NURSING STAFF ABSENTEEISM AT THE RED CROSS CHILDREN'S HOSPITAL AND IT'S FINANCIAL IMPLICATIONS

A MINI DISSERTATION SUBMITTED TO THE SCHOOL OF PUBLIC HEALTH AND FAMILY MEDICINE, UNIVERSITY OF CAPE TOWN IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF A MASTER OF PUBLIC HEALTH

SUBMITTED BY : RICHARD SIBONGISENI NGCOBO

MARCH 2006

TABLE OF CONTENTS

APPENDICES

ACRONYMS AND ABBREVIATIONS

AFR	Absence Frequency Rate
AIDS	Acquired Immune Deficiency Syndrome
AWOL	Absence Without Leave
DENOSA	Democratic Nurses Organization Of South Africa
EAP	Employee Assistance Programme
GAR	Gross Absence Rate
HIV	Human Immuno Virus
HRM	Human Resources Management
ICU	Intensive Care Unit
IMLC	Institutional Management and Labour Committee
NHLS	National Health Laboratory Services
OT	Operating Theatre
PAM	Professions Allied to Medicine
PERSAL	Personnel Salary Database
RCCH	Red Cross Children's Hospital
RWOPS	Remunerative Work Outside the Public Service
SANA	South African Nursing Association
SANC	South African Nursing Council
SPMS	Staff Performance Management System
SR	Severity Rate
TBH	Tygerberg Hospital
TDL	Temporary Disability Leave
UK	United Kingdom
WHO	World Health Organization

ABSTRACT

Absenteeism is a problem affecting the Public and the Private sector institutions alike. Anecdotal evidence from monthly absenteeism statistics and managers' comments suggest that it is also a problem for Red Cross Children's Hospital (RCCH). This dissertation describes the investigation into absenteeism among nurses at RCCH that was conducted by the writer in the year 2004. The writer reviewed attendance records for the year 2003. The main findings from the investigation and recommendations on management of absenteeism are then presented.

The overall objective of the study was to establish the determinants of absenteeism among nursing personnel of RCCH and financial implications thereof. This involved establishing the extent of absenteeism among the nursing personnel, identifying major causes, estimating the financial burden and making recommendations on how to manage this problem.

The study followed a descriptive as well as analytic methodology in presentation and discussion of results. The methodology included a review of the literature on absenteeism, motivation and migration of health personnel. The study has a qualitative and a quantitative aspect. Focus groups and in-depth interviews were conducted for collection of primary data from nurses. Two questionnaires were used as interview guides. Secondary data was collected from PERSAL database using the data capture sheet. Attendance records of all nurses were reviewed for the quantitative aspect of the study.

A major finding of the study was that absenteeism among nursing personnel at RCCH was above what most writers on the subject regard as acceptable level. Staff turnover was found to be high in the nursing department with staff leaving the service and posts remaining vacant. It was felt that there is difficulty in recruiting nurses especially from the outskirts of the Western Cape and other provinces because of lack of accommodation. It was suggested that Staff Residence policy be enforced to address this problem since it confers power of granting or refusing accommodation to management.

Stress was identified as the major cause of absenteeism by all interviewees. The source of stress was identified as both personal and work related problems.

The financial burden of nurses' absenteeism was estimated at more than one million rands for the year 2003.

Important recommendations that emerged from the study were that absenteeism control should be included in the job descriptions of supervisory positions. Development of institutional absenteeism policy was also recommended. It was also recommended that mechanisms be developed to recognize staff members with good attendance records.

CHAPTER 1

1.1. Background

The Department of Health is the second largest department after education in South Africa. This is in terms of both budget allocation and personnel numbers. It has national and provincial departments. There are nine provincial health departments. National transfers to provinces make up 97 percent of total provincial revenue. The Health and Welfare Departments of provincial governments get 37 percent of the total provincial revenue on average. This is second to the Department of Education, which gets 41 percent. More than 90 percent of the provincial health budgets are allocations from the National Department of Health (Budget Review, 2004)

Expenditure by provincial health departments by functional areas is categorised into Hospitals, Primary Health Care, HIV/AIDS, Nutrition, Emergency Medical Services, Administration, Training, Support, Facilities and Others. Hospitals spend 61 percent of provincial health departments budget by functional area (Health Systems Trust, 2004). Personnel expenditure is the largest share of provincial health expenditure by economic classification. In 2003/04 financial year personnel expenditure was 58 percent (Health Systems Trust, 2004)

The health sector is labour intensive, as revealed by personnel expenditure, and therefore human resources are the most significant component of the sector. However South Africa faces a variety of health personnel problems including lack of personnel in key areas of the health sector, inequitable distribution of available health personnel and significant attrition of trained personnel from the health sector and from the country (Health Systems Trust, 2004) The nursing profession is affected by all these personnel problems.

The maldistribution of health personnel occurs between public and private sector, urban and rural areas, formal and informal peri-urban areas and tertiary and primary levels of care. The greatest form of maldistribution is between the public and the private sector. In SA private health services consume 58 percent of total health expenditure and capture a high proportion of all types of personnel (except nurses) than the public sector

despite the fact that it caters for less than 20 percent of the population (Health Systems Trust, 2004) The distribution of nurses between the public and the private sector differs by provinces. The Western Cape and Gauteng Province has the lowest percentage of nurses in the public service at 30 percent. Limpopo Province has the highest percentage distribution of 80 percent nurses in the public service. The maldistribution between tertiary and primary level of care occurs in favour of the tertiary level. The majority of nurses are in tertiary hospitals.

There are three tertiary hospitals in the Western Cape Province, which are Groote Schuur Hospital, Tygerberg Hospital and Red Cross War Memorial Children's Hospital. Red Cross War Memorial Children's hospital was built in 1956. The initial idea came from the war veterans who wanted to build a living monument to honour those who suffered, sacrificed and served in the Second World War. They decided to give up a day's pay to the South African Red Cross Society to facilitate the building of the hospital. This wonderful gesture set the ball rolling, and, together with the community and government, the hospital was built (Children's Hospital Trust, 2004)

The hospital is situated in Rondebosch suburban area of the Western Cape Province. It is a tertiary hospital that falls under the Provincial Government of the Western Cape. Red Cross Children's hospital is the only public, dedicated paediatric hospital in Southern Africa. Because of this reason, children with complicated conditions from all over South Africa and countries in the region are referred to this hospital.

Red Cross Children's hospital is affiliated to the University of Cape Town. Medical students, specialist paediatric nurses and other allied professions, such as child psychologists and speech and occupational therapists, are trained at this institution. The hospital has 288 usable beds. It admits 1 690 patients on average per month. The hospital establishment consists of about 1 100 staff members. Approximately 50 percent of staff members are nurses. The Chief Executive Officer (CEO) is the head of the institution. The senior management team is comprised of the CEO, two medical superintendents, head of nursing department, head of professionals allied to medicine and clinical heads. The head of finance for RCCH (R van Haaght 2004, pers. comm., 03 December) estimated the equitable share (National government allocation) around 90

percent of the total hospital budget with the rest being a portion of user fees that is retained at the institution.

1.2. Introduction

Absenteeism can be defined as staff staying out of work when they are supposed to be on duty. It includes staff staying out of work due to ill health and also to attend to personal responsibilities. Personal responsibilities might include attending to sick family members and business that cannot be attended to during off days. Absenteeism is a problem that affects both the Public and the Private Sector. The problem of absenteeism can be worsened by staff shortages. This is the case with nursing staff as the attrition rate is high among nurses. Attrition can be attributed to staff moving from Public to Private sector, rural to urban areas and from developing to developed countries. There has also been a decrease in the number of nurses being trained due to a reduction in the number of training colleges for nurses.

Control of absenteeism is therefore crucial under these circumstances. The ideal situation is to have a zero percent absenteeism rate but this is unrealistic considering that employees have to contend with other complexities of life both within and outside the work place. The objective then becomes keeping absenteeism at an acceptable level. The question that follows is what is the acceptable level. Chapter 2 addresses this question by reviewing literature on this topic. Notwithstanding disagreement on the acceptable level of absenteeism, there is general agreement that it is a problem for most organizations.

Absenteeism is a cause for concern at RCCH since it impacts negatively on service delivery and finance for the hospital. It increases the workload of the remaining staff thus reducing their ability to render a good service. This also results in their exhaustion leading to them taking sick leave, which also exacerbates the problem. Procurement of replacement staff is a financial burden that cannot be predicted and budgeted for.

Budget constraints also make it difficult to employ more staff. In the past the three academic hospitals (Groote Schuur Hospital, Tygerberg Hospital and Red Cross Children's Hospital) in the Western Cape were allocated the larger share of the

provincial health budget. The shift in focus to a primary health care approach has led to a drastic reduction in the budget allocated to these hospitals (which RCCH is part of). The logic behind the shift was that when more money is allocated into the entry level of the health care system (primary level), this would lead to the reduction in the number of clients coming to tertiary level institutions. This has not been so. It has been either that the primary institutions have not been developed enough to offset the load from the tertiary institutions or their development has enabled them to identify more cases for referral to the tertiary level. As the only hospital in the sub-Saharan region that specializes in pediatrics, the effect on RCCH has probably been the worst.

Anecdotal evidence of hospital management view is that absenteeism is a problem for the hospital. There is no scientific study that was ever carried out to investigate the extent of absenteeism at RCCH. There is therefore insufficient understanding of the extent and complexity of this problem. This study aims at providing better understanding of the problem of absenteeism at RCCH and thus improves its management.

1.3. Problem Statement

Anecdotal evidence indicates that absenteeism is a cause for concern at RCCH with both financial as well as service delivery implications. This was obtained from a sample of monthly absenteeism reports, which are collected from various departments at the hospital. The report indicated that the monthly absenteeism rate is five percent on average (Business Status Report, 2004) This problem has financial implications for the organization that renders a twenty-four hour service.

Financial implications arise when there is a severe staff shortage that threatens delivery of basic services. Employment agencies, e.g. nursing agencies are requested to provide staff to ease the burden. This is additional cost to the salary budget. Moreover, personnel from the same institution are usually sent by the agencies to provide the service. This means that there is reduction in their resting period. When service providers are exhausted the quality of service is compromised and the organizational performance as a whole is negatively affected.

1.4. Research Question

What is the absenteeism rate among nursing personnel at RCCH? Is it high, acceptable or low? What are the factors that influence it? What are the financial implications of absenteeism for RCCH?

1.5. Aims and Objectives

The overall objective of this study is to identify the factors that influence the absenteeism rate among nursing personnel of RCCH. It also aims to establish the financial implications of absenteeism for RCCH.

More specifically it aims to establish the extent of absenteeism among nursing personnel and compare it with the norm. It also aims to identify the major causes of absenteeism among nursing personnel. This study also aims to estimate the financial burden of absenteeism for RCCH. Finally, it aims to make recommendations on how to manage absenteeism at the hospital.

CHAPTER 2

LITERATURE REVIEW

2.1. Introduction

This chapter reviews literature of both theoretical and empirical research on absenteeism. It starts by reviewing definitions of absenteeism and comparing them. The definition that is going to be used for the purpose of this study is then identified. This is followed by a review of literature on the causes of absenteeism. The next section review motivation theories and attempts to identify a link between motivation and work attendance. Literature on attrition of health personnel is reviewed under the topic: "Shortage of Nursing Staff as a contributing factor". This section is followed by the discussion of effects of absenteeism. Literature on health care financing and its implications for absenteeism are then reviewed. The subject is put into the South African context as most literature is from abroad and possible solutions are then explored.

2.2. Definition of Absenteeism

Absenteeism is the problem that is common to both public and private sector organizations. Bamford et al(2000) defines absenteeism as staff taking time off that has not been scheduled or staff taking more leave than is necessary or reasonable.
This definition covers both frequent short term and prolonged absences. It also covers sick leave since it is also unscheduled. Sick leave can also be disruptive as any other unscheduled leave in the operations of the organization. Absence event can be defined as any incident in which the individual is not at the expected location at a given time (Goodman et al, 1994). This definition is much broader since it covers late coming, returning late from tea breaks, disappearing during the course of the working day and leaving earlier than scheduled. For the purpose of this study absenteeism does not cover poor time keeping. This is because it is difficult to monitor as most departments generally, and nursing in particular, do not use the clocking system. The clocking system is the system where each employee has a card that he/ she feeds into the clocking machine when starting and ending the shift. The clocking machine then registers the time the shift was started and completed. The departments using the

clocking system also have a problem with monitoring poor time management because there is no objective system to monitor what happens between clocking in and clocking out times.

2.3. Causes of Absenteeism

Bamford et al(2000), categorises the causes of absenteeism into management and staff issues. Management issues include poor supervision, low staff morale, lack of proper systems and processes, and staff problems not being promptly addressed. Staff issues include personal problems related and unrelated to the work environment such as unpleasant work environment, substance abuse and caring for other family members.

In her study on the same subject that concentrates on factory workers in Cape Town organizations, Butler (1994) deals with causes of absenteeism under three main headings: personal, organizational and external factors. Her personal factors are similar to Bamford's staff issues except that she includes biographical factors like sex and age. She asserts that males and females have different roles that they play outside the work environment, which impacts on work attendance. Age is also seen as a factor since it comes with responsibilities and burdens like sickness. The influence of biographical factors on the level of absenteeism is corroborated by the study that was conducted by the Public Service Commission (2002). This study found absenteeism to be higher among females than males. The difference was attributed to the multiplicity of roles that females play e.g. in addition to formal employment they are mostly responsible for the household chores. Her organizational factors are more similar to Bamford's management issues. Under the third factor she includes factors external to the work environment such as socio/political and economic situation of a country, distance from work, quality and reliability of transport system and the weather.

The influence of unpleasant work environment on absenteeism is corroborated by a population survey that was conducted on a sample of 4209 randomly selected employed Finns. The study found that a tense and prejudiced climate is associated with a higher risk of work-related stress symptoms than a supportive climate. Workers employed in a tense climate were found to be three times more likely to develop work-related stress and took 1.6 days more than the average number of sick leave days

(Piirainen et al. 2003). This is in line with the reviewed literature on theoretical research that identified unpleasant work environment as one of the causes of absenteeism (Bamford et al, 2000).

The study on sick leave trends in the Public Service conducted by the Public Service Commission (2002) found that of the 366.092 public servants that took leave during the period 1 October 1999 to 30 September 2000, 45.58 percent were males and 54.42 percent females. The average number of days taken by the public servants for sick leave was higher among lower ranks and lower among the higher-ranking officials. The production level (lower ranks) had an average of 11.93 days per person and Director General level (higher ranks) average was 7.5 days per person (Public Service Commission, 2002).

In order to be able to distinguish between legitimate use of sick leave or leave of absence and abuse, one has to look at periods of the week, month or year in which absence is unusually high. Public Service Commission (2002) study found that Mondays were the days of the week on which sick leave mostly commences. It was found that 28 percent of the incidences of sick leave commenced on Mondays. There was also a high level of incidences where sick leave was taken before and after public holidays.

Goodman (1984) concludes that patterns (what he termed natural time periods) are more likely to develop and persist when legitimate leave must be used within a fixed period (or lost). This is also likely when there is no loss in holiday pay for absences preceding or following the holiday, and when there are no stipulations concerning the maximum number of absences within a fixed time period. We can then infer from Goodman's conclusion that the rate of sick leave is likely to be high among the public servants towards the end of a three-year sick leave cycle as they rush not to lose the remaining sick leave days.

In all the studies that were conducted into absenteeism, low staff morale always comes up as one of the causes and effects. The following section reviews motivation theories and establishes the link between motivation and work attendance.

2.4. Motivation as a contributing factor to work attendance

A low level of motivation is one of the reasons usually cited for poor attendance record. It is important to note that while employees may be faced with similar working conditions, their attendance records differ. The question is how does some employees maintain a good attendance record and others high absenteeism levels under similar circumstances. The partial answer to this question can be found by looking at motivation levels of employees. The term "motivation" is derived from the Latin word *movere*, which means to move (Steers et al, 1996,p. 8)

There are variations in the definition of motivation but all attempts at defining the term cover some forms of human behaviour. William Fox (1991, p. 107) defined motivation as a formulation used by those who study human behaviour to explain why people act as they do.

The following sample of definitions taken from Steers (1996, p. 8) indicates how the term is used.

"...the contemporary (immediate) influence on the direction, vigor, and persistence of action."

"...how behaviour gets started, is energized, is sustained, is directed, is stopped, and what kind of subjective reaction is present in the organism while all this is going on."

"...a process governing choices made by persons or lower organisms among alternative forms of voluntary activity."

The common denominator to these definitions is that they are all about behaviour. They attempt to explain how the behaviour is stimulated, directed and sustained.

The early approaches to human motivation were centered on the notion that human beings are motivated to seek pleasure and avoid pain. Epicurus, the Greek philosopher, articulated this proposition. The early theorists realized that in order for human beings to pursue the goal of seeking pleasure and avoiding pain, an intellect had to be developed (Franken, 1988). It was therefore thought that an intelligent human being would weigh the options before taking action in order to maximize pleasure and minimize pain. Therefore actions that might bring about pleasure in the short run and pain in future would be avoided. These early theorists did not explain the role of the intellect in basic motives like hunger. Therefore more theories were developed as an attempt to explain other variables involved in human motivation.

One of these theories and the most popular is that of Abraham Maslow. Maslow postulated that human behaviour is motivated by the desire to satisfy needs. He ranked needs into lower and higher order. According to Maslow there are five needs that can be arranged in the form of a hierarchy with the lower needs at the base and the higher order needs at the apex of the hierarchy. The five needs are physiological, safety, social needs, self-esteem and self-actualization (Fox, 1991). Lower order needs also called deficiency needs are physiological, safety and social needs. Maslow believed that the development of an individual's healthy personality would not be achieved if these needs are not met. Physiological needs include hunger and thirst. Safety needs include security from physical and emotional harm. Social needs include need for affection, belongingness, acceptance and friendship. The higher order needs, also called growth needs are self-esteem and self-actualization. The self-esteem needs include internal esteem factors such as self-respect, autonomy and achievement as well as external factors such as status and recognition. Self-actualization is a drive to achieve one's potential.

It can therefore be deduced that the motivation of an individual to work will be determined by the manner in which the nature of a job addresses individual needs. An employee who has already satisfied his/her deficiency needs will be demotivated by the work that does not provide autonomy to make decisions and utilize full potential. Therefore the managers need to look out for those signs and try to make the work more challenging for such individuals by using interventions like job enrichment.

Unlike Maslow another school of thought from motivational theorists asserts that every behaviour is learned. Learning theories were inspired by Ivan Pavlov's discovery of classical conditioning. Pavlov found that dogs could be made to salivate by ringing the bell, if the ringing of the bell was going to be followed immediately by the provision of food (Franken, 1988) This theory holds that behaviour is learned and can be sustained through reinforcement or stopped through punishment. There must be a direct association between reinforcement and punishment. It can therefore be assumed that rewarding individuals for good attendance will reinforce that behaviour and punishing for absenteeism will stop absenteeism behaviour.

Herzberg was the first to study motivation in the work environment. He studied organizational factors that influence work motivation. Herzberg's theory is based on his study of accountants and engineers. He asked about 200 accountants and engineers to explain work situations that made them feel good and those situations that made them feel bad. He came to the conclusion that job satisfaction and job dissatisfaction are not opposite ends of the same continuum. Therefore removing dissatisfiers will not bring about job satisfaction. This will lead to no dissatisfaction. Herzberg associated job satisfaction with content and dissatisfaction with context factors of the job. He concluded that the content factors of the job would lead to job satisfaction. He called these factors motivators. They include challenge of the work itself, responsibility, recognition, achievement, advancement and growth (Hellriegel et al, 2002)
It therefore follows that the presence of these factors will lead to higher motivation and productivity levels.

The context factors are those that determine whether there is dissatisfaction or no dissatisfaction. Herzberg call these factors hygiene factors. These are non-task characteristics of the work environment. They include policies and administration, supervision, interpersonal relations, working conditions and salary. If these factors are properly managed there will be no job dissatisfaction but not necessarily motivated employees. Poor management of these factors will manifest in negative work behaviour like absenteeism.

Another theory that is based on needs, like Maslow's theory, is that of McClelland. Unlike Maslow, McClelland related his theory to the organizational environment.
Steers (1996) asserts that McClelland's theory is based on the assumption that human beings acquire certain needs from culture of society in childhood. These are believed to influence adult behaviour in work situations. The four needs that people may learn are achievement needs (nAch), power needs (nPow), affiliation needs (nAff) and need for autonomy (nAut). He defines nAch as the behaviour towards competition with a standard of excellence He identified four characteristics of individuals with high nAch:

- A strong desire to assume personal responsibility for finding solutions to problems or performing a task.
- A tendency to set moderately difficult achievement goals and to take calculated risks.

- A strong desire for concrete performance feedback on tasks.
- A single-minded preoccupation with task accomplishment (Steers et al, 1996, p. 19)

These characteristics are associated with successful entrepreneurship.

The need for power is defined as the need to take control of the environment and influence the behaviour of others. It was suggested from research evidence that individuals with high nPow tend to be superior performers, to be in supervisor positions, to have above-average attendance records, and to be rated by others as having good leadership abilities (Steers et al, 1996, p. 19)

The need for affiliation is the desire for friendly and close interpersonal relationships. Individuals with high nAff tend to prefer teamwork than working alone. Their characteristics are suited for work involving interpersonal contacts like public relations. They will have good attendance records if the work environment satisfies their needs.

The need for autonomy is a desire for independence. Individuals with high nAut prefer to work alone and be in control of their work environment. The managers need to identify these individuals and involve them in goal setting to satisfy their needs.

Like Herzberg and McClelland, Vroom came up with a theory based on the work environment. Vroom's expectancy theory is based on the assumption that individuals make conscious choices about work behaviour (Franken, 1998). The choices that they make are based on expected outcomes. An individual will engage on certain behaviour if he/she expects that a certain outcome will follow the behaviour. The outcome has to be attractive to the individual. The individual will then exert an effort if he/she thinks that it will lead to an improvement in performance. The behaviour will persist if the individual believes that the performance will lead to a desired outcome.

Unlike learned needs theory, Vroom's theory concentrates on intrinsic motivation. This theory is based on the perception of an employee regardless of the correctness of such perception. It has been criticized for assuming that individuals make conscious and rational choices about work behaviour. Practical application of this theory will be that

managers will set attractive outcomes or goals for their subordinates that are also achievable through exerting extra effort.

While motivation is a personal factor that contributes to absenteeism, the next factor is more environmental.

2.5. Shortage of Nursing Staff as a Contributing Factor

The shortage of nursing staff in South Africa is a problem that contributes to high level of absenteeism. The shortage is caused by among other factors, the mobility of nurses. Nurses move from rural to urban, public to private sector and abroad. Physicians for Human Rights report states that about 17 sub-Saharan countries do not meet the WHO recommendations of 100 nurses per 100 000 population for the least developed countries (Physicians for Human Rights Report, 2004). The shortage of nurses leads to excessive workload for the remaining staff. Over worked nurses become exhausted and ill and this leads to them being absent from work.

These countries have 50 per 100 000 population or fewer nurses. The report estimated the number of South African nurses at 401 per 100 000 population in 2001. This is the highest number of nurses in sub-Saharan Africa. However South Africa has a problem of maldistribution of nurses. The public health sector serves about 80% of the country's population though has only about 50% of active nurses. "A study published by the Department of Health in 2003 estimated that more than 32 000 nursing posts were vacant. South African Health Review of 2003/2004 puts this figure at 42 000. These vacant posts represent significant portion of 86 000 nurses working in the public sector in South Africa" (Physicians for Human Rights Report, 2004)

Some of the reasons for migration of health professionals from developing to developed countries include low salaries and benefits, lack of job satisfaction, high risk of contracting infectious diseases like HIV/AIDS, pursuit of career development opportunities, training that does not adequately prepare them for conditions in which they will actually practice and poor quality of life.

The migration of health professionals has a negative effect on the health budgets of source countries. This is because these countries invest their financial resources on the training of these health professionals. In essence they don't get returns on their investments.

The following section looks at the effects of absenteeism for an absent employee, colleagues and the organization as a whole.

2.6. Effects of Absenteeism

The effect of absenteeism is that it negatively affects employee morale, hospital costs and the continuity and quality of patient care (Harter et al, 2001).
Unlike many other authors on this subject Butler (1994), asserts that absenteeism is not a totally negative phenomenon. She states that absenteeism has both positive and negative consequences. Positive consequences include recovery from illness and rest that has future benefits for the organization, increased flexibility and skills development for co-workers. Like other authors she lists negative consequences as increased workload for co-workers, undesired overtime, conflict in the workplace and decrease in productivity. In a situation where there is gross understaffing, the negative consequences far outweigh the positive because the lives of patients are put at risk.

One of the above-mentioned effects of absenteeism is that it negatively affects hospital costs. The following section further explores the financial implications of absenteeism.

2.7. Health Care Financing and Financial Implications of Absenteeism

There are five reimbursement methods for hospital care services viz. global budgets, cost-per-case, contracting, fee-for-service and administered prices (Hoffmeyer, 1994). The following section discusses global budgets, contracting, fee-for-service and administered prices as they relate to absenteeism.

A global budget is a fixed sum that is allocated to a service provider for a fixed period. The service provider has an obligation to meet demands with the allocated budget for the stated period. A global budget is set at a national level by the department of finance

taking account of presentations from national departments. The national department of health allocates funds to provincial departments based on need. Needs of provincial departments are determined by, among other variables, the population size, demographics, morbidity and mortality statistics. Provincial departments allocate budgets to different levels of care also taking account of representations from these levels. The levels are tertiary, secondary and primary health care institutions. The hospitals that admit patients outside their provincial borders receive a grant from the National Health Department. For those hospitals that treat patients outside South African borders like RCCH, the referring countries pay the cost of treatment. Global budgets are known to be effective in controlling expenditure in that they create incentives for productive efficiency, but can lead to quality reductions and wrong mix of services (Hoffmeyer, 1994). Absenteeism and staff turnover can also lead to an increase in personnel expenditure thus reducing the portion to be spent on actual services if not factored in during the budgeting process. Therefore in most countries, including South Africa, global budgets are used concurrently with other reimbursement methods.

Global budget is criticized for compromising the quality of health care services but fee-for-service, also known as user-charges, is recommended as a useful means of advancing towards such goals as a sustainable health services of adequate quality (Kutzin,.1995). Kutzin (1995) suggests that user-charges for publicly provided health services could lead to greater efficiency in the health sector than when services are provided free of charge because of the following reasons: Fees could dissuade unnecessary use of services. Secondly, by coordinating prices among different levels of facilities, fee system could encourage appropriate use of first-contact and referral facilities. Thirdly, where fees are charged in a facility, exemptions for such important services as prenatal care or tuberculosis treatment could encourage their greater usage.

Several conditions are necessary for the fee system to make a positive contribution to the goals of health sector reform. These conditions relate to policy, human resource capacity and institutional development. Policy requirement is that some or all fee revenues be retained at the collecting facility and periodic adjustment of fee levels be an integral part of the fee system. The human resource capacity must exist to collect and

use retained revenues to improve the quality of care in a manner that is recognizable to the local population. There must be sufficient personnel to assess income levels of clients and bill them accordingly. This funding option is therefore ineffective where there is understaffing and high levels of absenteeism Local investment institutions also need to be in place to prevent losses due to inflation. Other policy measures include changes in resource allocation in favour of first-contact facilities e.g. a waiver of fee payments in hospitals for persons who have been referred from first-contact facilities. The policies in user-charges and exemptions should be consistent with ability to pay in order to improve access for disadvantaged groups. It is also recommended that affordable supply of drugs be maintained for success of user-fee programmes since people are known to be more willing to pay for delivery of tangible products such as drugs than for other services. The fee-for-service method concentrates on the revenue side of the budget.

Contracting of publicly provided services is concerned with expenditure of public institutions' budgets. Government funds are used to purchase clinical or non-clinical services that cannot be efficiently provided by the public sector. The objective of contracting is to improve the quality and increase the quantity of services that are made available for a given amount of government expenditure. It is also a means of introducing market mechanisms in a selective way in order to gain the benefits of competition, while limiting or avoiding market failures of purely private system (Kutzin, 1995). In developing countries contracting most commonly occurs for non-clinical services of public hospitals in large urban areas. Cleaning and security services are partially contracted out at RCCH. The advantage of contracting option is that it frees managers from having to deal with absenteeism problems as service providers are paid to render services and they must ensure that workers are present to do so.

The necessary conditions for achieving efficiency through contracting are that competition for contracts among potential suppliers exists. Efficiency gains will not be achieved where there is only one supplier. The second condition is that civil servants be trained to act as contract managers. Public sector managers of contracts need to have skills to establish contract specifications, evaluate bids and monitor contractor performance. Performance criteria need to be specified, progress monitored and sanctions imposed to ensure compliance.

The last reimbursement method to be discussed is administered prices. These are ceilings for prices set by government for public sector institutions. These prices are based on the level of income of the client. Clients who are covered by Medical Aid Schemes are regarded as private patients and charged the maximum tariff. This method is criticised in that it is unlikely to reflect resource costs and will thus not give proper signals to participants in the market. Like fee-for-service, this method requires sufficient administrative staff to implement.

The above-mentioned reimbursement methods look at revenue and expenditure on services provided by the hospitals but does not look at expenditure on personnel providing the service. Financial costs of absenteeism fall into the category of personnel expenditure. Goodman (1984) identifies two approaches to classify the costs associated with absenteeism. The first approach, which is the aggregate approach, estimates the number of additional workers hired to offset the effects of absenteeism. The cost of recruiting, selecting, training, and paying these additional workers represent one way to estimate the costs of absenteeism. However absenteeism does not always lead to replacement.

The second approach, which is individual in perspective, estimates the incremental costs (or benefits) per day associated with a specific absent worker. If the absent worker is not replaced, the firm still incurs fringe-benefits costs. There may also be costs incurred through lower productivity or greater chances of accidents for other workers who work in an understaffed situation. If an absent worker is replaced, the task is to compare the marginal costs (benefits) that would have been incurred if the worker who was absent had come to work with the cost of replacement worker. This enumeration includes both direct costs (salary, overtime, fringe benefits, supervisory costs and costs of recruiting and training replacement) and indirect costs (productivity loss, accidents, grievance costs, and physical overheads).

Butler (1994) argued that one-day absence by an employee cost the employer more than one-day pay. She estimated costs to the organization at one and a half times the daily rate of pay of the absent employee. The reason for costs exceeding the daily rate of the absent employee is the cost of hiring a replacement. The costs can even be

higher than one and a half if we consider that the employer pays more per day for the replacement hired through the agency than the rate of an absent employee. In most cases the employer still has to pay the absent employee.

In the study of sick leave patterns in the Public Service conducted by the Public Service Commission, they used the salary of the sick employee as the only measure of financial costs of sick leave (PSC, 2002). This measure is easier to use because the information is readily available. Therefore this method of measurement is going to be used for the purpose of this study.

Before any possible solutions can be explored, we need to contextualise the subject of absenteeism.

2.8. South African Context

Most of the literature that has been written on this topic is from United States of America and European countries. In order to be able to make any feasible recommendations we need to contextualise this subject to the South African situation. We therefore need to look at what our legislation says in this regard. The legislative framework for working time and leave can be traced to the Basic Conditions of Employment Act, 1997. Schedule one of the Act provides for the gradual reduction of working hours to 40 hours per week and procedures to be followed.

Leave in the Public Service is currently regulated by *Circular H20 2001*. This circular is applicable to all employees employed in terms of the *Public Service Act 1994* as amended, and who fall within the scope of the Public Service Coordinating Bargaining Council. In accordance with this dispensation full time employees are entitled to 36 working days sick leave with full pay over a 3-year cycle. Unused sick leave lapses at the end of the leave cycle (Section 8, item 8.1) Section 8, item 8.4 stipulates that employees who apply for three or more sick leave days must submit a certificate from a registered and recognized medical practitioner as defined by the Health Professionals' Council of South Africa. According to item 8.6 the supervisor may request a medical certificate for periods less than 3 days in instances where a pattern in the utilization of sick leave has been established which indicates sick leave abuse.

2.9. Possible Solutions

The authors suggest change in management style and work conditions, provision of incentives, and development of attendance policy as solutions. They do not expatiate on the provision of incentives. Provision of monetary incentives, while it can motivate employees to improve attendance, is almost impractical in the Public Sector. The Public Service is highly regulated and that makes it very difficult to provide incentives for good attendance. The newly introduced Staff Performance Management System while providing incentives for good performance cannot be used for compensating employees for good attendance.

Most of the articles that explored solutions to absenteeism cited incentives as one of the effective solutions. This applies more specifically to sick leave. Critics to attendance incentives assert that they (incentives) send the wrong message about sick leave that put employees who are legitimately sick under pressure to report for work even when they are seriously ill, which could result in significant health damage and increased health care costs down the line. Some managers do not support the rewarding of good attendance because they regard this as an implicit requirement of the job (Butler, 1994).

Authors on this topic warn against stringent absenteeism policies that tend to treat all workers as though they are looking to shirk their responsibilities, while in reality 90% of employees are reliably at work. Such policies are counter productive in that they tend to lessen employee commitment and loyalty. The author further suggests that policies should show that you trust your employees and give them some latitude to contend with life's unavoidable complications.

CHAPTER 3

CONCEPTUAL FRAMEWORK

3.1. Introduction

This chapter attempts to identify major factors that influence the level of absenteeism. It draws mainly from reviewed literature. The factors identified are management issues; staff issues; shortage of staff; external factors and leave regulations. The interaction between these factors is then explored. Figure 1 is a graphical illustration of the relationship between these variables and absenteeism. Pointed lines indicate causal relationship between variables.

3.2. Conceptual Framework

Management issues were identified as causative factors of high level of absenteeism. These factors can be seen as shortcomings of management. They can be corrected through good human resource management. They include poor supervision, low staff morale and lack of proper management systems and processes. While these factors can lead directly to high levels of absenteeism, they can also indirectly lead to this problem by adversely affecting staff motivation that than manifest in high levels of absenteeism.

Other contributing factors to high absenteeism levels are staff issues. These are sometimes called personal issues or factors. They include unpleasant work environment, substance abuse and caring for other family members. Other authors include biographical factors such as sex and age under personal factors. They argue that these factors influence work attendance. Personal problems can also lead to low motivation levels that result in absenteeism being used as a coping mechanism.

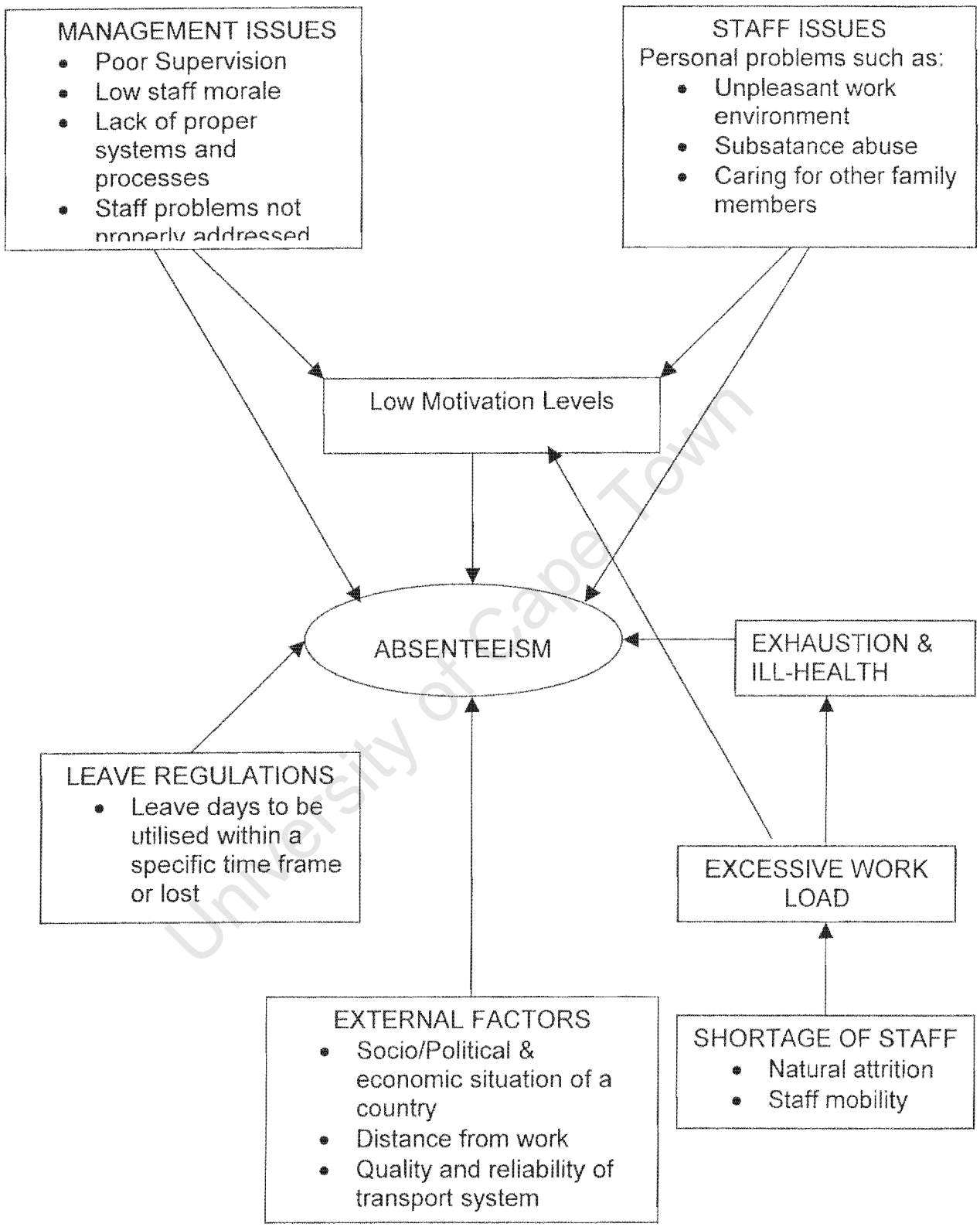
Shortage of staff is caused by among other things, staff mobility and natural attrition. As discussed in the previous chapter health personnel migrate from public to private institutions, rural and peri-urban to urban areas and from developing countries to developed countries. The high prevalence of HIV/ AIDS is a contributing factor to both

increased demand for health care and high attrition rates. Staff shortage results when those entering the service do not match the number of staff leaving the service. The remaining staff has to carry excessive workload, which leads to exhaustion and ill health. Sick leave is than used to recover from exhaustion and/or ill health. Excessive workload can also lead to low motivation levels, which manifest in absenteeism behaviour.

External factors that contribute to absenteeism are those factors outside the work environment. They include socio-political and economic situation of a country. Distance from work, quality and reliability of transport are other external factors that influence absenteeism levels. These are factors that can be better addressed at a political level as managers have no control over them.

Leave regulations can also contribute to high levels of absenteeism. An example is the regulation that stipulates that leave days must be used within a specific period or lost.

Figure 1



CHAPTER 4

RESEARCH METHODOLOGY

4.1. Introduction

This chapter looks at the methodology used in this study. It starts by reviewing methods that are generally used to measure absenteeism. Strengths and weaknesses of each method are identified and the method that is going to be mainly used for this study is identified. It follows by identifying the study design to be used. The study population and the manner in which it was sampled are then discussed. Finally it looks at how data was collected and analysed.

4.2. Measures Of Absenteeism

There are three measures of absenteeism that are most commonly used. These are: Gross Absence Rate, the Severity Rate and the Absence Frequency Rate.

4.2.1. Gross Absence Rate

The Gross Absence Rate is the total possible working days lost through absence as a percentage of the total number of days that would have been worked if there were no absences.

$$GAR = \frac{\text{Total days lost through all absences}}{\text{Total possible man-days}} \times 100/1$$

The numerator in the formula represents total days lost through sick leave and due to other causes. It is subject to bias when partial days worked are regarded as days worked or days lost. When they are regarded as days worked, it leads to an underestimation of days lost and when they are regarded as days lost it leads to an opposite bias. Partial days occur when an employee falls ill, is injured or has to attend to urgent private business after starting a day's work (Atkins, 1984). Organisations have different policies of recording this form of absence.

The denominator, possible man-days/ scheduled working days, raises a question of how to treat overtime work. Is the employee who does not report for overtime recorded as absent? The problem is that most companies do not record overtime work on a duty roster. There is therefore uncertainty with regard to overtime.

A disadvantage of the GAR is that it tends to be distorted by long absences particularly in smaller components. An absence of a longer duration, a week or more, by a few individuals tends to inflate the GAR.

The other problem with this measure, like other measures, is the determination of period over which absenteeism is measured. This can be monthly, quarterly or yearly. Nevertheless GAR is going to be used for the purpose of this study since it is appropriate in measuring the financial impact of absenteeism.

4.2.2. Absence Frequency Rate

The Absence Frequency Rate (AFR) measures the number of absence incidents per employee during a given period. The formula is:

$$\text{AFR} = \frac{\text{Total number of absence incidents over period/employee}}{\text{Average number in employment for that period}}$$

The AFR is expressed as a ratio. This is interpreted as the number of absence incidents per employee if absences were spread equally among all employees. This measure is more reliable because unlike GAR it is not distorted by long absences. Each absence is regarded as the single incidence regardless of duration. It is also important in that frequent short term sick absences are an indication of sick leave abuse in most instances.

The problems surrounding the numerator of this formula are whether to regard consecutive absences of different types as a single incident and whether to consider absence that is interrupted by official off days as a single incident.

4.2.3. Severity Rate

Severity Rate is the average length or duration of absences. The formula is:

$$\text{Severity Rate} = \frac{\text{Time lost due to absenteeism}}{\text{Number of Absences}}$$

The time metric may be hours or days but in most instances days are used since attendance is usually recorded in days. Using days as a metric leads to the same predicament as in GAR of how to record partial days. The denominator, which is number of absences, poses similar problems as the numerator of AFR. This is the problem of what to count as a single absence.

These two measures are going to be used to show variation in findings depending on the measure employed.

Sick absence of less than 3 percent is regarded as the norm according to the Private Sector hospital that was consulted in South Africa (Bamford et al, 2000). There was no statistics found from the studies done in the Public Sector. There is only anecdotal evidence from Red Cross Children's hospital that reflected the average absenteeism to be 5 percent.

In a study conducted by Butler (1994) among twenty Cape Town manufacturing companies, the average annual absenteeism rate was found to be 4.7 percent for 1992. The highest was 7.5 percent and the lowest rate 2.5 percent. The question that always arises is, "what is the acceptable absenteeism rate?" On this question Butler (2000) says, "if the Gross Absence Rate (GAR) is 10 percent, then absenteeism is serious by any standards, any rate over 5 percent should be regarded as an indicator of a situation needing further investigation. Absence below 3 percent can be seen as satisfactory, although capable of further improvement"(Butler, 1994).

4.3. Study Design

The study follows a descriptive as well as analytical methodology in presentation and discussion of results.

4.4. Study Population and Sampling

The study has a qualitative and quantitative aspect. Random sampling was used to determine whom to include in the qualitative study. The nominal roll was used as the sampling frame. The nominal roll is a list with the names of all nurses employed at the hospital and areas where they are allocated to work for a particular month. Fifty staff members were randomly selected from the nominal roll. Of those, 35 responded to the invitation to participate in the study. They completed the consent form, the questionnaire and availed themselves for interviews. The non-response rate was therefore 30 percent. The response group was composed of females only. Sixteen (45.7%) of respondents were auxiliary nurses, 7 (20.0%) were enrolled nurses and 12 (34.3%) were registered nurses. Three (8.6%) of respondents were below 30 years of age, 21 (60.0%) were in 30 to 49 years age category and 11 (31.4%) were in 50 years and above age category. Fourteen percent (14.3%) of the respondents were on salary level 3 and below, fourty percent (40.0%) were from level four to five and fourty six (45.7%) were on level six and above. 42.9% of respondents had a service record of ten years or less, 31.4% had eleven to twenty years' service, 14.3% had twenty one to thirty years and 11.4% had more than thirty years service. Secondary data was collected from the personnel database. Attendance records of all nurses were reviewed for quantitative aspect of the study.

The study population is the nursing staff employed at Red Cross Children's Hospital during the time of the study. Nursing staff constitutes about 50% of RCCH personnel establishment, which are approximately 500 staff members. They are categorized into 3 groups, which are auxiliary, enrolled and registered nurses. Auxiliary nurses are commonly called nursing assistants and they undergo one year nursing training. Enrolled nurses are staff nurses and the duration of their training is two years. Registered nurses are nursing sisters according to the layman's language. The duration of their training used to be three years until 1996 when the comprehensive course was introduced. The course that leads to qualification as the registered nurse is currently four years.

4.5. Data Collection

Two questionnaires were used to collect primary data for the qualitative aspect of the study. One questionnaire was designed for nursing managers i.e. area managers and above ranks. The other questionnaire was used for all categories below area managers. These questionnaires were used as guides for the focus groups and depth interviews. There were six focus groups composed of 4-8 nurses each. The participants were allowed to discuss the subject of absenteeism under the guidance of the facilitator. Depth /key informant interviews were conducted with head of nursing, head of finance and head of human resources. Data was obtained from personnel records using the data capture sheet for quantitative aspect.

4.6. Data Analysis

Attempt was made to establish a pattern of answers or common themes for qualitative data. Reporting was made in terms of dominant patterns. Epi-info was used for statistical analysis. Microsoft Excel was used to calculate absenteeism costs and graphical presentation of data.

CHAPTER 5

RESULTS

5.1. Introduction

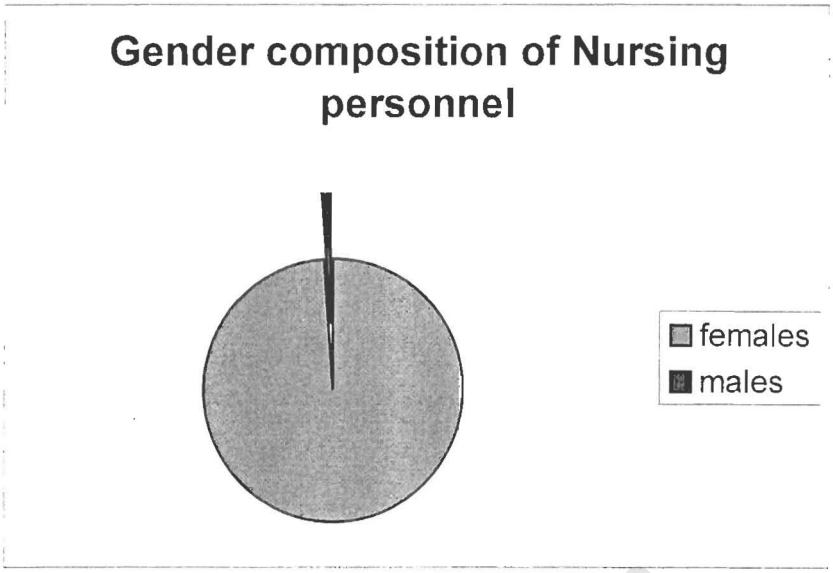
This chapter presents the result of the study. Secondary data was collected from PERSAL (personnel salary database). Leave records of all nursing personnel for January to December 2003 were reviewed. The findings are presented in the form of graphs and tables. The estimation of costs was based on salary levels. Each salary level has 16 notches, except for level 1 and 2 that have 12 notches, with 1% difference between them. The lowest salary notches were used for estimation. The reason for this is that PERSAL system only reflects salary levels not actual salary notches.

Recorded interviews were transcribed and then explored for common themes, which were established into units of meaning. The units of meaning that emerged were: understanding the problem of absenteeism, causes of absenteeism, effects of absenteeism and suggested solutions.

5.2. Demographic Profile of Nurses

Figure 2 is a graphical illustration of gender composition of nursing staff. Of the 516 nurses, 511 (99.03%) are females.

Figure 2



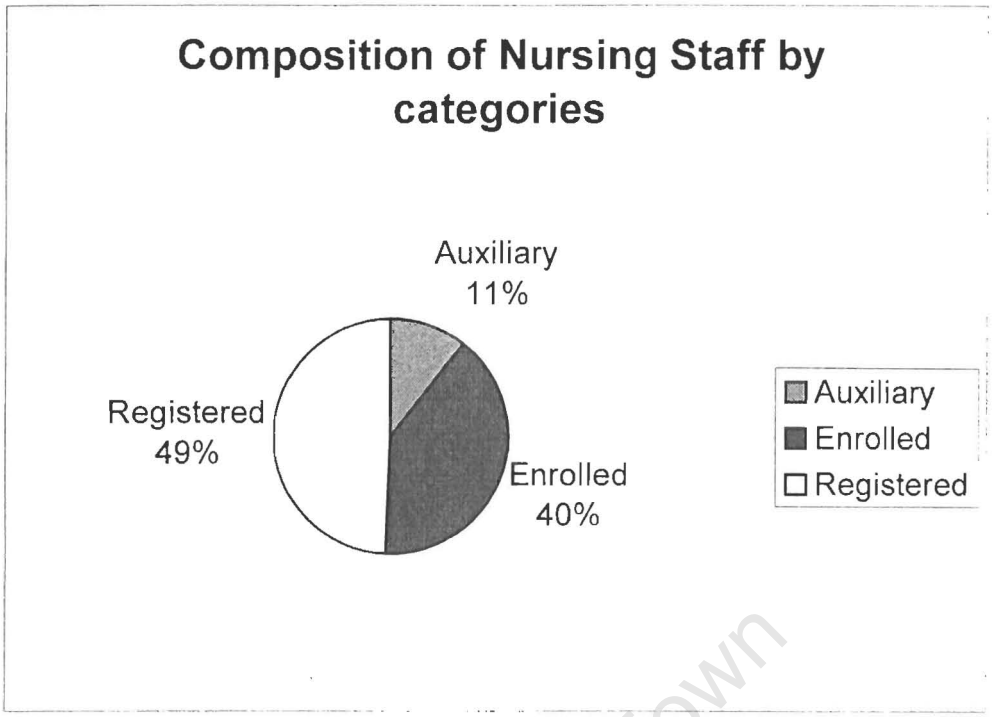
Age was divided into 3 categories namely cat. 1=<30 years, cat.2 =30-49 years and cat. 3=≥50 years. Table 1 illustrates age distribution of nurses according to the above-mentioned categories. The staff members that fall under category 1 were 64 (13%), category 2 –322 (64%) and category 3 had 117 (23%).

Table 1: Age distribution of Nursing Staff

Age Category	Number of Staff	Percentage
<30 years	64	13%
30-49 years	322	64%
≥50 years	117	23%
	503	100%

Figure 3 is an illustration per occupational categories. Auxiliary nurses form 11 percent, enrolled 40 percent and registered 49 percent of the total nursing population of RCCH.

Figure 3



5.3. Utilisation of Sick leave

Leave is recorded on a prescribed leave form by unit supervisors specifying the type of leave. Leave forms are then forwarded to the area manager for authorisation. Authorised leave forms are submitted to the Human Resources Management section to be captured on PERSAL system. The leave forms are then filed in employees' personnel files. The data for this study was obtained on PERSAL. The practice at RCCH is that when an employee falls ill after starting a shift and having worked fifty percent of scheduled time, it is regarded as a full day worked. When less than fifty percent of scheduled time was worked, it is regarded as sick leave day.

The average number of sick days taken per person during the period of the study is 7 days. Table 2 illustrates sick leave days taken per age category. Category I staff members took 71 (14%) sick days, 318(63%) for category 2 and 115 (23%) for category 3. Gross Absence Rate (GAR) was used as a measure of absence to arrive at these figures.

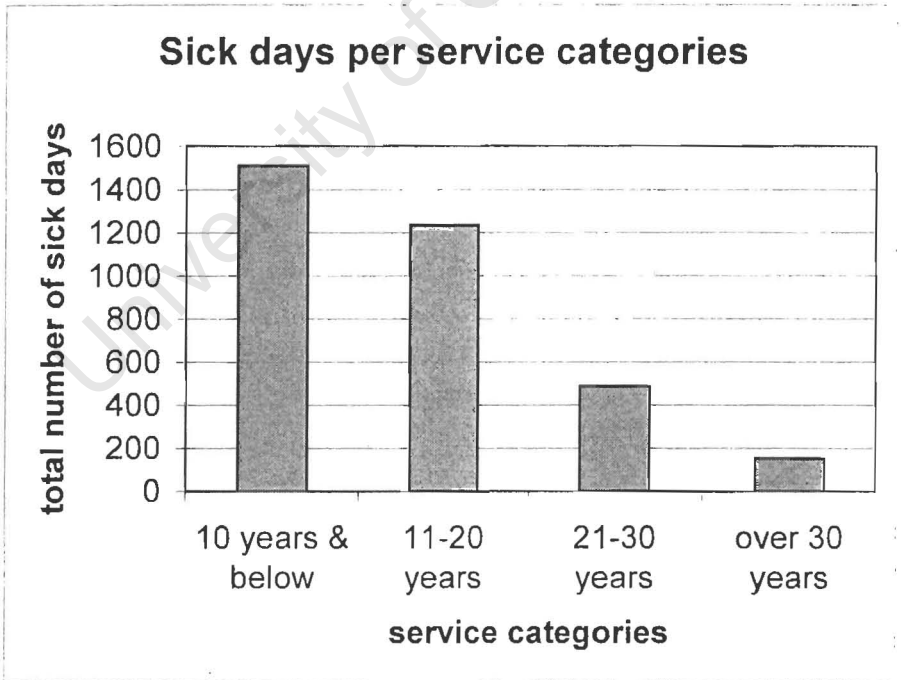
Table 2:Sick days taken per age categories

Age Category	Sick Days	Percentage	Cumulative
<30 years<	71	14%	14%
30-49 years	318	63%	77%
≥50 years	115	23%	100%
	504	100%	

Service of personnel was divided into 4 categories as follows: cat. 1 ≤ 10 years, cat. 2 = 11 - 20 years, cat. 3 = 21 - 30 years, cat. 4 > 30 years.

Category 1 staff took 1511 days of sick leave during January to December 2003. That is an average of 5 days per person. Category 2 members took 1234 days, which is 7 days per person on average. Category 3 staff members took 488 days, which is an average of 6 days per person. Category 4 staff took 236 sick days, which is 8 days person on average.

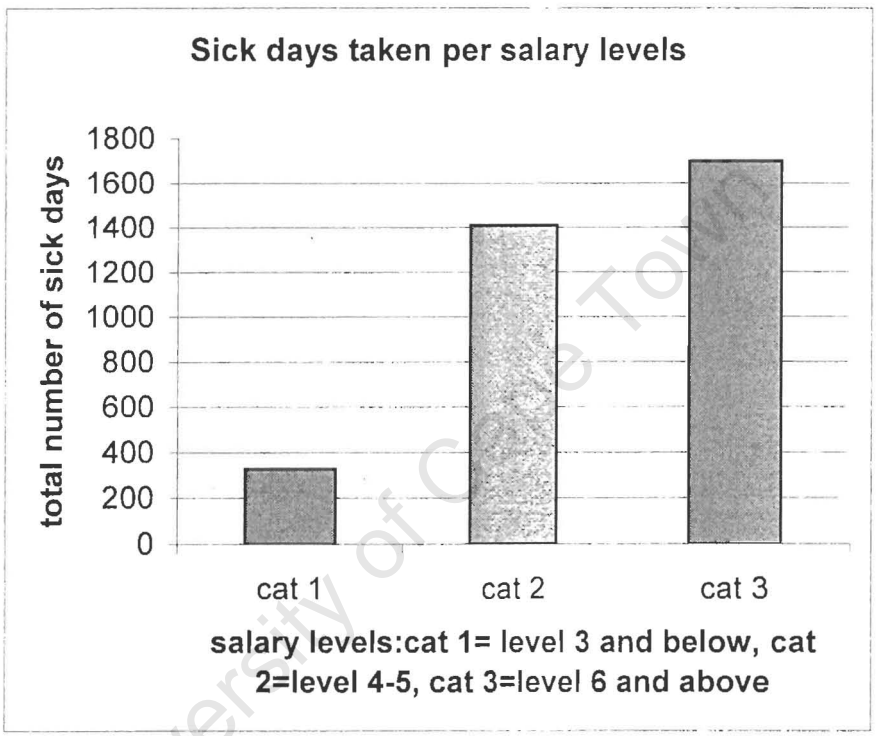
Figure 4



Sick leave was also considered according to salary levels. Salary levels were categorized into 3: category a=≤3, category b=4-5 and category c=≥6. Salary level 3 entry notch is R39, 389, level 4 is R46, 353, level 5 is R54, 837 and level 6 is R67, 887.

Category 1 staff is auxiliary nurses, category 2 is enrolled and category 3 is registered nurses. Figure 5 illustrate utilization of sick leave per salary level. Staff members that fall under category 1 are 54 and they took 328 sick leave days during the period of the study. That is an average of 6 days per person. Category 2 staff members are 206 and they took 1410, which is 7 days per person. Category 3 personnel are 254 and they took 1699 days, which is 7 days per person.

Figure 5



5.4. Measures of Absenteeism

The Gross Absence Rate (GAR) was calculated for sick leave and for absence due to other causes. GAR for sick leave was:

(i) 3451/516*220 percent
=3.04 percent

GAR for absences due to other causes was:

(ii) 1318/516*220 percent
=1.16 percent

The overall GAR was:

(iii) 4769/516*220 percent

=4.20 percent

The numerator is the total days lost through (i) sick leave, (ii) absences for reasons other than sickness and (iii) overall absences. The numerator was arrived at by multiplying the average number in employment for 2003 calendar year, which was 516, by the total possible working days for the period. The total possible working days for the period was calculated by multiplying the number of days that employees are supposed to work per month, which is 20 days, by the number of months that they are supposed to work per year, which is 11 months.

This means that 4.20 percent of the time that was supposed to be worked was lost through absenteeism, of which 3.04 percent was sick absence and 1.16 percent was absenteeism for reasons other than sickness.

The Absence Frequency Rate (AFR) for sick leave was calculated as follows:

(i) 1718/516

=3.33

Where 1718 is the total number of sick absence incidents for January to December 2003 and 516 the average number in employment for the same period. This implies that on average each employee was off-sick 3.33 times during January to December 2003 period.

Severity Rate (SR) for sick leave was calculated as follows:

(i) 3451/1718

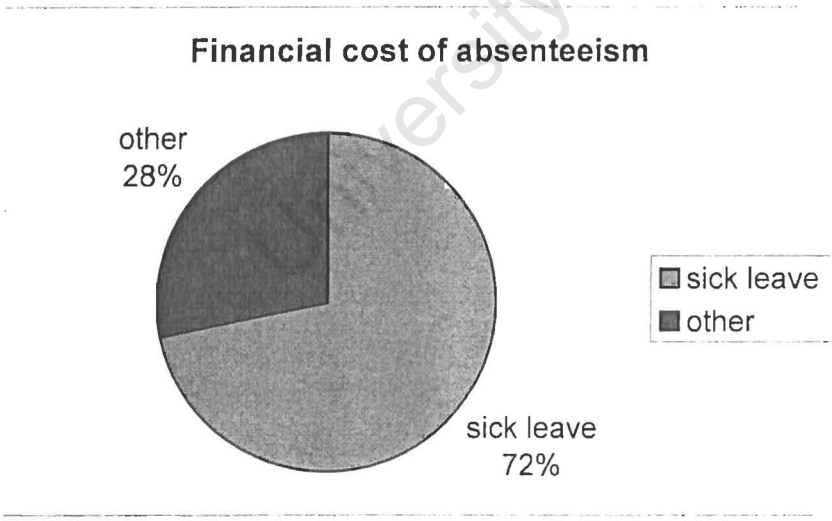
=2.01

This means that on average each sick leave had duration of 2.01 days

5.5. Financial Costs of Absenteeism

Figure 6 is the illustration of financial costs of absenteeism according to causes. The overall money spent on absence was R1,223 m, which is R876,949.35 on sick leave and R345,580.66 on absences for causes other than sick leave. The daily salary rate per person was multiplied by the number of sick days per person to obtain the financial cost of sick leave per person. The financial costs of sick leave per persons were than added to obtain R876, 949.35. The same formula was used to obtain financial costs of sick leave due to causes other than illness and overall financial costs (see details of costing of absenteeism in appendix 3). Money spent on sick absence is more than twice the amount spent on any other forms of absenteeism. This is excluding money spent on overtime and agency staff. According to the finance manager R350 000 is spent per month on agency staff. A further R215 000 is spent per month on overtime excluding commuted overtime that is paid to medical personnel. Of this expenditure 80 percent is estimated to be spent on nursing personnel. The highest amount that has been spent on overtime per month is R800 000.

Figure 6



5.6. Understanding the problem of absenteeism

Absenteeism is considered to be a major problem by nurses and nursing managers at Red Cross Children's hospital. It is seen as a general problem at the hospital as well as

a specific problem for the nursing department. There are different views on the severity of the problem. While the general feeling is that absenteeism among nursing staff is not worse off compared to other categories of staff, it is viewed as more serious in that it directly affects the core function of the institution, which is patient care. The budget is also adversely affected when replacement staff is called in to cover for absent employees. General absenteeism rate is slightly higher than 5%, according to nursing management. This is the target set by management. Nursing management's view is that there are few individuals with high rate of absenteeism, which inflates the overall rate. Some of these individuals are absent for legitimate reasons like chronic illnesses or hospitalization.

The dominant view is that there are no specific time frames when absenteeism is abnormally high. Anecdotal evidence, according to nursing management, suggests that absenteeism is high during paydays. There is a difficulty in picking up the trend because of the shift work of nurses.

Sick absence is seen as the major problem as it comprises the greater portion of absenteeism rate. The insignificant portion of unauthorized absenteeism is dealt with according to the disciplinary procedure. All nursing personnel agree that immediate supervisors are responsible for instituting disciplinary actions. Problem cases are referred to area managers for formal disciplinary inquiry. There has been no instance where an employee was dismissed for absenteeism during the period under review, according to nursing management. However there have been abscondments when nursing management was closing down on culprits.

5.7. Causes of absenteeism

The dominant view among nurses is that there is widespread favoritism with regard to allocation of benefits. This includes the allocation of overtime. The situation arises when there is severe staff shortage that impacts negatively on service delivery. Nurses that are off-duty are called in to work over time. They are then paid for over time or given their days off at a later stage. Nurses feel that the supervisors are unfair when deciding who has to be called for overtime. This is more so for Sundays and Public holidays since these days pay more than other normal days. Nurses that were interviewed

expressed the opinion that supervisors use criteria that are not in line with acceptable practice in deciding who to call for over time. One example is when the supervisor calls in the nurse for overtime because the nurse has financial difficulties. While this might appear as being sensitive to staff personal needs, it is an unfair form of discrimination. The feeling is that those staff members who discuss their personal problems openly are unfairly advantaged to the detriment of others. This results in an unpleasant working environment that causes nurses to use sick leave as an escape.

Dissatisfaction was also expressed with regard to implementation of staff performance management system (SPMS). The general feeling was that supervisors are inconsistent because they assist some staff members to write incident reports. They say that those staff members who are assisted tend to be awarded performance bonuses. Allocation of performance bonuses has created tension between staff members. Most staff members feel that interpersonal relation with the supervisor is the criterion rather than performance. There is perceived bias in favor of the same group of personnel who are seen to be in good terms with supervisors. Staff members feel demotivated by this perceived favoritism and work attendance is negatively affected.

Study leave was identified as another area where there is no clear criterion. Staff members expressed frustration with the waiting period for granting of study leave. Particularly auxiliary and enrolled nurses who are interested in bridging courses expressed this feeling. They think there is unfairness when they see staff members appointed after them granted study leave while they remain on the waiting list. While they understand that staff needs of the institution come first, they feel there must be openness with the criterion used to grant study leave. There is a general feeling of unfair discrimination that creates an unpleasant working environment, which was identified as among the causes of absenteeism in chapter 2.

Human Resource Management sees the lack of guidelines on implementation of temporary disability leave (TDL) as the cause of abuse of sick leave by staff members. TDL is a special type of sick leave that is granted when ordinary sick leave is exhausted. Ordinary sick leave is 36 days over a 3 years cycle. Unlike normal sick leave that is approved by the head of the department, the head of the institution approves TDL. The medical certificate completed by the recognized practitioner has to

accompany the application for TDL. Human resources management is of the view that reduction of sick leave days to 36 days per cycle does not act as deterrent against abuse of sick leave since staff members think that that they can utilize TDL when normal sick leave is exhausted.

Shortage of staff is the major cause of absenteeism according to all categories of nurses that were interviewed. Shortage of staff result in increased work load that leads to exhaustion. Staff members then take sick leave because of exhaustion. The opposing view from some managers was that if all staff members that are scheduled to work could be on duty, there would be no problems. The implication is that staffing is not the problem but absenteeism. This view is supported by the fact that most of the nurses are registered with nursing agencies. When they are supposed to be off duty they work for the agencies. They also tend to work for the agencies during their annual leave days. They are then exhausted when they have to work their scheduled days. Sick leave is then used for resting and official resting days are used to generate extra income.

Stress is another major cause of absenteeism according to all categories of nurses and managers. Stress result from both work and personal problems unrelated to work. The nature of work that nurses do is a source for stress. Nurses work long unsociable shifts including night duty, weekends and Public Holidays. Working with sick children is also a source of stress. This leads to a vicious cycle with work related stress causing personal or family problems. This results in increased stress levels that negatively affect work attendance.

5.8. Effects of absenteeism

Responses of surveyed managers can be classified into effects on staff members, effects on patients and effects on the organization. The general feeling is that absenteeism increases the workload for the remaining staff members. They have to share the duties of the absent employees in addition to their duties. This leads to exhaustion and reduction of staff morale. Stress levels increases and interpersonal relations deteriorate. Staff members feel let down by the absent employee and might not want to work the same shift with an employee who is absent on a regular basis. Exhaustion, low staff morale and high stress levels may lead to a vicious cycle with

other staff members becoming off-sick as a coping mechanism. If management is not seen to act against offenders, bad precedence is set. The problem is then exacerbated with other staff members engaging in similar behaviours.

Increased workload compromises the quality of care that staff renders to the patients. Patients are neglected because of insufficient staff to pay constant attention to their individual needs. This leads to an increase in reported negative incidents, which is reflected in morbidity statistics.

Absenteeism creates logistical problems that require rearrangement on a daily basis. At a unit level reassigning of duties has to be done to share duties of the absent employee among the remaining employees. If this response is inadequate, as it happens in extreme cases of staff shortage, the nursing manager in charge of the hospital for the day has to redeploy staff from less busy units to the unit with staff shortage. In instances of wide spread absenteeism, staff members that are off-duty are called in to work overtime. The nursing agencies are called as a last option to provide relief nurses. These logistical problems are a waste of time that would have been used productively. This also strains the financial resources of the hospital because in addition to paying for replacement staff, absent employees also have to be paid.

5.9. Suggested Solutions

Management suggested stricter control of remunerative work outside the public service (RWOPS). RWOPS is when nurses register with employment agencies to be on their employ during their off-days. They sign a contract of employment with employment agencies. Nurses have to get permission from institutional management to do RWOPS. The hospitals call on nursing agencies to provide them with nurses in cases of critical shortages. This may result in exhaustion, as nurses do not get enough time to rest. Increased level of absenteeism is seen as an indication of exhaustion and in such cases permission for RWOPS has to be reviewed. Before permission for RWOPS is granted nursing management must review the attendance record of the applicant. The attendance record must also be monitored after permission is granted for early detection of signs of exhaustion.

It was also suggested that there must be control in granting TDL. Supervisors have to stick to norms for granting of TDL. It must be made clear to employees that it is not meant for minor short periods of illness. However it is accepted that an employee might have an illness that incapacitate him/ her for a longer period. This might lead to utilization of all sick leave days. In this situation utilization of TDL for shorter periods of sickness is justifiable. Individuals who exhaust their sick leave days through different short duration illnesses must be investigated for abuse of sick leave. These cases must be dealt with through the disciplinary procedure.

It was suggested by some managers that management must improve management skills. It was said that managers need to develop themselves to be able to manage in a changed environment. While it is the responsibility of provincial administration to train staff in new systems, managers have a responsibility to develop themselves. Both line and senior managers must motivate their subordinates rather than only reprimand when something goes wrong. Staff members need to be reminded of employment contract that holds them responsible for work attendance. They must be made aware of the effects of absenteeism. Staff members also need to be made responsible and accountable for their actions. Managers have to develop their subordinates to enable them to function at an optimal level.

The general feeling of staff members is that better management will improve the situation. This includes fairness by supervisors. They want to be acknowledged for hard work. They don't expect monetary incentives but just "thank you" from management. While they are aware that salaries are not determined at an institutional level, their opinion is that improvement will eliminate the necessity of RWOPS thus improve attendance.

CHAPTER 6

DISCUSSION

6.1. Introduction

In this chapter the results of this study are discussed. The discussion compares and contrast the results with other studies reviewed in chapter two. It then attempts to explain the differences in the findings of this study. This chapter also puts the result of the study into context of chapter one, which is research questions and objectives. It follows the same themes that were established in the previous chapter and puts more meaning into them.

6.2. Understanding the Problem of Absenteeism

Absenteeism is seen as a general problem for the hospital and a serious problem for the nursing department in particular since it has the potential of negative effect on patients. The overall absenteeism for nursing personnel was found to be 4.20 percent. According to reviewed literature 3 percent can be seen as an acceptable rate although capable of further improvement. Surveyed managers indicated that only a small percentage of nurses have high absenteeism rate that inflate the overall rate. This is consistent with the assertion by authors on this subject against stringent absenteeism policies that tend to treat all employees as though they are looking to shirk responsibility, while in reality 90 percent of employees are reliably at work. The opinion of managers that were interviewed was that absenteeism is high among lower categories of staff. This is consistent with research findings in the public sector (Public Service Commission, 2002). However this is not corroborated by findings of this research. This study found absenteeism rates of different salary levels of staff to be similar. The influence of gender in absence could not be assessed because males are under represented in the nursing cadre. Different age groups were also found to have similar levels of absenteeism. Staff members who are in the service for more than 30 years have higher absenteeism levels compared to other groups with lesser years of service. They take 8 days sick leave per person on average per annum. This can be attributed to chronic illnesses that are associated with old age. While there were no big

differences in utilization of sick leave per age category, it would have been reasonably expected that younger staff members used lesser leave days because of health status.

Temporary Disability Leave (TDL) was another area that was identified as needing further clarification. Currently the procedural manual in respect of incapacity due to ill health guides the institution in this regard. According to the manual an employee who has exhausted his/her normal sick leave credit in a three year cycle (36 days) and who, according to the relevant medical practitioner (registered general practitioner or specialist), requires to be absent in the event of illness or due to disability that is not permanent, may be granted temporary disability leave with full pay. It goes further to state that the nature and extent of illness or injury as well as the estimated period of absence must be certified by the relevant medical practitioner in the form of a medical certificate. A maximum of 30 consecutive days may be granted for TDL. Formal investigation must be conducted if the period required for recuperation exceeds 30 days and if misutilisation of sick leave is suspected. The manual cautions against easy granting of TDL and advice that it should be supported by strong medical evidence. It is unclear about when to or not to grant TDL. The proposal that emerged from interviewed personnel is that the HRM unit of the institution formulates the hospital policy to assist the heads of departments in this regard. TDL should not be used for short term less serious illnesses or injuries. Where normal sick leave has already been exhausted, vacation leave and then capped leave may be used. TDL must be used as the last option.

Business status report (April 2004) shows that 78 posts were vacant at RCCH. The posts were not broken down into categories of staff but it is known that some of vacant posts are nursing posts. Nursing management has expressed concern about difficulty in recruitment of nurses. Among the difficulties mentioned is the lack of accommodation for nurses that reside outside the Western Cape province. The staff residence does not have enough vacant rooms to accommodate them. Eviction of staff from the staff residence is also not an easy option since it has to comply with legal requirements. Therefore the problem of lack of accommodation needs to be addressed. It needs to be instilled in the minds of staff members that staff residence is not a permanent accommodation. There is a policy in place that regulates stay at the rẽsidence. Residents are required to sign a contract that is renewable on a yearly basis subject to

approval by hospital management. This policy can be utilized to make space available for new recruits.

6.3. Causes of Absenteeism

All categories of staff that were interviewed identified stress as one of the major causes of absenteeism. The source of stress is both personal and work related problems. In order to address this problem an Employee Assistance Programme (EAP) has been introduced for the hospital. The service provider is a private company that offers a comprehensive service. Confidentiality of consultations is guaranteed. This service is still new and therefore most staff members are not aware of it. The availability of this service needs to be communicated extensively to staff members to ensure optimal utilization.

The general feeling among lower categories of staff was that there is widespread favoritism in the allocation of overtime, performance bonuses and study leave. Whether it really exists is not addressed in this study but the fact is that there is a perception. This perception creates an unpleasant working environment, which manifests in absenteeism. It therefore needs to be addressed as a matter of urgency. The problem might be lack of guidelines or poor communication of guidelines if they exist. Clear guidelines have to be developed if they are not in place. If guidelines are already in place, they have to be communicated to all staff members.

Two opposing views were expressed with regard to staffing. The popular view was that the institution is understaffed while the opposing view was that it is adequately staffed. The opposing view implies that work attendance/ non-attendance is the problem rather than staffing. Staffing standards are needed to resolve this issue. It must be determined how many nurses are needed per type of patient bed. Management will then be able to determine whether the institution is adequately staffed or not and if not, how many more nurses and what level of nurses are required. However anecdotal evidence of vacant nursing posts is an indication of understaffing. Nevertheless reduction in absenteeism will assist in improving service delivery regardless of whether the institution is understaffed or not.

6.4. Effects of Absenteeism

The findings of the study classified effects of absenteeism into effects on other staff members, effects on service delivery and effects on the organization. Effects on staff members confirms literature that was reviewed in Chapter 2 that absenteeism adversely affects interpersonal relations between staff members. This leads to an unpleasant working environment that results in other staff members also absenting themselves from work as a coping mechanism.

If the situation is not attended to, service delivery deteriorates. Poor service may lead to medico-legal hazards, which exposes the hospital to legal suites. This will have financial implications for the hospital.

Logistical problems that arise are a waste of time for management that would have been utilized fruitfully. There is therefore opportunity costs for the time spent reorganizing personnel to cover for absent employees.

6.5. Financial Costs of Absenteeism

It was found in the previous chapter that more than one million rands (R1.2m) was spent to pay salaries of nursing staff members that were absent in the year 2003. Sick leave expenditure was more than twice the amount spent on other absences. It was also established that approximately R4.2m on average is spent annually on agency staff and R2.6m on overtime. It is known from the financial manager that about 80 percent of this amount is spent on nursing personnel. Therefore approximately R5.44m is spent on nursing agency staff and overtime annually. The overall amount spent on nursing staff absence can be estimated to be R6.4m.

In the first quarter of 2004/05 financial year, the total personnel budget of RCCH was R37.592m. Of this R987 000 was spent on locums/agency staff, which is 2.63 percent of personnel budget. This figure increased to 3.13 percent for the second quarter. This is an indicator of expenditure on replacement staff for absenteeism or vacant posts. In April 2004, 7.67 percent posts at RCCH were vacant.

Poor service delivery that is a result of absenteeism also has financial implications in terms of lost revenue. A certain portion of revenue that is collected through user-fees is retained at the hospital to encourage revenue collection. The hospital therefore increases its revenue by attracting paying clients. Poor service delivery results in the hospital receiving only those clients who cannot afford private health care.

6.6. Utilization of Sick Leave by Nurses

Sick leave constitutes a greater percentage of absence among the nursing staff. Of the 4.20 percent absenteeism rate for 2003 calendar year 3.04% was sick absence. Therefore any attempt to lower the rate of absenteeism should focus on sick absence. This would require analysis of individuals' sick leave records to determine whether there is a pattern. Things to look for should include frequency and duration of sick leave. Frequent short-term sick leave should be further investigated. This investigation has to include whether sickness is certified if so what is the diagnosis. Sick leave of less than three days does not require certification in the public service. Therefore frequent uncertified sick leave might be an indicator of sick leave abuse. These individuals might be required to provide certificate of indisposition for periods lesser than three days. Sick leave abuse has to be addressed through the disciplinary procedure.

6.7. Measures of Absenteeism

The overall Gross Absence Rate of 4.20 percent is higher than the 3 percent acceptable level as per reviewed literature. This confirms the findings from interviewed managers and that absenteeism is not prevalent among staff members but is concentrated on few individuals who take excessive leave.

The Absence Frequency Rate also confirms this finding. If incidents of absenteeism are distributed equally among all nursing staff members, each staff member was off-sick 3 times in the year 2003. This does not appear to be high frequency but the indication is that only a few staff members are off-sick on a regular basis.

The Severity Rate, which is a measure of duration, is also low at 2 days per sick absence. If read together with the AFR it translates to each staff member taking 2 days

of sick leave 3 times a year. Obviously the majority of staff members with good attendance records brought down the rates of absenteeism.

6.8. Study limitations

PERSAL database categorizes leave into vacation, sick, shop steward, family responsibility and special leave. It does not provide information on the nature of illness for which sick leave was granted. It also does not differentiate between certified and uncertified sick leave. Therefore no conclusion could be made on the nature of illness accounting for high rate of sick absence. No conclusive evidence is available on sick leave abuse because of unavailability of information on certified and uncertified sick leave.

There is no differentiation between vacation leave that was pre-authorized and that authorized after it was taken. Vacation leave that is unauthorized at the time it is taken is disruptive and should be regarded as unauthorized absence. Vacation leave taken in excess of leave entitlement was viewed as absence for reasons other than ill health in this study. This is inaccurate because some staff members have capped leave credits, which they can utilize when current leave is exhausted. Capped leave is leave credits accumulated before 01 July 2000. After this date public service personnel are obliged to use all current leave days within the period of 18 months. Failure to adhere to this directive results in loss of days not utilized.

PERSAL salary information reflects the salary levels only and no salary notches. Each salary level has 16 notches. The first notch of each salary level was used to estimate the financial burden for this study. Therefore the financial burden arrived at is a conservative estimation.

CHAPTER 7

CONCLUSION AND RECOMMENDATIONS

7.1. Conclusion

Absenteeism is the problem for RCCH that threatens service delivery and institutional budget. The causes of absenteeism were identified in this study. They can be broadly classified into management and staff issues. Management issues include poor supervision and low staff morale. Staff issues include personal problems related and unrelated to work. Literature on motivation theories was reviewed to ascertain its influence on work attendance. Migration of health personnel was also reviewed to illuminate the imbalances in the health workforce especially nursing cadre. Gross absence rate is a measure of absenteeism that was used in this study. Absence Frequency rate and Severity Rate were used to show variation in findings depending on measure employed. The salaries of staff members that were absent were used as the measure of financial burden of absence. Information on expenditure for agency staff and overtime was obtained from finance department to arrive at the overall estimation of financial burden for the institution.

The study followed a descriptive as well as analytic methodology in presentation and discussion of results. Primary data was collected through interviews using two questionnaires as interview guides. Focus group interviews were conducted with nursing staff members and in-depth interviews with nursing, human resources and finance managers. Secondary data was obtained from PERSAL.

Absenteeism rate was found to be 4.20 percent according to the findings of this study. This is above the acceptable rate of 3 percent. The greater percentage of absenteeism was sick absence. The average number of sick days taken per person was 7 days per annum. An estimation of R6.4m was spent on nursing absence per annum.

7.2. Recommendations

This section offers recommendations to improve attendance/ reduce absenteeism. It is based on responses by interviewees to the question: " What do you think could be done to improve the situation?" and literature research by the writer. Recommendations are not in order of importance.

7.2.1. Responsibility for combating absenteeism

The first recommendation is that primary responsibility for combating absenteeism should be with the line manager. The line manager must ensure good attendance and time keeping by subordinates. Absenteeism control must be included in the job descriptions of all supervisory posts. It must also be a key performance area in individual performance plan of supervisors. This does not mean that supervisors must be appraised negatively because of poor attendance of subordinates. They must be able to explain to senior management what they have done to rectify the situation. Where the line manger is guilty of absenteeism, the next level supervisor must be held responsible for taking action.

7.2.2. Institutional absenteeism policy

It is recommended that institutional policy on absenteeism be developed. Notification of absence policy of the nursing division can be used as the starting point but the institutional policy must go beyond notification of absence. It must provide uniform interpretation of the new leave dispensation document. It must clarify matters like when is absence said to follow a pattern that is indicative of sick leave misutilisation. Terms that are frequently confused like absence without leave (AWOL) and leave without pay (LWOP) have to be clarified. This policy will have to be consulted with representative unions at the institution.

7.2.3. Collection, analysis and communication of absenteeism statistics

All departments must submit their monthly absenteeism reports on agreed time to be included in the consolidated report. The consolidated report must be tabled at the

Institutional Management and Labour Committee (IMLC) and senior management meetings. In these meetings the report must be analysed for missing data and the heads of departments not submitting their data must be called to account to senior management. The heads of departments with high rates must be called to explain the reasons and the steps they are taking to rectify the situation. The departmental heads have to communicate their statistics to their staff members in departmental meetings.

7.2.4. Recognition of good attendance

Staff members with good attendance records have to be recognized. The hospital board can be approached to fund this project. The alternative is to present the staff member with the certificate of good attendance as a token of appreciation. The certificate has to be signed by the chief executive officer of the institution. The names of the winners and may be photos can be displayed in the notice boards to be seen by all other staff members. The hospital newsletter can also be used to publish the winners. There can be departmental winners and over a period of time the overall winner.

7.2.5. Disciplinary action

Progressive disciplinary action must be taken against unauthorized absentees in accordance with the Disciplinary Procedure for the Public Service. This include corrective counseling, verbal warning, written warning, final written warning and formal disciplinary enquiry. The nature of disciplinary action taken is informed by the seriousness of transgression. The guiding principle is that discipline is a corrective measure and not a punitive one.

7.2.6. Control of RWOPS

Nursing management has to set limits to the number of days that nurses can do RWOPS at RCCH. A nurse cannot be expected to work her scheduled days and days meant for resting. This results in resting days being used for RWOPS and sick leave for resting. This is applicable to days-off and annual leave. Control of RWOPS is difficult when it is not done at the institution where the nurse is employed. Therefore granted

RWOPS have to be reviewed on an ongoing basis and permission withdrawn where sick leave abuse is identified.

7.3. Further Research Areas

Further research need to examine the leave forms and sick certificates. Information on whether leave was authorized or not will be extracted from leave forms. The nature of illness will be established from the sick certificates. This will enable the researchers to identify major causes of sick absence, which will assist management to address those causes. An example is that if the major cause is flu, employees can be encouraged to take the flu vaccine. Further research can also be conducted to compare attendance of employees who received a flu vaccine and those who did not.

Employees with good attendance records and those with bad ones need to be identified and investigated further. Good attendees can be profiled and this will assist managers in recruitment and selection process. This will also help managers to inculcate attitudes of good attendees to bad ones.

Research has to be conducted in more than one institution and comparisons made. The institutions will have to be similar e.g. compare three academic hospitals of the Western Cape. Investigation will then be conducted on what the institution with less absenteeism record is doing differently.

Further research has to identify staff members who have been granted RWOPS and compare their attendance records with those holding one job. Current evidence of sick leave abuse by staff members holding an additional job to supplement income is anecdotal.

BIBLIOGRAPHY

Atkin, RS & Goodman, PS 1984, "Methods of Defining and Measuring Absenteeism" in PS Goodman, R Atkin & Associates (eds), *Absenteeism: New Approaches to Understanding, Measuring and Managing Employee Absence*, Jossey Bass, California.

Bamford, L, Klein, B, & Engelbrecht, B 2000, *How to Monitor and Address Absenteeism in District Hospitals,* Health Systems Trust, Durban.

Business Status Report, 2004, Red Cross Children's Hospital

Butler, J 1994, "To Conduct an Investigation into Absenteeism in Cape Town Organisations", MsocSc Thesis, University of Cape Town.

Children'sHospitalTrust 2004, Retrieved November 04, 2004, from http://home.intekom.com/medisource/childrenshospitaltrust/hospital/hospital.htm

Cleary, S & Thomas, S 2002, *Mapping Health Services Trade in South Africa, Trade and Industrial Policy Strategies*, Muldersdrift.

EQUINET and HST, 2004, *Equity in the Distribution of Health Personnel: Regional Research Review Meeting Report*, Johannesburg.

Expenditure Trends and Cashflow Forecasts 2004/2005, 2004, Red Cross Children's Hospital.

Fox, W 1991 "Leadership and Motivation" in F Fox, E Schwella & H Wissink (eds), *Public Management*, Juta and Company Ltd, Cape Town, pp. 89-115.

Franken, RE 1988 *Human Motivation*, 2nd ed. Brooks/ Cole Publishing Company Pacific Groove, California.

Harter, TW & Tonya, W 2001, "Minimizing Absenteeism in the Workplace: Strategies for Nurse Managers", *Nursing Economics*. Vol. 19(2), pp53-55.

Hellriegel, D, Jackson, SE & Slocum, JW 2002 *Management: A Competency-Based Approach.* 9th ed. Cincinnati.

Heighway, V 1990, "Student Nurse Perceptions: A case study to illuminate the perceptions, developed by student nurses, which result in absenteeism as the behaviour of choice in response to difficulties in their educational programme", Mphil Thesis, University of Cape Town.

Hoffmeyer, UK and McCarthy, TR 1994, *Financing Health Care*, Kluwer Academic Plublishers, London.

Katzenellenbogen, JM, Joubert, G & Abdool Karim, SS 1997 *Epidemiology-A Manual for South Africa*, Oxford University Press, Cape Town.

Kutzin, J 1995, *Experience with Organizational and Financing Reform of the Health Sector*, World Health Organization, Geneva.

Levy, A. 1995, Industrial Relations Survival Kit, *Investigating Absenteeism in the Organisation*, Vol. 2.

Monthly Status Report-April 2004, (2004), Provincial Government of the Western Cape: Department of Health.

National Treasury, *Budget Review 2004*. Retrieved March 3, 2004, from http://treasury.gov.za/

Physicians for Human Rights, 2004 *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa*, Boston, MA.

Piirainen, H 2003, "Organisation Climate, Perceived Work-Related Symptoms and Sickness Absence: A Population-Based Survey", *Journal of Occupational and Environmental Medicine*, vol. 45.

"Position Statement: Nurse Retention, Transfer and Migration", 1999 *International Council of Nurses*, Geneva.

Public Service Commission, 2002 *Sick Leave trends in the Public Service*, Formset Printers Cape, Pretoria.

"South African Health Review: 2003/04", 2004, Durban, Health Systems Trust.

Steers, RM, Porter, LW & Bigley, GA 1996, *Motivation and Leadership at Work*, The MacGraw-Hill Companies, New York.

Van Der Merwe, R and Miller, S 1998, *Measuring Absence and Labour Turnover: A practical Guide to Recording and Control,* Lexicon Publishers, Johannesburg.

APPENDIX 1

A QUESTIONNAIRE DESIGNED FOR EMPLOYEES' VIEWS ON ABSENTEEISM

1.BIOGRAPHICAL DETAILS

1.1.PERSONAL DETAILS

1.1.1. Job title: .....1.1.2. Job level: .....

1.1.3. Department: ..... 1.1.4. Date completed:.....

2. QUESTIONS

2.1.How would you rate your work motivation level?

Very Low Very High

1	2	3	4	5

2.2.How do you rank your relationship with your immediate supervisor?

Poor Excellent

1	2	3	4	5

2.3.How would you rate the team spirit within your department?

Poor Excellent

1	2	3	4	5

2.4.How secure do you feel in your job?

Not secured at all Very secure

1	2	3	4	5

2.5. How do you feel about your career prospects?

Very bad Very good

1	2	3	4	5

2.6. How do you feel about availability of resources to do your work?

No resources sufficient resources

1	2	3	4	5

2.7.How would you say you are treated within the department?

Poor Excellent

1	2	3	4	5

2.8. What do you think are the main causes of absenteeism? (in priority order)

(a).....

(b).....

(c).....

(d).....

(e).....

2.9. Do you know the procedure for reporting unplanned absence?

Yes ☐ No ☐

2.9.1. If yes explain.

.....

.....

.....

.....

2.10. What do you think should be done to reduce the level of absenteeism?

.....

.....

.....

.....

.....

APPENDIX 2

A QUESTIONNAIRE DESIGNED FOR MANAGEMENT VIEWS ON ABSENTEEISM

TITLE OF THE RESPONDENT:.....

DEPARTMENT:.....

NAME OF THE INTERVIEWER:.....

DATE OF INTERVIEW:.....

1. To what extent is absenteeism a problem in the hospital?

Very serious problem	Serious problem	A problem	Satisfactory	Not a problem

2. To what extent is it a problem among the nursing staff?

Very serious problem	Serious problem	A problem	Satisfactory	Not a problem

3. Which departments are mostly affected by absenteeism?

.....
.....
.....

4. What is the nature and extent in terms of authorised and unauthorised absence?

.....
.....
.....

5. Are there specific time periods when absenteeism is high e.g. weekends, Mondays, after payday or after public holiday?

Yes ☐ No ☐

5.1. If the above response is yes, state which days is it high (start with the highest)

.....
.....
.....

6. What do you think are the main causes of absenteeism? (In priority order)

(a) .....
(b) .....
(c) .....
(d) .....
(e) .....

7. How is absenteeism recorded and monitored?

.....
.....
.....

9. Is there a written down policy on absenteeism?

Yes ☐ No ☐

9.1. If the answer to the above question is yes, state how is the policy communicated to staff members?

.....
.....
.....

10. What is done to ensure that patient care is not compromised as a result of absenteeism?

.....
.....
.....

11. What disciplinary measures are taken against offenders?

.....
.....
.....

12. Who is responsible for taking disciplinary measures against offenders?

.....
.....
.....

13. What do you think the effects of absenteeism are on your organisational performance? Please elaborate.

.....
.....
.....
.....
.....

14. What do you think could be done to improve the situation?

.....
.....
.....
.....
.....

APPENDIX 3

DATA CAPTURE SHEET

obs	Gende	DOB	Age	Appointed	Service	Salary I	Excess	Sick da	Incidents	R/Excess	R/Sick	R/Overall
1	F	14-Feb-1960	44	1-Oct-1984	19	8	2	8	4	R 807.84	R 3,231.36	R 4,039.20
2	F	15-Jan-1954	50	1-Mar-1972	32	5	15	2	2	R 3,163.20	R 421.76	R 3,584.96
3	F	19-Aug-1966	38	1-Apr-1986	17	8	1	5	4	R 403.92	R 2,019.60	R 2,458.80
4		6-Jun-1972	32	13-Sep-1992	12	4	0	1	1	R -	R 178.32	R 178.32
5	F	18-Apr-1973	31	1-Feb-1996	8	7	0	2	2		R 650.40	R 650.40
6	F	2-Jan-1944	60	1-Apr-1975	29	5	6	0	0	R 1,265.28		R 1,265.28
7	F	4-Apr-1974	30	1-Feb-1996	8	6	1	3	3	R 261.12	R 783.36	R 1,044.48
8	F	14-Jan-1958	46	1-Jul-2000	4	7	0	1	1		R 325.26	R 325.26
9	F	28-Dec-1957	47	16-Apr-1986	18	6	0	7	3		R 1,827.84	R 1,827.84
10	F	19-Nov-1974	30	1-May-1998	6	7	0	1	1		R 325.20	R 325.20
11	F	21-Feb-1961	43	1-Sep-1990	14	5	0	2	1		R 421.76	R 421.76
12	F	21-Jun-1974	30	1-May-2002	2	6	0	3	2		R 783.36	R 783.36
13	F	16-Jul-1950	54	4-Jan-1987	17	5	3	12	4	R 632.64	R 2,530.56	R 3,163.20
14	F	16-Feb-1964	40	1-May-1984	20	3	2	8	3	R 303.84	R 1,215.36	R 1,519.20
15	F	26-Feb-1968	36	1-Feb-2002	2	2	5	3	2	R 661.20	R 396.72	R 1,057.92
16	F	30-Jan-1971	33	1-Feb-1996	8	6	0	6	4		R 1,566.72	R 1,566.72
17	F	14-May-1969	35	1-May-1992	12	5	0	6	3		R 1,054.40	R 1,054.40
18	F	18-Jun-1952	52	7-Oct-1970	34	5	0	0	0			
19	F	26-Sep-1968	36	1-Dec-1990	14	5	0	0	0			
20	F	16-Oct-1964	40	1-Apr-1990	14	5	0	0	0			
21	F	16-Jun-1956	48	1-Mar-1991	13	5	4	6	4	R 843.52	R 1,265.28	R 2,108.80
22	F	31-Jan-1959	45	1-Jul-1981	28	5	3	1	3	R 632.64	R 210.88	R 843.52
23	F	7-Nov-1965	39	8-Jul-1984	20	5	0	2	2		R 421.76	R 421.76
24	F	12-Jan-1952	52	1-Jul-1983	21	5	0	2	2		R 421.76	R 421.76
25	F	11-May-1958	46	1-Jul-2002	2	3	4	8	3	R 607.68	R 1,215.36	R 1,823.04
26	F	24-Feb-1972	32	1-Jul-1991	13	8	0	0	0			
27	F	17-Dec-1968	36	1-Dec-1990	14	5	2	1	1	R 421.76	R 210.88	R 632.64
28	F	23-Mar-1976	28	1-Oct-1998	6	3	0	12	0		R 1,823.04	R 1,823.04
29	F	12-Jan-1972	32	1-Jul-2001	3	4	0	5	3		R 891.60	R 891.60

30	F	1-Nov-1975	29	1-Oct-1999	5	3	6	6	5	R	959.52	R	959.52	R	1,919.04
31	F	5-Oct-1968	36	1-Feb-1991	13	8	0	13	6			R	5,250.96	R	5,250.96
32	F	13-Mar-1953	51	1-Jan-1977	27	5	0	2	2			R	421.76	R	421.76
33	F	15-Oct-1971	33	1-Jul-1990	14	8	0	14	10			R	5,654.88	R	5,654.88
34	F	3-Dec-1972	32	1-Feb-1992	12	7	0	19	10			R	6,178.80	R	6,178.80
35	F	30-Nov-1972	32	1-Feb-1997	7	5	9	9	6	R	1,897.92	R	1,897.92	R	3,795.84
36	F	3-Dec-1968	36	1-Feb-1990	14	6	0	0	0						
37	F	8-Sep-1946	58	1-Mar-1969	35	11	0	0	0	R	7,725.52			R	7,725.52
38	F	5-Apr-1956	48	1-Jun-1994	10	5		0	0						
39	F	15-Sep-1949	55	1-Feb-1970	34	5	3	4	4	R	632.64	R	843.52	R	1,476.16
40	F	26-Nov-1952	52	1-Mar-1988	16	5	3	1	1	R	632.63	R	210.88	R	843.51
41	F	30-Sep-1956	48	15-Feb-1976	28	6	0	4	3			R	1,044.48	R	1,044.48
42	F	18-Jul-1962	42	1-Oct-1993	11	6	0	0	0						
43	F	3-Jul-1965	39	22-Mar-1987	17	5	0	0	0						
44	F	8-Oct-1960	44	1-Feb-1982	22	5	0	7	4			R	1,476.16	R	1,476.16
45	F	16-Dec-1947	57	1-Oct-1977	27	6	15	3	0	R	3,916.80	R	783.36	R	4,700.16
46	F	26-Aug-1946	58	12-Nov-1997	7	7	0	4	3			R	1,300.80	R	1,300.80
47	F	24-Nov-1981	23	1-Feb-2000	4	3	100	8	4	R	15,192.20	R	1,215.36	R	16,407.56
48	F	28-Sep-1964	40	1-Jan-1999	5	7	19	8	4	R	6,178.80	R	2,601.60	R	8,780.40
49	F	2-Mar-1962	42	1-Jun-1995	9	4	12	8	6	R	2,139.84	R	1,426.56	R	3,566.40
50	F	23-Aug-1959	45	1-May-1979	25	5	0	3	1			R	632.64	R	632.64
51	F	28-Jan-1963	41	1-Sep-1983	21	6	0	7	5			R	1,827.84	R	1,827.84
52	F	29-Dec-1953	51	1-Dec-1990	14	6	0	0	0						
53	F	16-Nov-1970	34	1-Jul-1989	15	8	7	3	2	R	2,827.44	R	1,211.76	R	4,039.20
54	F	28-Dec-1955	49	1-Dec-1979	25	5	0	1	1			R	210.88	R	210.88
55	F	14-Sep-1955	49	1-Feb-1991	13	5	0	34	3			R	7,169.92	R	7,169.92
56	F	19-Apr-1967	37	1-Feb-1989	15	8	0	9	7			R	3,635.28	R	3,635.28
57	F	16-Oct-1959	45	1-May-1984	20	5	0	2	2			R	421.76	R	421.76
58	F	1-Oct-1974	30	1-Jun-1998	6	4	7	59	9	R	1,248.24	R	10,520.88	R	11,769.12
59	F	6-Feb-1969	35	1-Nov-1994	10	5	0	11	4			R	2,319.68	R	2,319.68
60	F	25-Jan-1958	46	1-Sep-1992	12	6	7	0	0	R	1,945.08			R	1,945.08
61	F	8-Feb-1957	47	1-Jul-1989	15	6	0	13	8			R	2,809.56	R	2,809.56
62	F	21-Jul-1971	33	1-Feb-1991	13	7	6	0	0	R	1,951.20			R	1,951.20
63	F	12-Nov-1948	56	1-Mar-1984	20	5	0	10	6			R	2,108.80	R	2,108.80
64	F	13-Aug-1966	38	24-Jun-1999	5	4	0	0	0						
65	F	13-Feb-1973	31	1-May-1997	7	7	2	0	1	R	650.40			R	650.40

66	F	3-Aug-1951	53	1-Feb-1982	22	6	7	5	4	R	1,728.96	R	1,080.60	R	2,809.56
67	F	28-Jun-1954	50	1-Feb-1992	12	8	7	2	2	R	2,827.44	R	807.84	R	3,635.28
68	F	24-Jun-1968	36	1-Feb-2002	2	2	6	9	7	R	793.44	R	1,190.16	R	1,983.60
69	F	3-Aug-1957	47	15-Feb-1976	28	5	0	1	1			R	210.88	R	210.88
70	F	8-Apr-1975	29	1-Feb-1994	10	7	0	5	4			R	1,626.00	R	1,626.00
71	F	19-Apr-1971	33	1-Sep-2000	4	3	17	1	1	R	2,582.64	R	151.92	R	2,734.56
72	F	19-Sep-1951	53	1-Sep-1981	29	6	6	5	2	R	1,512.84	R	1,080.60	R	2,593.44
73	F	30-Mar-1953	51	1-Jan-1971	33	8	0	2	1			R	807.84	R	807.84
74	F	27-Nov-1973	31	1-Jun-1997	7	7	2	6	4	R	650.40	R	1,951.20	R	2,601.60
75	F	23-Mar-1969	35	2-Jun-1991	13	5	0	6	4			R	1,265.28	R	1,265.28
76	F	8-Jul-1960	44	1-May-1986	18	8	8	8	5	R	3,231.36	R	3,231.36	R	6,462.72
77	F	29-Apr-1951	53	1-Jun-1974	30	6	15	0	0	R	3,890.16			R	3,890.16
78	F	10-Oct-1954	50	1-Jan-1990	14	8	5	4	2	R	2,019.60	R	1,615.68	R	3,635.28
79	F	20-Mar-1948	56	1-Oct-1975	29	5	11	12	8	R	2,319.68	R	2,530.56	R	4,850.24
80	F	7-May-1955	49	11-Jul-1993	11	8	0	1	1			R	403.92	R	403.92
81	F	23-Nov-1963	41	1-Aug-2001	3	2	0	12	7			R	1,586.88	R	1,586.88
82	F	9-Jun-1974	30	1-Feb-1992	12	8	0	14	8			R	5,654.88	R	5,654.88
83	F	9-Apr-1955	49	1-Sep-1985	19	5	2	5	2	R	421.76	R	1,054.40	R	1,476.16
84		9-Jul-1959	45	1-Dec-1979	25	6	0	1	1			R	216.12	R	216.12
85	F	15-Nov-1961	43	16-Jan-1998	6	4	0	9	6			R	1,604.88	R	1,604.88
86	F	15-Aug-1942	62	2-Apr-1989	15	5	1	10	6	R	210.88	R	2,108.80	R	2,319.68
87	F	1-Aug-1949	55	9-Apr-1989	15	5	0	79	7			R	16,659.52	R	16,659.52
88	F	21-Jan-1965	39	14-Mar-1985	19	6	0	6	6			R	1,566.72	R	1,566.72
89	F	7-Aug-1944	60	1-Jan-1989	15	5	2	3	1	R	421.76	R	632.64	R	1,054.40
90	F	23-Oct-1960	44	2-Mar-1986	18	6	0	2	2			R	522.24	R	522.24
91	F	14-Apr-1960	44	1-Oct-1984	20	6	0	6	3				1,566.72		1,566.72
92	F	12-Jun-1979	25	1-Feb-1998	6	6	0	6	4			R	1,566.72	R	1,566.72
93		1-Sep-1975	29	1-Jun-1998	6	3	7	1	1	R	1,063.44	R	151.92	R	1,215.36
94	F	18-Sep-1973	31	1-Feb-1996	8	6	0	0	0						
95	F	24-Jul-1971	33	1-Nov-1994	10	5	0	10	5			R	2,108.80	R	2,108.80
96		26-Dec-1970	34	1-Jul-1990	14	8	0	13	7			R	5,250.96	R	5,250.96
97	F	23-Aug-1950	54	1-Mar-1983	21	5	8	7	4	R	1,687.04	R	1,476.16	R	3,163.20
98	F	12-Jan-1962	42	1-May-1982	22	5	0	11	7			R	2,319.68	R	2,319.68
99	F	6-Mar-1982	22	1-Feb-2000	4	3	5	14	3	R	759.60	R	2,126.88	R	2,886.48
100	F	18-Feb-1954	50	27-May-1984	20	6	0	0	0						
101	F	22-Jan-1958	46	1-Feb-1989	15	6	0	7	5			R	1,827.84	R	1,827.84

102	F	9-May-1970	34	1-Jan-2003	1	7	0	3	3			R	975.60	R	975.60
103	F	30-Oct-1979	25	1-Feb-1998	6	6	0	2	2			R	522.24	R	522.24
104	F	24-Jun-1976	28	1-Jan-2004		6	0		0						
105	F	19-Dec-1954	50	6-Sep-1987	17	8	0	0	0						
106	F	11-Jul-1951	53	1-Mar-1970	34	5	1	3	1	R	210.88	R	632.64	R	843.52
107	F	10-Dec-1971	33	1-Oct-1995	9	5	5	10	4	R	1,054.40	R	2,108.80	R	3,163.20
108	F	7-Apr-1977	27	1-Feb-1995	9	6	0	2	1			R	522.24	R	522.24
109	F	26-Jul-1968	36	1-Feb-2003	1	6	0	2	2			R	522.24	R	522.24
110	F	28-Oct-1975	29	1-Feb-2001	3	6	2	4	3	R	522.24	R	1,044.48	R	1,566.72
111	F	17-Oct-1968	36	3-Oct-1993	11	8	0	6	4			R	2,423.52	R	2,423.52
112	F	6-Feb-1961	43	1-Sep-1989	15	5	0	28	7			R	5,904.64	R	5,904.64
113	F	13-Jul-1952	52	1-Jul-1984	20	5	0	15	8			R	3,163.20	R	3,163.20
114	F	16-Nov-1973	31	1-Dec-2001	3	6	0	4	3			R	1,044.48	R	1,044.48
115	F	22-Jun-1950	54	1-Apr-1972	32	5	0	0	0						
116	F	4-Jun-1965	39	1-Aug-2000	4	3	0	4	2			R	607.68	R	607.68
117	F	7-May-1956	48	1-Jun-1975	29	5	3	3	2	R	632.64	R	632.64	R	1,265.28
118	F	1-Jul-1955	49	1-May-1978	26	5	0	12	6			R	2,530.56	R	2,530.56
119	F	3-Apr-1953	51	1-Jun-1997	7	5	2	4	4	R	421.76	R	843.52	R	1,265.28
120	F	30-Apr-1953	51	1-Nov-1982	22	9	0	0	0						
121	F	11-Aug-1967	37	1-May-1991	13	5	0	24	7			R	5,061.12	R	5,061.12
122	F	7-Dec-1953	51	1-Feb-1983	21	6	10	13	7	R	2,611.20	R	3,394.56	R	6,005.76
123	F	6-Dec-1971	33	1-Dec-1997	7	4	9	2	2	R	1,604.88	R	356.64	R	1,961.52
124	F	7-Oct-1964	40	1-Jan-1985	19	8	6	12	7	R	2,423.52	R	4,847.04	R	7,270.56
125	F	3-Sep-1960	44	1-Nov-1984	20	6	1	4	1	R	261.12	R	1,044.48	R	1,305.60
126	F	1-Aug-1960	44	1-Aug-1982	22	6	0	16	7			R	4,177.92	R	4,177.92
127	F	16-May-1964	40	1-Aug-2001	3	3	0	14	8			R	2,126.88	R	2,126.88
128	F	18-May-1960	44	8-May-1994	10	5	0	4	2			R	843.52	R	843.52
129	F	20-Oct-1965	39	1-Aug-1988	16	6	3	11	6	R	783.36	R	2,872.32	R	3,655.68
130	F	4-Feb-1973	31	1-Jun-1991	13	6	0	3	3			R	783.36	R	783.36
131	F	20-Nov-1954	50	10-Mar-1985	19	5	0	1	1			R	210.88	R	210.88
132	F	13-Dec-1950	54	15-Jun-1995	9	5	5	0	0	R	1,054.40			R	1,054.40
133	F	25-Aug-1947	57	1-Jan-1989	15	8	0	4	3			R	1,615.68	R	1,615.68
134	F	19-Dec-1972	32	1-May-1994	10	5	0	9	6			R	1,897.92	R	1,897.92
135	F	18-Sep-1976	28	1-Nov-1998	6	4	0	7	4			R	1,248.24	R	1,248.24
136	F	23-Jun-1951	53	10-Jun-1969	35	5	0	7	5			R	1,476.16	R	1,476.16
137	F	5-Aug-1953	51	3-Apr-1983	21	5	0	5	3			R	1,054.40	R	1,054.40

138	F	3-Dec-1952	52	1-Jan-1973	31	8	0	9	6			R	3,635.28	R	3,635.28
139	F	30-Jul-1946	58	1-Mar-1990	14	5	2	4	2	R	421.76	R	843.52	R	1,265.28
140	F	31-Jan-1961	43	1-Apr-1988	16	5	0	3	2			R	632.64	R	632.64
141	F	31-Jul-1970	34	1-Jan-1991	13	5	0	3	3			R	632.64	R	632.64
142	F	3-Jul-1955	49	1-Jan-2000	4	4	0	19	5			R	3,388.08	R	3,388.08
143	F	2-Aug-1967	37	1-Dec-1997	7	6	32	10	2	R	8,355.84	R	2,611.20	R	10,967.04
144	F	9-May-1971	33	1-Feb-1989	15	8	8	2	1	R	3,231.36	R	807.84	R	4,039.20
145	F	11-Aug-1973	31	1-Apr-2002	2	3	1	5	4	R	151.92	R	759.60	R	911.52
146		3-Nov-1957	47	1-Dec-1989	15	5	0	10	6			R	2,108.80	R	2,108.80
147	F	19-Mar-1973	31	17-Jan-1994	10	7	16	8	4	R	5,203.20	R	2,601.60	R	7,804.80
148	F	14-Jul-1955	49	9-Mar-1975	29	5	0	4	4			R	843.52	R	843.52
149	F	5-Jun-1956	48	1-Mar-1977	27	8	3	1	1	R	1,211.76	R	403.92	R	1,615.68
150	F	27-May-1959	45	1-Aug-1999	5	8	8	2	2	R	3,231.36	R	807.84	R	4,039.20
151	F	27-Oct-1971	33	1-Feb-1996	8	6	0	9	7			R	2,350.08	R	2,350.08
152	F	18-Jul-1975	29	1-Feb-1996	8	6	6	8	7	R	1,566.72	R	2,088.96	R	3,655.68
153	F	1-Oct-1956	48	1-Jan-1987	17	8	3	4	4	R	1,211.76	R	1,615.68	R	2,827.44
154	F	3-Sep-1976	28	1-Aug-2001	3	4	0	2	2			R	356.64	R	356.64
155	F	26-Nov-1966	38	1-Feb-1986	18	6	0	15	9			R	3,916.80	R	3,916.80
156	F	28-Jul-1959	45	6-Apr-1980	24	5	1	2	2	R	210.88	R	421.76	R	632.64
157	F	12-Sep-1953	51	1-Jun-1985	19	5	0	16	8			R	3,374.08	R	3,374.08
158	F	10-Oct-1959	45	1-Dec-1983	21	8	25	0	0	R	10,098.00			R	10,098.00
159	F	25-Jul-1975	29	1-May-1998	6	7	0	4	3			R	1,300.80	R	1,300.80
160	F	9-Apr-1947	57	20-Oct-1972	32	8	1	3	2	R	403.92	R	1,211.76	R	1,615.68
161	F	9-Dec-1968	36	1-Feb-1991	13	5	0	9	4			R	1,897.92	R	1,897.92
162	F	14-Dec-1960	44	1-Jul-2001	3	3	0	2	1			R	303.84	R	303.84
163	F	30-Sep-1971	33	19-Jan-1992	12	7	2	0	0	R	650.40			R	650.40
164	F	12-Apr-1974	30	1-Jul-1995	9	6	7	4	4	R	1,827.84	R	1,044.48	R	2,872.32
165	F	29-Aug-1971	33	1-Feb-1998	6	5	0	7	3			R	1,476.16	R	1,476.16
166	F			1-Feb-1998	6	6	0	3	8			R	783.36	R	783.36
167	F	29-Oct-1949	55	1-Jan-2002	2	8	0	20	7			R	8,078.40	R	8,078.40
168	F	9-Jan-1967	37	1-Jan-1991	13	5	12	12	0	R	2,530.56	R	1,054.40	R	3,584.96
169	F	28-May-1946	58	10-Jul-1983	21	5	0	0	6						
170	F	5-Jan-1956	48	1-Feb-1981	23	5	5	16	5	R	1,054.40	R	3,374.08	R	4,428.48
171				2-Feb-1997	7	6	5	7	2	R	1,305.60	R	1,827.84	R	3,133.44
172	F			1-Feb-2002	2	6	0	3	4			R	783.36	R	783.36
173	F	28-Jan-1967	37	24-Jul-2000	4	2	0	5	2			R	661.20	R	661.20

174	F	26-Dec-1960	44	1-Oct-2001	3	3	0	1	1			R	151.92	R 151.92
175	F	26-Dec-1970	34	1-Aug-2000	4	3	9	2	2	R	1,367.28	R	203.84	R 1,571.12
176	F	3-Dec-1949	55	1-Jan-1987	17	5	1	11	5	R	210.88	R	2,319.63	R 2,530.51
177	F	19-Jul-1978	26	1-Jan-2003	1	6	0	9	6			R	2,350.08	R 2,350.08
178	F	9-Nov-1971	33	1-Mar-2000	4	4	11	0	0	R	1,873.20			R 1,873.20
179	F	4-May-1959	45	1-Jun-1997	7	5	0	5	2			R	1,054.40	R 1,054.40
180	F	1-Aug-1966	38	1-Jun-1988	16	5	0	4	2			R	843.52	R 843.52
181	F	10-Jan-1972	32	1-Sep-2001	3	6	6	13	7	R	1,566.72	R	3,394.56	R 4,961.28
182	F	4-Jul-1958	46	1-Nov-1988	16	5	2	2	2	R	421.76	R	421.76	R 843.52
183	F	17-Jun-1968	36	15-Jan-2001	3	6	0	8	7			R	2,088.96	R 2,088.96
184	F	14-Jun-1964	40	1-Aug-2000	4	3	0	4	2			R	607.68	R 607.68
185	F	2-Feb-1961	43	14-Jan-1985	19	6	16	3	3	R	4,177.92	R	783.36	R 4,961.28
186	F	22-Sep-1974	30	1-Mar-2001	3	3	7	6	4	R	1,063.44	R	911.52	R 1,974.96
187	F	30-May-1971	33	1-Feb-2000	4	3	7	8	5	R	1,063.44	R	1,215.36	R 2,278.80
188	F	20-May-1956	48	1-Jan-1974	30	6	0	1	1			R	261.12	R 261.12
189	F	10-Jun-1979	25	3-Feb-1997	7	6	0	16	10			R	4,177.92	R 4,177.92
190	F	22-Aug-1971	33	1-Jul-1994	10	5	0	6	5			R	1,265.28	R 1,265.28
191	F	14-Dec-1979	25	1-Feb-1998	6	6	0	8	4			R	2,088.96	R 2,088.96
192	F	2-Jan-1975	29	1-Jun-1998	6	7	0	0	0					
193	F	20-Feb-1963	41	15-Jul-1996	8	7	0	5	3			R	1,626.00	R 1,626.00
194	F	22-Oct-1950	54	1-Apr-1973	31	5	11	0	1	R	2,319.68			R 2,319.68
195	F	24-May-1963	41	15-Feb-1998	6	4	9	32	11	R	1,604.88	R	5,706.24	R 7,311.12
196	F	25-May-1970	34	1-May-1994	10	5	0	4	2			R	843.52	R 843.52
197	F	11-Nov-1942	62	1-Aug-1990	14	8	0	2	2			R	807.84	R 807.84
198	F	30-Sep-1952	52	1-Nov-1981	23	5	0	2	2			R	421.76	R 421.76
199	F	5-Aug-1957	47	1-May-1981	23	5	0	6	6			R	1,265.28	R 1,265.28
200	F	20-Mar-1962	42	14-Oct-1984	20	6	0	4	2			R	1,044.48	R 1,044.48
201	F	3-Aug-1980	24	1-Feb-2000	4	6	0		0					
202	F	1-Jan-1969	35	1-Jun-1992	12	5	0	1	3			R	210.88	R 210.88
203	F	1-Jan-1955	49	1-Nov-1988	16	5	1	0	0	R	210.88			R 210.88
204	F	11-May-1971	33	1-Mar-2002	2	4	0	14	8			R	2,496.48	R 2,496.48
205	F	8-May-1967	37	1-Sep-1993	11	5	0	6	3			R	1,265.28	R 1,265.28
206	F	15-Jan-1966	38	1-Dec-1998	6	4	4	2	1	R	713.28	R	356.64	R 1,069.92
207	F	25-Jun-1956	48	3-Jun-1978	26	6	1	28	7	R	261.12	R	7,311.36	R 7,572.48
208	F	15-Aug-1960	44	1-Jul-2002	2	4	0	6	4			R	1,069.92	R 1,069.92
209	F	20-Sep-1961	43	16-Mar-1991	13	8	0	20	5			R	8,078.40	R 8,078.40

210	F	26-Aug-1955	49	1-Apr-1973	31	5	0	1	1			R	210.88	R 210.88
211	F	15-Jul-1948	56	7-Jun-1967	37	5	0	4	3			R	843.52	R 843.52
212	F	3-Apr-1954	48	1-Feb-1979	25	5	10	3	3	R	2,108.80	R	632.64	R 2,741.44
213	F	10-Mar-1968	36	1-Jul-1998	6	4	9	1	1	R	1,604.88	R	178.32	R 1,783.20
214	F	21-Dec-1954	50	1-Aug-2003	1	2	0		0					
215	F	9-Feb-1965	39	1-Mar-1983	21	8	1	7	4	R	403.92	R	2,827.44	R 3,231.36
216	F	7-Jul-1956	48	1-Sep-1990	14	5	0	5	3			R	1,054.40	R 1,054.40
217	F	5-Jan-1972	32	1-Aug-2001	3	3	0	3	3			R	405.76	R 405.76
218	F	2-Oct-1978	26	1-Feb-1998	6	6	0	4	2			R	1,044.48	R 1,044.48
219	F	12-Feb-1965	39	1-Feb-1992	12	6	0	6	3			R	1,566.72	R 1,566.72
220	F	10-May-1967	37	1-Oct-1988	6	5	0	15	8			R	3,163.20	R 3,163.20
221	F	24-Mar-1957	47	1-Jul-1990	14	8	22	3	2	R	8,886.24	R	1,211.76	R 10,098.00
222	F	25-Jan-1951	53	1-Dec-1974	30	5	0	5	3			R	1,054.40	R 1,054.40
223	F	23-May-1973	31	1-Feb-2003	1	6	0	1	1			R	261.12	R 261.12
224	F			1-Feb-1995	9	6	0	17	9			R	4,439.04	R 4,439.04
225	F	3-May-1967	37	1-Feb-1992	12	7	0	9	4			R	2,926.80	R 2,926.80
226	F	17-Jul-1951	53	1-Apr-1969	35	5	5	78	14	R	1,054.40	R	16,448.64	R 17,503.04
227	F	1-Feb-1966	38	1-Dec-1983	21	5	0	8	3			R	1,687.04	R 1,687.04
228	F	26-Jun-1945	59	1-Mar-1983	21	6	0	1	1			R	261.12	R 261.12
229	F			1-Feb-1996	8	6	0	12	8			R	3,133.44	R 3,133.44
230	F	13-Feb-1976	28	10-Mar-2003	1	6	0	23	16			R	6,005.76	R 6,005.76
231	F	4-Jul-1953	51	1-Sep-2001	3	2	0	13	7			R	1,719.12	R 1,719.12
232	F	15-Dec-1948	56	1-Nov-1986	18	5	3	9	5	R	421.76	R	1,897.92	R 2,319.68
233	F	6-Aug-1975	29	1-Feb-1995	9	6	2	5	3	R	783.36	R	1,305.60	R 2,088.96
234	F	11-Jan-1963	41	1-Jul-1994	10	5	0	10	9			R	2,108.80	R 2,108.80
235	F	28-Feb-1952	52	1-Aug-2001	3	3	0	0	0					
236	F	16-May-1955	49	1-May-1982	22	5	0	2	2			R	421.76	R 421.76
237	F	7-Dec-1962	42	1-Feb-2004		8	0	5	1			R	2,019.60	R 2,019.60
238	F	23-Aug-1956	48	1-Jul-2001	3	4	0	1	1			R	178.32	R 178.32
239	F	30-Dec-1965	39	1-Nov-1994	10	5	0	6	4			R	1,265.28	R 1,265.28
240	F	23-Aug-1964	40	1-Jan-2004		2	0		0					
241	F	10-May-1946	58	14-Jan-1974	30	8	8	0	0	R	3,231.36			R 3,231.36
242	F	15-May-1965	39	1-Jan-1984	20	8	9	2	2	R	3,635.28	R	807.84	R 4,443.12
243	F			1-Feb-2001	3	6	0	8	4			R	2,088.96	R 2,088.96
244	F	15-Jun-1967	37	1-Nov-1985	19	6	1	7	6	R	261.12			R 261.12
245	F	14-Mar-1963	41	1-Apr-1982	22	5	0	0	0					

246	F	16-Jan-1957	47	1-Aug-1989	15	5	0	9	6			R	1,897.92	R 1,897.92
247	F	23-Aug-1967	37	15-Jul-1996	8	8	0	10	3			R	4,039.20	R 4,039.20
248	F	17-Jul-1962	42	1-May-1983	21	5	0	3	3			R	632.64	R 632.64
249	F	26-Sep-1975	29	1-Dec-1998	6	6	0	3	1			R	783.36	R 783.36
250	F	2-Dec-1956	48	5-Aug-1984	20	5	0	2	1			R	421.76	R 421.76
251		28-Dec-1978	26	3-Feb-1997	7	6	0	7	5			R	1,827.84	R 1,827.84
252	F	25-Sep-1972	32	1-Feb-2000	4	3	0	1	6			R	151.92	R 151.92
253	F	18-Mar-1972	32	1-Aug-1998	6	7	0	7	1			R	2,276.40	R 2,276.40
254	F	16-Nov-1970	34	1-Jan-1999	5	3	2	3	2	R	303.84	R	455.76	R 759.60
255	F	21-Aug-1955	49	1-May-1989	15	5	0	19	1			R	4,006.72	R 4,006.72
256	F	1-Jul-1944	60	18-Apr-1966	38	7	0	4	7			R	1,300.80	R 1,300.80
257	F	1-Jul-1980	24	1-Feb-1990	5	6	0	6	2			R	1,566.72	R 1,566.72
258	F	24-Jan-1973	31	1-Feb-1992	12	7	0	14	4			R	4,552.80	R 4,552.80
259	F	10-Nov-1970	34	1-Feb-2002	2	6	0	7				R	1,827.84	R 1,827.84
260	F	21-Mar-1959	45	1-Jul-1984	20	5	4	1	4	R	843.52	R	210.88	R 1,054.40
261	F	10-Jul-1962	42	1-Jun-1984	20	6	0	4	1			R	1,044.48	R 1,044.48
262	F	8-Apr-1962	42	1-Feb-1991	13	5	8	11	4	R	1,687.04	R	2,319.68	R 4,006.72
263	F	15-Aug-1947	57	1-Feb-1984	20	5	0	3	6			R	632.64	R 632.64
264	F	9-Oct-1953	51	1-Dec-1978	26	8	0	9	1			R	3,635.28	R 3,635.28
265	F	16-Mar-1971	33	1-Mar-1990	14	8	8	5	4	R	3,231.36	R	2,019.60	R 5,250.96
266	F	4-Jun-1952	52	1-Mar-2001	3	3	3	9	1	R	455.76	R	1,367.28	R 1,823.04
267	F	6-Sep-1972	32	1-May-1997	7	7	0	28	6			R	9,105.60	R 9,105.60
268	F	18-Jan-1955	49	1-Dec-1980	24	5	6	5	10	R	1,265.28	R	1,054.40	R 2,319.68
269	F	27-Apr-1960	44	1-Jan-1989	15	6	0	11	5			R	2,872.32	R 2,872.32
270	F	14-May-1972	32	1-Feb-2002	2	6	0	10	8			R	2,611.20	R 2,611.20
271		28-Jul-1973	31	1-Jan-2000	4	6	0	3				R	783.36	R 783.36
272	F	22-Dec-1972	32	1-Aug-2002	2	3	10	23	2	R	1,519.20	R	3,494.16	R 5,013.36
273	F	8-Nov-1959	45	1-Jun-1992	12	2	0	8	14			R	1,057.92	R 1,057.92
274	F	18-Aug-1959	45	1-Jul-1985	19	8	1	4	5	R	403.92	R	1,615.68	R 2,019.60
275	F			1-Feb-2002	2	4	0	8	3			R	1,426.56	R 1,426.56
276	F	23-Oct-1971	33	1-Aug-1990	14	7	7	3	5	R	2,276.40	R	975.60	R 3,252.00
277	F	26-Oct-1965	39	1-Dec-1989	15	5	0	5	2			R	1,054.40	R 1,054.40
278	F	22-Dec-1970	34	1-Jan-1991	13	6	7	2	3	R	1,827.84	R	522.24	R 2,350.08
279	F	4-May-1973	31	1-Aug-2001	3	3	1	5	1	R	151.92	R	759.60	R 911.52
280	F	16-Sep-1971	33	1-Aug-2001	3	3	1	0	3	R	151.92			R 151.92
281	F	21-Jul-1977	27	1-Feb-1999	5	6	1	1	1	R	261.12	R	261.12	R 522.24

282	F	4-Oct-1952	52	11-Mar-1979	25	5	0	6	1			R	1,265.28	R	1,265.28
283	F	14-Apr-1949	55	9-Oct-1983	21	5	4	13	3	R	843.52	R	2,741.44	R	3,584.96
284	F	4-Feb-1970	34	1-Sep-1988	16	5	6	5	6	R	1,265.28	R	1,054.40	R	2,319.68
285	F	26-Oct-1957	47	1-Feb-1987	17	8	1	0	2	R	403.92			R	403.92
286	F	29-Jul-1943	61	1-Dec-1982	22	5	12	7	0		2,530.55		1,476.16		4,006.71
287	F	3-Sep-1951	53	1-Nov-1972	32	5	0	3	5			R	632.64	R	632.64
288	F	17-Apr-1976	28	1-Jan-2004		6	0	2	3			R	522.24	R	522.24
289	F	5-Nov-1952	52	14-Sep-1986	18	5	5	6	1	R	210.88	R	1,265.28	R	1,476.16
290	F	23-Sep-1954	50	5-Jul-1984	20	6	0	0	3						
291	F	30-Sep-1944	60	1-Jun-1976	28	5	29	6	0	R	6,115.52	R	1,265.28	R	7,380.80
292	F	24-Aug-1972	32	1-Jan-2001	3	6	0	24	2			R	6,266.88	R	6,266.88
293	F	30-Mar-1976	28	1-Feb-2002	2	6	0	12				R	3,133.44	R	3,133.44
294	F	30-Dec-1962	42	1-Jan-1988	16	6	0	11				R	2,872.32	R	2,872.32
295	F	28-Sep-1957	47	1-Oct-1988	16	5	0	3	6			R	632.64	R	632.64
296	F	18-Sep-1958	46	1-Oct-1982	22	5	0	4	2			R	843.52	R	843.52
297	F	2-Jan-1953	51	1-Sep-1990	14	5	0	15	1			R	3,163.20	R	3,163.20
298	F	3-Apr-1972	32	1-Feb-1991	13	8	0	20	3			R	8,078.40	R	8,078.40
299	F	3-May-1975	29	1-Feb-1995	9	6	0	9	9			R	2,350.08	R	2,350.08
300	F	23-Sep-1966	38	29-Aug-1994	10	8	3	0	6	R	1,211.76			R	1,211.76
301	F	25-Jul-1954	50	1-May-1994	10	6	0	13	0			R	3,394.56	R	3,394.56
302	F	26-Dec-1949	55	1-Aug-1989	15	6	3	0	7	R	783.36			R	783.36
303	F	16-Nov-1967	37	1-Sep-1995	9	5	0	0	0						
304	F	27-Dec-1953	51	1-Jun-1972	32	5	0	5	0			R	1,054.40	R	1,054.40
305	F	23-Dec-1977	27	1-Feb-2000	4	6	4	25	3		1,044.48		6,528.00		7,572.48
306	F	13-May-1969	35	1-Jan-1996	8	5	0	16	8			R	3,374.08	R	3,374.08
307	F	27-Nov-1965	39	1-Jun-1995	9	5	0	10	7			R	2,108.80	R	2,108.80
308	F	2-Mar-1954	50	1-Aug-2001	3	3	3	2	5	R	455.76	R	303.84	R	759.60
309	F	30-Nov-1981	23	1-Feb-1999	5	6	0	0	2						
310	F	3-Jan-1977	27	1-Feb-2002	2	6	2	11	0	R	522.24	R	2,872.32	R	3,394.56
311	F	22-Aug-1952	52	1-Oct-1993	11	8	0	17	7			R	6,866.64	R	6,866.64
312	F	10-Mar-1973	31	1-Nov-1998	6	3	0	14	6			R	2,126.88	R	2,126.88
313	F	27-Jun-1958	46	1-Dec-1979	25	5	0	4	5			R	843.52	R	843.52
314	F	13-Feb-1947	57	1-Jul-1980	24	5	0	0	3						
315	F	30-May-1948	56	1-Mar-1980	24	5	16	8	0	R	3,374.08	R	1,687.04	R	5,061.12
316	F	14-Oct-1976	28	1-Feb-1995	9	7	0	7	5			R	2,276.40	R	2,276.40
317	F	2-Feb-1946	58	1-Apr-1987	17	5	0	8	5			R	1,687.04	R	1,687.04

318		19-Oct-1966	38	1-Jun-1994	10	5	0	7	4			R	1,476.16	R	1,476.16
319	F	19-Oct-1964	40	1-Oct-1987	17	4	0	0	4						
320	F	22-Dec-1957	47	1-Jul-2002	2	4	0	0	0						
321	F	18-Mar-1972	32	1-Oct-1995	9	5	0	4	0			R	843.52	R	843.52
322	F	22-Jul-1959	45	1-Jul-1993	11	8	0	6	4			R	2,423.52	R	2,423.52
323	F	3-May-1954	50	1-Jan-1982	22	8	0	1	5			R	403.92	R	403.92
324	F	25-Jun-1960	44	1-Jan-1990	14	8	0	6	0			R	2,423.52	R	2,423.52
325	F	14-Aug-1944	60	16-Jan-1987	17	8	3	4	6	R	1,211.76	R	1,615.58	R	2,827.34
326	F	20-Jun-1949	55	1-Mar-1979	25	8	0	14	2			R	5,654.88	R	5,654.88
327	F	31-Dec-1957	47	1-Nov-1979	25	8	0	8	7			R	3,231.36	R	3,231.36
328	F	19-Feb-1958	46	7-Oct-1990	14	5	13	6	5	R	2,741.44	R	1,265.28	R	4,006.72
329	F	3-Jun-1960	44	1-Mar-1989	15	8	22	5	5	R	8,886.24	R	2,019.60	R	10,905.84
330	F	17-Aug-1964	40	1-Jun-1992	12	8	0	8	2			R	3,231.36	R	3,231.36
331	F	22-Oct-1979	25	1-Feb-1999	5	6	0	5	4			R	1,305.60	R	1,305.60
332	F	18-Jun-1973	31	5-Jan-2004		6	0		5						
333	F	6-Sep-1945	59	1-Sep-1964	40	5	2	7	0	R	421.76	R	1,476.16	R	1,897.92
334	F	18-Jan-1981	23	1-Feb-2002	2	6	0	8	2			R	2,088.96	R	2,088.96
335	F	1-Apr-1965	39	1-Jul-2001	3	2	2	9	5	R	264.48	R	1,190.16	R	1,454.64
336	F	28-Nov-1970	34	1-May-1994	10	5	0	6	6			R	1,265.28	R	1,265.28
337	F	7-Jul-1965	39	16-Jul-1986	18	6	15	11	4	R	3,916.80	R	2,872.32	R	6,789.12
338	F	12-Sep-1964	40	1-Feb-1985	19	5	2	2	5	R	421.76	R	421.76	R	843.52
339	F	1-Dec-1978	26	1-Feb-1998	6	6	0	0	2						
340	F	17-Feb-1960	44	1-Dec-1983	21	5	1	10	0	R	210.88	R	2,108.80	R	2,319.68
341	F	19-Oct-1956	48	1-Aug-1988	16	6	0	3	7			R	783.36	R	783.36
342	F	20-Oct-1971	33	1-Jul-2001	3	4	3	5	2	R	534.96	R	891.60	R	1,426.56
343	F	8-Jun-1968	36	17-Jan-1994	10	7	0	1	4			R	325.20	R	325.20
344	F	24-Mar-1959	45	1-Dec-1986	18	6	0	6	1			R	1,566.72	R	1,566.72
345	F	24-Jul-1962	42	1-Mar-2001	3	3	10	7	5	R	1,519.20	R	1,063.44	R	2,582.64
346	F	17-Sep-1958	46	1-Jul-1989	15	8	3	40	4	R	1,211.76	R	16,156.80	R	17,368.56
347	F	16-Mar-1960	44	21-Feb-1984	20	8	11	15	2		4,443.12		6,058.80		10,501.92
348	F	31-May-1966	38	1-Jul-1992	12	8	3	0	5	R	1,211.76			R	1,211.76
349	F	29-Jun-1956	48	1-Jul-1986	18	8	7	2	0	R	2,827.44	R	807.84	R	3,635.28
350	F	30-Mar-1952	52	1-Sep-2003	1	2	0		1						
351	F	13-Sep-1961	43	15-Apr-1984	20	8	0	0							
352	F	9-Jun-1953	51	19-Sep-1982	22	8	6	8	0	R	2,423.52	R	3,231.36	R	5,654.88
353	F	1-Sep-1981	23	1-Feb-2000	4	6	0	5	5			R	1,305.60	R	1,305.60

354	F	17-Jun-1960	44	2-Jul-1984	20	8	25	6	2	R	10,098.00	R	2,423.52	R 12,521.52
355	F	3-May-1971	33	1-May-1990	14	6	0	12	4			R	3,133.44	R 3,133.44
356	F	9-Mar-1953	51	7-Jul-1974	30	5	0	0	8					
357	F	14-Aug-1967	37	1-Oct-1993	11	6	2	17	0	R	522.24	R	4,439.04	R 4,961.28
358	F	12-Oct-1959	45	1-Mar-1989	19	5	0	2	8			R	421.76	R 421.76
359	F	10-Feb-1947	57	1-Jan-1995	9	8	0	0	2					
360	F	24-Jul-1978	26	1-Feb-1999	5	6	0	9	0			R	2,350.08	R 2,350.08
361	F	12-May-1973	31	1-Feb-1992	12	7	0	4	6			R	1,300.80	R 1,300.80
362	F	1-May-1951	53	1-Mar-1970	34	5	0	9	3			R	1,897.92	R 1,897.92
363	F	20-Nov-1952	52	1-Jan-1978	26	5	0	4	6			R	843.52	R 843.52
364	F	4-Aug-1964	40	1-May-1984	20	8	0	6	3				2,423.52	2,423.52
365	F	25-Oct-1949	55	1-Jan-1983	21	8	9	3	3	R	3,635.28	R	1,211.76	R 4,847.04
366	F	11-Apr-1967	37	1-May-1991	13	5	26	2	2	R	5,482.88	R	421.76	R 5,904.64
367	F	24-Jun-1977	27	1-Feb-1998	6	6	9	5	1	R	2,350.08	R	1,305.60	R 3,655.68
368		8-Aug-1979	25				0		5					
369	F	19-Dec-1972	32	1-Feb-1991	13	8	7	13	7	R	2,827.44	R	5,250.96	R 8,078.40
370	F	11-Apr-1953	51	1-Jun-1998	6	4	2	7	4	R	356.64	R	1,248.24	R 1,604.88
371	F	4-Mar-1961	43	4-Oct-1987	17	7	0	3	2			R	957.60	R 957.60
372		3-May-1962	42	1-Oct-1981	23	8	1	29	9	R	403.92	R	11,713.68	R 12,117.60
373	F	27-Oct-1967	37	1-Feb-1988	16	8	0	5	1			R	2,019.60	R 2,019.60
374	F	4-Feb-1973	31	1-Mar-1996	8	4	0	15	8				2,674.80	2,674.80
375	F	1-Apr-1957	47	1-Jul-1986	18	8	0	4	3			R	1,615.68	R 1,615.68
376	F	7-Mar-1962	42	9-Apr-1986	18	6	0	8	5			R	2,088.96	R 2,088.96
377	F			1-Jul-1977	27	8	0	4	0			R	1,615.68	R 1,615.68
378	F	17-Jun-1952	52	1-May-1972	32	5	0	0	1					
379	F	8-Apr-1955	49	1-Jan-1984	20	8	0	5	1			R	2,019.60	R 2,019.60
380	F	4-Dec-1947	57	8-Feb-1976	28	5	3	1	0	R	632.64	R	210.88	R 843.52
381	F	18-Apr-1965	39	10-Jun-1984	10	5	4	0	4	R	843.52			R 843.52
382	F	3-Sep-1964	40	1-Mar-2002	2	2	0	10	2			R	1,322.40	R 1,322.40
383	F	3-Oct-1944	60	1-Mar-1988	16	5	0	3	3			R	632.64	R 632.64
384	F	24-Nov-1968	36	1-Oct-2001	3	6	0	3	4			R	783.36	R 783.36
385	F	7-Nov-1961	43	1-Jan-1981	23	8	0		7					
386	F	14-Oct-1974	30	1-Mar-2002	2	6	0	7	3			R	1,827.84	R 1,827.84
387	F	6-Mar-1959	45	15-Oct-1995	9	5	0	6	4			R	1,265.28	R 1,265.28
388	F	30-Aug-1958	46	9-Sep-1990	14	5	0	7	5			R	1,476.16	R 1,476.16
389	F	27-Feb-1964	40	1-Nov-1987	17	6	0	7	5			R	1,827.84	R 1,827.84

390	F	18-Jul-1958	46	1-Sep-2000	4	3	6	8	2	R	911.52	R	1,215.36	R	2,126.88
391	F	22-Sep-1962	42	1-Mar-1989	15	5	7	3	2	R	1,476.16	R	632.64	R	2,108.80
392	F	21-Nov-1955	49	10-Dec-1989	15	8	0	2	3			R	807.84	R	807.84
393	F	1-Jun-1976	28	1-Feb-2000	4	3	0	5	2			R	759.60	R	759.60
394	F	23-Mar-1950	54	1-May-1971	33	5	0	3	5			R	632.64	R	632.64
395	F	28-Jun-1949	55	1-Aug-1973	31	8	3	11	5	R	1,211.76	R	4,443.12	R	5,654.88
396	F	2-Dec-1971	33	1-Jul-1997	7	7	0	7	4			R	2,276.40	R	2,276.40
397	F	12-Aug-1957	47	1-Nov-1983	21	5	0	7	1			R	1,476.16	R	1,476.16
398	F	20-Oct-1952	52	1-Apr-1971	33	8	0	2	1			R	807.84	R	807.84
399	F	1-Dec-1965	39	1-Jan-1991	13	5	3	0	0	R	632.64			R	632.64
400	F	22-Aug-1976	28	12-Jan-2004		6	0		6						
401	F	24-Dec-1952	52	2-Dec-1973	31	5	0	23	2			R	4,850.24	R	4,850.24
402	F	10-Jul-1943	61	1-Nov-1984	20	8	0	3	5			R	1,211.76	R	1,211.76
403	F	4-Oct-1969	35	1-Jan-1988	16	5	0	10	1			R	2,108.80	R	2,108.80
404	F	8-Aug-1965	39	1-Mar-1998	6	7	0	3	7			R	975.60	R	975.60
405	F	23-Dec-1942	62	1-Jan-1985	19	8	0	14	3			R	5,654.88	R	5,654.88
406	F	10-Jul-1961	43	1-Aug-2001	3	3	1	3	5	R	151.92	R	455.76	R	607.68
407	F	21-Jan-1971	33	1-Jun-1994	10	6	0	17	1			R	4,439.04	R	4,439.04
408		3-Jan-1966	38	1-Feb-1992	12	6	0	2	7			R	522.24	R	522.24
409	F	13-Oct-1977	27	1-Feb-1998	6	6	1	11	0	R	261.12	R	2,872.32	R	3,133.44
410	F	28-Aug-1962	42	1-Sep-1990	14	8	37	11	1	R	14,945.04	R	4,443.12	R	19,388.16
411	F	8-Jun-1947	57	1-Apr-1979	25	5	0	1	0			R	210.88	R	210.88
412		2-Dec-1955	49	15-Mar-1982	22	5	3	0	6	R	632.64			R	632.64
413	F	29-Oct-1975	29	15-Feb-2002	2	3	0	9	1			R	1,367.28	R	1,367.28
414	F	21-Sep-1967	37	4-Nov-1990	14	5	0	1	4			R	210.88	R	210.88
415	F	11-Jul-1964	40	1-Feb-1990	14	6	0	5	2			R	1,305.60	R	1,305.60
416	F	27-Apr-1942	62	1-Apr-1987	17	8	0	5	2			R	2,019.60	R	2,019.60
417	F	22-Mar-1968	36	1-Nov-1994	10	5	0	2	7			R	421.76	R	421.76
418	F	26-Sep-1975	29	1-Feb-2002	2	3	0	14	5			R	2,126.88	R	2,126.88
419	F	8-Jul-1979	25	1-Feb-2003	1	6	0	11	0			R	2,872.32	R	2,872.32
420	M	11-Sep-1962	42	6-Sep-1987	17	6	0	0	4						
421	F	20-May-1966	38	1-Feb-1989	15	8	3	6	7	R	1,211.76	R	2,423.52	R	3,635.28
422	F	20-May-1959	45	1-Jan-2001	3	7	0	15	1			R	4,878.00	R	4,878.00
423	F	21-Feb-1946	58	1-Jun-1971	33	5	0	1	2			R	210.88	R	210.88
424	F	1-Mar-1968	36	18-Jan-1993	11	5	0	6	4			R	1,265.28	R	1,265.28
425	F	10-Nov-1943	61	1-Jun-1980	24	5	16	5	1	R	3,374.08	R	1,054.40	R	4,428.48

426	F	12-Feb-1959	45	1-Mar-1988	16	8	0		2					
427	F	6-Dec-1976	28	1-Feb-1995	9	6	0	3	6			R	783.36	R 783.36
428	F	30-Apr-1976	28	4-Jan-1995	9	6	2	11	3	R	522.24	R	2,872.32	R 3,394.56
429	F	13-Sep-1957	47	1-Sep-1982	22	6	0	6	11			R	1,566.72	R 1,566.72
430	F	31-Aug-1969	35	1-Jul-1994	10	5	0	34	7			R	7,169.92	R 7,169.92
431	F			1-Nov-1982	22	5	3	12	1	R	632.64	R	2,530.56	R 3,163.20
432	F	20-May-1964	40	1-Feb-1989	15	5	0	1	0			R	210.88	R 210.88
433	F	2-Aug-1955	49	1-Sep-1979	25	5	0	0	3					
434	M	5-Mar-1975	29	1-Dec-1997	7	7	0	3	1			R	975.60	R 975.60
435	M	16-Jun-1965	39	1-Dec-1995	9	6	0	3	1			R	783.36	R 783.36
436	F	27-Nov-1952	52	1-Mar-1970	34	5	1	2	4	R	210.88	R	421.76	R 632.64
437	F			17-Jan-1988	16	5	0		5					
438	F	1-Mar-1964	40	1-Jul-2001	3	3	0	8	3			R	1,215.36	R 1,215.36
439	F	14-Oct-1967	37	1-Aug-2000	4	3	3	3	2	R	455.76	R	455.76	R 911.52
440	F	28-May-1956	48	21-Mar-1981	23	6	0	4	1			R	1,044.48	R 1,044.48
441	M	14-Jul-1971	33	1-May-1997	7	7	0	1	1			R	325.20	R 325.20
442		19-Sep-1974	30	1-May-1998	6	5	0	3	2			R	632.64	R 632.64
443	F	20-Apr-1967	37	1-Oct-1994	10	3	0	4	15			R	607.68	R 607.68
444	M	26-Aug-1962	42	1-Apr-1981	23	8	0	25	2			R	10,098.00	R 10,098.00
445	F	12-Jan-1957	47	1-May-1998	6	4	0	3	11			R	534.96	R 534.96
446	F	12-Sep-1952	52	1-Nov-1971	33	5	0	36	2			R	7,591.68	R 7,591.68
447	F	17-Jun-1947	57	11-May-1968	36	8	0	16	8			R	6,264.72	R 6,264.72
448	F	4-Jan-1968	36	1-Oct-1998	6	4	0	15	1			R	2,674.80	R 2,674.80
449	F	19-Feb-1951	53	1-Jul-1971	33	5	0	1	5			R	210.88	R 210.88
450	F	18-Aug-1945	59	1-Sep-1985	19	5	3	6	3	R	632.64	R	1,265.28	R 1,897.92
451	F	13-Jul-1966	38	1-Jun-1988	16	5	0	5	2			R	1,054.40	R 1,054.40
452	F	25-Jul-1980	24	1-Feb-1990	14	6	0	5	9			R	1,305.60	R 1,305.60
453	F	26-Dec-1973	31	3-Feb-1997	7	6	0	11	3			R	2,872.32	R 2,872.32
454	F	14-Aug-1968	36	1-Dec-1995	9	4	0	3	2			R	534.96	R 534.96
455	F	24-Sep-1943	61	1-Sep-1984	20	5	0	2	2			R	421.76	R 421.76
456	F	13-Nov-1976	28	1-Feb-1998	6	6	0	3	0			R	783.36	R 783.36
457	F	7-Feb-1954	50	24-Mar-1976	28	5	6	0	5	R	1,265.28			R 1,265.28
458	F	25-Mar-1960	44	1-Mar-2000	4	2	0	10	3			R	1,322.40	R 1,322.40
459	F	24-Sep-1962	42	1-May-1988	16	5	0	9	4			R	1,897.92	R 1,897.92
460	F	29-Oct-1956	48	17-Apr-1988	16	8	3	7	2	R	1,211.76	R	2,827.44	R 4,039.20
461	F	1-Oct-1965	39	1-Jun-1988	16	6	0	5	5			R	1,305.60	R 1,305.60

462	F	8-Sep-1980	24	1-Jan-2003	1	6	0	5	6			R	1,305.60	R	1,305.60
463	F	25-Jan-1967	37	1-Aug-2001	3	3	16	9	3	R	2,430.72	R	1,367.28	R	3,798.00
464	F	11-Nov-1948	56	1-Jun-1977	27	6	14	5	2	R	3,655.68	R	1,305.60	R	4,961.28
465	F			1-Jan-1994	10	8	11	5	1	R	4,443.12	R	2,019.60	R	6,462.72
466				1-Sep-2002	1	6	0	0	0						
467	F	19-Sep-1975	29	1-May-1998	6	7	4	25	8	R	1,300.48	R	8,128.00	R	9,428.48
468	F	29-Aug-1957	45	1-Dec-1993	11	8	0	1	3			R	403.92	R	403.92
469	F	13-Feb-1979	25	22-Feb-2004		6	0		0						
470	F	18-May-1960	44	1-Oct-1980	24	6	0	11	7			R	2,872.32	R	2,872.32
471	F	18-Apr-1965	39	1-Jun-1994	10	5	0	6	1			R	1,265.28	R	1,265.28
472	F	7-Mar-1949	55	15-Sep-1984	20	5	0	0	3						
473	F	19-Mar-1970	34	1-May-1995	9	8	9	11	3	R	3,635.28	R	4,443.12	R	8,078.40
474	F	20-Sep-1960	44	1-Aug-1990	14	5	0	3	3			R	632.64	R	632.64
475	F	27-Mar-1978	26	1-Feb-1998	6	6	0	4	6			R	1,044.48	R	1,044.48
476	F	9-Dec-1955	49	1-Oct-1987	17	5	0	5	2			R	1,054.40	R	1,054.40
477	F	10-Aug-1969	35	1-Jan-1996	8	5	0	4	3			R	843.52	R	843.52
478	F	8-Feb-1956	48	16-Oct-1994	10	6	0	10	4			R	2,611.20	R	2,611.20
479	F	10-Jun-1982	22	1-Feb-2000	4	3	0	2	2			R	303.84	R	303.84
480	F	31-Jul-1956	48	2-Jun-1978	26	5	0	3	0			R	632.64	R	632.64
481	F	20-Mar-1967	37	1-Feb-2000	4	2	2	12	7	R	264.48	R	1,586.88	R	1,851.36
482	F	22-May-1946	58	1-May-1979	25	8	0	3	0			R	1,211.76	R	1,211.76
483	F	29-May-1952	52	1-Jun-1987	17	8	5	0	1	R	2,019.60			R	2,019.60
484	F	12-Apr-1979	25	1-Jul-2004		6	5	14	1	R	1,305.60	R	3,655.68	R	4,961.28
485	F	11-May-1975	29	4-May-1998	6	4	18	0	5	R	3,209.76			R	3,209.76
486	F	6-Jun-1977	27	1-Feb-1999	5	6	0	1				R	261.12	R	261.12
487	F	27-Sep-1962	42	1-Jul-1992	12	6	3	8	0	R	783.36	R	2,088.96	R	2,872.32
488	F	14-Sep-1976	28	1-Oct-2001	3	6	0	5	0			R	1,305.60	R	1,305.60
489	F	27-Apr-1968	36	4-May-1998	6	4	7	0	4	R	1,248.24			R	1,248.24
490	F	17-May-1963	41	1-Jul-1985	19	8	0	0	3						
491	F	24-Jun-1944	60	4-Jan-1982	22	5	0	5	4			R	1,054.40	R	1,054.40
492	F	18-Apr-1978	26	1-Aug-2001	3	3	0	6	4			R	911.52	R	911.52
493	F	9-Oct-1955	49	1-Sep-1999	5	4	8	5	4	R	1,426.56	R	713.28	R	2,139.84
494	F	4-Jan-1975	29	1-Apr-2002	2	3	0	5	3			R	759.60	R	759.60
495	F	31-Jan-1973	31	1-Mar-1998	6	4	0	6	3				1,069.92		1,069.92
496	F	22-Feb-1969	35	15-May-1998	6	4	3	18	2	R	534.96	R	3,209.76	R	3,744.72
497	F	27-Sep-1961	43	1-Jan-1985	19	8	0	2	0			R	807.84	R	807.84

498	F	22-Jan-1972	32	1-Aug-2003	1	2	0	4	0			R	528.96	R 528.96
499	F	27-Aug-1972	32	1-Nov-1994	10	5	0	0	2					
500	F	3-Apr-1977	27	1-Feb-1998	6	6	0	0	5					
501	F	26-Feb-1957	47	1-Jan-1984	20	8	2	2	0	R	807.84	R	807.84	R 1,615.68
502	F	30-Dec-1970	34	1-Feb-1991	13	7	7	8		R	2,276.40	R	2,601.60	R 4,878.00
503	F	14-May-1950	54	1-Apr-1974	30	6	0	45	2			R	11,750.40	R 11,750.40
504	F	7-Apr-1953	51	1-Jul-1988	16	5	0	7	5			R	1,476.16	R 1,476.16
505	F	28-Nov-1970	34	1-Jun-1995	9	4	8	3	2	R	1,426.56	R	534.96	R 1,961.52
506	F	27-Sep-1957	47	11-Mar-1979	25	5	20	2	1	R	4,217.60	R	421.76	R 4,639.36
507	F	27-Mar-1973	31	1-Dec-1998	6	4	15	4	3	R	2,674.80	R	713.28	R 3,388.08
508	F	7-Dec-1972	32	1-May-1997	7	7	14	21	9	R	4,552.80	R	6,829.20	R 11,382.00
509	F	27-Jan-1960	44	1-Apr-1988	16	6	0	22	9			R	5,744.64	R 5,744.64
510	F	5-May-1949	55	15-Feb-1987	17	5	0	7	6			R	1,476.16	R 1,476.16
511	F	18-Oct-1968	36	1-Dec-1997	7	4	1	15	3	R	178.32	R	2,674.80	R 2,853.12
512	F			1-Jan-1985	19	8	0	7	3			R	2,827.44	R 2,827.44
513	F	11-Oct-1964	40	1-Jan-1987	17	8	1	9	5	R	403.92		R 3,635.28	R 4,039.20
514	F	28-Jun-1964	40	1-Jun-1995	9	6	0	1	1			R	261.12	R 261.12
515	F	20-Sep-1958	46	16-Dec-1981	23	5	14	1	1	R	2,952.32	R	210.88	R 3,163.20
516	F	7-Nov-1942	62	1-Apr-1971	33	8	0	0	0					
TOTAL							**1318**	**3451**	**1718**	**R**	**345,545.38**		**R 876,949.35**	**R 1,222,530.01**

APPENDIX 4

511 Staff Residence
Red Cross Children's hospital
Klipfontein Road
RONDEBOSCH
7700

Dear Sir/ Madam

CONSENT TO PARTICIPATE IN THE STUDY OF ABSENTEEISM

I, RS Ngcobo, am undertaking a research project as a partial fulfilment of the requirement for the award of a Master of Public Health.

The title of the project is: **Nursing staff absenteeism at Red Cross Children's Hospital and its financial implications.** The purpose of the study is to establish the determinants of absenteeism among nursing personnel of Red Cross Children's Hospital. This involves establishing the extent and identifying major causes of absenteeism among nursing personnel. The other aspect of the study is to estimate the financial burden of absenteeism for the hospital. It is hoped that the study will assist managers in managing absenteeism.

I request your consent to participate freely in this study. Your confidentiality will be protected at all times. You are free to withdraw from the study if at any time you feel uncomfortable and you have the right to decline answering any of the questions.

The results of this study will be shared with nursing and institutional management and the final report will be made available to you on request.

If you willingly agree to participate in this study, please sign this consent letter as evidence of your permission.

Yours sincerely

RS Ngcobo
Phone Number: (021) 658 5417 (w)

I_____, have read this consent letter and willingly agree to participate in this study. I know my rights as a respondent and the researcher promises to respect them at all times throughout this study.

Signed:_____(Respondent)

Date:_____

APPENDIX 5

511 Staff Residence
Red Cross Children's Hospital
RONDEBOSCH
7700
23 June 2004

Chief Executive Officer
Red Cross Children's Hospital
RONDEBOSCH
7700

Dear Dr Adams

I hereby request your approval to conduct a research as a partial fulfillment of the requirements for the award of a Master of Public Health.

The title of the thesis is "Nursing Staff Absenteeism at Red Cross Children's Hospital and its Financial Implications". The objective of the study is to establish the determinants of absenteeism among nursing personnel of Red Cross Children's Hospital and financial implications. The study will involve interviews with nursing personnel and managers and getting information on absenteeism from personnel salary information system (Persal).

I am submitting a final protocol and all relevant appendices for approval. I greatly appreciate your assistance in this matter and hope that I have included all the necessary documentation for a successful approval of my application.

Yours sincerely

Richard Sibongiseni Ngcobo

Contact Details:
Tel: (021) 658 5417
Email: Rngcobo@pgwc.gov.za