



**HEALTH AND PRODUCTIVITY MANAGEMENT POLICY
FOR THE
PUBLIC SERVICE**

ANNEXURE A

2023

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ABREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AU	African Union
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
COIDA	Compensation for Occupational Injuries and Diseases Act
DG	Director General
DoH	Department of Health
DOL	Department of Labour
DPSA	Department of Public Service and Administration
EH&W	Employee Health and Wellness
EH&WSF	Employee Health & Wellness Strategic Framework
IDP's	Integrated Development Plans
ILO	International Labor Organisation
IR	Industrial Relations
ISO	International Standardization Organisation
HIV	Human Immunodeficiency Virus
HOD	Head of Department
HPM	Health and Productivity Management
HR	Human Resources
HRD	Human Resource Development
MDG's	Millennium Development Goals
M&E	Monitoring and Evaluation
NEPAD	New Partnership for Africa's Development
OD	Organisational Development
PILIR	Policy and Procedure on Incapacity Leave & Ill-Health Retirement
ROI	Return on Investment
SABS	South African Buro of Standards
WHO	World Health Organisation



PART A: GENERAL

1. INTRODUCTION

The rationale and intended outcome related to Health and Productivity Management is an essential programme in the workplace that presents state-of-the-art health and productivity research (operational research), assessment of return on investments, expenditure tracking, absenteeism management [Productivity Management] . The policy provides for Health and Productivity Management defined as: *“the integrated management of health risks (incidence) and socially determined diseases for chronic illness, occupational injuries & diseases, mental diseases and disability to reduce employees’ total health-related costs, including direct medical expenditures, unnecessary absence from work, and lost performance at work – also known as ‘Presenteesim’”* in the Public Service world of work.

Non-communicable diseases, which are chronic in nature, are increasing at an alarming rates and are responsible for the vast majority of deaths that occur worldwide. According to the World Health Organization (2015), the leading causes of early death and disability are currently cardiovascular diseases, diabetes, cancer, and chronic respiratory diseases, with 80% of deaths taking place in low and middle income countries (LMICs). It is estimated that Non-Communicable Diseases (NCDs) kill 41 million people a year globally, which equates to 71% of all global deaths. The WHO estimates that deaths from NCDs are likely to increase globally by 17% over the next ten years. South Africa is one of the Country going through this epidemiological transition from communicable to non-communicable diseases, which has resulted in a twofold burden of infectious and non-infectious diseases on nations. Although diabetes mellitus is the second biggest cause of mortality in South Africa, tuberculosis remains the country's leading cause of death despite continuing to fall year over year. The National Development Plan (NDP), which is South Africa's vision for 2030, was adopted as a response to the quadruple burden of health challenges the country is facing, including diseases like tuberculosis, maternal and child morbidity and mortality, non-communicable diseases (mainly related to lifestyle), violence, injuries, and trauma. Additionally, NCDs and mental health disorders are leading causes of mortality, morbidity and disability in South Africa. Although the burden due to communicable disease has decreased since the late 2000s, the NCD mortality rate has increased from 55% in 2015 to 60% in 2018.



According to the WHO, Covid-19 caused an enormous impact on human life globally (Nguse & Wassenaar, 2021). In South Africa, the Covid-19 pandemic increased the incidence of mental disorders (Slaven, 2021). Many people with pre-existing mental disorders were worsened due to social distancing, quarantine, lockdown, and other restrictions that were implemented. Furthermore, the subsequent economic and social consequences led to an increase in the burden of mental disorders (Slaven et al, 2021). According to the Human Science Research Council (HSRC), during the pandemic 33% of South Africans were depressed, while 45% were fearful, and 29% were experiencing loneliness during the first lockdown period. In addition, COVID-19 led to mental health presentations such as post-traumatic stress disorder, mood disorders, anxiety disorders, phobias, and obsessive-compulsive disorders (Naidu, 2020). In addition, the DPSA Health Risk Manager's reports confirm that these are the top ten diseases/ailments that lead to incapacity in the public service: Musculoskeletal Diseases, Mental Diseases, Respiratory Diseases, Cardiac Disease, Chronic Fatigue Syndrome, HIV, Diabetic Mellitus, Hyperlipidaemia, Neoplasm and Neurological Conditions

According to WHO (2013), major depression and schizophrenia have a 40% to 60% greater chance of dying prematurely than the general population, owing to physical health problems that are often left unattended [such as cancers, cardiovascular diseases, diabetes and HIV Infection) and suicide. Suicide is the second most common cause of death among young people worldwide. There is also substantial concurrence of mental disorders and substance use disorders. Global mental, neurological and substance use disorders account for 13% of the total burden of disease. Depression alone accounts for 4.3% of the global burden of disease and is among the largest single causes of disability worldwide [11 % of all years lived with disability globally], particularly for women. Recent study estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to US\$ 16.3 million between 2011 and 2030.

The Health and productivity of employees do impact on other pillars of the framework. Traditional disease management programmes, health education and promotion programmes and productivity improvement and Public Service delivery improvement in particular have been integrated thus far. This framework puts all these interventions together to form a comprehensive health and productivity management programme to be implemented in the public service.

2. SCOPE

This policy is applicable to all National and Provincial Departments as contemplated in the Public Service Act 1994.



3. OBJECTIVES

3.1. The objectives of this policy are to:

- 3.1.1. Management of Non Communicable Diseases and Communicable Disease (excluding HIV/AIDS and TB (Focus on the areas of Disease Management).
- 3.1.2. Management of Mental Health in the work place.
- 3.1.3. Management of Incapacity due to ill Health and Retirement.
- 3.1.4. Enhance Work Place Health Education & Promotion and Productivity Management.

4. MISSION

4.1. The mission of this policy is to-

- 4.1.1. Operationalise EH&WSF for the Public Service.
- 4.1.2. Promote the general health of employees through awareness, education, risk assessment, and support.
- 4.1.3. Mitigate the impact and effect of communicable and non-communicable diseases on the productivity and quality of life of individuals.

5. PRINCIPLES

5.1 The Health and Productivity Management programme is underpinned by the following principles:

- 5.1.1 Focus on all levels of employment, senior and executive management, middle managers, operational and technical staff as well as staff at the lowest level of the occupational ladder.
- 5.1.2 Responding to the needs of designated groups such as women, older persons, people with disabilities and people living with HIV and AIDS.
- 5.1.3 Representation of targeted groups, a non-sexist, non-racist and fully inclusive Public Service.
- 5.1.4 Cohesiveness with HRD processes.
- 5.1.5 Equality and non-discrimination upholding the value that discrimination on any unfair grounds should be eliminated.
- 5.1.6 Promote healthy integration and embracing change.
- 5.1.7 Human dignity, autonomy, development and empowerment.



- 5.1.8 Barrier-free Public Service.
- 5.1.9 Collaborative Partnerships.
- 5.1.10 Confidentiality and ethical behavior.
- 5.1.11 Policy Coherence in terms of DPSA Policy measures to be aligned with other departments' measures.
- 5.1.12 Coherence of models: The service delivery models should offer the same benefits to public servants despite it being in-house, outsourced, or DOH collaboration.
- 5.1.13 Programme coherence: the programmes that are offered should not contradict each other in the various departments.

6. LEGAL FRAMEWORK

This policy should be read in conjunction with the following instruments:

6.1 INTERNATIONAL INSTRUMENTS UNDERPINNING HP MANAGEMENT

- 6.1.1 WHO Global Strategy on Occupational Health for All;
- 6.1.2 WHO Global Worker's Plan 2008-2017;
- 6.1.3 ILO Decent Work Agenda 2007-2015;
- 6.1.4 ILO Promotional Framework for Occupational Safety Convention 2006;
- 6.1.5 United Nations Convention on the Rights of People with Disabilities;
- 6.1.6 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW);
- 6.1.7 The Beijing Declaration and its Platform for Action, 1995 (+10);
- 6.1.8 WHO Global Strategy on Prevention and Control of non communicable Diseases (April 2008);
- 6.1.9 Recommendations of the Commission on Social determinants of Health (August 2008);
- 6.1.10 United Nations Millennium Declaration and its Development Goals (MDGs);
- 6.1.11 The International Convention on Population Development 1994 (+10);
- 6.1.12 World Summit on Sustainable Development, Johannesburg 2002;
- 6.1.13 WHO Commission on Social Determinants of Health

6.2 LEGAL FRAMEWORK FOR HP MANAGEMENT WITHIN THE PUBLIC SERVICE

- 6.2.1 Constitution of the RSA Act, 1996;
- 6.2.2 Disaster Management Act, 2002 (Act No. 57 of 2002);



- 6.2.3 Basic Conditions of Employment Act, 1997 (Act No. 75 of 1997);
- 6.2.4 Occupational Health and Safety Act, 1993 (Act No. 85 of 1993);
- 6.2.5 Employment Equity Act, 1998 (Acts No. 55 of 1998; Act No. 97 of 1998; Act No. 9 of 1999);
- 6.2.6 Labour Relations Act, 1995 (Act No. 66 of 1995);
- 6.2.7 National Disaster Management Framework;
- 6.2.8 Promotion of Equality and Prevention of Unfair Discrimination Act, 2000 (Act No.4 of 2000);
- 6.2.9 Public Service Act of 1994 as Amended & Regulations;
- 6.2.10 Compensation for Occupational Diseases and Injuries Act, 1993 (Act No.130 of 1993);

- 6.2.11 Mental Health Care Act, 2002 (Act No. 17, 2002);
 - a) The Medical Schemes Act, 1998 (Act No. 131 of 1998);
 - b) National Health (Care) Act, 2003 (Act No. 60 of 2003);
 - c) Tobacco Products Control Amendment Act, 1999 (Act No. 12 of 1999);
 - d) Mental Health Care Regulations, 2003 (No. 14 of 2003).

6.3 STRATEGIC FRAMEWORKS APPLICABLE TO HPM WITHIN THE PUBLIC SERVICE

- 6.3.1 National Strategic Plan on HIV&AIDS, STI and TB 2012-2016;
- 6.3.2 Strategic Plan for the Prevention and Control of Non-Communicable Diseases, 2012-2016
- 6.3.3 National Strategic Framework on Stigma and Discrimination;
- 6.3.4 National Occupational Health and Safety Policy of 2005.

6.4 ECONOMIC AND SOCIAL POLICY, PROGRAMMES AND STRATEGY

- 6.4.1 Presidential Pronouncements and Budget Speech;
- 6.4.2 Integrated Development Plans (IDPs);
- 6.4.3 Occupational Health Policy 2005 (Department of Labour);
- 6.4.4 Medium Term Strategic Framework;
- 6.4.5 National Spatial Development Strategies;
- 6.4.6 Provincial Growth and Development Strategies.



7. DEFINITIONS

7.1 Health and Productivity Management

Institute of Health and Productivity Management defines Health and Productivity Management (HPM) as integration of data and services related to all aspects of employee health that affect work performance. It includes measuring the impact of targeted interventions on both employee health and productivity. The Health, Productivity and Management value chain designs benefits and programmes to provide incentives, change behavior, reduce risks, improve health, which impact on medical costs and disabilities, improve functionality, which translates into enhanced worker productivity.

7.2 Disease Management

Disease Management has evolved from managed care, specialty capitation, and health service demand management, and refers to the processes and people concerned with improving or maintaining health in large populations. Disease Management is concerned with common chronic illnesses, and the reduction of future complications associated with those diseases. Disease management mitigate the impact of diseases by promoting the objectives of communicable and non-communicable diseases. The idea is to ease the disease path, rather than cure the disease. Improving quality and activities for daily living are first and foremost.

Disease management increases knowledge of diseases and promotes essential attitude change. It creates a demand for information and services, reduces stigma and discrimination against certain illnesses and promotes care and support of vulnerable employees.

7.3 Chronic Illness

A chronic illness is a word used to describe a group of health conditions that lasts a long time. In fact, the root word of chronic is "chronos," which refers to time. There are many kinds of chronic illnesses - most chronic illnesses are not contagious. Chronic illnesses can be genetic, meaning that parents can pass the tendency to get them on to their children before they are born through genes.



7.4 Mental Health

Mental health is a basic component of positive health and well-being. It is necessary to help management of life successfully, and provide emotional and spiritual resilience to allow enjoyment of life and dealing with distress and disappointment. Mental health can be very positive and worth aiming to have. However, we all go through times in our lives where we may experience mental illness. 'Mental illness' is a shorthand term for a variety of illnesses that affect our mental well-being. It covers a range of symptoms and experiences.

7.5 Temporary Incapacity Leave

Incapacity leave is a leave benefit that can be applied for in the event where normal sick leave has been exhausted in the three year sick leave cycle. Incapacity leave is for management purposes categorized into two types:

7.5.1 Short incapacity – this is when the period of incapacity leave that is requested, is 29 days or less;

7.5.2 Long incapacity – this is when one applies for 30 or more days of incapacity leave.

7.6 Ill-Health Retirement

When an employee becomes permanently unable to work due to medical reasons, he/she could be discharged or retired from the employment of the public service on medical grounds.

Either the employee or the employer could initiate an ill-health retirement, should it be suspected that the employee has become permanently unable to work.

The Employer should:

7.6.1 If necessary, request the employee to complete ill –health retirement specific application forms;



7.6.2 Manage and investigate the employee's application, with the assistance of a Health Risk Manager, in terms of the Policy and Procedure on Incapacity Leave and Ill-Health Retirement (PILIR).

7.6.3 The employer will notify the employee of the findings and take appropriate action according to these findings.

7.7 Injury on Duty and Occupational Diseases

An injury on duty is taken to mean a personal injury sustained in an accident occurring during the performance of an employee's work. An Occupational disease is like any other disease, with the distinction that it was caused solely or principally by factors peculiar to the working environment. It is also described as a disease arising out of and contracted in the course of an employee's employment as listed in Schedule 3 of the Compensation for Occupational Injuries and Disease Act, 1993 (Act No 130 of 1993).

7.8 Health Education and Promotion

Health Education and Promotion in the workplace is defined as a variety of communication dissemination and information transfer activities that are intended to enhance the knowledge levels of individuals help catalyze and reinforce behaviour change while intentionally leading to improved individual health and productivity.

7.9 DG/HOD

Means head of a national department, the office of the premier, a provincial department, or a head of a national or provincial government component, and includes any employee acting in such post.

7.10 Senior Manager

Means a member of the Senior Management Services (SMS) who is tasked with championing the Health and Productivity Management programme within the Public Service workplace.

7.11 Employee



Means a person appointed in terms of the Public Service Act No. 1994 and the Employment of Educators Act, 1998 (Act No. 76 of 1998).

7.12 Health and Safety Committee

It is a committee that initiates, develops, promotes, maintains and reviews measures to ensure the health and safety of employees at work. The employer shall in respect of each workplace, where two or more health and safety representatives have been designated, establish one or more health and safety committee(s).

7.13 Peer Educator

A peer educator is an employee who is trained in working with his/her peers, sharing information and guiding a discussion using his/her peer experience and knowledge.

7.14 Steering Committee

The **dpsa** has established Steering Committees for all components of Human Resource Management and Development, including EH&W, which have quarterly meetings. These are at provincial and national levels. The Steering Committee is a vehicle of coordination, communication, collaboration and consultation, which seeks to establish harmonised communication of the EH&W Framework; build commitment for its implementation and create avenues through which collaborative initiatives can be forged. Senior managers and EH&W practitioners are the representatives on the Steering Committees.

7.15 The Health and Wellness Coordinator

Is an employee tasked with the responsibility to coordinate the implementation of EH&W programmes, which include HPM programmes. The Health and Wellness Coordinator can be professionally trained to perform therapeutic interventions, if not trained, such cases should be referred.



8. ROLE PLAYERS

8.1 This policy involves the following role players:

8.1.1 The Head of Department shall ensure that:

- a) HPM in the workplace will encompass the prevention and management of chronic diseases, infectious diseases, occupational injuries, disability and occupational diseases so as to reduce the burden of disease by early entry into disease management programs in order to enhance productivity in the Public Service;
- b) Mental health in the workplace is addressed by:
 - i) Providing support options which are confidential and non-stigmatized;
 - ii) Reviewing employment practices to ensure that staff with a history of mental health problems is not excluded.
- c) Injury on duty and incapacity due to ill health is managed in terms of the Policy and Procedure on Incapacity Leave and Ill-Health Retirement (PILIR);
- d) Managers ensure that targeted employees must attend training on Health and Productivity Management programs;
- e) Systems /procedures/ delegations are adapted to establish a fertile environment for implementation and the management of Health and Productivity Management programs;
- f) Support should be provided to employees who truly need such support through Health and Wellness Programmes, i.e. to take action where necessary e.g. to adapt an incapacitated employee's work environment when so advised;
- g) The management of health programmes is changed to promote both employees' health and enhance service delivery;
- h) Appoint a designated senior manager to champion Health and Productivity Management Programmes in the workplace.

8.1.2 The Designated Senior Manager:

- a) Develop capacity building programmes, i.e.
 - (i) Promote competence development of practitioners;
 - (ii) Improve capacity development of auxiliary functions (OD, HR, IR, Skills



- Development, Change Management etc.);
- (iii) Assist with HPM promotion at an organisational level.
- b) Form organizational support initiatives; i.e.
- (i) Establish an appropriate organisation structure for HPM;
 - (ii) Ensure Human Resource planning and management;
 - (iii) Develop integrated HPM information management system;
 - (iv) Provide physical resources and facilities;
 - (v) Ensure financial planning and budgeting; and
 - (vi) Mobilize management support.
- c) Develop Governance and Institutional Initiatives, i.e.
- (i) Establish an HPM Steering Committee;
 - (ii) Obtain Stakeholder commitment and development;
 - (iii) Develop and implement an ethical framework for HPM;
 - (iv) Develop the management of wellness care;
 - (v) Develop and implement management standards for HPM;
 - (vi) Develop and maintain an effective communication system;
 - (vii) Develop and implement a system for monitoring, evaluation and impact analysis.
- d) Develop Economic Growth and Development Initiatives, i.e.
- (i) Mitigate the impact of diseases on the economy;
 - (ii) Ensure responsiveness to the Government's Programme of Action;
 - (iii) Ensure responsiveness to Millennium Development Goals; and
 - (iv) Integrating NEPAD, AU and Global programmes for the economic sector.

8.1.3 The Employee should:

- a) Ensure that he/she registers early into disease management programmes in order to manage the disease and enhance productivity in the Public Service;
- b) Participate in care and preventive programmes to minimize the effects of a disease,



- or chronic condition through integrative care and preventive care;
- c) Take reasonable care for the health and safety of him/herself and of other persons who may be affected by his/her acts or omissions;
 - d) If involved in any incident which may affect his/her health or which has caused an injury to him/herself, report such incident to his/her employer or to his/her health and safety representative, as soon as practicable; and
 - e) Comply with standards as set by legislation, regulations, SABS, ISO and DOL.

8.1.4 The Health and Productivity Management Committee:

- a) Act as a focal point for the distribution of evidence-based and generic health and Productivity management promotional material at the workplace;
- b) Identify potential causes that influence productivity in the workplace;
- c) Take initiative to implement awareness activities and to communicate health and productivity information in the workplace;
- d) Make recommendations to the employer regarding policy matters and implementation procedures, including any matter affecting the wellness of employees;
- e) Supporting staff training with regard to employee health, productivity and wellness;
- f) Discuss any incident at the workplace or section thereof in which or in consequence of which any person was injured, became ill or died, and may in writing report on the incident to an inspector;
- g) Keep record of each recommendation made to an employer and of any report made to an inspector;
- h) Involve Labour Relations movements; and
- i) Serve as a vehicle of communication to promote wellness initiatives within the workplace.
- j) Submit monthly reports of activities to the HPM coordinator

8.1.6 The HPM Coordinator:

- a) Coordinate the implementation of HPM projects and interventions;
- b) Plan, monitor and manage HPM according to strategies, policies and budgetary guidelines;



- c) Make provision for counselling to individual employees and to their immediate family members;
- d) Identify personal development needs for individual employees;
- e) Analyze and evaluate data and communicate information, statistics and results to various stakeholders and management;
- f) Coordinate activities of Peer Educators; and
- g) Promote work-life balance for employees.

8.1.7 The HPM Steering Committee:

- a) Establish harmonized communication of the HPM Policy at provincial and national level;
- b) Serve as a vehicle of coordination, communication, collaboration and consultation of issues pertaining employee health and productivity with other stakeholders and Departments;
- c) Create avenues through which collaborative initiatives can be forged; and
- d) Meet quarterly to discuss HPM Policy matters.

8.1.7 The Labour Representatives:

- a) Represent employees in the workplace;
- b) Ensure that the employer fulfill the mandates of health and productivity legislation in order to optimize health and productivity in the workplace;
- c) Sit in on health and productivity steering committee meetings; and
- d) Make presentations to the employer on agreed issues affecting the health and productivity of employees in the workplace.

9. FINANCIAL IMPLICATIONS

The cost associated with the implementation of this policy must be met from the individual department's budget.

10. IMPLEMENTATION



The Generic Implementation plan for Health and Productivity Management is the alignment of the logical framework commonly used in policy, programme and project management (inherent in the result based model) and the 12 components of an effective M&E system and the organizational structure for implementation of the EH&W. The implementation of this policy will follow the result base model.

11. MONITORING AND EVALUATION

Monitoring and evaluation has a significant role to play in HPM interventions as it assists in assessing whether the programme is appropriate, cost effective and meeting the set objectives. The 12 components that should be included in the HPM M&E System are indicated below:

- 11.1 Organisational structures with EH&W M&E functions;
- 11.2 Human capacity for EHW M&E;
- 11.3 Partnerships to plan, coordinate, and manage the M&E system;
- 11.4 National multisectoral EH&W M&E plan ;
- 11.5 Annual costed national EH&W M&E work plan;
- 11.6 Advocacy, communications, and culture for EH&W M&E;
- 11.7 Routine EH&W programme monitoring;
- 11.8 Surveys and surveillance;
- 11.9 National and sub-national EH&W Databases;
- 11.10 Supportive supervision and data auditing;
- 11.11 EH&W evaluation and research; and
- 11.12 Data dissemination and use.

Regular monitoring of progress on Health and Productivity Management programmes should be conducted quarterly through reports submitted to the DPSA by all departments. These reports will inform implementation, monitoring and evaluation, and future planning. An effective, efficient and implementable monitoring and evaluation system is required if this Health and Productivity Management Policy is to be successful in measuring achievements of the policy objectives. Departments would be expected to develop indicators as appropriate for micro and meso levels of governance

12. REVIEW

The policy will be reviewed as and when there are new developments or after every three years.



PART B: IMPLEMENTATION OF POLICY OBJECTIVES: MANAGEMENT OF NON COMMUNICABLE DISEASES AND COMMUNICABLE DISEASE

1. Aim

Disease and Chronic illness Management seeks to mitigate the impact of disease management. Ensure that the reduction of barriers to disease management remains a strategic priority in all departments. Actively involve employees in self care, as it is critical. Classify occupational diseases in the workplace and reduce the risk of employees acquiring an infectious disease through their work.

2. Policy Principles:

See Part A, paragraph 5.

3. Policy Measures

- 3.1. Integrated Health Risk assessment and management to improve Chronic Disease management and the measuring of the impact on employee health and productivity.
- 3.2. Utilisation of disease management programmes through co-operation between medical practitioners and patients to reduce barriers at the workplace.



- 3.3 Implementation of strategies to reduce the risk of employees contracting Communicable and non-communicable diseases and need for medical interventions.
- 3.4 Conducting of awareness programmes on Communicable and non-communicable diseases.

4. Procedural Arrangements

All procedural arrangements for implementation will be the same as identified for the role of the Designated Senior Manager in part A paragraph 7.1.2 of this policy. This policy will be further implemented as according to the Implementation Guide.

PART C: IMPLEMENTATION OF POLICY OBJECTIVES: MENTAL HEALTH MANAGEMENT

1. Aim

The aim of Mental Health Management is to reduce stigma and discrimination against mental diseases.

2. Policy Principles:

See Part A, paragraph 5.

3. Policy Measures

- 3.1 Developing and implementing of a Toolkit for Mental Health Promotion in the workplace which looks at practical steps for addressing mental health.
- 3.2 Reduction of stigma and discrimination against people living with mental diseases as well as the promotion of human rights and wellness.
- 3.3 Establish mental health support mechanism in the workplace.

4. Procedural Arrangements

All procedural arrangements for implementation will be the same as identified for the role of the Designated Senior Manager in part A, paragraph 7.1.2 of this policy. This policy will be further implemented as according to the Implementation Guide.



PART D: IMPLEMENTATION OF POLICY OBJECTIVES: MANAGEMENT OF INCAPACITY DUE TO ILL HEALTH AND RETIREMENT

1. Aim

The aim of this objective is to manage and investigate the employee's application of incapacity due to ill-health retirement, with the assistance of a Health Risk manager, in terms of Policy and Procedure on Incapacity Leave and Ill-Health Retirement (PILIR); the creation of a supportive environment for Health and Productivity Management and DPSA to champion and assist departments, improve productivity, increase morale, to curb abuse and increase service delivery, protect the employees, as well as complying with the law. This will help focus on the risk that really matter in the workplace – the ones with the potential to cause real harm.

2. Policy Principles:

See Part A, paragraph 5.

3. Policy Measures

3.1 Integration of Health Risk Assessment and Productivity Management.

3.2 Implementation of on PILIR.

3.3 Provide counseling and support services.

3.4 Develop cost effective health care programmes.

4. Procedural Arrangements



All procedural arrangements for implementation will be the same as identified for the role of the Designated Senior Manager in part A, paragraph 7.1.2 of this policy. This policy will be further implemented as according to the Implementation Guide.

PART E: IMPLEMENTATION OF POLICY OBJECTIVES: HEALTH EDUCATION AND PROMOTION

1. Aim

The aim of Health Education is the promotion of healthy behavior using educational processes to affect change and to reinforce health practices of employees, their families, and government departments. Health Promotion aims to implement processes that can be employed to change the conditions that affect employee health and focus on increasing the options available to people to exercise more control over their own health and over their environments. It also aims to make choices, conducive to health, possible. It further strengthens systems for workplace learning in Health and Productivity Management, develop effective behaviour change communication programmes, and ensure specific training for Public Service Employees on Health and Productivity Management programmes to achieve and sustain an environment that acknowledges and responds effectively to diversity.

2. Policy Principles

See Part A, paragraph 5.

3. Policy Measures

- 3.1 Develop personal skills and re-orientate health services.
- 3.2 Behavior change communication.
- 3.3 E-health knowledge and information's.
- 3.4 Strengthening systems for workplace health management.

4. Procedural Arrangements

All procedural arrangements for implementation will be the same as identified for the role of the Designated



Senior Manager in part A, paragraph 7.1.2 of this policy. This policy will be further implemented as according to the Implementation Guide.