
CHAPTER FIVE

DEVELOPMENT OF BEST PRACTICES FOR

THE CONTINGENCY MANAGEMENT OF HEALTH-RELATED

ABSENTEEISM

5.1 INTRODUCTION 218
5.2 BEST PRACTICES 219
5.3 PRESENTATION OF BEST PRACTICES FOR THE
CONTINGENCY MANAGEMENT OF HEALTH-RELATED
ABSENTEEISM 221

5.3.1 Design and integrate policies on absenteeism and health
management 223
5.3.2 Manage absenteeism 223
5.3.3 Promote corporate health 225

5.3.3.1 Maintain wellness 226
5.3.3.2 Manage ill-health and mental diseases 227
5.3.3.3 Manage HIV/AIDS 228

5.3.4 Manage the continuity of production and service delivery 231

5.4 CONCLUSION 232
CHAPTER FIVE

DEVELOPMENT OF BEST PRACTICES FOR
THE CONTINGENCY MANAGEMENT OF HEALTH-RELATED
ABSENTEEISM

5.1 INTRODUCTION

From the presentation in Chapter two, it became evident that health-related absenteeism is a reality with which organisations are faced. In Chapter two, various health-related illnesses and conditions and their impact on absenteeism were discussed. In Chapter three, specific attention was given to strategies that can be adopted to prevent, control and reduce health-related absenteeism in organisations, while Chapter four focused on strategies aimed at ensuring the continuity of production and service provision despite the prevalence of health-related absenteeism. The main objective of this study was to develop best practice guidelines that could be applied for the contingency management of health-related absenteeism in the motor manufacturing industry.

The theoretical research findings presented in the previous chapters were used as a basis for the development of best practice guidelines for the contingency management of health-related absenteeism. These best practice guidelines formed the basis for the design of the survey questionnaire used in this research.
to determine the extent to which organisations in the motor manufacturing industry agreed that these best practice guidelines could assist them in the contingency management of health-related absenteeism. In this chapter, the concept ‘best practices’ is defined and best practice guidelines for the contingency management of health-related absenteeism are presented.

5.2 BEST PRACTICES

The Centre for Health Promotion at the University of Toronto acknowledges that many definitions of best practices exist and that these definitions depend on the origin and users of the definition (Goodstadt & Kahan, 2002). For the purposes of this centre for health promotion, the concept ‘best practices’ is defined as that set of procedures and activities that are consistent with health promotion values, theories/beliefs, evidence and an understanding of the environment that will likely lead to the achievement of health promotion goals.

Best practices are also defined as those strategies, activities or approaches which, through research and evaluation, are identified as effective at achieving a specific goal (Center for Substance Abuse Prevention: 2003).

According to Brewster et al (2003: 34-36), the best practices paradigm in human resources management implies that there is a direct relationship between specific human resources practices and company performance. These authors suggest that integrated systems or bundles of human resources practices will have more influence on company performance than individual or isolated
practices. This implies that best practices for the contingency management of health-related absenteeism should contribute to organisational performance and that the best practices should be integrated with each other. The authors also suggest that the impact of best practices on company performance is enhanced when they are linked to the company’s strategic orientation of continued competitiveness. A contingency approach attempts to link human resource management practices with specific organisational strategies.

From the above discussion the following characteristics of best practices are identified:

- Best practices are a set of integrated activities, procedures, strategies or approaches;
- Best practices are aimed at achieving specific goals, such as to strengthen and maintain the organisation’s performance and competitiveness; and
- Best practices are founded on knowledge, research and evaluation.

For the purposes of this study, best practices for the management of health-related absenteeism can be defined as a set of integrated strategies, activities and procedures, which are identified and verified through scientific research, and can be utilised by organisations for the contingency management of health-related absenteeism. These best practices are aimed at achieving the overall organisational goal which is optimal productivity and focused on specific organisational strategies which are integrated with each other, namely the management of absenteeism, the promotion of corporate health and ensuring the continuity of production and service provision during periods of absenteeism. The
best practices identified in the theoretical study for this research are presented below.

5.3 PRESENTATION OF BEST PRACTICES FOR THE CONTINGENCY MANAGEMENT OF HEALTH-RELATED ABSENTEEISM

The purpose of this section is to present best practices for the contingency management of health-related absenteeism as identified in the literature study. These best practices can serve as guidelines for organisations in the development of appropriate strategies for the contingency management of health-related absenteeism. They can also assist organisations in evaluating the current strategies used for the contingency management of health-related absenteeism and to determine whether these should be maintained in their present form, modified or discontinued.

The best practices for the contingency management of health-related absenteeism that were uncovered and summarised in the literature survey are presented in Figure 5.1. These best practices were identified in the theoretical study and formed the basis for the development of the questionnaire used in this research. The best practices focus on three main areas, namely the management of absenteeism, the promotion of corporate health and the continuity of production and service provision. A more comprehensive discussion of these best practices is presented below.
5.3.1 Design and integrate corporate policies on absenteeism and health management

Workplace policies act as general guidelines for organisational decision-making and the development of workplace strategies. Policies related to the contingency management of health-related absenteeism include absenteeism, return-to-work, disability, corporate wellness, employee assistance, substance abuse, stress/trauma and HIV/AIDS policies. These workplace policies should be integrated to ensure a comprehensive approach to the contingency management of health-related absenteeism, and to prevent discrepancies and ambiguity (Moodley, 2003).

5.3.2 Manage absenteeism

The first main area related to the contingency management of health-related absenteeism, is the management of absenteeism. The following best practices contribute to the effective management of absenteeism:

- The recording of absenteeism. Record-keeping forms the basis of any absenteeism management system as it provides the necessary data to determine the extent and nature of absenteeism in various groups, departments and sections of an organisation. Recording-keeping also provides the basis for dealing with individual absenteeism and individual absentee trends, allowing the problem to be identified timeously, the employee counselled and alternative work arrangements made if the
employee’s health does not enable him/her to continue with a normal work schedule.

- The measurement and analysis of absenteeism. The most commonly used measurements for absenteeism are the time lost index, which measures the monthly absenteeism rate for a group, and the absence frequency rate, which measures the number of incidents per employee. These two measurements indicate the degree of seriousness of the absenteeism, and whether the reasons provided for absenteeism are health-related, authorised or unexcused. This analysis allows management to compare the absenteeism levels of various groups, departments or sections in the organisation in order to decide on appropriate interventions.

- The benchmarking and reporting of absenteeism rates. Benchmarking involves the systematic comparison of absenteeism figures with those of similar organisations. Absenteeism figures and the analysis thereof should be reported to managers, employees, trade unions and the human resources department for appropriate decision-making.

- The management of incapacity. One of the purposes of absenteeism records is to identify employees who are, due to health reasons, and despite counselling and alternative work arrangements, unable to continue with their employment. In this case, the employee is dismissed or boarded due to incapacity.

The management of absenteeism is a main component in the contingency management of health-related absenteeism. In addition, absenteeism information generated through the recording and measurement of absenteeism
are also used in the promotion of corporate health and the management of the continuity of production and service provision. In the next section, attention is shifted to the promotion of corporate health.

5.3.3 Promote corporate health

The management of corporate health is the second main focus area in the contingency management of health-related absenteeism. The promotion of corporate health is divided into three sub-areas, namely the maintenance of wellness, the management of ill-health/mental diseases and the management of HIV/AIDS. The rationale for this division is based on the need to prevent health-related absenteeism by promoting the wellness of employees, the need to reduce the effect on absenteeism of current ill-health and mental problems of employees, and thirdly, the need to address HIV/AIDS separately as it is currently perceived as a major threat to individuals, organisations, communities and the economy in general. HIV/AIDS is expected to have a substantial effect on absenteeism levels in organisations if it is not managed strategically. A contingency approach to any situation involves, firstly, the risk being identified, secondly, the risk being prevented, thirdly, the risk being reduced and fourthly, careful plans being made to deal with a situation should the preventative actions not succeed. Maintaining wellness in the organisation is aimed at preventing health-related absenteeism.
5.3.3.1 Maintain wellness

Wellness interventions aim at keeping employees healthy and free of illness or conditions that could result in absenteeism. The following best practices contribute to the management of wellness in the workplace:

- The appraisal of health risks. The purpose of health risk appraisals is to assess whether the employees have health-related conditions, such as obesity or high blood pressure, that could ultimately lead to illness and therefore impact on absenteeism levels in the organisation. The measurement and analysis of absenteeism also contributes to identifying health-related issues in the organisation.

- The establishment of wellness programmes. Wellness programmes focus on the emotional, physical, cognitive and spiritual wellness of employees.

- The maintenance of workplace ergonomics. Ergonomics is aimed at providing a fit between the physical work environment and the individual employee in order to promote performance and reduce injury and illness, which could lead to absenteeism.

Absenteeism can be prevented if health risks in the workplace are identified and managed through wellness programmes and good workplace ergonomics. However, this is not a guarantee that people will not get ill. The next best practice is to manage ill-health and mental diseases in the workplace, a strategy aimed at reducing the impact of ill-health on absenteeism levels in the organisation.
5.3.3.2 **Manage ill-health and mental diseases**

The management of ill-health and mental diseases involves managing illness strategically to reduce its impact on absenteeism levels. Best practices related to the management of ill-health and mental diseases include:

- **The conducting of prevalence studies/audits and surveys.** In order to manage ill-health and mental diseases constructively, its prevalence in the organisation should be determined first. Additional information can be obtained through absenteeism records and the assessment of health risks in the organisation.

- **The provision of health benefits.** Health benefits include a medical aid or sick fund which could give employees access to relevant and professional health-care and medication.

- **The provision of occupational health-care.** This includes on-site health clinics, manned or serviced by occupational health-care nurses and medical practitioners. Services include monitoring employee health and on-site treatment.

- **The provision of disease-specific education.** Disease-specific education enables employees to manage their own illness by adopting the correct attitudes and behaviours to reduce the impact of the illness and to speed up recovery.

- **The management of individual cases.** This implies referring the employee who is unwell to a professional person or body who can manage the problem professionally so that the cost and time spent on rehabilitation is decreased, and absenteeism minimised.
• The utilisation of employee assistance programmes (EAPs). The main focus areas of an EAP are HIV/AIDS, disability, addiction, stress and trauma. An EAP is a structural tool that is used to identify and resolve productivity and absenteeism problems related to personal problems.

The above best practices contribute to the contingency management of health-related absenteeism as they are aimed at minimising the impact of ill-health on absenteeism. The management of HIV/AIDS in the workplace aims at preventing and minimising the impact of this pandemic on absenteeism levels. HIV/AIDS is presented separately as the expected impact of this pandemic, both on the country and economy, has compelled the government, through the Code of Good Practice on HIV/AIDS (discussed in paragraph 2.6.7), and organisations, through workplace policies and strategies, to focus specifically on the management of HIV/AIDS in the workplace.

Although it is presented as a separate strategy in the contingency management of health-related absenteeism, the management of HIV/AIDS should be integrated with all other strategies aimed at reducing absenteeism in the workplace.

5.3.3.3 Manage HIV/AIDS

The management of HIV/AIDS in the workplace requires a strategic and comprehensive approach. Best practices related to the management of HIV/AIDS include:
• The conducting of HIV/AIDS prevalence and impact studies. Prevalence studies estimate the occurrence of HIV-infection among the employee population while impact studies estimate, amongst others, the effect of HIV/AIDS on productivity and absenteeism levels in the organisation.

• The appointment of a HIV/AIDS task team. A dedicated task team ensures that HIV/AIDS is managed strategically, an HIV/AIDS policy is developed, necessary resources are made available, all stakeholders participate in the process and that the momentum of HIV/AIDS programmes is maintained.

• The increasing of awareness. Awareness is aimed at preventing HIV-infections, encouraging voluntary testing and reducing discrimination. The distribution of condoms is aimed at both making people aware of HIV/AIDS and encouraging them to take preventative action.

• The education of stakeholders. Stakeholders include groups such as managers, supervisors, peer helpers and employees. Education is more than awareness as it provides more in-depth knowledge of HIV/AIDS and how to manage it.

• The provision of access to anti-retroviral treatment. An Old Mutual Healthcare Survey (2001) suggests that access to treatment reduces the number of AIDS sicknesses over time.

• The management of individual cases. This includes providing support and counselling to employees who are affected by HIV/AIDS to help them deal with the physical and emotional challenges posed by this syndrome.

• Networking between communities. Many organisations do not have the expertise and resources to manage HIV/AIDS in the workplace. For this
reason, close co-operation with the community, which could include non-
governmental organisations, community-based organisations or faith-
based organisations, is suggested. On the other hand, organisations are
encouraged to share their expertise and resources with the community in
order to combat the impact of the pandemic on the country and
community as a whole.

- Ongoing research and evaluation. Continuous research and evaluation
  assist in identifying and refining the best practices for the management of
  HIV/AIDS in the workplace.

The abovementioned interventions related to HIV/AIDS are aimed at
preventing and reducing health-related absenteeism in the workplace.
Awareness programmes aim at preventing further infections, while the
management of individual HIV/AIDS cases aims at reducing the impact of the
syndrome on absenteeism levels, production and service provision.

Considering the prevalence of various diseases and health conditions in
South Africa, as was discussed in Chapter two, it is accepted that
absenteeism in organisations cannot be totally eliminated. A challenge to
organisations is to maintain a desirable level of production and service
provision despite absenteeism. The next paragraph presents best practices
aimed at ensuring the continuity of production and service delivery during
periods of absenteeism.
5.3.4 Manage the continuity of production and service delivery

Absenteeism causes fluctuating staff levels that can be disruptive to production and service delivery. The Institute for Employment Studies (Brewster et al, 2003: 15) has developed a model for flexibility aimed at increasing the efficiency of human resources utilisation in a fluctuating environment. Best practices related to the flexible utilisation of human resources are:

- Design a flexible organisation by adopting alternative work arrangements, such as flexitime, job-sharing, telecommuting and compressed work-weeks, and alternative employment practices, such as contingency employment and sub-contracting.

- Estimate future human resources needs. This implies the careful monitoring of available labour or skills in the organisation through effective human resources planning. Greif (1991:182) emphasises the use of absenteeism records to estimate staff levels.

- Talent actions plans include recruitment, training and the optimal use of available talent.

- The integration of talent action plans refers to the alignment and monitoring of all human resources actions aimed at ensuring the continuity of production and service delivery.

- Adjusting the production and service processes aims at making processes more flexible to accommodate fluctuations caused by absenteeism.
The automation of production and service delivery processes reduces the need for human resources and combats the negative effect of absenteeism.

The above processes and actions are aimed at managing the continuity of production and service provision in such a way the disruptive effect of absenteeism will be reduced to a minimum. It was indicated in paragraph 5.2 that best practices can be defined as a set of integrated strategies, activities and procedures, identified and verified through scientific research, which can be utilised by organisations for the contingency management of health-related absenteeism. In Figure 5.1 both the vertical and horizontal arrows illustrate that the various best practices should not be seen in isolation but should be integrated with each other. These best practices should also continuously be evaluated and adjusted according to the demands of a changing environment.

5.4 CONCLUSION

In this chapter, a model of best practices for the contingency management of health-related absenteeism was presented. This model includes the design and integration of corporate health policies, the management of absenteeism, promotion of corporate health (which includes the maintenance of wellness, management of ill-health/mental illnesses and the management of HV/AIDS) and the management of production and service provision to ensure continuity.

In the next chapter, the research methodology utilised for this study, is discussed.
# CHAPTER SIX

## RESEARCH METHODOLOGY

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>INTRODUCTION</td>
<td>234</td>
</tr>
<tr>
<td>6.2</td>
<td>PROFESSIONAL RESEARCH DESIGN</td>
<td>235</td>
</tr>
<tr>
<td>6.3</td>
<td>THE EMPIRICAL STUDY</td>
<td>237</td>
</tr>
<tr>
<td>6.3.1</td>
<td>Population and sampling</td>
<td>238</td>
</tr>
<tr>
<td>6.3.2</td>
<td>The questionnaire</td>
<td>239</td>
</tr>
<tr>
<td>6.3.2.1</td>
<td>Development of the questionnaire</td>
<td>240</td>
</tr>
<tr>
<td>6.3.2.2</td>
<td>Reliability and validity of the measuring instrument</td>
<td>242</td>
</tr>
<tr>
<td>6.3.2.3</td>
<td>Questionnaire covering letter</td>
<td>245</td>
</tr>
<tr>
<td>6.3.3</td>
<td>Pilot study</td>
<td>245</td>
</tr>
<tr>
<td>6.3.4</td>
<td>Administering the questionnaire</td>
<td>247</td>
</tr>
<tr>
<td>6.3.5</td>
<td>Response rate</td>
<td>249</td>
</tr>
<tr>
<td>6.4</td>
<td>PRESENTATION AND ANALYSIS OF THE BIOGRAPHICAL INFORMATION</td>
<td>251</td>
</tr>
<tr>
<td>6.4.1</td>
<td>Organisational size</td>
<td>252</td>
</tr>
<tr>
<td>6.4.2</td>
<td>Operational focus</td>
<td>253</td>
</tr>
<tr>
<td>6.4.3</td>
<td>Functional area</td>
<td>254</td>
</tr>
<tr>
<td>6.4.4</td>
<td>Gender</td>
<td>255</td>
</tr>
<tr>
<td>6.4.5</td>
<td>Language</td>
<td>256</td>
</tr>
<tr>
<td>6.4.6</td>
<td>Training programmes/workshops related to the contingency management</td>
<td>257</td>
</tr>
<tr>
<td></td>
<td>of health-related absenteeism</td>
<td></td>
</tr>
<tr>
<td>6.4.7</td>
<td>Gross Absence Rate</td>
<td>259</td>
</tr>
<tr>
<td>6.4.8</td>
<td>Percentage of absenteeism attributed to ill-health</td>
<td>261</td>
</tr>
<tr>
<td>6.4.9</td>
<td>Health-related organisational policies</td>
<td>262</td>
</tr>
<tr>
<td>6.5</td>
<td>CONCLUSION</td>
<td>265</td>
</tr>
</tbody>
</table>
CHAPTER SIX

RESEARCH METHODOLOGY

6.1 INTRODUCTION

In Chapter five, a model of best practices for the contingency management of health-related absenteeism was presented. This model was developed from best practice guidelines revealed in the literature study. Chapter two focused on the scope and impact of health-related absenteeism on organisations, Chapter three on contingency management strategies aimed at promoting a healthy workforce and reducing health-related absenteeism and Chapter four on contingency management strategies aimed at ensuring the continuity of production and service delivery in the face of absenteeism.

The objective of this chapter is to describe the research methodology that was used during this study. The chapter focuses on professional research and design, the population, questionnaire, pilot study, survey and survey response rate. The biographical information gathered during the survey is also presented and discussed.
6.2 PROFESSIONAL RESEARCH DESIGN

De Vos, Strydom, Fouché and Delport (2002: 50) perceive professional research as aimed, not only at problem-solving, but also the development of scientific knowledge. Saunders, Lewis and Thornhill (2000: 92) define a research design as the overall approach that is followed to answer research questions. For this reason, it is important that the researcher gives enough thought to the research questions he/she wants answered. The research design utilised for this study emerged from identifying the main problem and related sub-problems. The main problem was:

What contingency strategies can be utilised by organisations to manage health-related absenteeism?

An analysis of the main problem resulted in the identification of five sub-problems:

SUB-PROBLEM ONE:

What is the impact of health-related issues and absenteeism on organisations?

SUB-PROBLEM TWO:

What contingency management strategies can be utilised by organisations to reduce health-related absenteeism?
SUB-PROBLEM THREE:

What contingency management strategies can be utilised by organisations to maintain undisrupted production and service delivery in the face of absenteeism?

SUB-PROBLEM FOUR:

To what extent do organisations utilise effective contingency strategies to reduce health-related absenteeism?

SUB-PROBLEM FIVE:

To what extent do organisations utilise effective contingency strategies to maintain undisrupted production and provision of services?

The following broad procedures were adopted to solve the main and sub-problems:

a) In Chapter two, a literature study was conducted to evaluate the impact of health-related issues and absenteeism on organisations. Attention was also given to the legal parameters that guide the management of health-related absenteeism. In Chapter three, contingency management strategies, aimed at reducing health-related absenteeism in organisations, and in Chapter four, contingency management strategies, aimed at maintaining undisrupted production and service delivery in the face of absenteeism, were discussed.
b) In order to resolve sub-problems four and five, a model of best practices for the contingency management of health-related absenteeism, which was presented in chapter five, was used as a basis to develop the survey questionnaire. The survey questionnaire was used to establish the extent to which organisations in the motor manufacturing industry agreed or disagreed with the identified best practices for the contingency management of health-related absenteeism. The survey questionnaire was administered to organisations in the motor manufacturing industry located in the Nelson Mandela Metropolitan and Buffalo City areas. The results, obtained from the statistical analysis of the responses collected through the survey, form the basis for recommendations made with regard to the contingency management of health-related absenteeism.

6.3 THE EMPIRICAL STUDY

The empirical study was conducted by means of a survey, which allows the collection of a large amount of information. A survey gives the researcher more control over the research process, but he/she should then spend adequate time on developing and piloting the questionnaire (De Vos et al, 2000: 94). In this section, the population, the questionnaire, the pilot study, the survey and the research response rate are discussed in detail. The biographical information collected during the survey is also presented and discussed.
6.3.1 Population and sampling

While planning a study, a researcher has to decide whether to include the whole population or only a sub-set of the population in the empirical study. According to De Vos et al (2002: 199) and Saunders et al (2000: 150), a population (also termed universum) can be considered as a full set of cases that reflect the characteristics that the researcher is interested in. A population does not necessarily consist of people. A population can also consist of organisations, products, objects or events. When a population is too big to include in a study, a representative sample from the population is selected. A range of sampling can be used to select a representative subset of the population. Saunders et al (2000: 151) indicate that sampling is justified when it is impractical, expensive and too time-consuming to include the entire population. Sampling techniques are divided into probability and non-probability sampling. In the case of probability sampling, the sample is statistically chosen at random, which gives every unit of the population the same chance to be selected for participation in the study. Non-probability sampling is more subjective in nature as the researcher exercises more control over the selection of units (De Vos, 2002: 200-209). Non-probability sampling was used in this study as the population was small.

The target population for this study consisted of all organisations in the motor manufacturing industry in the Nelson Mandela Metropolitan and Buffalo City areas that employed more than fifty employees. For the purposes of this study, a database of all companies operating in the automobile and automobile
component industry in the Nelson Mandela Metropolitan and Buffalo City Metropolitan areas was used. This database was compiled from information obtained from the Port Elizabeth Regional Chamber of Commerce and the Border/Kei Chamber of Commerce and Industry. In addition, the database was compared to other available databases, such as that of the National Association of Automotive Component and Allied Manufacturers (NAACAM), to ensure that all organisations that met the criteria were included. Seventy organisations that employed more than 50 employees were identified from the database. It was evident that it would be feasible to include all these organisations in the empirical study, and as a result, the total population was included. The administration of the questionnaire is discussed in paragraph 6.3.4.

6.3.2 The questionnaire

Saunders et al (2000: 279) indicate that the questionnaire is a suitable data collecting method for the identification and description of different variables, such as those found in organisational practices or in the opinions or attitudes of people. The careful design of the individual questions, sensible layout of the questionnaire, coherent explanation of the purpose of the questionnaire and pilot testing contribute to better response rates, and maximise the validity and reliability of the questionnaire. The development of the questionnaire used in this study is discussed below.
6.3.2.1 Development of the questionnaire

The development of the questionnaire used in this study was based on the theoretical model of best practices that was presented in Chapter five.

Struwig and Stead (2001: 89-90) provide the following guidelines for the development of a questionnaire:

- Provide clear and precise instructions;
- Divide the questionnaire into logical sections according to subject;
- Start with easier questions;
- Proceed from general to specific questions;
- Ask personal and sensitive questions last;
- Avoid technological terms;
- Employ the respondent’s vocabulary; and
- Minimise the number of questions.

Struwig and Stead (2001: 90-92) also provide guidelines for the content and phrasing of questions. The aim is to phrase questions in such a manner that respondents will accurately interpret each question and not be influenced to give specific answers.

In addition, the researcher has to carefully consider the format or structure of the questions. Types of questions that could be included in a questionnaire are open-ended questions, multiple-choice questions, checklists, dichotomous questions that require a ‘yes’ or ‘no’ answer, ranking questions and scaled-
response questions. According to Struwig and Stead (2001: 95), scaled-
response questions, such as the Likert-type scale, are preferable to other forms
of questions as they provide ordinal data.

The questionnaire used for the purposes of this study was constructed to meet
the criteria suggested by Struwig and Stead (2001: 95). The questionnaire was
divided into four sections:

- Section A required biographical data and consisted of open-
  ended, multiple choice and dichotomous questions;
- Section B, C and D were formatted according to a Likert-type
  scale. Section B contained questions related to the management
  of health-related absenteeism;
- Section C contained questions related to the promotion of
  corporate health, and includes sections on the management of
  wellness, ill-health/mental problems and HIV/AIDS. It also
  included a section on success factors for programmes aimed
  preventing and reducing health-related absenteeism; and
- Section D contained questions related to the continuity of
  production and service delivery in the face of increasing
  absenteeism.

The careful design of a questionnaire contributes to its reliability and validity as a
measuring instrument.
6.3.2.2 Reliability and validity of the measuring instrument

Reliability and validity are important concepts in the context of measurement as they contribute to the objective and scientific nature of research (De Vos et al, 2002: 166).

Reliability

Leedy (1997: 35) defines reliability as the consistency with which a measuring instrument performs. Reliability can be determined by means of a test-retest, internal consistency and alternative form approach (Saunders et al, 2000: 307).

The test-retest method implies that a questionnaire is administered twice to the same group of people. The disadvantage of this method is that people may be reluctant to complete the same questionnaire twice, and if the researcher allows a lengthy interval between testing, the likelihood of eliciting the exact same responses will reduce. In this study, these problems were overcome by making use of a pilot study, which served as a type of test-retest method. The responses received from the pilot study could be compared to those received from the survey in order to make a judgment about the reliability of the questionnaire.

Internal consistency involves correlating responses to each question with those received to other questions, or to questions within the same sub-section of the questionnaire. After administering the questionnaire used in this study, the responses to sections B-D were statistically tested for internal consistency. The
Cronbach alphas for each sub-scale were acceptable (refer to paragraphs 7.2.1 to 7.2.6).

Alternative form implies checking the responses given to similar questions to verify the similarity of the responses. This method is more subjective in nature, as the researcher has to judge the similarity of questions. It is also possible that respondents might give dissimilar responses due to fatigue experienced while answering a long questionnaire. Though alternative form gives an indication of reliability, consistency is not proven without any doubt. Alternative form reliability testing was not applied in this study.

Validity


Content validity refers to the extent to which the measuring instrument measures the actual concepts related to the topic.

Face validity is closely related to content validity but differs in the sense that it measures ‘apparent’ validity rather than ‘actual’ validity. Inadequate face validity might cause resistance in respondents and therefore contaminate the results.
Criterion validity relates to how performance on one measure relates to performance on another measure, called a criterion. It is essential that the criterion selected is reliable and valid so that it can be used as a standard against which to measure the results of the measuring instrument (Leedy, 1997: 33).

Construct validity indicates the degree to which a measuring instrument successfully measures a theoretical construct. In the case of this study, construct validity implies the extent to which the measuring instrument measures contingency management strategies aimed at managing health-related absenteeism.

The following actions were taken to improve the content, face and construct validity of the questionnaire:

- The development of the questionnaire was based on the model of best practices for the contingency management of health-related absenteeism, which is presented in Chapter five. This model is based on the literature study presented in Chapters two, three and four; and
- The questionnaire was subjected to the scrutiny of academics and professionals in the field of human resources management as part of the pilot study.
6.3.2.3 Questionnaire covering letter

The purpose of a questionnaire covering letter is to explain the reasons for the survey. Saunders et al (2000: 303) suggest the following guidelines for the design of a covering letter:

- Use good quality paper, include an official letterhead and telephone number;
- Use a 12 point font size and one sheet only;
- Use the recipient's title and name if possible;
- Explain the purpose and use of the questionnaire;
- Explain why the recipient is important, and how long it will take to complete the questionnaire;
- Indicate confidentiality or anonymity;
- Explain how the results will be used;
- Provide a contact number or address;
- Thank the respondent for his/her participation in the study; and
- Provide a signature, name and surname.

The above suggestions were considered in the design of the covering letter (Refer to Appendix I).

6.3.3 Pilot study

De Vos et al (2002: 211) perceive a pilot study as a dress rehearsal of the main study. The purpose of a pilot study is to administer the questionnaire to a small
number of people who possess similar characteristics to the target group in order to ensure that the respondents will not encounter problems with completing the questionnaire and that the researcher will not have problems with the analysis of the responses. A pilot study also allows an assessment of the validity and reliability of the questionnaire (Saunders et al, 2000:304). A pilot study can elicit information about the time it took to complete the questionnaire, the clarity of instructions and questions, whether respondents felt uneasy about answering certain questions, whether major topics were omitted and whether the layout was clear and attractive. In addition, respondents must be encouraged to suggest any other improvements to the questionnaire.

The approach used for the pilot study in this project was as follows:

- The questionnaire was given to two senior academics, who also occupied managerial positions. Both these academics had experience in human resources management and health-related absenteeism.

- The questionnaire was given to two statisticians who assisted with the statistical analysis. These individuals provided feedback on the content, wording and layout of the questionnaire, which was then considered and used to improve the questionnaire.

- The questionnaire was given to four senior human resources practitioners who were requested to complete and evaluate the questionnaire in terms of the following:
  - length of time needed to complete the questionnaire;
  - clarity of the instructions, questions and words;
The comments received from the pilot study were used to refine the questionnaire so that it could be distributed to the target group of senior human resources practitioners.

### 6.3.4 Administering the questionnaire

The population for the study consisted of the motor and motor component industry in the Nelson Mandela Metropolitan and Buffalo City Metropolitan areas. The names of suitable organisations, which employed more than 50 employees, were compiled from various databases (refer to paragraph 6.3.1). After careful consideration, it was decided to include the total population, a total of 70 organisations, in the empirical study. Each organisation was contacted and the name of the human resources manager obtained. In the absence of a human resources manager, the name of the most senior person responsible for human resources or the management of health-related absenteeism was obtained. It was therefore ascertained that the potential respondents could be considered as specialists in the field of health-related absenteeism and that they could, due to their knowledge and experience, make a constructive contribution to identifying the best practices for the contingency management of health-related absenteeism. Saunders et al (2000: 308) state that the objective of administering a questionnaire is to gain access to the sample (in this case the population) and to maximise the response rate.
The following procedure was followed in administering the questionnaire:

- Each potential respondent was contacted by telephone to advise him/her to expect the questionnaire. According to Saunders et al (2000: 308), prior notification establishes personal contact with the respondent and subsequently raises the perceived importance of the study. Each respondent was questioned about the preferred method of delivery. Eighty seven per cent (87%) of the target group preferred to receive and return the questionnaire by email, while thirteen per cent (13%) preferred a facsimile. According to Struwig and Stead (2001: 103), emails can be used in the same manner as traditional mail surveys. The advantage of an email survey is that it is easy, cheap and fast to conduct. The researcher, however, needs to use a good administrative system to manage the process well.

- The covering letter and questionnaire were emailed to each potential respondent and faxed to those who preferred a facsimile.

- Each person who returned the questionnaire was thanked, either by means of an email or a telephonic call, for his/her contribution to the study.

- A follow-up email was sent or a telephonic call made to each potential respondent after one week to remind non-respondents to answer.

- A second follow-up was conducted after three weeks to potential respondents who had not yet responded. A copy of the covering letter and the questionnaire were included.
According to Saunders et al (2000: 310) a third follow-up may become necessary if the response rate is low. Recorded delivery by post, telephone calls and even calling in person can be used.

6.3.5 Response rate

The covering letter and questionnaire were sent to 70 organisations. Table 6.1 represents the geographical dispersion of these organisations.

Table 6.1: Number of companies surveyed

<table>
<thead>
<tr>
<th>REGION</th>
<th>NUMBER OF COMPANIES</th>
<th>PERCENTAGE %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buffalo City Metropole</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Nelson Mandela Metropolitan Municipality</td>
<td>63</td>
<td>90</td>
</tr>
<tr>
<td>TOTAL</td>
<td>70</td>
<td>100</td>
</tr>
</tbody>
</table>

Chart 6.1 provides a visual representation of the geographical dispersion of organisations surveyed.

Chart 6.1: Number of companies surveyed
It is evident that most organisations that were surveyed were located in the Nelson Mandela Metropolitan Municipal area.

Table 6.2 indicates the number of responses received from the survey.

Table 6.2: Number of responses received on or before due date

<table>
<thead>
<tr>
<th>REGION</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENTAGE OF TOTAL RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buffalo City Metropole</td>
<td>2</td>
<td>2.8</td>
</tr>
<tr>
<td>Nelson Mandela Metropolitan Municipality</td>
<td>27</td>
<td>38.5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>29</td>
<td>41.4</td>
</tr>
</tbody>
</table>

From Table 6.2 it is evident that two (2.8%) responses were received from organisations situated in the Buffalo City Metropole, while 27 (38.5%) were received from the Nelson Mandela Metropolitan Municipality before the due date.

Table 6.3 indicates the number of responses received after a second follow-up, which was conducted either by email or telephonically.

Table 6.3: Total number of responses received after the second follow-up

<table>
<thead>
<tr>
<th>REGION</th>
<th>NUMBER OF COMPANIES</th>
<th>PERCENTAGE %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buffalo City Metropole</td>
<td>3</td>
<td>4.2</td>
</tr>
<tr>
<td>Nelson Mandela Metropolitan Municipality</td>
<td>53</td>
<td>75.7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>56</td>
<td>80</td>
</tr>
</tbody>
</table>

Saunders et al (2000: 158) state that the smaller the sample (population in this case), the higher the response rate has to be in order to reduce the margin of error and enable the researcher to generalise the results to the whole population.
The margin of error indicates the accuracy with which the collected data will represent the characteristics of the total population.

Various authors have different opinions about what a good response rate constitutes. Saunders et al (2000: 158) report a wide variation (from 15 to 99 per cent) in response rates received in studies that aimed at collecting primary data. These authors suggest that it is useful to compare the response rate with those received from similar studies. On the other hand, De Vos et al (2002: 172) indicate that a 60 per cent response rate is good, while a 70 per cent response rate is excellent. The response rate of 80 per cent received for this study was therefore considered as acceptable.

6.4 PRESENTATION AND ANALYSIS OF THE BIOGRAPHICAL INFORMATION

Section A of the questionnaire required of the respondents to provide information about themselves, such as gender and home language, and their organisation, such as the number of people in employment and average absenteeism rate. These questions were included in the questionnaire due to their potential value as independent variables to probe similarities or differences in the responses to various sections of the questionnaire. The information obtained from the questions contained in Section A is presented and discussed below.
6.4.1 Organisational size

Question A1 required of the respondents to indicate the number of people employed in their organisation. This provides an indication of the size of the organisations that participated in the survey. The results are presented in Table 6.4.

Table 6.4: Responses with regard to organisational size

<table>
<thead>
<tr>
<th>ORGANISATIONAL SIZE</th>
<th>RESPONSE FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-100</td>
<td>10</td>
<td>17.9</td>
</tr>
<tr>
<td>101-200</td>
<td>13</td>
<td>23.2</td>
</tr>
<tr>
<td>201-300</td>
<td>8</td>
<td>14.3</td>
</tr>
<tr>
<td>301-400</td>
<td>8</td>
<td>14.3</td>
</tr>
<tr>
<td>401-1000</td>
<td>10</td>
<td>17.9</td>
</tr>
<tr>
<td>1001+</td>
<td>7</td>
<td>12.5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>56</td>
<td>100</td>
</tr>
</tbody>
</table>

Chart 6.2 provides a visual presentation of the size of the organisations that participated in the survey.

Chart 6.2: Organisational size

![Organisational size chart](image)
It is evident from Table 6.4 and Chart 6.2 that the organisations that participated in this study represented a broad spectrum in terms of organisational size.

### 6.4.2 Operational focus

Question A3 required of the respondents to indicate the operational focus of the organisation. The results are presented in Table 6.5 and Chart 6.3.

**Table 6.5: Responses with regard to operational focus**

<table>
<thead>
<tr>
<th>OPERATIONAL FOCUS</th>
<th>RESPONSE FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor vehicles</td>
<td>3</td>
<td>5.4</td>
</tr>
<tr>
<td>Components</td>
<td>45</td>
<td>80.4</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>14.3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>56</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Chart 6.3: Responses with regard to operational focus**

It is evident from both Table 6.5 and Chart 6.3 that most of the organisations that participated in the survey operated in the motor component sector (80.4%).
Motor vehicle manufacturers comprised 5.4 per cent of the surveyed organisations, while a total of 14.3 per cent of organisations represented auxiliary services.

6.4.3 Functional area

Question A4 required of the respondents to indicate the functional area they were employed in. Responses to this question are presented in Table 6.6 and Chart 6.4.

Table 6.6: Responses with regard to functional area employed in

<table>
<thead>
<tr>
<th>FUNCTIONAL AREA</th>
<th>RESPONSE FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line management</td>
<td>5</td>
<td>8.9</td>
</tr>
<tr>
<td>Human Resources Management</td>
<td>43</td>
<td>76.8</td>
</tr>
<tr>
<td>Health Services</td>
<td>4</td>
<td>7.1</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>56</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Chart 6.4: Responses with regard to functional area employed in
It is evident from both Table 6.6 and Chart 6.4 that most of the respondents (76.8%) represented human resources management. Nine per cent of the respondents were line managers and seven per cent were from health services, while another seven percent had other functions in the organisation. As was indicated in paragraph 6.3.4, every organisation in the population was contacted to obtain the name of the most senior person responsible for either human resources management or the management of health-related absenteeism. It can therefore be assumed that in cases where a line manager or a person in another function responded, the organisation did not have a dedicated human resources department but that the respondent was, nevertheless, responsible for the management of human resources and absenteeism in the organisation.

### 6.4.4 Gender

Question A5 required of the respondents to indicate their gender. Table 6.7 and Chart 6.5 present responses received to this question.

**Table 6.7:** Responses with regard to gender

<table>
<thead>
<tr>
<th>GENDER</th>
<th>RESPONSE FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>31</td>
<td>55.4</td>
</tr>
<tr>
<td>Male</td>
<td>25</td>
<td>44.6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>56</td>
<td>100</td>
</tr>
</tbody>
</table>
More females (55.4%) than males (44.6%) participated in the survey. However, both genders were adequately represented.

### 6.4.5 Language

Question A6 required of the respondents to indicate their home language. The results are presented in Table 6.8 and Chart 6.6.

Table 6.8: Responses with regard to home language

<table>
<thead>
<tr>
<th>HOME LANGUAGE</th>
<th>RESPONSE FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afrikaans</td>
<td>14</td>
<td>25</td>
</tr>
<tr>
<td>English</td>
<td>37</td>
<td>66.1</td>
</tr>
<tr>
<td>Xhosa</td>
<td>5</td>
<td>8.9</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>56</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Most of the respondents were English-speaking (66.1%), while twenty-five per cent (25%) were Afrikaans-speaking and a minority (9.9%) Xhosa-speaking. These figures were not representative of the general population in the areas in which the study was conducted but could be considered as representative of senior management in human resources management.

### 6.4.6 Training programmes/workshops related to the contingency management of health-related absenteeism

Question A7 required of the respondents to indicate whether their organisation had, in the previous twelve months, arranged a training programme/workshop on absenteeism, corporate health and contingency strategies to maintain production and service delivery during periods of high absenteeism. The results are presented in Table 6.9 and graph 6.1. One respondent did not respond to the question on corporate health.
Table 6.9: Training programmes/workshops presented in the previous twelve months

<table>
<thead>
<tr>
<th>TRAINING PROGRAMME/WORKSHOP</th>
<th>RESPONSE FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Absenteeism</td>
<td>18</td>
<td>38</td>
</tr>
<tr>
<td>Corporate health</td>
<td>17</td>
<td>38</td>
</tr>
<tr>
<td>Contingency strategies</td>
<td>18</td>
<td>38</td>
</tr>
</tbody>
</table>

Graph 6.1: Training programmes/workshops presented in the previous twelve months

It is clear that in terms of absenteeism, corporate health and contingency strategies, a third of the respondents, in each case, indicated that their organisation had arranged a training programme/workshop during the previous twelve months. It is therefore evident that these issues are a concern to approximately a third of organisations and that they are attempting to find ways with which to address them.
6.4.7 Gross Absence Rate

Question A8 required of the respondents to indicate the bracket in which the organisation's average absenteeism rate fell. This measure is an indication of the Gross Absence Rate (GAR) or the average time lost due to absenteeism. The GAR does not only include time lost due to sick-leave, but also due to authorised or unexcused absence. The responses received to question A8 are presented in Table 6.10 and Chart 6.7.

Table 6.10: Gross Absence Rate

<table>
<thead>
<tr>
<th>GAR</th>
<th>RESPONSE FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3%</td>
<td>17</td>
<td>30.4</td>
</tr>
<tr>
<td>4-6%</td>
<td>29</td>
<td>51.8</td>
</tr>
<tr>
<td>7-10%</td>
<td>8</td>
<td>14.3</td>
</tr>
<tr>
<td>More than 10%</td>
<td>2</td>
<td>3.6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>56</td>
<td>100</td>
</tr>
</tbody>
</table>

Chart 6.7: Gross Absence Rate
A GAR of 3 per cent (3%) represents the international norm and is therefore considered as acceptable. Thirty per cent (30.4%) of the respondents indicated that their organisation had an average absenteeism rate of one to three per cent (1-3%). More than half of the respondents (51.8%) indicated that their organisation experienced an absenteeism rate of between four and six per cent (4-6%). This could be considered as a high GAR that requires corrective action. A further 14 per cent (14.3%) of respondents indicated an absenteeism rate of between seven and ten per cent (7-10%). This could be considered as a very high GAR that could have serious consequences for the continuity of production and service delivery, and organisational profits. A minority of respondents (3.6%) indicated a GAR of above 11 per cent.

It can therefore be concluded that approximately 70 per cent of organisations in the automobile and automobile component industry in the Eastern Cape region have an absenteeism rate higher than the international norm. In paragraph 6.4.6 it was stated that a third of the respondents indicated that their organisation had, in the previous twelve months, arranged a training programme/workshop related to absenteeism, health-related issues or contingency strategies aimed at maintaining production and service delivery in the face of absenteeism. In the next paragraph, it becomes evident that a third of the respondents indicated that their organisations experienced high levels of absenteeism due to genuine ill-health. The above information could indicate that, although many organisations experience a high rate of absenteeism, inadequate attention is given to managing it constructively.
6.4.8 Percentage of absenteeism attributed to ill-health

Whereas question A8 required of the respondents to indicate the organisation’s GAR, question A9 required of them to indicate the percentage of absenteeism that they attributed to genuine ill-health. This could indicate the extent to which health-related absenteeism, in contrast to general absenteeism, was considered as a problem. The responses to question A9 are presented in Table 6.11 and Chart 6.8. The total number of responses was 54 responses, as two respondents did not respond to this question.

Table 6.11: Percentage absenteeism attributed to genuine ill-health

<table>
<thead>
<tr>
<th>ABSENTEEISM ATTRIBUTED TO GENUINE ILL-HEALTH</th>
<th>RESPONSE FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2.5%</td>
<td>26</td>
<td>48.1%</td>
</tr>
<tr>
<td>2.6-3%</td>
<td>10</td>
<td>18.5%</td>
</tr>
<tr>
<td>3.1-5%</td>
<td>15</td>
<td>27.7%</td>
</tr>
<tr>
<td>5.1+ %</td>
<td>3</td>
<td>5.5%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>54</td>
<td>100%</td>
</tr>
</tbody>
</table>

Chart 6.8: Percentage absenteeism attributed to genuine ill-health
It is evident that almost half of the respondents (48.1%) attributed one to 2.5 per cent of the GAR to genuine ill-health. This could be considered as acceptable on the premise that a GAR of three per cent (3%) is considered as acceptable, and that allowance (in the region of 0.5%) should be made for authorised absenteeism. Three per cent sick-leave is allowed on the assumption that people inevitably get sick, and that sick-leave is basically intended to accommodate genuinely sick people. Approximately nineteen per cent (18.5%) of the respondents indicated that they attributed between 2.6 and three per cent of absenteeism to genuine ill-health. This level of health-related absenteeism can be considered as on the borderline of being acceptable/non-acceptable. Approximately twenty-eight per cent (27.8%) of the respondents attributed 3.1 to five per cent of absenteeism to genuine ill-health, while almost six per cent (5.5%) attributed more than five per cent (5.1+%) of absenteeism to genuine ill-health. This could be an indication that health-related absenteeism was reaching unacceptable levels in approximately a third of the organisations that participated in the study.

6.4.9 Health-related organisational policies

In Chapter three, various health-related organisational policies, aimed at controlling and reducing absenteeism in organisations, were discussed. Question A10 required that the respondents indicate the policies adopted in their organisations. The responses to this question are presented in Table 6.12 and Graph 6.12 (a and b).
Table 6.12: Health-related organisational policies

<table>
<thead>
<tr>
<th>POLICY</th>
<th>RESPONSE FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Absenteeism</td>
<td>55</td>
<td>1</td>
</tr>
<tr>
<td>Return-to-work</td>
<td>33</td>
<td>23</td>
</tr>
<tr>
<td>Disability</td>
<td>48</td>
<td>8</td>
</tr>
<tr>
<td>Corporate wellness</td>
<td>17</td>
<td>39</td>
</tr>
<tr>
<td>Employee-assistance programme (EAP)</td>
<td>33</td>
<td>23</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>39</td>
<td>16</td>
</tr>
<tr>
<td>Stress</td>
<td>10</td>
<td>46</td>
</tr>
<tr>
<td>Trauma</td>
<td>9</td>
<td>47</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>42</td>
<td>14</td>
</tr>
</tbody>
</table>

Graph 6.2 (a): Health-related organisational policies
It is evident that almost all the organisations (98.2%) had a policy on absenteeism. The majority of respondents indicated that their organisation had a policy on disability (85.7%) and substance abuse (69.6%). The percentage for both employee assistance and return-to-work policies was 58.9 per cent. Employee assistance programmes provide a formal vehicle for counselling employees who are regularly absent and is therefore important to the contingency management of health-related absenteeism. Return-to-work policies aim at reducing the length of absenteeism by providing a formal mechanism for accommodating employees who are recovering from illness or injury. Both these mechanisms have been indicated as important to the management of health-related absenteeism in organisations (refer to paragraphs 3.2.2 and 3.2.5) and it can therefore be concluded that the current percentage of organisations that utilise them, is relatively low.
Less than a third of the respondents indicated that their organisation had a corporate wellness (30.4%), stress (17.9%) and trauma (16.1%) policy. In chapter three, the role of these policies in the contingency management of health-related absenteeism was discussed. An overall corporate wellness policy enhances the integration and alignment of all health-related policies, while stress and trauma policies are perceived as important to organisations whose employees are exposed to a challenging environment, both in the work place and at home. These low figures suggest a failure by organisations to manage these important aspects of absenteeism.

Three quarters of the respondents (75%) indicated that their organisation had a policy on HIV/AIDS. A study done by the Eastern Cape Bench Marking Club in 2002 revealed that 55.6 per cent of organisations had an HIV/AIDS policy in place, while a follow-up study in 2003 revealed that 67.5 per cent of organisations had an HIV/AIDS policy in place. These figures suggest that organisations were increasingly formulating policies in order to combat this pandemic.

6.5 CONCLUSION

This chapter presented the research methodology used during this study and focused on professional research and design, the population, questionnaire, pilot study, survey and survey response rate. The biographical information gathered
during the survey (Section A of the questionnaire) was also presented and discussed.

In the next chapter, the results obtained from the rest of the questionnaire are presented and discussed to determine the extent to which representatives of organisations in the motor industry agree with the best practices for the contingency management of health-related absenteeism, which were identified in the theoretical study.
# CHAPTER SEVEN

## ANALYSIS AND INTERPRETATION OF RESULTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>INTRODUCTION</td>
<td>268</td>
</tr>
<tr>
<td>7.2</td>
<td>QUANTITATIVE ANALYSIS OF RESULTS</td>
<td>269</td>
</tr>
<tr>
<td>7.2.1</td>
<td>Actions aimed at reducing health-related absenteeism</td>
<td>270</td>
</tr>
<tr>
<td>7.2.2</td>
<td>Wellness actions aimed at reducing health-related absenteeism</td>
<td>274</td>
</tr>
<tr>
<td>7.2.3</td>
<td>Reducing absenteeism through the management of ill-health and mental problems</td>
<td>277</td>
</tr>
<tr>
<td>7.2.4</td>
<td>Reducing absenteeism through the management of HIV/AIDS</td>
<td>279</td>
</tr>
<tr>
<td>7.2.5</td>
<td>Success factors for programmes aimed at preventing and reducing health-related absenteeism</td>
<td>282</td>
</tr>
<tr>
<td>7.2.6</td>
<td>Continuity of production and services in the face of increasing absenteeism</td>
<td>284</td>
</tr>
<tr>
<td>7.2.7</td>
<td>Results obtained from ANOVA</td>
<td>289</td>
</tr>
<tr>
<td>7.2.8</td>
<td>Analysis of results obtained from factorial ANOVA</td>
<td>304</td>
</tr>
<tr>
<td>7.2.9</td>
<td>Discriminant analysis</td>
<td>316</td>
</tr>
<tr>
<td>7.3</td>
<td>REVIEW OF QUANTITATIVE ANALYSIS</td>
<td>325</td>
</tr>
<tr>
<td>7.3.1</td>
<td>Actions aimed at reducing health-related absenteeism (Section B)</td>
<td>326</td>
</tr>
<tr>
<td>7.3.2</td>
<td>Wellness actions aimed at reducing health-related absenteeism (Section C1)</td>
<td>327</td>
</tr>
<tr>
<td>7.3.3</td>
<td>Reducing absenteeism through the management of ill-health and mental problems (Section C2)</td>
<td>328</td>
</tr>
<tr>
<td>7.3.4</td>
<td>Reducing absenteeism through the management of HIV/AIDS (Section C3)</td>
<td>329</td>
</tr>
<tr>
<td>7.3.5</td>
<td>Success factors for programmes aimed at preventing and reducing health-related absenteeism (Section C4)</td>
<td>331</td>
</tr>
<tr>
<td>7.3.6</td>
<td>Practices aimed at ensuring the continuity of production and services in the face of increasing absenteeism (Section D)</td>
<td>332</td>
</tr>
<tr>
<td>7.4</td>
<td>CONCLUSION</td>
<td>333</td>
</tr>
</tbody>
</table>
CHAPTER SEVEN

ANALYSIS AND INTERPRETATION OF RESULTS

7.1 INTRODUCTION

In Chapter six, the research methodology used in this study was presented and discussed. The data collected from Section A of the questionnaire was presented and analysed.

The aim of this chapter is to assist in the resolution of sub-problems four and five.

SUB-PROBLEM FOUR:

To what extent do organisations utilise effective contingency strategies to reduce health-related absenteeism?

SUB-PROBLEM FIVE:

To what extent do organisations utilise effective contingency strategies to maintain undisrupted production and provision of services?
The results from Sections B to D of the survey questionnaire are presented in the same order as they appeared in the questionnaire. The questionnaire consisted of six main sections, namely:

- Actions aimed at reducing health-related absenteeism (Section B);
- Wellness actions aimed at reducing health-related absenteeism (Section C1);
- Actions aimed at reducing absenteeism through the management of ill-health and mental problems (Section C2);
- Actions aimed at reducing absenteeism through the management of HIV/AIDS (Section C3);
- Factors important to the success of programmes aimed at preventing and reducing health-related absenteeism (Section C4); and
- Practices aimed at ensuring the continuity of production and service provision during periods of high absenteeism (Section D).

The research findings are presented in tabular form. These tables were compiled with the aid of computer printouts generated by means of the SPSS version 11.0 programme.

7.2 QUANTITATIVE ANALYSIS OF RESULTS

Descriptive and inferential statistics were used to analyse the raw data obtained from the survey. The descriptive data included measures of central tendency and dispersion of selected variables. Sections B to D of the questionnaire were
developed according to a Likert-type scale and, for each item, the respondents had to indicate whether they strongly agreed, agreed, were uncertain, disagreed or strongly disagreed with each statement. Numerical values, ranging from five (strongly agree) to one (strongly disagree), were used to enable the quantitative analysis of the results. Inferential statistics employed included Pearson’s correlation, Cronbach alpha reliability analysis, one-way ANOVA, factorial ANOVA and discriminant function analysis. The quantitative analysis of the results from Sections B to D is presented below.

7.2.1 Actions aimed at reducing health-related absenteeism

Section B of the questionnaire required of the respondents to indicate the practices that were important to the management of health-related absenteeism. This section focused on the recording, calculation, analysis, benchmarking and communication of absenteeism data, and the management of incapacity due to ill-health. Table 7.1 shows the means and standard deviations of the scores for Section B.
Table 7.1: Means and standard deviations of scores for Section B

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recording absenteeism accurately</td>
<td>56</td>
<td>4.86</td>
<td>.353</td>
</tr>
<tr>
<td>Calculating monthly absenteeism rates for each work-group or department</td>
<td>56</td>
<td>4.55</td>
<td>.570</td>
</tr>
<tr>
<td>Calculating monthly absenteeism frequency rates for each work-group</td>
<td>56</td>
<td>4.43</td>
<td>.628</td>
</tr>
<tr>
<td>Determining the average absenteeism rate for the whole organisation</td>
<td>56</td>
<td>4.64</td>
<td>.520</td>
</tr>
<tr>
<td>Systematically analysing absenteeism figures to determine trends and problems</td>
<td>55</td>
<td>4.49</td>
<td>.742</td>
</tr>
<tr>
<td>Benchmarking absenteeism rates for each work group with those of other work groups</td>
<td>56</td>
<td>4.04</td>
<td>.830</td>
</tr>
<tr>
<td>Benchmarking the absenteeism rate for the organisation with those of similar organisations</td>
<td>56</td>
<td>4.07</td>
<td>.806</td>
</tr>
<tr>
<td>Communicating absenteeism figures to stakeholders such as employees, managers and trade unions</td>
<td>56</td>
<td>4.52</td>
<td>.738</td>
</tr>
<tr>
<td>Dealing timeously with incapacity due to ill-health</td>
<td>56</td>
<td>4.66</td>
<td>.478</td>
</tr>
<tr>
<td>Managing incapacity due to ill-health in a legally compliant manner</td>
<td>54</td>
<td>4.67</td>
<td>.514</td>
</tr>
<tr>
<td>Counselling employees with health-related problems</td>
<td>56</td>
<td>4.66</td>
<td>.514</td>
</tr>
<tr>
<td>Providing alternative work arrangements for unwell employees</td>
<td>55</td>
<td>4.16</td>
<td>.788</td>
</tr>
</tbody>
</table>

An analysis of the mean and standard deviation of the variables in Section B revealed an aggregate mean of 4.47. All the mean scores for variables in this section were above four, indicating agreement to strong agreement on all the items. The standard deviation indicated that the spread of the results was relatively narrow, ranging between .353 and .830. This indicated agreement among the respondents about the actions required for the management of health-related absenteeism in organisations. The variable ‘recording absenteeism accurately’ obtained the highest mean (4.86) and the lowest standard deviation (.353), while the variable ‘benchmarking the absenteeism rate for the organisation with those of similar organisations’ obtained the lowest mean (4.04) and the highest standard deviation (.830). These results confirm the
theoretical findings, which indicated that record-keeping was the first step in the successful management of absenteeism (refer to paragraph 3.3). Though it was highlighted in the theoretical study that benchmarking was undertaken by few companies only, the empirical study revealed that it was perceived as an important strategy in the management of health-related absenteeism.

The total scores for Section B were correlated with the total scores for all the other sections. The results are presented in Table 7.2.

Table 7.2: Correlations of scores for Section B with all other sections

<table>
<thead>
<tr>
<th>B1 Total (Absence management)</th>
<th>B1 Total</th>
<th>C1 Total</th>
<th>C2 Total</th>
<th>C3 Total</th>
<th>C4 Total</th>
<th>D1 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Correlation</td>
<td>1</td>
<td>.011</td>
<td>-.011</td>
<td>.249</td>
<td>.190</td>
<td>-.032</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.</td>
<td>.935</td>
<td>.935</td>
<td>.065</td>
<td>.160</td>
<td>.815</td>
</tr>
<tr>
<td>N</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
</tr>
</tbody>
</table>

It is evident that no significant correlation was found between the total scores for Section B and the total scores for other sections. It can therefore be concluded that Section B measured an independent construct.

The Cronbach alpha is a test of internal consistency and reliability. It measures how well a set of items measures a single construct and therefore indicates whether items in a questionnaire or sub-scale belong together (UCLA: n.d.). Reynaldo and Santos (1999) state that an Alpha co-efficient of >0.7 is acceptable. The Cronbach alpha for Section B was .8835, which implied internal consistency or reliability. Table 7.3 provides descriptive data, namely the
corrected mean if an item is deleted, the item to total section correlation and the Cronbach alpha if the item is deleted.

**Table 7.3:** Corrected item means, correlations and internal consistency coefficients of Section B (12 items)

<table>
<thead>
<tr>
<th>Section</th>
<th>Mean if Item Deleted</th>
<th>Corrected item - Total Section Correlation</th>
<th>Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1A</td>
<td>48.8113</td>
<td>.4686</td>
<td>.8813</td>
</tr>
<tr>
<td>B1B</td>
<td>49.1132</td>
<td>.5970</td>
<td>.8738</td>
</tr>
<tr>
<td>B1C</td>
<td>49.2075</td>
<td>.5107</td>
<td>.8782</td>
</tr>
<tr>
<td>B1D</td>
<td>49.0377</td>
<td>.5040</td>
<td>.8785</td>
</tr>
<tr>
<td>B1E</td>
<td>49.1887</td>
<td>.6735</td>
<td>.8687</td>
</tr>
<tr>
<td>B1F</td>
<td>49.6415</td>
<td>.7200</td>
<td>.8658</td>
</tr>
<tr>
<td>B1G</td>
<td>49.6038</td>
<td>.6929</td>
<td>.8677</td>
</tr>
<tr>
<td>B1H</td>
<td>49.1698</td>
<td>.6195</td>
<td>.8723</td>
</tr>
<tr>
<td>B1I</td>
<td>48.9811</td>
<td>.6161</td>
<td>.8742</td>
</tr>
<tr>
<td>B1J</td>
<td>49.0000</td>
<td>.5405</td>
<td>.8769</td>
</tr>
<tr>
<td>B1K</td>
<td>49.0189</td>
<td>.6938</td>
<td>.8698</td>
</tr>
<tr>
<td>B1L</td>
<td>49.4906</td>
<td>.4877</td>
<td>.8816</td>
</tr>
</tbody>
</table>

Table 7.3 shows that item B1F had the highest correlation with the rest of the items and that the Alpha score would decrease to .8658 if the item were deleted from Section B. All the items contributed positively to the Cronbach alpha of .8835 and it can be concluded that there was internal consistency among the items in Section B. It was therefore not necessary to delete any item from Section B.
7.2.2 Wellness actions aimed at reducing health-related absenteeism

Section C1 of the questionnaire required of the respondents to indicate the wellness practices that were important to reducing health-related absenteeism. Table 7.4 shows the means and standard deviations of scores for Section C1.

| Introducing an integrated corporate wellness programme | 56 | 4.16 | .733 |
| Assessing health risks such as smoking, obesity, high blood pressure and cholesterol of all organisational members | 56 | 3.86 | .841 |
| Introducing wellness interventions such as weight reduction, smoking cessation and fitness improvement programmes | 56 | 3.75 | .899 |
| Training employees in stress management | 56 | 4.09 | .769 |
| Introducing substance abuse prevention and control programmes | 55 | 4.13 | .747 |
| Providing work environment that is healthy and safe | 55 | 4.78 | .534 |

An analysis of the mean and standard deviation of the variables in Section C1 revealed an aggregate mean of 4.12, indicating a tendency toward agreement on all the items. The standard deviation indicated that the spread of the results was relatively narrow, ranging between .534 and .899. The item ‘providing work environment that is healthy and safe’ obtained the highest mean (4.78) and lowest standard deviation (.534), while the item ‘introducing wellness interventions such as weight reduction, smoking cessation and fitness improvement programmes’ obtained the lowest mean (3.75) and highest
standard deviation (8.99). The results indicated that respondents agreed with the wellness actions aimed at reducing health-related absenteeism in organisations.

The total scores for Section C1 were correlated with the scores for all the other sections of the questionnaire. The results are presented in Table 7.5.

**Table 7.5:** Correlations of scores for Section C1 with all other sections

<table>
<thead>
<tr>
<th></th>
<th>B1 Total</th>
<th>C1 Total</th>
<th>C2 Total</th>
<th>C3 Total</th>
<th>C4 Total</th>
<th>D1 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Correlation</td>
<td>.011</td>
<td>1</td>
<td>.415</td>
<td>.121</td>
<td>.324</td>
<td>-.017</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.935</td>
<td>.001</td>
<td>.374</td>
<td>.015</td>
<td>.904</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
</tr>
</tbody>
</table>

A weak positive correlation existed between the total scores for Sections C1 and C2 (p<0.01), and C1 and C4 (p<0.05). Section C2 measured practices that contributed to the management of ill-health and mental problems, while Section C4 measured the success factors for programmes aimed at the preventing and reducing of health-related absenteeism.

The Cronbach alpha for Section C1 was high at a level of .8356, which implied internal consistency or reliability. Table 7.6 provides descriptive data, namely the corrected mean if an item is deleted, the item to total section correlation and the Cronbach alpha if the item is deleted.
Table 7.6: Corrected item means, correlations and internal consistency coefficients of Section C1 (6 items)

<table>
<thead>
<tr>
<th>Section</th>
<th>Mean if Item deleted</th>
<th>Corrected item - Total Section Correlation</th>
<th>Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1A</td>
<td>20.6111</td>
<td>.6621</td>
<td>.7987</td>
</tr>
<tr>
<td>C1B</td>
<td>20.9074</td>
<td>.7495</td>
<td>.7777</td>
</tr>
<tr>
<td>C1C</td>
<td>21.0185</td>
<td>.7795</td>
<td>.7699</td>
</tr>
<tr>
<td>C1D</td>
<td>20.6852</td>
<td>.6831</td>
<td>.7936</td>
</tr>
<tr>
<td>C1E</td>
<td>20.6667</td>
<td>.5880</td>
<td>.8132</td>
</tr>
<tr>
<td>C1F</td>
<td>20.0000</td>
<td>.1705</td>
<td>.8725</td>
</tr>
</tbody>
</table>

The table shows that items C1B and C1C were best correlated with the rest of the items and that the Alpha score would decrease to .7777 and .7699 respectively if these items were deleted from Section C1. Item C1F correlated least with the other items in Section C1 (.1705). It could be reasoned that ‘providing a work environment that is healthy and safe’ (Item C1F) is not directly related to wellness, but that it is nevertheless perceived as important to the management of absenteeism in organisations. If this item were deleted from Section C1, the Alpha would increase to .8725. However, as all the items contributed to the Cronbach alpha of .8835, it can be concluded that there was internal consistency among the items in Section C1 and that there was no need to delete any item from Section C1.
7.2.3 Reducing absenteeism through the management of ill-health and mental problems

Section C2 required of respondents to indicate the practices that contributed to the management of ill-health and mental problems. Table 7.7 shows the means and standard deviations of scores for Section C2.

Table 7.7: Means and standard deviations of scores for Section C2

<table>
<thead>
<tr>
<th>Practice</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determining the prevalence of diseases, such as TB, cancer, asthma or diabetes among organisational members</td>
<td>56</td>
<td>4.36</td>
<td>.749</td>
</tr>
<tr>
<td>Assessing stress levels in the organisation</td>
<td>56</td>
<td>4.09</td>
<td>.793</td>
</tr>
<tr>
<td>Providing health benefits such as medical aid or sick funds in line with health needs of employees</td>
<td>56</td>
<td>4.43</td>
<td>.759</td>
</tr>
<tr>
<td>Providing on-site occupational health services</td>
<td>55</td>
<td>4.44</td>
<td>.739</td>
</tr>
<tr>
<td>Providing access to disease-specific information</td>
<td>55</td>
<td>4.33</td>
<td>.668</td>
</tr>
<tr>
<td>Refering an unwell employee to a professional person or body who can assist in managing the problem professionally</td>
<td>56</td>
<td>4.54</td>
<td>.538</td>
</tr>
<tr>
<td>Establishing an Employee Assistance Programme</td>
<td>55</td>
<td>4.33</td>
<td>.695</td>
</tr>
</tbody>
</table>

An analysis of the mean and standard deviation of the variables in Section C2 revealed an aggregate mean of 4.36. This suggests a tendency toward agreement and strong agreement on all the items. The standard deviation indicated that the spread of the results was relatively narrow, ranging between .538 and .793, indicating that the respondents were relatively consistent in the way they responded to the items in this section.
The total scores for Section C2 were correlated with the scores for all the other sections of the questionnaire. The results are presented in Table 7.8.

**Table 7.8:** Correlations of scores for Section C2 with all other sections

<table>
<thead>
<tr>
<th></th>
<th>B1 Total</th>
<th>C1 Total</th>
<th>C2 Total</th>
<th>C3 Total</th>
<th>C4 Total</th>
<th>D1 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2 Total</td>
<td>Pearson Correlation</td>
<td>-.011</td>
<td>.415</td>
<td>1</td>
<td>.201</td>
<td>.225</td>
</tr>
<tr>
<td>(Management of ill-health)</td>
<td>Sig. (2-tailed)</td>
<td>.933</td>
<td>.001</td>
<td>.138</td>
<td>.096</td>
<td>.001</td>
</tr>
<tr>
<td>N</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
</tr>
</tbody>
</table>

A weak positive correlation existed between the total scores for Sections C2 and D ($p<0.01$). Section D measured contingency strategies aimed at maintaining production and service delivery in the face of absenteeism.

The Cronbach alpha for Section C2 was high at a level of .8157, which implied internal consistency or reliability. Table 7.9 provides descriptive data, namely the corrected mean if an item is deleted, the item to total section correlation and the Cronbach alpha if the item is deleted.
Table 7.9: Corrected item means, correlations and internal consistency coefficients of Section C2 (7 items)

<table>
<thead>
<tr>
<th>Section</th>
<th>Mean if Item deleted</th>
<th>Corrected item - Total Section Correlation</th>
<th>Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2A</td>
<td>26.0189</td>
<td>.5315</td>
<td>.7957</td>
</tr>
<tr>
<td>C2B</td>
<td>26.3019</td>
<td>.4852</td>
<td>.8051</td>
</tr>
<tr>
<td>C2C</td>
<td>25.9623</td>
<td>.4608</td>
<td>.8086</td>
</tr>
<tr>
<td>C2D</td>
<td>25.9434</td>
<td>.6670</td>
<td>.7707</td>
</tr>
<tr>
<td>C2E</td>
<td>26.0566</td>
<td>.5717</td>
<td>.7888</td>
</tr>
<tr>
<td>C2F</td>
<td>25.8491</td>
<td>.6214</td>
<td>.7862</td>
</tr>
<tr>
<td>C2G</td>
<td>26.0189</td>
<td>.5998</td>
<td>.7835</td>
</tr>
</tbody>
</table>

The table shows that item C2D correlated best with the rest of the items and that the Alpha score would decrease to .7707 if this item were deleted from Section C2. All the items contributed to the Cronbach alpha of .8835 and it can be concluded that there was internal consistency for Section C2. It was therefore not necessary to delete any item from this section.

7.2.4 Reducing absenteeism through the management of HIV/AIDS

Section C3 required of respondents to indicate the practices that contributed to the management of HIV/AIDS. Table 7.10 shows the means and standard deviations of scores for Section C3.
Table 7.10: Means and standard deviations of scores for Section C3

<table>
<thead>
<tr>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using scientific measurements to determine the prevalence of HIV/AIDS among organisational members in compliance to legal parameters</td>
<td>56</td>
<td>3.95</td>
</tr>
<tr>
<td>Planning strategically for the financial impact of HIV/AIDS on health needs and benefits</td>
<td>56</td>
<td>4.25</td>
</tr>
<tr>
<td>Launching HIV/AIDS awareness campaigns</td>
<td>56</td>
<td>4.64</td>
</tr>
<tr>
<td>Conducting HIV/AIDS training and educational workshops</td>
<td>56</td>
<td>4.64</td>
</tr>
<tr>
<td>Providing access to anti-retroviral treatment</td>
<td>56</td>
<td>3.88</td>
</tr>
<tr>
<td>Counselling and supporting employees affected by HIV/AIDS</td>
<td>56</td>
<td>4.39</td>
</tr>
<tr>
<td>Distributing condoms</td>
<td>56</td>
<td>4.21</td>
</tr>
<tr>
<td>Networking and sharing resources with community organisations to combat HIV/AIDS</td>
<td>56</td>
<td>4.11</td>
</tr>
<tr>
<td>Engaging in on-going research and evaluation to identify the best strategies for dealing with HIV/AIDS in the workplace</td>
<td>56</td>
<td>4.23</td>
</tr>
</tbody>
</table>

An analysis of the mean and standard deviation of the variables in Section C3 revealed an aggregate mean of 4.25. This indicated a tendency toward agreement and strong agreement on all the items in this section. The lowest mean scores were obtained for the item ‘using scientific measurements to determine the prevalence of HIV/AIDS among organisational members in compliance to legal parameters’ (mean 3.95 and standard deviation .980) and the item ‘providing access to anti-retroviral treatment’ (mean 3.88 and standard deviation .974).

The total scores for Section C3 were correlated with the scores for all the other sections of the questionnaire. The results are presented in Table 7.11.
Table 7.11: Correlations of scores for Section C3 with all other sections

<table>
<thead>
<tr>
<th></th>
<th>B1 Total</th>
<th>C1 Total</th>
<th>C2 Total</th>
<th>C3 Total</th>
<th>C4 Total</th>
<th>D1 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>C3 Total (Management of HIV/AIDS)</td>
<td>Pearson Correlation</td>
<td>.249</td>
<td>.121</td>
<td>.201</td>
<td>1</td>
<td>.741</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.065</td>
<td>.374</td>
<td>.138</td>
<td>.</td>
<td>.000</td>
</tr>
<tr>
<td>N</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
</tr>
</tbody>
</table>

A strong, positive relationship (p<0,01) was found between the total scores for Section C3 and those for Section C4 (success factors for programmes aimed at preventing and reducing health-related absenteeism).

The Cronbach alpha for Section C3 was high at a level of .8809, which implied internal consistency or reliability. Table 7.12 provides descriptive data, namely the corrected mean if an item is deleted, the item to total section correlation and the Cronbach alpha if the item is deleted.

Table 7.12: Corrected item means, correlations and internal consistency coefficients of Section C3 (6 items)

<table>
<thead>
<tr>
<th>Section</th>
<th>Mean if Item deleted</th>
<th>Corrected item - Total Section Correlation</th>
<th>Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>C3A</td>
<td>34.3571</td>
<td>.5575</td>
<td>.8766</td>
</tr>
<tr>
<td>C3B</td>
<td>34.0536</td>
<td>.6680</td>
<td>.8655</td>
</tr>
<tr>
<td>C3C</td>
<td>33.6607</td>
<td>.6824</td>
<td>.8668</td>
</tr>
<tr>
<td>C3D</td>
<td>33.6607</td>
<td>.7533</td>
<td>.8624</td>
</tr>
<tr>
<td>C3E</td>
<td>34.4286</td>
<td>.5382</td>
<td>.8784</td>
</tr>
<tr>
<td>C3F</td>
<td>33.9107</td>
<td>.7463</td>
<td>.8578</td>
</tr>
<tr>
<td>C3G</td>
<td>34.0893</td>
<td>.5053</td>
<td>.8814</td>
</tr>
<tr>
<td>C3H</td>
<td>34.1964</td>
<td>.7493</td>
<td>.8569</td>
</tr>
<tr>
<td>C3I</td>
<td>34.0714</td>
<td>.6533</td>
<td>.8658</td>
</tr>
</tbody>
</table>
Table 7.12 shows that all the items correlated positively with the rest of the items of Section C3 and that the Alpha score would not be affected if any item were deleted from this section, indicating no need to delete any item from this section.

### 7.2.5 Success factors for programmes aimed at preventing and reducing health-related absenteeism

Section C4 required of respondents to indicate the success factors for programmes aimed at preventing and reducing health-related absenteeism. Table 7.9 shows the means and standard deviations of scores for Section C4.

**Table 7.13:** Means and standard deviations of scores for Section C4

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A constructive and supportive organisational culture</td>
<td>56</td>
<td>4.48</td>
<td>.632</td>
</tr>
<tr>
<td>Top management support</td>
<td>56</td>
<td>4.66</td>
<td>.611</td>
</tr>
<tr>
<td>Ownership of programmes by a task or project team</td>
<td>56</td>
<td>4.30</td>
<td>.658</td>
</tr>
<tr>
<td>Employee participation in planning and executing of workplace programmes</td>
<td>56</td>
<td>4.34</td>
<td>.695</td>
</tr>
<tr>
<td>Communicating/marketing of workplace programmes</td>
<td>56</td>
<td>4.29</td>
<td>.706</td>
</tr>
<tr>
<td>Continuous evaluation of effectiveness of programmes</td>
<td>56</td>
<td>4.38</td>
<td>.648</td>
</tr>
<tr>
<td>Aligning all health- and absenteeism-related policies and interventions</td>
<td>56</td>
<td>4.23</td>
<td>.738</td>
</tr>
</tbody>
</table>

An analysis of the mean and standard deviation of the variables in Section C4 revealed an aggregate mean of 4.38. This suggested a tendency toward agreement and strong agreement on all the items in this section. The standard
deviation indicated that the spread of the results was relatively narrow, ranging between .611 and .738.

The total scores for Section C4 were correlated with the scores for all the other sections of the questionnaire. The results are presented in Table 7.14.

**Table 7.14: Correlations of scores for Section C4 with all other sections**

<table>
<thead>
<tr>
<th></th>
<th>B1 Total</th>
<th>C1 Total</th>
<th>C2 Total</th>
<th>C3 Total</th>
<th>C4 Total</th>
<th>D1 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>C4 Total (Success factors) Pearson Correlation</td>
<td>.190</td>
<td>.324</td>
<td>.225</td>
<td>.741</td>
<td>1</td>
<td>.111</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.160</td>
<td>.015</td>
<td>.096</td>
<td>.000</td>
<td>.417</td>
</tr>
<tr>
<td>N</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
</tr>
</tbody>
</table>

As indicated in paragraph 7.2.4, a strong, positive relationship (p<0.01) was found between the total scores for Section C4 and those for Section C3 (the management of HIV/AIDS). The implication is that HIV/AIDS interventions will be more effective when applied in a more conducive environment.

The Cronbach alpha for Section C4 was high at a level of .8983, which implied internal consistency or reliability among the items contained in this section. Table 7.15 provides descriptive data, namely the corrected mean if an item is deleted, the item to total section correlation and the Cronbach alpha if the item is deleted.
Table 7.15: Corrected item means, correlations and internal consistency coefficients of Section C4 (7 items)

<table>
<thead>
<tr>
<th>Section</th>
<th>Mean if Item deleted</th>
<th>Corrected item - Total Section Correlation</th>
<th>Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>C4A</td>
<td>26.1964</td>
<td>.7614</td>
<td>.8770</td>
</tr>
<tr>
<td>C4B</td>
<td>26.0179</td>
<td>.5869</td>
<td>.8957</td>
</tr>
<tr>
<td>C4C</td>
<td>26.3750</td>
<td>.6533</td>
<td>.8889</td>
</tr>
<tr>
<td>C4D</td>
<td>26.3393</td>
<td>.7420</td>
<td>.8786</td>
</tr>
<tr>
<td>C4E</td>
<td>26.3929</td>
<td>.7513</td>
<td>.8775</td>
</tr>
<tr>
<td>C4F</td>
<td>26.3036</td>
<td>.8559</td>
<td>.8658</td>
</tr>
<tr>
<td>C4G</td>
<td>26.4464</td>
<td>.5906</td>
<td>.8978</td>
</tr>
</tbody>
</table>

Table 7.15 shows the correlation of each item with the rest of the items and that the Alpha would not be negatively affected if any of the items were deleted from Section C2. All the items contributed to the Cronbach alpha of .8835 and it can be concluded that there was internal consistency among the items contained in Section C2. There was no need to delete any item from this section.

7.2.6 Continuity of production and service provision in the face of increasing absenteeism

Section D of the questionnaire required of the respondents to indicate the strategies aimed at ensuring the continuity of production and service provision in the face of increasing absenteeism. Table 7.16 shows the means and standard deviations of scores for Section D.
Table 7.16: Means and standard deviations of scores for Section D

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carefully monitoring availability of labour in organisation</td>
<td>55</td>
<td>4.44</td>
<td>.688</td>
</tr>
<tr>
<td>Retaining a core permanent workforce while contracting out all other jobs to part-timers</td>
<td>55</td>
<td>3.33</td>
<td>1.123</td>
</tr>
<tr>
<td>Outsourcing non-core functions to other organisations</td>
<td>55</td>
<td>3.40</td>
<td>1.011</td>
</tr>
<tr>
<td>Introducing flexible work-hours to reduce the impact of absenteeism on production</td>
<td>56</td>
<td>2.96</td>
<td>1.144</td>
</tr>
<tr>
<td>Shortening the work-week by letting employees work longer hours on other days</td>
<td>56</td>
<td>2.57</td>
<td>.912</td>
</tr>
<tr>
<td>Introducing telecommuting to allow employees, via computer, to work from home where possible</td>
<td>56</td>
<td>2.77</td>
<td>1.112</td>
</tr>
<tr>
<td>Employing two people to share one job on a rotational basis</td>
<td>55</td>
<td>2.58</td>
<td>1.117</td>
</tr>
<tr>
<td>Providing a motivating work environment to ensure production and service targets are met even when some employees are absent</td>
<td>56</td>
<td>4.45</td>
<td>.601</td>
</tr>
<tr>
<td>Training potential employees for jobs requiring specialised skills a month or two before they are needed</td>
<td>56</td>
<td>4.50</td>
<td>.632</td>
</tr>
<tr>
<td>Developing a skills inventory to identify available skills</td>
<td>55</td>
<td>4.53</td>
<td>.634</td>
</tr>
<tr>
<td>Maintaining replacement charts to indicate which employees can replace others</td>
<td>56</td>
<td>4.52</td>
<td>.632</td>
</tr>
<tr>
<td>Scheduling overtime when employees are sick to ensure production and service targets are met</td>
<td>55</td>
<td>3.65</td>
<td>1.092</td>
</tr>
<tr>
<td>Introducing multi-skilling to ensure critical skills are available</td>
<td>56</td>
<td>4.68</td>
<td>.508</td>
</tr>
<tr>
<td>Obtaining additional manpower through learnerships funded by Skills Development Fund</td>
<td>56</td>
<td>4.07</td>
<td>.931</td>
</tr>
<tr>
<td>Making production processes more flexible to cater for increased absenteeism</td>
<td>56</td>
<td>3.48</td>
<td>1.144</td>
</tr>
<tr>
<td>Automating processes to combat absenteeism</td>
<td>56</td>
<td>3.54</td>
<td>1.144</td>
</tr>
</tbody>
</table>

An analysis of the mean and standard deviation of the variables in Section D revealed an aggregate mean of 3.71. It is evident that a broader spread of responses was received for this section (standard deviation ranging from .508 to 1.144), indicating less agreement among the respondents with regard to items in
this section. Table 7.17 indicates that the following items were relatively
distanced from the aggregate mean:

- Introducing flexible work hours to reduce the impact of absenteeism on
  production (mean 2.96);
- Introducing telecommuting to allow employees, via computer, to work
  from home where possible (mean 2.77);
- Employing two people to share one job on a rotational basis (mean 2.58);
  and
- Shortening the work-week by letting employees work longer hours on
  other days (mean 2.57). A low standard deviation (.912) to this item
  indicated relative congruence among the scores.

The scores to the above items indicated a tendency among respondents toward
being uncertain or disagreeing with these items. The low agreement with these
items could be based on the nature of the manufacturing industry, where
sequential interdependence or team work require of employees to be physically
present at work.

The following items had relatively high mean scores:

- Introducing multi-skilling to ensure critical skills are available (mean 4.68);
- Developing a skills inventory to identify available skills (mean 4.53);
- Maintaining replacement charts to indicate which employees can replace
  others (4.52);
- Training potential employees for jobs requiring specialised skills a month
  or two before they are needed (mean 4.50);
Providing a motivating work environment to ensure production and service targets are met even when some employees are absent (mean 4.45);

Carefully monitoring availability of labour in organisation (mean 4.44); and

Obtaining additional manpower through learnerships funded by Skills Development Fund (mean 4.07).

The total scores for Section D were correlated with the total scores for all the other sections. The results are presented in Table 7.17.

**Table 7.17:** Correlations of scores for Section D with all other sections

<table>
<thead>
<tr>
<th></th>
<th>B1 Total</th>
<th>C1 Total</th>
<th>C2 Total</th>
<th>C3 Total</th>
<th>C4 Total</th>
<th>D1 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D1 Total</strong></td>
<td>Pearson Correlation</td>
<td>-.032</td>
<td>-.017</td>
<td>.448</td>
<td>.245</td>
<td>.111</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.815</td>
<td>.904</td>
<td>.001</td>
<td>.069</td>
<td>.417</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
</tr>
</tbody>
</table>

As was indicated in paragraph 7.2.3, a weak positive correlation existed between the total scores for Section D and Section C2 (p<0.01). Section C2 measured practices that contributed to the management of ill-health and mental problems.

The Cronbach alpha for Section D was high at a level of .8325, which implied internal consistency or reliability. Table 7.18 provides descriptive data, namely the corrected mean if an item is deleted, the item to total section correlation and the Cronbach alpha if the item is deleted.
Table 7.18: Corrected item means, correlations and internal consistency coefficients of Section D (16 items)

<table>
<thead>
<tr>
<th>Section</th>
<th>Mean if Item deleted</th>
<th>Corrected item - Total Section Correlation</th>
<th>Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>DA</td>
<td>54.8302</td>
<td>.2562</td>
<td>.8321</td>
</tr>
<tr>
<td>DB</td>
<td>55.9057</td>
<td>.3908</td>
<td>.8276</td>
</tr>
<tr>
<td>DC</td>
<td>55.8113</td>
<td>.2369</td>
<td>.8362</td>
</tr>
<tr>
<td>DD</td>
<td>56.3396</td>
<td>.4850</td>
<td>.8208</td>
</tr>
<tr>
<td>DE</td>
<td>56.7547</td>
<td>.4172</td>
<td>.8248</td>
</tr>
<tr>
<td>DF</td>
<td>56.5472</td>
<td>.3050</td>
<td>.8330</td>
</tr>
<tr>
<td>DG</td>
<td>56.6792</td>
<td>.4782</td>
<td>.8214</td>
</tr>
<tr>
<td>DH</td>
<td>54.7925</td>
<td>.5381</td>
<td>.8213</td>
</tr>
<tr>
<td>DI</td>
<td>54.7547</td>
<td>.6006</td>
<td>.8182</td>
</tr>
<tr>
<td>DJ</td>
<td>54.7358</td>
<td>.5365</td>
<td>.8208</td>
</tr>
<tr>
<td>DK</td>
<td>54.7358</td>
<td>.4865</td>
<td>.8228</td>
</tr>
<tr>
<td>DL</td>
<td>55.5849</td>
<td>.5335</td>
<td>.8174</td>
</tr>
<tr>
<td>DM</td>
<td>54.5849</td>
<td>.4408</td>
<td>.8260</td>
</tr>
<tr>
<td>DN</td>
<td>55.2264</td>
<td>.6871</td>
<td>.8085</td>
</tr>
<tr>
<td>DO</td>
<td>55.7358</td>
<td>.4847</td>
<td>.8211</td>
</tr>
<tr>
<td>DP</td>
<td>55.6604</td>
<td>.5269</td>
<td>.8180</td>
</tr>
</tbody>
</table>

Table 7.18 shows that item DA and DC correlated least with the rest of the items. All the items contributed to the Cronbach alpha of .8835 and it can be concluded that there is internal consistency for Section B, indicating no need to delete any item from this section.

In the next paragraph, results obtained from conducting an analysis of variance of selected independent variables and the total scores obtained from the different sections of the questionnaire (dependent variables) are presented.
7.2.7 Results obtained from ANOVA

The ANOVA (analysis of variance) is used to determine whether significant differences exist in the test results obtained from various groups (Johnson & Wichern, 1997: 468). The ANOVA was selected as method of analysis due to a relatively small population, which would result in small cell groups being selected for the purpose of comparison. The ANOVA also would also allow the researcher to determine whether selected independent variables resulted in significant differences in total scores for each section of the questionnaire. The ANOVA comparison is based on the premise that $H_0: \mu_1=\mu_2$, and that there is no difference between the results of the groups. The test statistic for the ANOVA is the F ratio. If the $H_0$ is correct and there are no differences between the groups, the F ratio will be close to one. A ratio of bigger than one implies that there are differences in the test results of the groups. Differences are significant if $p<0.05$ (Saunders et al, 2000: 362). Comparisons between groups can only be made if the groups are relatively similar, and to probe this, the Levene’s test of homogeneity of variances was adopted. Homogeneity is implied by a $p>0.5$, which indicates that the distribution of scores in both populations is similar.

In this study, comparisons were made between the results obtained for the following groups:

- Organisations that employed between 50 and 300 employees and those that employed 301 or more employees;
- Organisations with a Gross Absence Rate (GAR) of one to three per cent (1-3%) and those with a GAR of more than 4 per cent (4%+);
• Organisations with a GARSick (genuine illness) of less than 2.5 per cent (<=2.5%) and those with a GARSick (genuine illness) of 2.6 per cent or more (>=2.6%); and
• Organisations with and without a policy on HIV/AIDS.

In this section, one-way ANOVA comparisons of the results for the groups listed above are presented and analysed.

a) Size of organisation

The first independent variable identified and used for the comparison of results was organisational size. Small organisations were identified as those employing 50 to 300 employees and large organisations those employing 301 or more employees. This distinction was made based on the fact that, in South Africa, small to medium organisations in the manufacturing industry are defined as those employing 50 to 200 full-time employees (Schoeman, 2003: 6). This figure was raised to 300 to make provision for part-time and contract employees.

Table 7.19 represents the number of responses according to organisational size.

Table 7.19: Number of responses according to organisational size

<table>
<thead>
<tr>
<th>NUMBER OF PEOPLE EMPLOYED</th>
<th>RESPONSE FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-300</td>
<td>31</td>
<td>55.4</td>
</tr>
<tr>
<td>301+</td>
<td>25</td>
<td>44.6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>56</td>
<td>100</td>
</tr>
</tbody>
</table>
It is evident that more responses were received from smaller organisations. However, both small and large organisations were adequately represented to make comparisons between the scores received from these two groups viable.

The results for homogeneity of variances for small and large organisations are presented in Table 7.20.

**Table 7.20:** Homogeneity of variances for small and large organisations' total scores for each section of the questionnaire

<table>
<thead>
<tr>
<th>Sections</th>
<th>Levene Statistic</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 Total (Absence)</td>
<td>3.4999</td>
<td>.067</td>
</tr>
<tr>
<td>C1 Total (Wellness)</td>
<td>0.058</td>
<td>.810</td>
</tr>
<tr>
<td>C2 Total (Ill-health)</td>
<td>.599</td>
<td>.442</td>
</tr>
<tr>
<td>C3 Total (HIV/AIDS)</td>
<td>2.440</td>
<td>.124</td>
</tr>
<tr>
<td>C4 Total (Success factors)</td>
<td>.002</td>
<td>.963</td>
</tr>
<tr>
<td>D1 Total (Contingency Strategies)</td>
<td>2.912</td>
<td>.094</td>
</tr>
</tbody>
</table>

Notes:
- Absence = the management of absenteeism
- Wellness = the management of wellness
- Ill-health = the management of ill-health and mental problems
- HIV/AIDS = the management of HIV/AIDS
- Success factors = success factors for programmes aimed at the management of health-related absenteeism
- Contingency strategies = strategies aimed at ensuring the continuity of production and service delivery in the face of increasing absenteeism

Most homogeneity of variances (p>0.05) for small and large organisations occurred for total scores for C1 (Wellness), C2 (Ill-health) and C4 (Success factors) and to a lesser extent for total scores for B1 (Absence), C3 (HIV/AIDS) and D1 (Contingency strategies), which allowed the groups to be compared.

Results in terms of results for B1 Total (Absence) and D1 (Contingency
strategies) should be read with caution. The implication is that the distribution of scores for small and large organisations for Sections B1 and D1 was too dissimilar to allow a fair comparison. Table 7.21 below confirms that the score distribution for large organisations for Section B1 was very dispersed, while the score distribution for small organisations for Section D1 was very dispersed. The implication is that there was too little congruence in the way respondents from small and large organisations responded to these sections to perceive them as similar groups.

Table 7.21 presents descriptive statistics for total scores for the various sections according to small and large organisations.

**Table 7.21:** Descriptive statistics for section total scores for small and large organisations

<table>
<thead>
<tr>
<th>Section</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 TOTAL (Small) (Large)</td>
<td>31 25</td>
<td>56.29 65.72</td>
<td>18.00 42.03</td>
</tr>
<tr>
<td>C1 TOTAL (Small) (Large)</td>
<td>31 25</td>
<td>27.77 28.60</td>
<td>17.08 19.35</td>
</tr>
<tr>
<td>C2 TOTAL (Small) (Large)</td>
<td>31 25</td>
<td>36.29 34.68</td>
<td>24.55 19.78</td>
</tr>
<tr>
<td>C3 TOTAL (Small) (Large)</td>
<td>31 25</td>
<td>37.87 38.84</td>
<td>4.94 5.57</td>
</tr>
<tr>
<td>C4 TOTAL (Small) (Large)</td>
<td>31 25</td>
<td>30.00 31.52</td>
<td>4.05 3.10</td>
</tr>
<tr>
<td>D1 TOTAL (Small) (Large)</td>
<td>31 25</td>
<td>73.26 65.24</td>
<td>63.06 19.83</td>
</tr>
</tbody>
</table>

Results from Table 7.21 indicate higher mean scores for totals for Section B1 and lower mean scores for totals for Section D for large organisations. The results also indicate that the standard deviation for larger organisations was
higher for scores for Section B1, while, for scores for Section D1, the standard
deviation was higher for small organisations. Respondents from large
organisations disagreed more about items in B1 (Absence) and respondents
from smaller organisations disagreed more about items in D1 (Contingency
strategies). The standard deviation for both small and large organisations was
low for Sections C3 (HIV/AIDS) and C4 (Success factors), which indicated
agreement among respondents from both small and large organisations with
regard to items in these sections.

Table 7.22 presents the ANOVA table for group total mean scores for small and
large organisations.

Table 7.22: Analysis of variance for group total mean scores for Sections B1
to D1 for small and large organisations

<table>
<thead>
<tr>
<th></th>
<th>Sum of squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 TOTAL</td>
<td>Treatment Error</td>
<td>1230.573</td>
<td>1</td>
<td>1230.573</td>
<td>1.275</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>52117.427</td>
<td>54</td>
<td>965.138</td>
<td></td>
</tr>
<tr>
<td>C1 TOTAL</td>
<td>Treatment Error</td>
<td>9.438</td>
<td>1</td>
<td>9.438</td>
<td>.029</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>17735.419</td>
<td>54</td>
<td>328.434</td>
<td></td>
</tr>
<tr>
<td>C2 TOTAL</td>
<td>Treatment Error</td>
<td>35.887</td>
<td>1</td>
<td>35.887</td>
<td>.071</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>27469.827</td>
<td>54</td>
<td>508.701</td>
<td></td>
</tr>
<tr>
<td>C3 TOTAL</td>
<td>Treatment Error</td>
<td>12.995</td>
<td>1</td>
<td>12.995</td>
<td>.475</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>1476.844</td>
<td>54</td>
<td>27.349</td>
<td></td>
</tr>
<tr>
<td>C4 TOTAL</td>
<td>Treatment Error</td>
<td>31.974</td>
<td>1</td>
<td>31.974</td>
<td>2.391</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>722.240</td>
<td>54</td>
<td>13.375</td>
<td></td>
</tr>
<tr>
<td>D1 TOTAL</td>
<td>Treatment Error</td>
<td>889.719</td>
<td>1</td>
<td>889.719</td>
<td>.373</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>128732.50</td>
<td>54</td>
<td>2383.935</td>
<td></td>
</tr>
</tbody>
</table>

The analysis of variance for small and large organisations showed no significant
results (p>0.5). Results for Table 7.21 indicated that organisational size was not
significantly related to the total means scores for Sections B1 to D1. It can
therefore be concluded that organisations size did not result in different responses to the questionnaire used in this study, and that respondents from small and large organisations were in agreement with regard to the strategies for the contingency management of health-related absenteeism.

b) Gross Absence Rate (GAR)

The GAR indicates the percentage time lost due to absenteeism and includes all categories of absenteeism, namely sick, authorised and unexcused absenteeism. The international acceptable norm for the GAR is three per cent (refer to paragraph 3.3.2). For purposes of analysis, a distinction was made between organisations with a GAR of one to three per cent (1-3%) and those with a GAR of more than 4 per cent (4%+).

Table 7.23 represents the number of responses according to GAR.

<table>
<thead>
<tr>
<th>GAR</th>
<th>RESPONSE FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3%</td>
<td>17</td>
<td>30.4</td>
</tr>
<tr>
<td>4%+</td>
<td>39</td>
<td>69.6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>56</td>
<td>100</td>
</tr>
</tbody>
</table>

More respondents came from organisations with a GAR of four per cent and more (69.6%). Results indicate that almost seventy per cent (69.6%) of the organisations surveyed had a GAR that did not meet international standards.
The results for homogeneity of variances for organisations with a low and high GAR are presented in Table 7.24.

**Table 7.24:** Homogeneity of variances for organisations with a low and high GAR for totals for each section of the questionnaire

<table>
<thead>
<tr>
<th>Sections</th>
<th>Levene Statistic</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 Total (Absence)</td>
<td>.174</td>
<td>.678</td>
</tr>
<tr>
<td>C1 Total (Wellness)</td>
<td>2.016</td>
<td>.161</td>
</tr>
<tr>
<td>C2 Total (Ill-health)</td>
<td>.048</td>
<td>.828</td>
</tr>
<tr>
<td>C3 Total (HIV/AIDS)</td>
<td>1.239</td>
<td>.271</td>
</tr>
<tr>
<td>C4 Total (Success factors)</td>
<td>.657</td>
<td>.421</td>
</tr>
<tr>
<td>D1 Total (Contingency Strategies)</td>
<td>5.023</td>
<td>.029</td>
</tr>
</tbody>
</table>

Results suggested that homogeneity of variances (p>0.05) for organisations with a low and high GAR was too low for total scores for D1 to make comparisons between these two groups useful. Homogeneity for variances for scores was highest for totals for B1 (Absence) and C2 (Ill-health), indicating that the distribution of scores for organisations with a low and high GAR was similar for these sections, that these groups can be considered as relatively similar and that fair comparisons can be made between scores obtained from these groups.

Table 7.25 presents descriptive statistics for total scores for the various sections according to GAR.
Table 7.25: Descriptive statistics of section total scores for organisations according to GAR

<table>
<thead>
<tr>
<th>Section</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 TOTAL (1-3%) (4%+)</td>
<td>17</td>
<td>60.41</td>
<td>18.00</td>
</tr>
<tr>
<td></td>
<td>39</td>
<td>60.54</td>
<td>42.03</td>
</tr>
<tr>
<td>C1 TOTAL (1-3%) (4%+)</td>
<td>17</td>
<td>26.12</td>
<td>17.08</td>
</tr>
<tr>
<td></td>
<td>39</td>
<td>29.03</td>
<td>19.35</td>
</tr>
<tr>
<td>C2 TOTAL (1-3%) (4%+)</td>
<td>17</td>
<td>36.59</td>
<td>24.55</td>
</tr>
<tr>
<td></td>
<td>39</td>
<td>35.13</td>
<td>19.78</td>
</tr>
<tr>
<td>C3 TOTAL (1-3%) (4%+)</td>
<td>17</td>
<td>39.94</td>
<td>4.94</td>
</tr>
<tr>
<td></td>
<td>39</td>
<td>37.59</td>
<td>5.57</td>
</tr>
<tr>
<td>C4 TOTAL (1-3%) (4%+)</td>
<td>17</td>
<td>31.65</td>
<td>4.05</td>
</tr>
<tr>
<td></td>
<td>39</td>
<td>30.26</td>
<td>3.10</td>
</tr>
<tr>
<td>D1 TOTAL (1-3%) (4%+)</td>
<td>17</td>
<td>82.71</td>
<td>63.06</td>
</tr>
<tr>
<td></td>
<td>39</td>
<td>64.00</td>
<td>19.83</td>
</tr>
</tbody>
</table>

Results from Table 7.25 indicate that the standard deviation for organisations with a low (1-3%) and high (4%+) GAR was lowest for scores for Sections C3 (HIV/AIDS) and C4 (Success factors), which indicated agreement among respondents with regards to the items in these sections. Respondents from organisations with a high GAR (4%+) disagreed more with regards to items in B1 (Absence) and respondents from organisations with a low GAR (1-3%) disagreed more about items in D1 (Contingency strategies). The standard deviation for both organisations with a low and high GAR was low for Sections C3 (HIV/AIDS) and C4 (Success factors), which indicated agreement in terms of these sections. The results indicate that respondents from organisations with a low GAR showed a higher tendency toward agreement with the items in Section D1 (Contingency strategies) but that the individual responses were more varied.

Table 7.26 presents the ANOVA table for total scores for organisations with a low and high GAR.
### Table 7.26: Analysis of variance for group total mean scores for Sections B1 to D1 for organisations with a low and high GAR

<table>
<thead>
<tr>
<th></th>
<th>Sum of squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 TOTAL</td>
<td>Treatment</td>
<td>.190</td>
<td>1</td>
<td>.190</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>53347.810</td>
<td>54</td>
<td>987.922</td>
<td></td>
</tr>
<tr>
<td>C1 TOTAL</td>
<td>Treatment</td>
<td>100.118</td>
<td>1</td>
<td>100.118</td>
<td>.306</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>17644.739</td>
<td>54</td>
<td>326.754</td>
<td></td>
</tr>
<tr>
<td>C2 TOTAL</td>
<td>Treatment</td>
<td>25.238</td>
<td>1</td>
<td>25.238</td>
<td>.050</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>27480.477</td>
<td>54</td>
<td>508.898</td>
<td></td>
</tr>
<tr>
<td>C3 TOTAL</td>
<td>Treatment</td>
<td>65.462</td>
<td>1</td>
<td>65.462</td>
<td>2.482</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>1424.377</td>
<td>54</td>
<td>26.377</td>
<td></td>
</tr>
<tr>
<td>C4 TOTAL</td>
<td>Treatment</td>
<td>22.896</td>
<td>1</td>
<td>22.896</td>
<td>1.691</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>731.318</td>
<td>54</td>
<td>13.543</td>
<td></td>
</tr>
<tr>
<td>D1 TOTAL</td>
<td>Treatment</td>
<td>4142.685</td>
<td>1</td>
<td>4142.685</td>
<td>1.783</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>125479.53</td>
<td>54</td>
<td>2323.695</td>
<td></td>
</tr>
</tbody>
</table>

The analysis of variance for organisations with a low and high GAR showed no significant results. Results for Table 7.26 indicate that GAR was not significantly related to the total means scores for Sections B1 to D1. It can therefore be concluded that GAR was not a determining factor in the way respondents responded to the items in the questionnaire.

c) **Gross Absence Rate Sick (GARSick)**

The GARSick indicates the percentage time lost due to genuine health-related absenteeism and excludes other reasons for absenteeism. For purposes of analysis, a distinction was made between organisations with a GARSick of less than 2.5 per cent (<2.5%) and a GARSick of 2.6 per cent or more (2.6+%). The rationale behind this distinction is based on a three per cent (3%) norm that is internationally accepted for the overall GAR (all categories of absenteeism) and
the assumption that this three per cent mostly provides for genuine illness (2.5 per cent), but also leaves room for authorised leave and unexcused leave (0.5%) – reasons other than genuine illness (refer to paragraph 3.3.3). It is therefore assumed that a GARSick of 2.5 per cent (2.5%) is considered as acceptable, while a GARSick of more than 2.5 per cent (2.6+%%) is considered as unacceptable. Table 7.27 represents the number of responses according to GARSick.

Table 7.27: Number of responses according to GARSick

<table>
<thead>
<tr>
<th>GARSICK</th>
<th>RESPONSE FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;=2.5%</td>
<td>26</td>
<td>46.4</td>
</tr>
<tr>
<td>2.6+%</td>
<td>30</td>
<td>53.6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>56</td>
<td>100</td>
</tr>
</tbody>
</table>

Results indicate that almost half of the organisations surveyed had a GARSick of 2.5 per cent or less (low GARSick) or a GARSick of 2.6 per cent or more (high GARSick).

The results for homogeneity of variances for organisations with a low and high GARSick are presented in Table 7.28.
Table 7.28: Homogeneity of variances for organisations with a low and high GARSick for totals for each section of the questionnaire

Results suggest that homogeneity of variances ($p > 0.05$) for organisations with a low and high GARSick was too low for total scores for C1 and C2 to make comparisons between these two groups useful. Homogeneity for variances of scores was highest for totals for B1 (Absence), C3 (HIV/AIDS) and D1 (Contingency strategies), which implied that the response patterns for these sections were similar enough for the scores to be compared. Table 7.29 presents descriptive statistics for total scores for the various sections according to GARSick.

Table 7.29: Descriptive statistics of total scores for sections for organisations according to GARSick

<table>
<thead>
<tr>
<th>Sections</th>
<th>Levene Statistic</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 Total (Absence)</td>
<td>.031</td>
<td>.860</td>
</tr>
<tr>
<td>C1 Total (Wellness)</td>
<td>4.886</td>
<td>.031</td>
</tr>
<tr>
<td>C2 Total (Ill-health)</td>
<td>9.997</td>
<td>.003</td>
</tr>
<tr>
<td>C3 Total (HIV/AIDS)</td>
<td>.133</td>
<td>.717</td>
</tr>
<tr>
<td>C4 Total (Success factors)</td>
<td>.646</td>
<td>.425</td>
</tr>
<tr>
<td>D1 Total (Contingency Strategies)</td>
<td>.054</td>
<td>.816</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sections</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 TOTAL (&lt;=2.5%)</td>
<td>26</td>
<td>61.54</td>
<td>26.78</td>
</tr>
<tr>
<td>(2.6%+)</td>
<td>30</td>
<td>59.60</td>
<td>34.92</td>
</tr>
<tr>
<td>C1 TOTAL (&lt;=2.5%)</td>
<td>26</td>
<td>25.15</td>
<td>3.51</td>
</tr>
<tr>
<td>(2.6%+)</td>
<td>30</td>
<td>30.73</td>
<td>24.21</td>
</tr>
<tr>
<td>C2 TOTAL (&lt;=2.5%)</td>
<td>26</td>
<td>30.38</td>
<td>3.32</td>
</tr>
<tr>
<td>(2.6%+)</td>
<td>30</td>
<td>40.07</td>
<td>29.90</td>
</tr>
<tr>
<td>C3 TOTAL (&lt;=2.5%)</td>
<td>26</td>
<td>38.65</td>
<td>5.19</td>
</tr>
<tr>
<td>(2.6%+)</td>
<td>30</td>
<td>38.00</td>
<td>5.28</td>
</tr>
<tr>
<td>C4 TOTAL (&lt;=2.5%)</td>
<td>26</td>
<td>31.73</td>
<td>2.76</td>
</tr>
<tr>
<td>(2.6%+)</td>
<td>30</td>
<td>29.77</td>
<td>4.19</td>
</tr>
<tr>
<td>D1 TOTAL (&lt;=2.5%)</td>
<td>26</td>
<td>71.96</td>
<td>56.58</td>
</tr>
<tr>
<td>(2.6%+)</td>
<td>30</td>
<td>67.70</td>
<td>41.25</td>
</tr>
</tbody>
</table>
Results from Table 7.29 indicated that the standard deviation for organisations with a low GARSick (≤2.5%) and high GARSick (>2.6%) was lowest for scores for Sections C3 (HIV/AIDS) and C4 (Success factors) which indicated agreement among respondents with regards to the items in these sections. Standard deviations for both groups were high for scores for Sections B1 (Absence) and D1 (Contingency strategies), which indicated disagreement among respondents of these groups with regards to items in these sections. Standard deviations for scores for Sections C1 (Wellness) and C2 (Ill-health) were low for organisations with a low GARSick and high for organisations with a high GARSick. As indicated, homogeneity of variance was also low with regards to these sections, which is thus confirmed by these results.

Table 7.30 presents the ANOVA table for total scores for organisations with a low and high GARSick.

**Table 7.30:** Analysis of variance for group total mean scores for Sections B1 to D1 for organisations with a low and high GARSick

<table>
<thead>
<tr>
<th>Section</th>
<th>Treatment</th>
<th>Error</th>
<th>Sum of squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 TOTAL</td>
<td>Treatment</td>
<td>52.338</td>
<td>5295.662</td>
<td>1</td>
<td>52.338</td>
<td>.053</td>
<td>.819</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td></td>
<td></td>
<td>54</td>
<td>986.957</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C1 TOTAL</td>
<td>Treatment</td>
<td>433.606</td>
<td>17311.251</td>
<td>1</td>
<td>433.606</td>
<td>1.353</td>
<td>.205</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td></td>
<td></td>
<td>54</td>
<td>320.579</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C2 TOTAL</td>
<td>Treatment</td>
<td>1305.694</td>
<td>26200.021</td>
<td>1</td>
<td>1305.694</td>
<td>2.691</td>
<td>.107</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td></td>
<td></td>
<td>54</td>
<td>485.186</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C3 TOTAL</td>
<td>Treatment</td>
<td>5.955</td>
<td>1483.885</td>
<td>1</td>
<td>5.955</td>
<td>.217</td>
<td>.643</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td></td>
<td></td>
<td>54</td>
<td>27.479</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C4 TOTAL</td>
<td>Treatment</td>
<td>53.732</td>
<td>700.482</td>
<td>1</td>
<td>53.732</td>
<td>4.142</td>
<td>.047</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td></td>
<td></td>
<td>54</td>
<td>12.972</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1 TOTAL</td>
<td>Treatment</td>
<td>252.953</td>
<td>129369.26</td>
<td>1</td>
<td>252.953</td>
<td>.106</td>
<td>.746</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td></td>
<td></td>
<td>54</td>
<td>2395.727</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The results for the analysis of variance presented in Table 7.30 indicated significant differences between scores for Section C4 (Success factors) for organisations with a low and high GARSick. The implication could be that GARSick was lower in organisations that provided a constructive and supportive environment for programmes aimed at preventing and reducing health-related absenteeism. No significant differences between scores for the other sections are indicated for organisations with a low and high GARSick. Due to low homogeneity of variance for total scores for Sections C1 and C2 for organisations with a low and high GARSick, results of these sections could not be considered for interpretation.

d) HIV/AIDS policy

A one-way analysis of variances was performed to determine whether significant differences existed between the scores obtained for organisations that had an HIV/AIDS policy and those organisations that did not have an HIV/AIDS policy.

Table 7.31 represents the number of responses according to HIV/AIDS policy.

**Table 7.31:** Number of responses according to HIV/AIDS policy

<table>
<thead>
<tr>
<th>HIV/AIDS POLICY</th>
<th>RESPONSE FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>14</td>
<td>25</td>
</tr>
<tr>
<td>YES</td>
<td>42</td>
<td>75</td>
</tr>
<tr>
<td>TOTAL</td>
<td>56</td>
<td>100</td>
</tr>
</tbody>
</table>
Results indicate that a quarter of respondents indicated that their organisation did not have an HIV/AIDS policy, while three quarters of respondents indicated that their organisation did have an HIV/AIDS policy.

The results for homogeneity of variances for organisations with and without an HIV/AIDS policy are presented in Table 7.32.

Table 7.32: Homogeneity of variances for organisations with and without an HIV/AIDS policy for totals for each section of the questionnaire

<table>
<thead>
<tr>
<th>Section</th>
<th>Levene Statistic</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 Total (Absence)</td>
<td>0.000</td>
<td>.997</td>
</tr>
<tr>
<td>C1 Total (Wellness)</td>
<td>2.049</td>
<td>.158</td>
</tr>
<tr>
<td>C2 Total (Ill-health)</td>
<td>.438</td>
<td>.511</td>
</tr>
<tr>
<td>C3 Total (HIV/AIDS)</td>
<td>2.645</td>
<td>.110</td>
</tr>
<tr>
<td>C4 Total (Success factors)</td>
<td>3.109</td>
<td>.084</td>
</tr>
<tr>
<td>D1 Total (Contingency Strategies)</td>
<td>1.739</td>
<td>.193</td>
</tr>
</tbody>
</table>

Results suggest that homogeneity of variance (p>0.05) for organisations with and without an HIV/AIDS policy occurred and that comparisons could be made between these groups. Homogeneity of variances was lowest for scores for Section C4 (Success factors) and results related to this section should be read with caution. Homogeneity of variance was highest for total scores to B1 (Absence).

Table 7.33 presents descriptive statistics of total scores for organisations with and without an HIV/AIDS policy.
Table 7.33: Descriptive statistics of total scores for sections for organisations without (NO) or with (YES) an HIV/AIDS policy

<table>
<thead>
<tr>
<th>Section</th>
<th>Organisation</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 TOTAL</td>
<td>NO</td>
<td>14</td>
<td>59.64</td>
<td>26.55</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>42</td>
<td>60.79</td>
<td>32.82</td>
</tr>
<tr>
<td>C1 TOTAL</td>
<td>NO</td>
<td>14</td>
<td>30.50</td>
<td>25.42</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>42</td>
<td>27.36</td>
<td>15.01</td>
</tr>
<tr>
<td>C2 TOTAL</td>
<td>NO</td>
<td>14</td>
<td>36.43</td>
<td>26.23</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>42</td>
<td>35.29</td>
<td>21.27</td>
</tr>
<tr>
<td>C3 TOTAL</td>
<td>NO</td>
<td>14</td>
<td>35.57</td>
<td>6.91</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>42</td>
<td>39.21</td>
<td>4.22</td>
</tr>
<tr>
<td>C4 TOTAL</td>
<td>NO</td>
<td>14</td>
<td>29.86</td>
<td>5.55</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>42</td>
<td>30.95</td>
<td>2.89</td>
</tr>
<tr>
<td>D1 TOTAL</td>
<td>NO</td>
<td>14</td>
<td>59.36</td>
<td>10.76</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>42</td>
<td>73.12</td>
<td>55.46</td>
</tr>
</tbody>
</table>

Results from Table 7.33 indicated that the standard deviation for scores for Sections C3 (HIV/AIDS) and C4 (Success factors) was low for both organisations with and without an HIV/AIDS policy, which indicated agreement among respondents with regard to the items in these sections. Standard deviations were lower for scores for Sections B1 (Absence) and higher for C1 (Wellness) for organisations without an HIV/AIDS policy. The standard deviation for scores for D1 was higher for organisations with an HIV/AIDS policy (55.46) than for organisations without an HIV/AIDS policy (10.76). While respondents from organisations with an HIV/AIDS policy collectively answered more positively to items in Section D1, the individual responses were more varied than those from organisations without an HIV/AIDS policy.

Table 7.34 presents the ANOVA table for total scores for the various sections for organisations with and without an HIV/AIDS policy.
Table 7.34: Analysis of variance for group total mean scores for Sections B1 to D1 for organisations with and without an HIV/AIDS policy

<table>
<thead>
<tr>
<th></th>
<th>Sum of squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 TOTAL</td>
<td>Treatment Error</td>
<td>13.714</td>
<td>53334.286</td>
<td>13.714</td>
<td>.014</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>54</td>
<td>987.672</td>
<td>987.672</td>
<td></td>
</tr>
<tr>
<td>C1 TOTAL</td>
<td>Treatment Error</td>
<td>103.714</td>
<td>17641.143</td>
<td>103.741</td>
<td>.317</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>54</td>
<td>326.688</td>
<td>326.688</td>
<td></td>
</tr>
<tr>
<td>C2 TOTAL</td>
<td>Treatment Error</td>
<td>13.714</td>
<td>27492.000</td>
<td>13.714</td>
<td>.027</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>54</td>
<td>509.111</td>
<td>509.111</td>
<td></td>
</tr>
<tr>
<td>C3 TOTAL</td>
<td>Treatment Error</td>
<td>139.339</td>
<td>1350.500</td>
<td>139.339</td>
<td>5.572</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>54</td>
<td>25.009</td>
<td>25.009</td>
<td></td>
</tr>
<tr>
<td>C4 TOTAL</td>
<td>Treatment Error</td>
<td>12.595</td>
<td>741.619</td>
<td>12.595</td>
<td>.917</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>54</td>
<td>13.734</td>
<td>13.734</td>
<td></td>
</tr>
</tbody>
</table>

The results for the analysis of variance presented in Table 7.34 indicated significant differences for scores for Section C3 (HIV/AIDS) for organisations with and without an HIV/AIDS policy. No significant differences for scores for the other sections are indicated for organisations with and without an HIV/AIDS policy.

Factorial analysis of variance was conducted to determine the interaction effect of variables on test results.

7.2.8 Analysis of results obtained from factorial ANOVA

The factorial ANOVA is similar to the one-way ANOVA, except that more than one independent variable is included in the analysis, and that the interaction effect of the independent variables on the dependent variable or variables (test results) is investigated (Struwig & Stead, 2001:162). The factorial analysis was selected as method of analysis to determine whether a combination of
independent variables, namely the GAR and GARSick, would significantly affect the responses received to items in the questionnaire. An analysis of the effect of independent variables on tests results can only be done when the groups are relatively similar in terms of the distribution of variances. To probe this, Levene’s test of the homogeneity of variances was used.

A 2x2 (GAR2 by GARSick2) factorial design was used. GARs were divided into two groups, namely GARs of three per cent and less (<=3%) and GARs of four per cent or more (>=4%). GARSick was divided into GARSick of below 2.5 per cent (<=2.5%) and GARSick of 2.6 per cent or more (>=2.6%). The analysis of variance was computed with the scores for the Sections of the questionnaire. A .05 level of significance was utilised for the statistical analysis.

a) Relationship between GAR, GARSick and total scores for B1 (Absence)

The interaction effect between the GAR, GARSick and the scores for Section B1 (the management of health-related absenteeism) was computed. Levene’s test for homogeneity of variance indicated p=.964 for GAR, GARSick and B1 Total, which implied that these groups were adequately similar to make comparisons viable.

The results from the factorial analysis of variance are presented in Table 7.35:
Table 7.35: Effects and main effect of the relationship between GAR, GARSick and totals for B1 (Absence)

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAR</td>
<td>63.641</td>
<td>1</td>
<td>63.641</td>
<td>.062</td>
<td>.804</td>
</tr>
<tr>
<td>GARSick</td>
<td>121.442</td>
<td>1</td>
<td>121.441</td>
<td>.119</td>
<td>.732</td>
</tr>
<tr>
<td>GAR*GARSick</td>
<td>41.402</td>
<td>1</td>
<td>41.401</td>
<td>.040</td>
<td>.841</td>
</tr>
<tr>
<td>Error</td>
<td>53225.842</td>
<td>52</td>
<td>1023.574</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The results suggest that there was no significant main effect for GAR or GARSick, and no interaction effects for GAR and GARSick. The means and standard deviations for the main effects are presented in Table 7.36.

Table 7.36: Means and standard deviations for total scores for B1 (Absence) for GAR and GARSick

<table>
<thead>
<tr>
<th>KEY</th>
<th>Variables</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>GAR 1-3%</td>
<td>61.27</td>
<td>25.07</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>GARSick &lt;=2.5%</td>
<td>54.00</td>
<td>8.49</td>
<td>2</td>
</tr>
<tr>
<td>B</td>
<td>GARSick &gt;=2.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>C</td>
<td>GAR 4%+</td>
<td>61.91</td>
<td>30.21</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>GARSick &lt;=2.5%</td>
<td>60.00</td>
<td>36.12</td>
<td>28</td>
</tr>
<tr>
<td>D</td>
<td>GARSick &gt;=2.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td>39</td>
</tr>
</tbody>
</table>

The factorial design of GAR=1-3 per cent and GARSick >=2.6 per cent (Key B) resulted in a small cell (N=2) that could influence effective analysis. The mean scores suggest little difference between the different groups, while the standard deviation scores for GAR=1-3 percent / GARSick <=2.5% (Key A) are slightly lower than those for GAR=4%+ / GARSick <=2.5% (Key C) and for GAR=4%+ / GARSick >=2.6% (Key D). This evidence supports the results obtained from the factorial ANOVA, which indicated that no significant differences occurred.
between the results of organisations with a low and high GAR and the total scores for Section B, and the results of organisations with a low and high GARSick and the total scores for Section B.

The multi-factor analysis of variance investigation failed to establish a relationship between the absenteeism rate (GAR) and the health-related absenteeism rate (GARSick) in organisations and the way in which absenteeism is managed (results for Section B). The results support the notion that, despite the fact that much attention is given to the management of absenteeism in the workplace, it continues to be a problem (refer to paragraph 1.1).

b) Relationship between GAR, GARSick and the total scores for C1 (Wellness)

The interaction effect between the GAR, GARSick and the scores to Section C1 (Wellness) was computed. Levene’s test for homogeneity of variance indicated \( p=0.135 \) for GAR, GARSick and C1 Total. This indicates relatively low homogeneity; therefore the results should be read with caution. Homogeneity was also found to be low for comparative one-way ANOVAS in terms of section C (refer to paragraph 7.2.7 b and c).

The results from the factorial analysis of variance are presented in Table 7.37.
Table 7.37: Effects and main effect of the relationship between GAR, GARSick and totals for C1 (Wellness)

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAR</td>
<td>14.171</td>
<td>1</td>
<td>14.171</td>
<td>.043</td>
<td>.837</td>
</tr>
<tr>
<td>GARSick</td>
<td>64.361</td>
<td>1</td>
<td>64.361</td>
<td>.194</td>
<td>.661</td>
</tr>
<tr>
<td>GAR*GARSick</td>
<td>94.166</td>
<td>1</td>
<td>94.166</td>
<td>.284</td>
<td>.596</td>
</tr>
<tr>
<td>Error</td>
<td>17213.760</td>
<td>52</td>
<td>331.034</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The results suggest that there was no significant main effect for GAR or GARSick, and no interaction effects for GAR and GARSick. The means and standard deviations for the main effects are presented in Table 7.38.

Table 7.38: Means and standard deviations for total scores for C1 (Wellness) for GAR and GARSick

<table>
<thead>
<tr>
<th>KEY</th>
<th>Variables</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-B</td>
<td>GAR 1-3% GARSick &lt;=2.5%</td>
<td>26.20</td>
<td>3.23</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>GARSick &gt;=2.6%</td>
<td>25.50</td>
<td>3.54</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>2</strong></td>
<td><strong>17</strong></td>
<td></td>
</tr>
<tr>
<td>C-D</td>
<td>GAR 4%+ GARSick &lt;=2.5%</td>
<td>23.73</td>
<td>3.50</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>GARSick &gt;=2.6%</td>
<td>31.11</td>
<td>25.04</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>28</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The mean score is slightly higher (31.11) and the standard deviation much higher for interaction factor GAR=4%+ and GARSick >=2.6% (Key D) than for the other factors. However, because the factorial ANOVA, as well as one-way comparative ANOVAS, revealed no significant differences between the test scores, it is assumed that the differences in mean scores and standard deviations have no practical implications.
The results suggest that there are no significant differences among organisations in terms of the management of wellness (Section C1). The investigation failed to establish a relationship between the absenteeism rate (GAR) and the health-related absenteeism rate (GARSick) in organisations, and wellness actions as listed in Section C1. This evidence supports the results obtained from the factorial ANOVA, which indicated that no significant differences occurred between the results of organisations with a low and high GAR and the total scores for C1, and the results of organisations with a low and high GARSick and the total scores for C1. The results could imply that, while respondents from the respective groups perceived wellness strategies as important to the contingency management of health-related absenteeism, these strategies were not practically applied in such a way that they significantly affected the GAR and GARSick levels in organisations.

c) Relationship between GAR, GARSick and total scores for C2 (Ill-health and mental problems)

The interaction effect between the GAR, GARSick and the total scores for C2 (Ill-health) was computed. Levene’s test for homogeneity of variance indicated p=.001 for GAR, GARSick and C2 Total. This indicates a lack of homogeneity; therefore the results should be read with caution. Homogeneity was also found to be low for comparative one-way ANOVAS (refer to paragraph 7.2.7 b and c).

The results from the factorial analysis of variance are presented in Table 7.39.
Table 7.39: Effects and main effect of the relationship between GAR, GARSick and totals for C2 (ill-health)

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAR</td>
<td>2575.377</td>
<td>1</td>
<td>2575.377</td>
<td>5.797</td>
<td>.020</td>
</tr>
<tr>
<td>GARSick</td>
<td>4337.260</td>
<td>1</td>
<td>4337.260</td>
<td>9.763</td>
<td>.003</td>
</tr>
<tr>
<td>GAR*GARSick</td>
<td>2197.346</td>
<td>1</td>
<td>2197.346</td>
<td>4.946</td>
<td>.031</td>
</tr>
<tr>
<td>Error</td>
<td>23100.089</td>
<td>52</td>
<td>444.232</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The results suggest that there was a significant main effect for GAR and GARSick, and interaction effects for GAR and GARSick. However, as homogeneity was not established (p<.05), no meaningful conclusions could be drawn from these results. The detected differences do not necessarily have any practical significance.

The means and standard deviations for the main effects are presented in Table 7.40.

Table 7.40: Means and standard deviations for total scores for C2 (ill-health) for GAR and GARSick

<table>
<thead>
<tr>
<th>KEY</th>
<th>Variables</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>GAR 1-3%</td>
<td>31.07</td>
<td>3.28</td>
<td>15</td>
</tr>
<tr>
<td>B</td>
<td>GARSick &lt;=2.5%</td>
<td>78.00</td>
<td>70.71</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>GARSick &gt;=2.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>C</td>
<td>GAR 4%+</td>
<td>29.45</td>
<td>3.30</td>
<td>11</td>
</tr>
<tr>
<td>D</td>
<td>GARSick &lt;=2.5%</td>
<td>37.36</td>
<td>25.71</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>GARSick &gt;=2.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td>39</td>
</tr>
</tbody>
</table>

The mean score and standard deviation for factors GAR=1-3% and GARSick <=2.5% (Key A) were lower than for GARSick >=2.6% (Key B). The high standard deviation for Key B suggests that these respondents were not in agreement in
terms of the management of ill-health and mental problems (Section C2). The differences in mean scores and standard deviations explain why low homogeneity of variance was indicated for these group and the results should therefore be read with caution. It can therefore not be concluded that organisations manage ill-health and mental problems in such a way that it has a significant effect on the GAR and GARSick levels in the organisation.

d) Relationship between GAR, GARSick and total scores for C3 (HIV/AIDS)

The interaction effect between the GAR, GARSick and the total scores for C3 (HIV/AIDS) was computed. Levene’s test for homogeneity of variance indicated p=.492 for GAR, GARSick and total scores for C3.

The results from the factorial analysis of variance are presented in Table 7.41:

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAR</td>
<td>38.510</td>
<td>1</td>
<td>38.510</td>
<td>1.413</td>
<td>.240</td>
</tr>
<tr>
<td>GARSick</td>
<td>1.485</td>
<td>1</td>
<td>1.485</td>
<td>.054</td>
<td>.816</td>
</tr>
<tr>
<td>GAR*GARSick</td>
<td>1.121</td>
<td>1</td>
<td>1.121</td>
<td>.041</td>
<td>.840</td>
</tr>
<tr>
<td>Error</td>
<td>1417.271</td>
<td>52</td>
<td>27.255</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The results suggest that there was no significant main effect for GAR or GARSick, and no interaction effects for GAR and GARSick. This result confirms the results from the comparative ANOVA (refer to paragraph 7.2.7 b and c). The means and standard deviations for the main effects are presented in Table 7.42.
Table 7.42: Means and standard deviations for total scores for C3 (HIV/AIDS) for GAR and GARSick

<table>
<thead>
<tr>
<th>KEY</th>
<th>Variables</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>GAR 1-3%</td>
<td>39.93</td>
<td>4.13</td>
<td>15</td>
</tr>
<tr>
<td>B</td>
<td>GARSick &lt;=2.5%</td>
<td>40.00</td>
<td>5.66</td>
<td></td>
</tr>
<tr>
<td></td>
<td>GARSick &gt;=2.6%</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>C</td>
<td>GAR 4%+</td>
<td>36.91</td>
<td>6.14</td>
<td>11</td>
</tr>
<tr>
<td>D</td>
<td>GARSick &lt;=2.5%</td>
<td>37.86</td>
<td>5.34</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>GARSick &gt;=2.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>39</td>
</tr>
</tbody>
</table>

The mean scores and standard deviation for all the interaction factors were similar. The results suggest that there were no significant differences between responses in terms of the management of HIV/AIDS (Section C3) for organisations with low and high GARs and GARS. The investigation failed to establish a relationship between the absenteeism rate (GAR) and the health-related absenteeism rate (GARS) in organisations, and actions related to the management of HIV/AIDS as listed in Section C3 of the questionnaire. The results could imply that, while the management of HIV/AIDS in the workplace is perceived as important, there is no evidence that it is managed in such a manner that it affects the GAR and GARS levels in organisations.

e) Relationship between GAR, GARS and total scores for C4 (Success factors)

The interaction effect between the GAR, GARS and the total scores for C4 (Success factors) was computed. Levene’s test for homogeneity of variance indicated $p=.869$ for GAR, GARS and total scores for C4.

The results from the factorial analysis of variance are presented in Table 7.43.
Table 7.43: Effects and main effect of the relationship between GAR, GARSick and total scores for C4 (Success factors)

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAR</td>
<td>1.300</td>
<td>1</td>
<td>1.300</td>
<td>.097</td>
<td>.757</td>
</tr>
<tr>
<td>GARSick</td>
<td>14.975</td>
<td>1</td>
<td>14.975</td>
<td>1.114</td>
<td>.296</td>
</tr>
<tr>
<td>GAR*GARSick</td>
<td>.558</td>
<td>1</td>
<td>.558</td>
<td>.042</td>
<td>.839</td>
</tr>
<tr>
<td>Error</td>
<td>699.160</td>
<td>52</td>
<td>13.445</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The results suggest that there was no significant main effect for GAR or GARSick, and no interaction effects for GAR and GARSick. These results partially conform with the results from the comparative one-way ANOVA, which failed to indicate significant differences between GAR and the total scores for C4, but indicated significant differences between GARSick and the total scores for C4.

The means and standard deviations for the main effects are presented in Table 7.44.

Table 7.44: Means and standard deviations for total scores for C4 (Success factors) for GAR and GARSick

<table>
<thead>
<tr>
<th>KEY</th>
<th>Variables</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>GAR 1-3%</td>
<td>31.80</td>
<td>2.70</td>
<td>15</td>
</tr>
<tr>
<td>B</td>
<td>GARSick &lt;=2.5%</td>
<td>30.50</td>
<td>3.54</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>GARSick &gt;=2.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>GAR 4%+</td>
<td>31.64</td>
<td>2.98</td>
<td>11</td>
</tr>
<tr>
<td>D</td>
<td>GARSick &lt;=2.5%</td>
<td>29.71</td>
<td>4.28</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>GARSick &gt;=2.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td>39</td>
</tr>
</tbody>
</table>

The mean scores and standard deviation for the interaction factors were similar.
The results suggest that there are no significant differences for responses in terms of success factors for programmes aimed at the management of health-related absenteeism (Section C4) for organisations with low and high GARs and GARSick. The investigation failed to establish a relationship between the absenteeism rate (GAR) and the health-related absenteeism rate (GARSick) in organisations, and the success factors for programmes aimed at the management of health-related absenteeism as listed in Section C4 of the questionnaire. The results could imply the absence of these success factors, which included top-management support, a constructive and supportive organisational culture, ownership of programmes by a task or project team and the alignment of all health- and absenteeism-related policies and interventions, in organisations. It could be possible that actions aimed at reducing health-related absenteeism were not applied as a holistic organisational strategy but rather as isolated efforts by line managers or human resources practitioners and therefore did not significantly affect the GAR or GARSick. Results from this study suggested that less than a third of organisations that participated in this study had arranged a training programme or workshop on absenteeism and corporate health in the previous twelve months, which could indicate a lack of strategic planning in this regard (refer to paragraph 6.4.6).

f) Relationship between GAR, GARSick and total scores for D (Contingency strategies)

The interaction effect between the GAR, GARSick and the total scores for D (Contingency strategies) was computed. Levene’s test for homogeneity of variance indicated p=.229 for GAR, GARSick and total score for D.
The results from the factorial analysis of variance are presented in Table 7.45.

**Table 7.45:** Effects and main effect of the relationship between GAR, GARSick and total scores for D (Contingency strategies)

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAR</td>
<td>5036.361</td>
<td>1</td>
<td>5036.361</td>
<td>2.109</td>
<td>.152</td>
</tr>
<tr>
<td>GARSick</td>
<td>1282.526</td>
<td>1</td>
<td>1282.526</td>
<td>.537</td>
<td>.467</td>
</tr>
<tr>
<td>GAR*GARSick</td>
<td>761.779</td>
<td>1</td>
<td>761.779</td>
<td>.319</td>
<td>.575</td>
</tr>
<tr>
<td>Error</td>
<td>124157.292</td>
<td>52</td>
<td>2387.640</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The results suggest that there was no significant main effect for GAR or GARSick, and no interaction effects for GAR and GARSick. These results confirm the results from the comparative ANOVA discussed in paragraph 7.2.7 (b and c). The means and standard deviations for the main effects are presented in Table 7.46.

**Table 7.46:** Means and standard deviations for total scores for D (Contingency strategies) for GAR and GARSick

<table>
<thead>
<tr>
<th>KEY</th>
<th>Variables</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>A B</td>
<td>GAR 1-3%</td>
<td>79.60</td>
<td>74.29</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>GARSick &lt;=2.5%</td>
<td>106.00</td>
<td>67.88</td>
<td>2</td>
</tr>
<tr>
<td>C D</td>
<td>GAR 4%+</td>
<td>61.55</td>
<td>8.27</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>GARSick &lt;=2.5%</td>
<td>64.96</td>
<td>39.25</td>
<td>28</td>
</tr>
</tbody>
</table>

Mean scores to Key B were higher than for Key A, while the standard deviation for Key B was lower than for Key A. Results to Key C were not analysed due to a small N (2). However, mean scores for Key C and D were similar.
The results suggest that there were no significant differences for responses in terms of contingency strategies (Section D) for organisations with low and high GARs and GARsSick. The investigation failed to establish a relationship between the absenteeism rate (GAR) and the health-related absenteeism rate (GARSick) in organisations, and contingency strategies aimed at ensuring the continuity of production and service provision in the face of absenteeism as listed in Section D of the questionnaire. The results confirm those obtained by the one-way ANOVA, which also failed to establish a relationship between the GARs and GARsSick of organisations, and results for Section D (Contingency strategies). The results could indicate a lack of attention to contingency strategies aimed at ensuring the continuity of production and service delivery. The results from Section A of the questionnaire suggested that less than a third of the organisations that participated in this study had arranged a training programme/workshop on contingency strategies during the previous twelve months, which support the above comments (refer to paragraph 6.4.6). In addition, it was indicated in Chapter four (refer to paragraph 4.1) that the literature study revealed little or no reference to contingency management strategies in relation to the management of health-related absenteeism or absenteeism in general.

7.2.9 Discriminant analysis

Discriminant analysis is used to determine whether or not a statistically significant relationship between an independent variable and dependent variables exists, and can thus be used to predict group membership. This statistical method was selected for this study to test the correctness of the results
obtained from the ANOVA and factorial ANOVA. Discriminant analysis provides a reversed perspective to both the ANOVA and factorial ANOVA in the sense that the dependent variables (test scores) used for these tests, were used as independent variable in the discriminant analysis test. Discriminant analysis was used to determine whether the mean scores for the various sections (independent variables or predictors) could predict membership to the following dependent variables:

- Small or large organisation (size of organisation);
- Organisations with low or high GAR;
- Organisations with low or high GARSick; and
- Organisations with HIV/AIDS policy or no HIV/AIDS policy.

The above dependent variables served as independent variables for the ANOVA test. However, for the purpose of discriminant analysis they served as dependent variables.

a) Organisational size

A discriminant analysis was done for organisational size where respondents were divided into two groups, namely those belonging to small organisations (50-300 in employment) and those belonging to large organisations (301+ in employment). The independent variables were the total scores for sections B to D.
Table 7.47 provides standardised discriminant function co-efficients for total scores for sections B to D according to small (50-300 people employed) and large (301+ people employed) organisations.

**Table 7.47:** Standardised Discriminant Function Co-efficients for Section scores for organisational size

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 TOTAL</td>
<td>.465</td>
</tr>
<tr>
<td>C1 TOTAL</td>
<td>-.213</td>
</tr>
<tr>
<td>C2 TOTAL</td>
<td>-.087</td>
</tr>
<tr>
<td>C3 TOTAL</td>
<td>-.559</td>
</tr>
<tr>
<td>C4 TOTAL</td>
<td>1.190</td>
</tr>
<tr>
<td>D1 TOTAL</td>
<td>-.256</td>
</tr>
</tbody>
</table>

The standardised discriminant function co-efficients indicate the extent to which each co-efficient contributes to group discrimination on a function and the direction of that relation. B1, C3 and C4 contributed most to organizational size discrimination as the co-efficients were greater than .30 or less than -.30. The canonical correlation was .278. The canonical correlation co-efficient measures the relation between the discriminant score (size of organisation) and independent variables (total scores) (Struwig & Stead, 2001: 160-161). Wilks' Lambda (.923) indicated that the results could not be projected to 92 per cent of the population. The Chi-square statistic corresponding with Wilks' Lambda (p=.665) implied that differences between the groups were not significant.
The results failed to show that the mean total scores for the various sections for the two groups (small and large organisations) were significantly different and therefore failed to predict membership to these groups. The results are congruent with those received from the ANOVA, which failed to indicate significant differences between organisational size and the scores for the various sections (refer to paragraph 7.2.7 a). The results suggest that respondents from small and large organisations perceived the contingency management of health-related absenteeism in the same way.

b) GAR

A discriminant analysis was done for GAR where respondents were divided into two groups, namely those who reported a GAR of three per cent or less and those who reported a GAR of four per cent or more. The independent variables were the total scores for sections B to D.

Table 7.48 provides standardised discriminant function co-efficients for sections B to D total scores according to GAR.
Table 7.48: Standardised Discriminant Function Co-efficients for Section scores for GAR

<table>
<thead>
<tr>
<th>Variables</th>
<th>Co-efficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 TOTAL</td>
<td>-.178</td>
</tr>
<tr>
<td>C1 TOTAL</td>
<td>-.399</td>
</tr>
<tr>
<td>C2 TOTAL</td>
<td>-.169</td>
</tr>
<tr>
<td>C3 TOTAL</td>
<td>.392</td>
</tr>
<tr>
<td>C4 TOTAL</td>
<td>.476</td>
</tr>
<tr>
<td>D1 TOTAL</td>
<td>.561</td>
</tr>
</tbody>
</table>

The standardised discriminant function co-efficients indicated that C1, C3, C4 and D1 contributed most to GAR discrimination as the co-efficients were greater than .30 or less than -.30. The canonical correlation was .641. The canonical correlation co-efficient measures the relation between the discriminant score (GAR) and independent variables (total scores). However, the Wilks' Lambda (.920) indicated that the results could not be projected to 92 per cent of the population. The Chi-square statistic corresponding with Wilks' Lambda was not significant (p=.641) which indicated that no significant differences were found between the two groups.

The results show that the mean total scores for the various sections failed to predict membership to the two groups (GAR <=3% and GAR=4%+). The results are congruent with those received from the factorial ANOVA, which failed to indicate a significant relationship between GAR and scores for the various
sections (refer to paragraph 7.2.7 b). The results suggest that there were no significant differences in the perceptions of respondents from organisations with a low or high GAR in terms of the best practices for the contingency management of health-related absenteeism.

c) GARSick

A discriminant analysis was done for GARSick where respondents were divided into two groups, namely those who reported a GARSick of 2.5 per cent or less and those reporting a GARSick of 2.6 per cent or more. The independent variables were the total scores for sections B to D.

Table 7.49 provides standardised discriminant function co-efficients for sections B to D total scores according to GARSick.

**Table 7.49**: Standardised Discriminant Function Co-efficients for Section scores for GARSick

<table>
<thead>
<tr>
<th>Variables</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 TOTAL</td>
<td>-.019</td>
</tr>
<tr>
<td>C1 TOTAL</td>
<td>-.454</td>
</tr>
<tr>
<td>C2 TOTAL</td>
<td>-.653</td>
</tr>
<tr>
<td>C3 TOTAL</td>
<td>.917</td>
</tr>
<tr>
<td>C4 TOTAL</td>
<td>-1.481</td>
</tr>
<tr>
<td>D1 TOTAL</td>
<td>-.448</td>
</tr>
</tbody>
</table>
The Chi-square statistic corresponding with Wilks’ Lambda was statistically significant at .018, which implied that there was a relationship between the dependent groups (low and high GARSick) and the independent variables. The standardised discriminant function co-efficients indicated that, except for Section B, all the section mean scores contributed to GARSick discrimination as their co-efficients were greater than .30 or less than -.30. The total means scores for Section C4 (Contingency factors), C2 (Ill-health), C1 (Wellness) and C3 (HIV/AIDS), in this order, contributed most to distinguishing between the two groups (low and high GARSick). The canonical correlation was .508. The canonical correlation co-efficient measures the relation between the discriminant score (GARSick) and independent variables (total scores). The Wilks’ Lambda was .742 which implies that about 74 per cent of the variance was not explained by group differences.

The comparative ANOVA investigation (refer to paragraph 7.2.7 c) revealed a significant relationship between GARSick and results for C4 (Success factors), but failed to establish a relationship between GARSick and the results for the other sections. Table 7.50 presents descriptive statistics for total scores for the Section C4 for organisations with a low GARSick (<=2.5%) and organisations with a high GARSick (2.6%+).
Table 7.50: Descriptive statistics of total scores for C4 for organisations according to GARSick

<table>
<thead>
<tr>
<th>C4 TOTAL</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;=2.5%</td>
<td>26</td>
<td>31.73</td>
<td>2.76</td>
</tr>
<tr>
<td>2.6+%</td>
<td>30</td>
<td>29.77</td>
<td>4.19</td>
</tr>
</tbody>
</table>

It is evident from Table 7.40 that the mean scores for organisations with a low and high GARSick were not much different from each other. The standard deviation for organisations with a low GARSick was lower (2.76) for organisations with a high GARSick, indicating that responses from these organisations were more congruent.

Both discriminant analysis and an ANOVA investigation found a relationship between GARSick and results to Section C4 (Success factors). The results could imply that organisations that observed these success factors (constructive organisational culture, top management support, ownership, communication, marketing, continuous evaluation and alignment of health-related programmes) experienced different GARSick levels than those that did not.

d) HIV/AIDS policy

A discriminant analysis was done for HIV/AIDS where respondents were divided into two groups, namely those who reported that their organisation had an HIV/AIDS policy and those who reported that their organisation did not have an HIV/AIDS policy. The independent variables were the total scores for sections B to D.
Table 7.51 provides standardised discriminant function co-efficients for sections B to D total scores according to HIV/AIDS policy.

Table 7.51: Standardised Discriminant Function Co-efficients for Section scores for HIV/AIDS policy

<table>
<thead>
<tr>
<th>Variables</th>
<th>Co-efficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1 TOTAL</td>
<td>-.187</td>
</tr>
<tr>
<td>C1 TOTAL</td>
<td>-.107</td>
</tr>
<tr>
<td>C2 TOTAL</td>
<td>-.276</td>
</tr>
<tr>
<td>C3 TOTAL</td>
<td>1.286</td>
</tr>
<tr>
<td>C4 TOTAL</td>
<td>-.502</td>
</tr>
<tr>
<td>D1 TOTAL</td>
<td>.209</td>
</tr>
</tbody>
</table>

The standardised discriminant function co-efficients indicated that C3 and C4 contributed most to GAR discrimination as the co-efficients were greater than .30 or less than -.30. The canonical correlation was .359. The canonical correlation co-efficient measures the relation between the discriminant score (size of organisation) and independent variables (total scores). The Wilks’ Lambda (.871) indicates that more than 80 per cent of variances could not be explained by differences between the two groups (low and high GARSick) The Chi-square statistic was not significant (p=.316) and detected differences therefore have no practical implications.

The results show that the mean total scores for the various sections failed to predict membership to the two groups (HIV/AIDS policy and no HIV/AIDS policy).
The results are congruent with those received from the factorial ANOVA that failed to indicate a significant relationship between HIV/AIDS policy and scores for the various sections (refer to paragraph 7.2.7 d). The results could suggest that though respondents from organisations with and without an HIV/AIDS policy agreed on how HIV/AIDS should be managed, some still did not practically apply these strategies in the workplace. The results could also indicate that having an HIV/AIDS policy in place is no guarantee that HIV/AIDS is managed in an organisation.

In the next section, the research results are discussed and integrated.

7.3 REVIEW OF QUANTITATIVE ANALYSIS

In Chapter five, a model (refer to Figure 5.1) of best practices for the contingency management of health-related absenteeism was presented and discussed. The theoretical research findings presented in the Chapters two, three and four were used as a basis for the development of the model. The model served as the basis for the development of the questionnaire used in this study. The purpose of this section is to review the findings of the quantitative analysis to determine whether the model of best practices for the contingency management of health-related absenteeism should be adapted or changed. The structure of the review is congruent with the structure of the model and the questionnaire.
7.3.1 Actions aimed at reducing health-related absenteeism

(Section B)

The management of health-related absenteeism focuses on the recording, calculation, analysis, benchmarking, communication of absenteeism data and the management of incapacity due to ill-health. The Cronbach Alpha test revealed internal consistency among the test items in Section B, which contained items related to the management of health-related absenteeism. This section can be perceived as a reliable measure of strategies aimed at the management of health-related absenteeism.

An examination of the results for Section B revealed that respondents were in agreement with the practices aimed at the management of health-related absenteeism (refer to Table 7.1). Most agreement was reached for ‘recording absenteeism accurately’ and ‘dealing timeously with incapacity due to ill-health’.

The statistical analysis failed to find a relationship between organisational size, GAR, GARSick, HIV/AIDS policy and the results for Section B. It can therefore be concluded that respondents from small and large organisations, organisations with a low and high GAR or GARSick and organisations with and without an HIV/AIDS policy agreed in terms of the strategies aimed at the management of health-related absenteeism.
The results suggested that, in terms of items listed in Section B of the questionnaire, no changes were required to the proposed model of best practices for the contingency management of health-related absenteeism.

### 7.3.2 Wellness actions aimed at reducing health-related absenteeism (Section C1)

Wellness actions focus on an integrated wellness programme, the assessment of health risks, wellness interventions, stress training, the prevention of substance abuse and the provision of a healthy and safe workplace. The Cronbach Alpha test revealed internal consistency among the test items in Section C2. This implied that this section could be perceived as a reliable measure of wellness strategies aimed at preventing absenteeism. The item ‘providing a work environment that is healthy and safe’ had a relatively low correlation (.1705) with the rest of the items, which implied that this item could be perceived as the least reliable indicator of wellness.

An examination of the results for Section C1 revealed that respondents were in agreement with the practices aimed at establishing wellness in the organisation (refer to Table 7.4). Most agreement was reached for ‘providing a work environment that is healthy and safe’ and ‘introducing an integrated corporate wellness programme’. Although ‘providing a work environment that is healthy and safe’ was implicated as a less reliable indicator of workplace wellness, it was nevertheless perceived as important to the management of health-related absenteeism.
The statistical analysis failed to find a relationship between organisational size, GAR, GARSick, HIV/AIDS policy and the results for Section C1. It can therefore be concluded that respondents from small and large organisations, organisations with a low and high GAR or GARSick and organisations with and without an HIV/AIDS policy agreed in terms of the strategies aimed at establishing wellness in organisations.

The results suggested that, in terms of items listed in Section C1 of the questionnaire, no changes were required to the proposed model of best practices for the contingency management of health-related absenteeism.

### 7.3.3 Reducing absenteeism through the management of ill-health and mental problems (Section C2)

The management of ill-health and mental problems include determining the prevalence of diseases, assessing stress levels, providing health benefits, on-site occupational health services, disease-specific information, referring an unwell person to professional assistance and establishing an Employee Assistance programme (EAP). The Cronbach Alpha test revealed internal consistency among the test items in Section C2. This implied that this section was a reliable measure of strategies aimed at the management ill-health and mental problems to reduce absenteeism.

An examination of the results for Section C2 revealed that respondents were in agreement with the practices aimed at managing ill-health and mental problems
(refer to Table 7.7). Most agreement was reached for ‘referring an unwell employee to a professional person or body who can assist in managing the problem professionally’ and ‘providing on-site occupational health services’.

The statistical analysis failed to find a relationship between organisational size, GAR, GARSick, HIV/AIDS policy and the results for Section C2. It can therefore be concluded that respondents from small and large organisations, organisations with a low and high GAR or GARSick and organisations with and without an HIV/AIDS policy agreed in terms of the strategies aimed managing ill-health and mental problems in organisations.

The results suggested that, in terms of items listed in Section C2 of the questionnaire, no changes were required to the proposed model of best practices for the contingency management of health-related absenteeism.

7.3.4 Reducing absenteeism through the management of HIV/AIDS (Section C3)

The management of HIV/AIDS focuses on assessing the prevalence of HIV/AIDS in the organisation, planning for the financial impact of HIV/AIDS, providing awareness campaigns, training and educational interventions, access to treatment, counselling, the distribution of condoms, networking with the community and the on-going research and evaluation of intervention strategies. The Cronbach Alpha test revealed internal consistency among the test items in
Section C3, indicating this section as a reliable measure of strategies aimed at the management of HIV/AIDS to reduce absenteeism.

An examination of the results for Section C3 revealed that respondents were in agreement with all the practices aimed at managing HIV/AIDS (refer to Table 7.10). Respondents mostly agreed that awareness campaigns, training and education interventions, counselling and support for those affected by HIV/AIDS, on-going research and evaluation, financial planning for the impact of the pandemic, and lastly, the distribution of condoms and networking with the community were best strategies for the management of HIV/AIDS. The least support was shown for prevalence studies and the provision of access to anti-retroviral treatment, which could be a consequence of the legal and financial implications associated with these actions.

The results suggested that respondents from small and large organisations, as well as from organisations with a high and low GAR and GARSick, agreed on the identified strategies for managing HIV/AIDS. Significant differences were found between the results from organisations with and without an HIV/AIDS policy in terms of how HIV/AIDS should be managed. However, these results were not confirmed by the discriminant analysis test. No conclusive interpretations could therefore be made for organisations with and without an HIV/AIDS policy. A strong positive correlation was found between the HIV/AIDS strategies and the success factors for health-related absenteeism programmes. This correlation could imply that the management of HIV/AIDS could not be separated from the success factors for programmes aimed at preventing and reducing health-related absenteeism. This is congruent with the theory discussed in paragraph 3.5.
The results suggested that, in terms of items listed in Section C3 of the questionnaire, no changes were required to the proposed model of best practices for the management of HIV/AIDS in organisations.

### 7.3.5 Success factors for programmes aimed at preventing and reducing health-related absenteeism (Section C4)

Success factors for programmes aimed at preventing and reducing health-related absenteeism included a supportive organisational culture, top management support, ownership by a task/project team, employee participation, communication, marketing and continuous evaluation of such programmes and aligning all health- and absenteeism-related policies and interventions. The Cronbach Alpha test revealed internal consistency among the test items in Section C4. This implied that this section could be perceived as a reliable measure of success factors needed for programmes aimed at preventing and reducing health-related absenteeism.

An examination of the results for Section C4 revealed that respondents were in agreement with all the success factors for programmes aimed at preventing and reducing health-related absenteeism (refer to Table 7.13).

The statistical analysis failed to find a relationship between organisational size, GAR and HIV/AIDS policy and the results for Section C4. However, both the one-way ANOVA and the discriminant analysis test revealed significant
differences between the results for organisations with a low and high GARSick and the results for Section C4. More refined statistical tests are required to reveal the exact nature of these differences. The factorial ANOVA failed to find significant differences between GAR and GARSick, and the test results for C4. It can therefore be concluded that respondents from small and large organisations and organisations with a low and high GAR and organisations with and without an HIV/AIDS policy agreed in terms of the success factors for programmes aimed at preventing and reducing health-related absenteeism. Respondents from organisations with a low and high GARSick showed differences in terms of the success factors needed.

The results suggested that, in terms of items listed in Section C4 of the questionnaire, no changes were required to the proposed model of best practices for the management of HIV/AIDS in organisations.

7.3.6 Practices aimed at ensuring the continuity of production and service provision in the face of increasing absenteeism (Section D)

Practices aimed at ensuring continuity during high periods of absenteeism related to designing a flexible organisation by adopting alternative work arrangements, monitoring future human resources needs, talent actions plans and introducing flexible and automated production processes. The Cronbach Alpha test revealed internal consistency among the test items in Section D, which implied reliability of this section as a measure of contingency strategies aimed at
ensuring the continuity of production and service provision in the face of increasing absenteeism.

An examination of the results for Section D revealed that the introduction of flexible work hours, a compressed work-week, telecommuting and job-sharing were not perceived as viable options for maintaining continuity of production and service provision in the organisation (mean scores less than three). The most preferred options were monitoring staff levels, maintaining a skills inventory and replacement charts, providing a motivating work environment, pre-need training for specialised jobs, multi-skilling and creating more capacity through learnerships funded by the Skills Development Fund (refer to Table 7.17).

The statistical analysis failed to find a relationship between organisational size, GAR, GARSick and HIV/AIDS policy and the results for Section D. It can therefore be concluded that respondents from small and large organisations and organisations with a low and high GAR and organisations with and without an HIV/AIDS policy agreed in terms of strategies aimed at ensuring the continuity of production and service provision in the face of increasing health-related absenteeism.

7.4 CONCLUSION

In Chapter seven the statistical analysis and results from the empirical study were presented and analysed. The quantitative research findings were summarised, integrated and discussed.
The final chapter presents a summary of the main findings. Conclusions and recommendations related to the study are also presented.
# CHAPTER EIGHT

## SUMMARY, RECOMMENDATIONS AND CONCLUSION

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1 INTRODUCTION</td>
<td>336</td>
</tr>
<tr>
<td>8.2 SUMMARY OF THE STUDY</td>
<td>336</td>
</tr>
<tr>
<td>8.3 RECOMMENDATIONS</td>
<td>340</td>
</tr>
<tr>
<td>8.4 PROBLEMS AND LIMITATIONS</td>
<td>343</td>
</tr>
<tr>
<td>8.5 CONCLUSION</td>
<td>343</td>
</tr>
</tbody>
</table>
CHAPTER EIGHT

SUMMARY, RECOMMENDATIONS AND CONCLUSION

8.1 INTRODUCTION

The purpose of this final chapter is to take a holistic view of this study and what it has accomplished by closing the loop between the main problem, sub-problems and the main findings. The problems and limitations of the study will be highlighted and recommendations for future research will be presented.

8.2 SUMMARY OF THE STUDY

In this section, the main problem and sub-problems are repeated to indicate which actions were taken to address each problem. The main findings related to each sub-problem are reiterated.

The main problem identified was:

What contingency strategies can be utilised by organisations to manage health-related absenteeism?

The rationale behind the study was to address the continuous problems organisations experience with high levels of absenteeism, which are aggravated
by the proliferation of various diseases, including HIV/AIDS. While most previous research focused on absenteeism as delinquent behaviour, a need exists to investigate and formulate best practices for the contingency management of health-related absenteeism.

Sub-problems were identified to resolve the main problem. The sub-problems are listed below.

SUB-PROBLEM ONE:

What is the impact of health-related issues and absenteeism on organisations?

A literature study was conducted to identify the extent and nature of health-related absenteeism in South African organisations. The impact of absenteeism on productivity and the financial implications thereof were investigated (refer to Chapter two). Results from the empirical study suggest that two-thirds of organisations in the automobile and automobile component industry have an absenteeism rate that is higher than the international norm of three per cent, while a third of organisations have a genuine health-related absenteeism rate that is currently at an unacceptable level.

SUB-PROBLEM TWO:

What contingency management strategies can be utilised by organisations in order to reduce health-related absenteeism?
Chapter two of the study considered the legal parameters within which health-related absenteeism should be managed. Chapter three focused on organisational policies that support and guide the effective management of health-related absenteeism. The logical integration of these policies reduces ambiguity and enhances an effort to manage health-related absenteeism. This chapter also addressed the recording, measurement and analysis of absenteeism, a holistic approach to health in organisations, which included wellness, the management of ill-health and the management of HIV/AIDS, as well as the importance of a healthy and safe work environment.

SUB-PROBLEM THREE:

What contingency management strategies can be utilised by organisations to maintain undisrupted production and provision of services in the face of absenteeism?

Chapter four provided a theoretical overview of the contingency management strategies that organisations could utilise to maintain undisrupted production and service provision in periods of high absenteeism. This entails monitoring human resources levels, optimising available human resources, creating flexible work arrangements and employment practices, and considering production and service processes that could be affected by high levels of absenteeism.

The theoretical research findings were integrated into a model of best practices for the contingency management of health-related absenteeism, which were presented and discussed in Chapter five. The model formed the basis for the
development of a questionnaire that was used to resolve sub-problems four and five.

SUB-PROBLEM FOUR:

To what extent do organisations utilise effective contingency strategies to reduce health-related absenteeism?

SUB-PROBLEM FIVE:

To what extent do organisations utilise effective contingency strategies to maintain undisrupted production and provision of services?

In order to resolve sub-problems four and five, the questionnaire, developed from the theoretical model in Chapter five, was administered to senior human resources practitioners, health practitioners or line managers who were responsible for the management of health-related absenteeism in organisations in the motor and motor component sectors in the Nelson Mandela Metropolitan Municipality and Buffalo City Metropole. The results from the survey were statistically analysed and interpreted.

The results suggest that respondents are in agreement with the contingency strategies aimed at reducing health-related absenteeism.

The results of the survey suggest that respondents are not fully in agreement with the strategies aimed at maintaining undisrupted production and service
provision during periods of high absenteeism. In particular, there was disagreement with regard to alternative work arrangements such as flexible work hours, a compressed work-week, telecommuting and job-sharing. It appears that respondents do not agree that these are possible contingent actions that employers can institute.

Based on the research findings, recommendations are made and areas for future research highlighted.

8.3 RECOMMENDATIONS

It was indicated in Chapter six that the goal of research is to solve problems and develop scientific knowledge (Vos, Strydom, Fouché and Delport, 2002: 50). The purpose of the study was to develop best practices for the contingency management of health-related absenteeism. To achieve this goal, theoretical and empirical studies were conducted.

The model of best practices for the contingency management of health-related absenteeism can serve as a guideline for organisations that want to pro-actively and constructively address absenteeism in organisations. In addition, it can be used as a guideline for organisations to benchmark their health-related absenteeism strategies with those of other organisations.

The following recommendations emerged from the research conducted:

a) Health-related absenteeism should be addressed in an integrated manner. To achieve this goal, a designated task-team should take
responsibility and ensure that relevant health-related policies and programmes are developed and integrated.

b) A constructive and supportive organisational culture, top management support, employee participation, effective marketing and communication, and continuous evaluation should be established and maintained for the successful introduction of any programme aimed at prevention and reduction of health-related absenteeism in the organisation.

c) The literature study and the empirical study suggested that organisations did not give much attention to the continuity of production and service delivery as an integral part of a contingency strategy aimed at reducing the negative effects of high levels of absenteeism, especially in terms of the expected effect of HIV/AIDS. It is therefore recommended that contingency planning be introduced and linked to the human resources planning and provisioning processes.

The following areas for future research have been identified:

a) The study was restricted to the motor and motor component industry in the Nelson Mandela Metropolitan Municipality and Buffalo City Metropole. Similar studies could be conducted in other areas and within other industries.
b) The study was primarily aimed at human resources practitioners and not line managers. Future research could include both human resources practitioners and line managers, which would enable a comparative study between these two functions. While human resources practitioners are primarily responsible for the introduction of programmes aimed at the management and control of health-related absenteeism, including wellness and HIV/AIDS programmes, line managers are primarily responsible for the continuity of production and service provision during periods of high absenteeism and could be better positioned to suggest best practices in this regard.

c) A longitudinal study could be conducted to monitor the absenteeism and health-related absenteeism rates in organisations, and the extent to which organisations apply the best practices as identified in this study.

d) It was indicated that a supportive and constructive culture is necessary for programmes aimed at preventing and reducing health-related absenteeism. Further research could identify the elements of a supportive and constructive culture necessary for the successful implementation of such programmes.

e) The study revealed that alternative work arrangements such as flexible work hours, a compressed work-week, telecommuting and job-sharing were not considered as viable options for creating flexible organisations. Further research could verify whether this perspective
was only applicable to the motor and motor component industry or whether it is also relevant to other sectors. In addition, further research could explore ways in which alternative work arrangements could be implemented to make it a more viable option.

8.4 PROBLEMS AND LIMITATIONS

No major problems were experienced during the duration of the study. Minor problems related to the administration of the questionnaire and specifically to obtaining an adequate number of responses. This problem was overcome by a follow-up survey. The eventual high response rate that was attained and the number of respondents who indicated that they would like to receive a synopsis of the results demonstrated that the survey was positively received by industry.

A limitation of the research was that it focused on human resources practitioners and not line managers. This aspect was addressed in paragraph 8.3 (b) of the study.

8.5 CONCLUSION

Absenteeism, in general, is an issue that organisations are challenged with on a daily basis. The proliferation of various diseases, and specifically HIV/AIDS, is contributing to this problem. An integrated and strategic approach is required to deal effectively and constructively with the immediate and expected future impact of health-related issues on absenteeism.
Health-related absenteeism is an organisational risk that should be recognised, defined, measured and managed. Measurement contributes to identifying vulnerable areas that need immediate attention and future trends and potential problems that can be prevented from occurring. In addition, contingency plans ensure that production and service delivery are not disrupted during periods of high absenteeism.
REFERENCES


Blot, N. 2003. Medical consultant, Port Elizabeth. Personal communication.


Gilham, A. September 2000. Absenteeism is affecting productivity. *Infocom, Port Elizabeth Regional Chamber of Commerce and Industry*, p. 17.


Sick leave costs state R632m. 24 May 2002. Eastern Province Herald, p. 3.


Zeelie, J.J. 2003. Head of Unit for Health Services, Port Elizabeth Technikon. Personal communication.
**BEST PRACTICES FOR THE CONTINGENCY MANAGEMENT OF HEALTH-RELATED ABSENTEEISM**

- **Design and integrate corporate policies on absenteeism- and health management**
  - **Manage absenteeism**
    - Record absenteeism
    - Measure, analyse, benchmark and report absenteeism rates
    - Manage incapacity
  - **Promote corporate health**
    - Maintain wellness
    - Appraise health risks
    - Establish wellness programmes
    - Maintain workplace ergonomics
  - **Manage ill-health and mental diseases**
    - Conduct prevalence studies/audits/surveys
  - **Manage HIV/AIDS**
    - Conduct HIV/AIDS prevalence and impact studies
    - Appoint HIV/AIDS task team
    - Increase awareness
    - Educate stakeholders
    - Manage individual cases
    - Network with community
    - Conduct research
    - Manage the continuity of production and services
      - Design a flexible organisation
      - Estimate future human resources needs
      - Adjust the production and service processes
      - Introduce and modify lean manufacturing
      - Automate processes
  - **Maintain workplace ergonomics**
  - **Conduct prevalence studies/audits/surveys**
    - Manage ill-health and mental diseases
  - **Conduct HIV/AIDS prevalence and impact studies**
    - Appoint HIV/AIDS task team
    - Increase awareness
    - Educate stakeholders
    - Manage individual cases
    - Network with community
    - Conduct research
  - **Appraise health risks**
  - **Provide health benefits**
  - **Provide occupational health-care**
  - **Provide disease-specific education**
  - **Manage individual cases**
  - **Utilise EAPs**
  - **Conduct research**
  - **Continuous evaluation and corrective action**

---

**Figure 5.1:** A theoretical model of best practices for the contingency management of health-related absenteeism