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CHAPTER 1: RESEARCH ORIENTATION

Education, particularly higher education, will take Africa into the mainstream of globalisation.

John Agyekum Kufor

1.1 INTRODUCTION

Globalisation as a process affects the economic, political, social and cultural relations in societies around the world. As higher education institutions (HEIs) exist within the world, they cannot be unaffected by globalisation, especially where the world changes around an institution and where time, speed and capacity become valued commodities within the larger society. In a global economic order, knowledge as represented by human capital, is a commodity that increasingly moves between countries, and companies need to embrace new tactics to retain human capital (Herbert, 2016, p. 65). Globalisation has not only led to the general global competition among employers for the best human capital, but also specific competition among HEIs for the best intellectual capital (Arokiasamy, 2011, p. 73; Taberner, 2017, p. 2). As HEIs respond to global changes, their responses have a direct impact on the psychological well-being and physical wellness of their employees (Bezuidenhout, 2015, p. 13; Bezuidenhout & Cilliers, 2010; Darabi, Macaskill & Reidy, 2016, p. 14; Poalses & Bezuidenhout, 2018, p. 185; Sang, Teo, Cooper & Bohle, 2013, p. 32; Shaw & Ward, 2014; Setati, 2014, p. 151; Yusof & Khan, 2013, p. 95).

Chapter 1 offers a summary of the changing world for HEIs from an international, national and the specific open distance learning institution's perspective, as well as the effect on the psychological and physical capacity of HEIs' employees. From this, the problem statement, research purpose and questions were formulated. In the chapter I share my research archetype and the associated design and methodology. A concise summary of the methods used to ensure the trustworthiness and a brief deliberation on the ethical considerations for the study are presented. The chapter concludes with an outline of the thesis.

1.2 CHANGING WORLD FOR HIGHER EDUCATION INSTITUTIONS

Globally higher education institutions (HEIs) are on the verge of major changes due to the increasingly complex and competitive environment they operate in. Consequently, these institutions need to respond to the contemporary, global challenges such as international and national economic, political, educational, social, demographic, environmental, and technological changes (Arokiasamy, 2011, p. 78; Calderon & Mathies, 2013, p. 77; Daniel; 2015, p. 904-905; Overstreet, 2017, p. 10; Paliwal, 2018, p. 16.1; Scott, 2013, p. 275; Suganya, 2017, p. 1; Taberner, 2017, p. 2). These challenges are presented in more detail below.

1.2.1 International higher education challenges

The changing world requires of HEIs to develop strategies and approaches to respond to a number of challenges. The first challenge is the continued massification of higher education whereby the numbers of students are growing. According to Arokiasamy (2011, p. 76) this increased demand in education is a phenomenon in rapidly expanding developing nations, as education is perceived as the quickest route for social mobility. In addition, many governments across the globe expand higher education in order to develop professionals with high levels of innovation and creativity to achieve global competitiveness (Mok & Wu, 2016, p. 78). The growing number of students results in a greater workload and longer working hours for the employees at the HEIs (Bexley, Arkoudis & James, 2013, p. 397; Shaw & Ward, 2014). This growth requires proper planning of resources such as human, financial, and facilities, by HEIs (Bexley et al., 2013, p. 397; Calderon & Mathies, 2013, p. 78; Darabi et al., 2016, p. 4-5).

Secondly, there is a continuous decrease of public funding. Funding problems at public HEIs will not disappear in the near future. HEIs will be required to operate within rigid financial constraints, become more efficient and productive,

do more with less and meet more social needs, resulting in increased privatisation and marketisation of the institutions (Arokiasamy, 2011, p. 76; Calderon & Mathies, 2013, p. 80; Combs, 2018, pp. 11-12; Darabi et al., 2016, p. 11; Gepper & Hollinshead, 2017, p. 146; Morson & Schapiro, 2015; Shaw & Ward, 2014; Thomas, Antony, Francis & Fisher, 2015, p. 983; Tierney, 2014, pp. 1419-1420).

The reduction in public funding leads to the third challenge, namely, that HEIs must explore various avenues for additional funding from other organisations such as the private sector, non-governmental organisations and donors. This means that, as they develop numerous partnerships with these other organisations, they become increasingly accountable to them, resulting in additional governance or accountability responsibilities. HEIs will be required to meet the various reporting requirements of these external funding organisations and will not be able to rely on a single, standard report, and will, therefore need to change their traditional governance structures (Arokiasamy, 2011, p. 76; Bexley et al., 2013, p. 397; Calderon & Mathies, 2013, p. 79-80; Gepper & Hollinshead, 2017, p. 146; Overstreet, 2017, p. 10; Tierney, 2014, p. 1419).

The fourth challenge is the changing role of academics due to the greater number of students, funding pressures, diversification of institutional missions and the impact of these on the traditional academic work roles such as teaching, research and student service (Bexley et al., 2013, p. 385; Darabi et al., 2016, pp. 9-10; Tierney, 2014, p. 1421). A shortfall in academic staff may be created due to anticipated retirements, career changes and possible departures by academic employees due to the globalisation in the higher education sector (Bexley et al., 2013, p. 385). There is also a change in the tenure of academic employees (permanent versus contract appointment). In 1975, 57 percent of all full- and part-time faculty employees in the USA were permanently employed, a figure that has fallen to below 35 percent in 2014 (Morson & Schapiro, 2015; Tierney, 2014, p. 1421). In Australia there is also a trend towards the

casualisation of academic employment, whereby short- and/or medium-term and sessional contracts are concluded (Bexley et al., 2013, p. 385).

The last key challenge that requires careful analysis is the impact of technology on HEIs. As a result of technology, online education may increase with greater emphasis on learning outcomes than credit hours earned in a classroom. This will result in that no additional funding is required for more buildings to accommodate the growing number of students. Against the background of a continued reduction in funding, an added benefit of the increased use of technology, may be that costs could significantly decrease as large numbers of students use technology and fewer academic staff may be required (Arkorful & Abaidoo, 2015, p. 34; Tierney, 2014, pp. 1423-1425).

To adapt to the challenges in the changing environment, HEIs react in different ways. Some of these are internal re-organisation, merging of departments and the merger of institutions. The main driving force behind the merger of many HEIs appears to be the maximisation of economies of scale and the hope of achieving administrative, economic, and academic advantages to improve competitiveness (Dasborough, Lamb & Suseno, 2015, p. 579; Puusa & Kekäle, 2013, p. 205). In the Australian higher education sector, it was found that during these changes, employees experienced the change differently. This requires that line managers should not join employees in one homogenous group, but rather have various individual change management interventions to manage individual employee's change experiences into positive outcomes (Dasborough et al., 2015, p. 587). In addition, many academics are overwhelmed with the increased workload expectations due to the rising student numbers, increased administrative work, accountability expectations, increasing pressure to produce measurable outputs and the accompanying diversification of academic work roles. This requires a systematic response to deal with the unmanaged growth in the expectations on academic employees (Bexley et al., 2013, p. 397).

The foregoing challenges, such as the increasing number of students, reduced funding, additional workload (including additional workload to attract external research funding), and additional governance duties, have a negative impact on the psychological well-being and physical wellness of higher education employees (Darabi et al., 2016, p. 14; Sang et al., 2013, p. 32; Shaw & Ward, 2014; Yusof & Khan, 2013, p. 95). In the United Kingdom mental health problems are on the rise among academics due to the challenges in the higher education system (Shaw & Ward, 2014). The challenges may cause tiredness, sleeping problems, lack of concentration, decreased institutional commitment, poor morale, and in some instances, even staff turnover (Darabi et al., 2016, p. 14; Yusoff & Khan, 2013, pp. 90, 95). Sang et al. (2013, p. 32) found that there was a significant difference in the job stressors between academic and non-academic employees, where academic employees reported higher levels of job stressors and job dissatisfaction than non-academic employees.

Darabi et al. (2016, p. 14) contend that it will be in the interest of HEIs to address these challenges as it will reduce the academic employees' work-related stress and allow them more time to focus on the core business of teaching and research. Melnyk, Amaya, Szalacha and Hoying (2016, p. 310) argue that although HEIs are the ideal place to enhance the health of the academic employees, they actually lag behind corporate America regarding wellness programmes. Stone, Crooks and Owen (2013, p. 153) argue that in a knowledge economy, employees are valued for their intellect and abilities to produce information, hence academic employees are classical knowledge employees as they use their minds to create and communicate knowledge. Theoretically, this should mean that the physical state of their bodies is irrelevant; however, as HEIs are operating within a larger social context in which physical impairment is coded as synonymous with inability, prevalent understanding of (dis)ability infiltrate the higher education environment and serves as backdrop against which academic employees are judged. Stone et al. (2013, p. 169) argue that as chronic illness and disability are highly stigmatised,

workplaces should become friendly places that welcome diversity. They recommend that it would be useful for human resource departments to make information on disability and reasonable accommodation available to all employees and that the information be explicitly provided to new employees. HEIs need not only educate themselves on diversity but must also create a working climate which allows employees to feel welcome in all their diversity (Stone et al., 2013, p. 170). Despite these suggestions on how to address the identified challenges, limited research has been done on the impact of the challenges on the psychological well-being and physical wellness of higher education employees, resulting in a scarcity of evidence, thus creating a knowledge gap (Sang et al., 2013, p. 16; Shaw & Ward, 2014; Yusoff & Khan, 2013, p. 91).

1.2.2 South African higher education challenges

Since the dawn of democracy in 1994, HEIs in South Africa were exposed to several major transformation initiatives. The National Commission on Higher Education (NCHE) that dealt with the transformation of the higher education sector received international assistance from among others, the American Council on Education, Centre for Higher Education Policy Studies in the Netherlands, and Commonwealth Management Services in the United Kingdom (Cloete, 2014, p. 1361). This resulted in the transformed South African higher education sector model, largely drawing from the developed countries such as the United States of America, the United Kingdom, the Netherlands and Australia (Setati, 2014, p. 1).

Higher education in South Africa has shifted from a fragmented and structurally racialised system to a relatively integrated and inclusive system through government enforced mergers, which reduced the number of South African HEIs from 36 universities and technikons to 23 institutions, consisting of 11 universities, six universities of technology and six comprehensive institutions (Davis, 2013, p. 167, Herbst & Conradie, 2011, p. 2; The Ministerial Oversight

Committee on Transformation in South African Public Universities, 2015; Universities South Africa, 2015, p. 1). Over and above HEIs' transformation to dissolve the racialised inequalities that existed among the institutions, they also had to adapt to the fast changing, technology-driven and information-based competitive and globalised economies (Sehoole, 2005, p. 164). Two new HEIs, the University of Mpumalanga and the Sol Plaatje University were established in the Mpumalanga and Northern Cape provinces respectively, where no universities or technikons existed (Pityana, 2004, p. 10; University of Mpumalanga, 2015; University of Sol Plaatje, 2015).

One of the current transformation initiatives in higher education is the expansion of quality distance education due to the inability of the South African higher education sector to accommodate the required growth in the post-school sector. The Policy for the Provision of Distance Education in South African Universities (Republic of South Africa, 2014, p. 10) suggests that by expanding distance education, the higher education sector can accommodate the growing demand more cost-effectively and cost-efficiently than the traditional face-to-face education. The Policy for the Provision of Distance Education in South African Universities (Republic of South Africa, 2014, p. 12) supports additional HEIs, both public and private institutions, in offering distance education programmes, provided they demonstrate their capacity to do so and meet the required standards.

Several challenges such as the declining state funding which decreased from 0,76% of the gross domestic product in 2000 to 0,74% in 2016; increased student numbers that rose from 480 000 in 1994 to 975 837 in 2016; organisational culture issues, and new technological developments contribute to the increasing demands on employees of HEIs in South Africa. These challenges force HEIs to adapt for competitive and sustainability reasons, including the generation of a third stream of income to compliment the income from state subsidies and student fees (Africa Check, 2016; Badat, 2015, pp. 74-75; Council on Higher Education, 2018, p. 3; Davis, 2013;

Makhanya, 2017, p. 13; Moolman & Jacobs, 2018, pp. 180-182; Netswera, Rankhumise & Mavundla, 2005; The Ministerial Oversight Committee on Transformation in South African Public Universities, 2015; Theron, Barkhuizen & Du Plessis, 2014; Universities South Africa, 2015, p. 20). The practice to generate additional revenue by increasing student fees is no longer a viable option, due to the #FeesMustFall campaign in 2015, which resulted in no tuition fee increases for the 2016 academic year. The intention was that government would make up the short-fall to HEIs, against the background that education is generally underfunded in South Africa, which includes the largely state-funded National Student Financial Aid Scheme (NSFAS) that is supposed to support all deserving students for undergraduate and postgraduate studies (Badat, 2015, pp. 74-75; Moolman & Jacobs, 2018, pp. 178-179). As early as 2004 Pityana (2004, p. 10) raised a concern regarding the funding of higher education in South Africa. He indicated that one of the criticisms of the merger policy is that the funding for the mergers was inadequate. Similarly, Ntshoe, Higgs, Higgs and Wolhuter (2008, pp. 393-395) argue that public university academics have transformed into “academic capitalists” to generate the much needed third stream income that will benefit the individual, the institution and the country.

The above-mentioned challenges have the effect that HEIs are almost in a continuous transformation process (Pityana, 2004; Republic of South Africa, 2014). Employees are at the heart of this continuous transformation and it has an impact on them, either positive or negative. Setati (2014, pp. 151,157) points out that the transformation in higher education has an impact on the general health of employees. Bezuidenhout and Cilliers (2010) found that, due to numerous challenges that female academics face in the continuously changing landscape of the South African higher education sector, the cynicism sub-dimension of burnout shows especially strong indications of increase. In other words, the constant changes may contribute to ill health and incapacity of HEI employees. The challenge of increased student numbers results in academic employees experiencing high levels of stress relating to overload and

work-life balance. The high levels of stress impact more on the psychological well-being of the academic employees than their physical well-being. Due to the job demands (having too much work; working under time pressure), academic employees also experience moderate to high levels of burnout (Barkhuizen, 2005, pp. 101, 103, 135-136). Herbst and Conradie (2011, p. 2) argue that very little research has been devoted to the impact of the major transformation that occurred in the South African higher education sector on the personal and emotional experiences of employees at HEIs.

Other challenges that the South African HEIs face, are an ageing professoriate, high student/employee ratios, low levels of academic staff qualifications and low levels of high-level skill production. In 2015, over half of the 17 800 permanent academic employees were over the age of 50 and a significant number of them will have retired by 2020. Since 1994 the student population has more than doubled and the number of permanent academic employees has only increased by approximately 40% over the same period, resulting in the ratio of students to permanent academic staff members increasing from 39 in 1994 to 55 in 2014 (Council on Higher Education, 2016, pp. 295, 297; The Ministerial Oversight Committee on Transformation in South African Public Universities, 2015). These statistics confirm Liebenberg and Barnes' (2012, p. 37) concern that, should there not be proper capacity planning, it will shift the key academic performance responsibilities of teaching and learning, research, academic citizenship and community engagement to the remaining decreasing number of academic employees. This shift may then lead to overburdened academic employees and may have a negative impact on their health.

1.2.3 Open Distance Learning institution challenges

The Open Distance Learning (ODL) institution where the study was undertaken is the result of a merger between three former higher education distance learning institutions in 2004. The ODL institution confirms that it finds itself in a

second wave of transformation since the original merger process in 2004 (University of South Africa, 2014c, p. 4).

The research should be seen against the background that the ODL institution is strategically seeking to establish itself and be recognised as a leading open distance electronic learning institution (ODeL) among the mega-universities of the world (Makhanya, 2017, pp. 8, 15; University of South Africa, 2015a, p. 3). This strategic focus area was reconfirmed in the institution's 2016–2030 Strategic Plan (University of South Africa, 2015b, p. 12): “Towards becoming a leading ODeL, comprehensive university in teaching and learning, research, innovation and community engagement based on scholarship.” One of the challenges that the ODL institution identified, was that the majority of its sister institutions among the mega-universities reached vast numbers of students with a fraction of the staffing levels. The ODL institution argues that attention should be given to achieving economies of scale and scope where practical (University of South Africa, 2015a, p. 3). It appears that the ODL institution would prefer to increase the number of students per academic ratio. This may have an impact on the workload of the decreasing number of academics and may lead to incapacity due to work overload.

A second challenge faced by the ODL institution is that, although it is confirmed as the dedicated public provider of distance education in South Africa, it no longer has the exclusive rights as the only ODL institution. This brings about increased competition (from traditional and private HEIs, locally, continentally, and globally) that may potentially impact on student numbers, in turn impacting on state funding. This has the impact that the ODL institution should make it an absolute imperative to creatively sustain, in the national, continental and global ODL domains, a competitive edge (Makhanya, 2017, pp. 8,13; Republic of South Africa, 2014, p. 12; University of South Africa, 2014c, p. 4; University of South Africa, 2015b, p. 4). To achieve the competitive edge, the ODL institution may demand more output from the employees. Linked with the concern raised by Liebenberg and Barnes (2012, p. 37) that, due to an increasing number of

students and the ageing of academic employees, key academic performance responsibilities will shift to the remaining number of academic employees, demanding more output, which may have a negative impact on their health.

Another challenge faced by the ODL institution, is the highly complex task of distance educators balancing their academic responsibilities. According to Bezuidenhout (2015, p. 9) the academic key performance areas at the ODL institution consists of teaching and learning, research, academic citizenship and community engagement. It translates into work-role conflicts between student success, support, quality demands, maintaining high academic standards, and producing quality and quantity research outputs. Due to the perceived changing work-role expectations of distance educators, it is possible that they may suffer from high stress levels and mental health problems (Barkhuizen, 2005, p. 103; Bezuidenhout, 2015, p. 13; Poalses & Bezuidenhout, 2018, p. 180).

As with other HEIs, the ODL institution also faces challenges of declining state funding, compliance to an enhanced regulatory regime, quality improvement and assurance, increased pressure to generate a third stream of income, and financial sustainability (University of South Africa, 2015a, p. 2). The ODL institution has migrated from an annual reporting format to a more rigorous and demanding integrated reporting format as guided by the reporting regulations of the Department of Higher Education and Training; the audit standards of the South African Auditor General; the International Integrated Reporting Framework; King IV Code; the Global Reporting initiative; the United Nations Global Compact and recommendations by the institution's Audit and Enterprise Risk Management Committee of Council (Makhanya, 2017, pp. 6, 8, 14; Universities South Africa, 2015, pp. 7-8; University of South Africa, 2014c, p. 4). According to Davis (2013, p. 168) these additional compliance requirements resulted in growing administrative demands, compliance, and reporting workloads for academic employees of HEIs. This non-academic workload may also cause higher stress levels.

The challenges that the ODL institution will face due to the two newly established public HEIs and the increasing competition from leading private HEIs offering distance learning programmes, are yet to be determined. Another challenge faced by the ODL institution, is the impact of the deliverables as contained in the 2016–2030 Strategic Plan of the ODL institution (University of South Africa, 2015b) on the employment and psychological contracts between employees and the institution. In terms of the employment contract, the expected deliverables will lead to the amendment of key performance areas in individual performance contracts. The amendment to the performance contracts may lead to an employee perceiving a breach of the psychological contract in that the employee may feel that the ODL institution failed to uphold its perceived reciprocal obligations in terms of the psychological contract. The employee may even perceive the amendment of the performance contract as unfair and unjust. Ramjee (2002, p. 6) argues that the psychological contract is the key variable that causes organisational change to succeed or fail, and it is therefore crucial that an employer should understand the philosophy thereof. Kiazad, Seibert, and Kraimer (2014, p. 550) contend that as institutions compete in a turbulent business environment they find it increasingly difficult to fulfil their obligations to employees as perceived in the psychological contract. This may also be valid at the ODL institution that has been in a continuous transformative mode for the last two decades. A psychological contract breach occurs when the employee believes that the employer fails to respond to his or her contribution in a manner that he or she believes the employer is obliged to do. A perceived breach may be problematic and stressful – it goes beyond perceptions of inequity and dissatisfaction – it involves feelings of betrayal and deeper psychological distress (Rosseau, 1989, p. 128).

As the ODL institution is transforming into an ODeL institution, which will impact on the work roles of employees, so will the expectations from both role players change, meaning that the psychological contract will become dynamic and may have to be constantly “renegotiated” (Ramjee, 2002, p. 31; Schein, 1980, p. 24). If, in this constant renegotiating process, there is no convergence of

expectations, it will result in discontent between parties, which may cause increased stress for employees (Ramjee, 2002, p. 107).

These various contracts referred to above are summarised in Table 1.1.

Table 1.1: Summary of key elements of employment, performance and psychological contracts (own compilation)

Employee	Type of agreement	Employer
Provide service	Employment contract	Pay for service
Key performance areas	Performance agreement	Set standards
Expectations: Dignity and worth.	Psychological contract	Expectations: Motivated employee serving the interest of the institution.

In the continuous journey of transformation since democracy in 1994, the 2004 merger and the institutions' 2016–2030 strategic vision to become a leading ODeL institution, the ODL institution needs to design and implement human resource interventions that will limit the impact on its employees. These interventions should attempt to renegotiate, and not breach, the psychological contract (in particular) to ensure that the impact of the journey does not result in incapacitated employees. In addition, the interventions should be done in such a manner that the employees have a fair perception of the organisational justice, so that their attitudes, behaviour, and performance contribute to the success of the ODL institution.

1.3 PROBLEM STATEMENT

The global higher education landscape is changing due to constant transformation. The main reasons for the transformation are increased student numbers, the reduction in state funding, privatisation, new governance structures in terms of compliance and accountability, the changing role of academic employees, and the increased use of new technology. To stay competitive, relevant and sustainable, the HEIs need to adjust to the challenges they are facing. Some of the interventions are internal, such as re-organisation, merging of departments, exploring additional revenue streams, and changing the method of teaching, such as distance education or even open distance electronic learning.

Employees of HEIs are at the heart of this continuous change as they render the academic services to students. In particular, the roles and workload of academics are changing. The literature indicates that the changes have a negative impact on the health of the academic employees (Barkhuizen, 2005, p. 103; Bezuidenhout, 2015, p. 13; Darabi et al., 2016, p. 14; Poalses & Bezuidenhout, 2018, p. 180; Sang et al., 2013, p. 32; Shaw & Ward, 2014; Yusoff & Khan, 2013, p. 95). The impact of these changes is not limited to the direct employment relationship (employment contract) but may also have an impact on the psychological contract between employees and the institution that, when breached, may lead to psychological distress. Fourie (1999, p. 286) found that in trying to cope with the transformation of higher education in South Africa, many academics go through the same psychological stages that terminally ill patients experience, namely denial, anger, bargaining, depression, and finally, acceptance.

Research literature has shown that having an incapacity management framework benefits both the employer and the affected employee in that it ensures healthy employees who assist the employer to remain competitive and sustainable (Bexley et al., 2013, p. 397; Dasborough et al., 2015, p. 587). In

addition, the South African employment legislation places certain statutory obligations on an employer when an employee is viewed incapacitated or disabled due to illness. These laws also stipulate that should it not be feasible to reasonably accommodate an employee, the employment contract may be terminated. However, the legislation does not provide for a detailed incapacity management framework providing employers and employees with clear guidance on the prescribed actions, specifically regarding the accommodation of affected employees in the workplace. This lack of clarity has resulted in a knowledge gap in terms of how incapacity or disability due to illness in the workplace should be managed.

The ODL institution, although making provision for sick leave (short-term incapacity) in its leave policy, and also for disability risk insurance in cases of permanent disability, does not make any provision for temporary incapacity leave for these employees. It only provides for temporary incapacity leave for approximately seven percent of the institution's permanent employees, who retained this as a personalised pre-merger condition of employment. In addition, there is no formally negotiated and approved policy and procedures that deal with the management of incapacity due to ill health, reasonable accommodation for incapacity, or fair termination of employment in terms of incapacity due to illness. In practice, this leads to uncertainty and additional stress for line managers and fellow employees. This results in a knowledge gap on how to holistically manage incapacity due to ill health at the institution. The knowledge gap informed this study, which investigated the management of incapacity in the ODL institution within the provisions of the relevant legislation and best practices. Further research is required to establish what constitutes reasonable accommodation of affected employees at the ODL institution. Lastly, the ODL institution does not have a formalised policy or procedures in place to guide the delegated authority when an employee needs to be dismissed due to incapacity due to ill health.

1.4 RESEARCH PURPOSE

The general purpose of this research was to develop a incapacity management framework by exploring the incapacity management practices at an ODL institution.

1.5 RESEARCH QUESTIONS

Primarily, this study explored the incapacity management practices in an ODL institution in South Africa and the study was guided by the following research questions:

1.5.1 Central research question

What elements should comprise an effective and comprehensive incapacity management framework suitable for an ODL institution in order to ensure that incapacity management is done fairly and equitably?

1.5.2 Sub-questions

- 1.5.2.1 How should incapacity in the workplace be managed in order to ensure that organisational justice is achieved?
- 1.5.2.2 How is incapacity conceptualised in the workplace and what are the incapacity management practices available in a workplace?
- 1.5.2.3 What are the statutory and regulatory obligations that organisations need to comply with in managing incapacity in the workplace and what are the implications thereof?
- 1.5.2.4 What are the minimum requirements for accommodating incapacity and the generally accepted reasonable accommodation practices available in a workplace?

- 1.5.2.5 What are the real-life experiences of affected employees and managers in terms of the current incapacity management practices in the ODL institution?
- 1.5.2.6 What acceptable incapacity management practices can the ODL institution put in place to ensure that incapacitated employees can be rehabilitated and retained?
- 1.5.2.7 What recommendations can be made for the ODL institution to develop new, or amend existing policies and procedures to manage incapacity cases, which result from ill health?

1.6 RESEARCH PARADIGM

Although research is often viewed as the methodology to systematically collect and logically analyse data for a specific purpose or to increase one's knowledge of a phenomenon, it is important to perform the research within a specific research paradigm. According to Mackenzie and Knipe (2006, p. 194) a paradigm provides the basis for research decisions on design, methodology, methods and literature.

A research paradigm is a basic set of beliefs, principles, and assumptions that guide how a researcher views the world and interprets and acts within that world. It is the philosophy through which the researcher examines the methodological aspects of the research project to determine the research methods that will be used and guide the way in which data will be analysed (Creswell, 2007, p. 19; Kivinja & Kuyini, 2017, p. 26). The research paradigm differs from the everyday use of the term "paradigm" as it is encapsulated in a particular epistemology, ontology and axiology that guides the researcher towards a particular methodology (Kivinja & Kuyini, 2017, pp. 26-29; Wahyuni, 2012, p. 69).

The three main research paradigms predominantly used in research are known as the positivist, interpretivist paradigms, and critical enquiry. A fourth research

paradigm comprising of a mixture of the other three paradigms, is named the pragmatic paradigm (Creswell, 2007, p. 19; Creswell & Miller, 1997, pp. 33-34; Elshafie, 2013, p. 5; Kivinja & Kuyini, 2017, p. 30; Shah & Al-Bargi, 2013, p. 253).

After careful analysis of the various research paradigms, I opted to conduct this research within the interpretive research paradigm, subscribing to its epistemological and ontological philosophies that informed my methodology. The interpretive research paradigm is also referred to as constructivism as it emphasises the ability of the individual to construct meaning (Mack, 2010, p. 7; Mackenzie & Knipe, 2006, p. 195; Wahyuni, 2012, p. 71). By applying the interpretive research paradigm, the researcher seeks to construct and interpret the research phenomena as experienced, interpreted, and understood by the research participants in their social and cultural world. It is recognised that participants with their own background, experience and assumptions, contribute to the ongoing constructing of reality, with and through the interaction in their world. The knowledge of the phenomena, therefore, forms part of the participant's knowledge and the researcher must make every effort to understand the participant's point of view and his or her interpretation of the social phenomena. This requires of the researcher to engage with the participants in their natural world where data are gathered about their lived experiences in their daily interactions (Creswell & Miller, 1997, p. 37; Elshafie, 2013, p. 7; Kivinja & Kuyini, 2017, p. 33; Mackenzie & Knipe, 2006, p. 195; McMillan & Schumacher, 2014, p. 345; Rossman & Rallis, 2012, p. 8; Shah & Al-Bargi, 2013, p. 256; Thanh & Thanh, 2015, p. 24; Wahyuni, 2012, p. 71). I now describe the concepts "epistemology", "ontology", and "axiology" within the interpretive paradigm.

Epistemology is the theory of knowledge or the way of knowing the world. It requires the researcher to ask what acceptable knowledge is and what is known to be acceptable, true, and valid that can be taken as evidence. The epistemological assumptions of the interpretive paradigm are that there is no

correct route or one particular method to knowledge. There is an understanding that the participants and the researcher will construct knowledge socially as a result of their personal experiences of the real life investigated within the natural settings. Knowledge arises from particular real-life situations and is not reducible to simplistic interpretation. Knowledge is gained through personal experience whereby the researcher and participants are engaged in interactive processes of data collection. The researcher must make meaning of the research data through his or her own thinking and cognitive processes of interpretation, as influenced by the interactions with the participants and the social context (Creswell, 2007, p. 18; Creswell & Miller, 1997, p. 37; Elshafie, 2013, pp. 5, 7; Kivinja & Kuyini, 2017, pp. 27, 33; Mack, 2010, p. 8; Robson, 2011, p. 525; Rossman & Rallis, 2012, p. 7; Shah & Al-Bargi, 2013, p. 257; Wahyuni, 2012, pp. 69, 71).

Ontology refers to a branch of philosophy concerned with the reality – how do researchers view reality, the nature of the human beings in the real world and how it influences human beings' behaviour. The assumptions of ontology mean that the researcher believes that the reality of the phenomenon under investigation may have multiple perspectives as a result of the participants' knowledge, views, interpretations and experiences, which are subjective. The realities can meaningfully be explored and constructed or reconstructed through human interaction between the researcher and the participants. As I was the person who obtained the relevant data through interviews with participants and analysed the relevant documents, I was the research instrument in describing and interpreting the incapacity phenomenon (Creswell, 2007, p. 16; Creswell & Miller, 1997, p. 37; Denzin & Lincoln, 1994, p. 108; Elshafie, 2013, pp. 5, 8; Kivinja & Kuyini, 2017, pp. 27, 33; Mack, 2010, p. 8; Poggenpoel & Myburgh, 2003, p. 418; Robson, 2011, p. 525; Shah & Al-Bargi, 2013, p. 257; Wahyuni, 2012, p. 71).

Axiology refers to how the researcher is a moral (ethical) person in the world, by defining, evaluating and understanding concepts of right and wrong behaviour

relating to the research. I complied with the prescribed ethical requirements and attempted to provide a balanced axiology through the understanding and recognition of the role my values and perceptions may have had on the collection and analysis of the data and the reporting on the findings (Creswell, 2007, p. 18; Elshafie, 2013, p. 5; Kivinja & Kuyini, 2017, p. 27; Robson, 2011, p. 525; Rossman & Rallis, 2012, p. 69; Wahyuni, 2012, p. 71).

Given that I subscribed to the epistemological, ontological and axiological philosophies of the interpretive research paradigm, a qualitative research approach appeared to be the most suitable as it is interpretive in nature, does not test hypotheses, nor believes that I can control aspects of the world I am exploring. It allows for the exploration of the perceptions and understanding of participants' personal experiences (Rossman & Rallis, 2012, pp. 6-7; Stake, 2010, p. 1).

Methodology is the logical application of methods, approaches and procedures to obtain knowledge about the world. It includes assumptions made, limitations encountered, and how they are mitigated or minimised (Elshafie, 2013, p. 5; Kivinja & Kuyini, 2017, p. 28; Robson, 2011, p. 525).

A very important relationship exists between the research paradigm and methodology, as the methodological implications of the choice of paradigm permeate the research question(s), participant selection, data collection instruments, procedures, and analysis. Whereas the interpretive research paradigm endeavours to understand a participant's point of view and lived experiences within a certain context and natural setting, I opted for a case study design. The case study design allowed me to interact with the participants through semi-structured interviews, to gain knowledge of their personal experiences on incapacity management in the ODL institution. To make meaning of the data collected and to find answers for the research questions, the data were analysed using thematic analysis.

1.7 RESEARCH DESIGN AND METHODOLOGY

The literature confirms that, due to the continuous transformation (especially in higher education), employees' health will be affected (Barkhuizen, 2005, pp. 101, 103; Bezuidenhout, 2015, p. 13; Bezuidenhout & Cilliers, 2010; Darabi et al., 2016, p. 14; Sang et al., 2013, p. 32; Setati, 2014, p. 151; Shaw & Ward, 2014; Yusoff & Khan, 2013, p. 95). However, research on the management of incapacity due to ill health in the higher education sector is limited, and therefore I opted for an exploratory approach, especially in the natural context of an ODL institution (Herbst & Conradie, 2011, p. 2; Sang et al., 2013, p. 16; Shaw & Ward, 2014; Yusoff & Khan, 2013, p. 91). Exploratory research does not intend to offer final and conclusive answers to the research questions, but merely to explore the research topic with varying levels of depth, to provide a researcher with an improved understanding of a phenomenon. Applying the interpretive research paradigm assisted me to understand the research phenomena (incapacity management) as experienced by the research participants in their social and cultural contexts.

This knowledge gap on incapacity management in an ODL environment lent itself to a qualitative, explorative case study design. This philosophical and methodological choice offered an opportunity to gain an in-depth understanding of the participants' real-life experiences and perspectives regarding the management of ill health incapacity in an ODL context. The exploratory phase comprised of two methods of data collection, namely interviews and document analysis. The document analysis included an analysis of relevant literature, transcribed interviews, documents (including policies and procedures), and legislation associated with the phenomenon of incapacity management. This study was contextual in that it allowed for the investigation of the phenomenon of incapacity management in the ODL institution and involved current employees, retirees, line managers who manage current incapacitated

employees, and line managers who previously managed retirees who retired due to ill health.

This necessitated that the participants, as well as relevant documentation, needed to be selected. The 16 participants were selected through purposive sampling because they could contribute relevant knowledge and insights regarding the phenomenon of incapacity management based on their personal experiences. Documentation that could shed light on the topic under research was selected and analysed. Thus, data for this study were collected from interviews and documents.

Prior to the interviews, I invited the participants to take part in the study by using a participant information sheet (Annexure A) that indicated the purpose of the study, why the participant was selected, the participant's rights, and the confidentiality of the interviews. The interviews explored the phenomenon of incapacity management in the ODL institution. The interviews were conducted in a private, natural, and neutral setting as per the participants' choice. To enhance the rigour of the study, the interviews were transcribed by me and participant validation ("member checking") employed – a summary of the interview was provided to the relevant participant to confirm the correctness of the content.

In this study thematic analysis was chosen as the most appropriate method to analyse the data to report on the participants' experiences (Robson, 2011, p. 474; Vaismoradi, Turenen & Bondas, 2013, p. 403).

Various measures, such as triangulation (including an experienced co-coder to analyse the interviews), prolonged engagement, member checking, and peer review, were used to enhance the truthfulness and rigour of this research. The research design and methodology are described in detail in chapter 5.

1.8 POTENTIAL VALUE ADDED BY THIS STUDY

The promulgation of a policy on ODL and other transformation initiatives in the South African higher education sector have resulted in assumptions that cases of incapacity are likely to increase. More specifically, stress and depression are likely to show an increased manifestation that may adversely impact employee wellness and institutional performance (Barkhuizen, 2005, p. 103; Bezuidenhout, 2015; Haafkens, Kopnina, Meerman & Van Dijk, 2011; Shaw & Ward, 2014).

Although incapacity due to ill health is included in both the Labour Relations Act 66 of 1995 and Employment Equity Act 55 of 1998, which have been in existence for more than two decades, there is still vagueness on how this phenomenon should be managed (Burger 2013, p. 4; Republic of South Africa, 1995, Schedule 8, s 10-11; Republic of South Africa, 2015b, s 1). No in-depth research could be found that investigated management of employee incapacity within a higher education institution in South Africa. Therefore, a need exists for the development of an incapacity management framework that will contribute to improved employer-employee relationships in the South African higher education sector. However, it must be emphasised that the current study sought to develop a framework focused on the ODL institution.

The first valuable contribution of the study is that it provides for an incapacity management framework, and thereby expands the general body of knowledge of human resource management, especially in relation to incapacity management. Secondly, it makes a unique contribution to the management of incapacity in the higher education sector, but with specific reference to an ODL institution. Thirdly, it may have an impact on the human resource policies and procedures and/or conditions of employment of the ODL institution. These will enable the ODL institution to provide adequate support for incapacitated employees, and ensures that it is compliant with legislative requirements.

1.9 DELIMITATIONS AND ASSUMPTIONS

The study was confined to research dealing with incapacity cases due to ill health at an ODL institution in South Africa. The research, therefore, investigated the perspectives of incapacitated employees and their line managers regarding incapacity management at the institution. The sample included academic and administrative employees. The study was not intended to distinguish between the aforementioned categories of employees based on their occupational level, nature of appointment, race, gender, and/or age.

The underlying assumption was that the participants were not able to fully perform in their key performance areas due to (a) medical condition(s), hence their inclusion in the study. The intention was not to establish the root causes of the incapacity of the employees. Furthermore, presenteeism, where an employee decides not to stay home due to his or her illness, was not explored in this study.

Although the South African legislation makes a distinction between incapacity and disability, for the purpose of this study it was assumed that both terms are synonymous in the context where the disability relates to an employee who acquired a long-term physical or mental illness during employment. The reason for this assumption is that in both scenarios the employer has an obligation to assess the medical condition of the employee, and to consider the possible alternative arrangements that can be made to reasonably accommodate the employee's health condition.

This study assumed that the research purpose and objectives could best be achieved through a case study design and data collected through interviews and document analysis.

1.10 ETHICAL CONSIDERATIONS

Throughout the study I adhered to the various ethical requirements as prescribed in section 12(2) of the Constitution of the Republic of South Africa, 1996 (Republic of South Africa, 1996); the Guidelines on Ethics in Health Research (Republic of South Africa, 2015a); and the ethical guidelines and standards as stipulated by the ODL institution (University of South Africa, 2014b). This adherence is described in more detail in chapter 5 of the study.

1.11 CHAPTER DIVISION

The study is divided into the following chapters:

Chapter 1 provides the context of the research. It presents the background and rationale for the study, the research problem, the central research and sub-questions, research paradigm, methodology, and delimitations and assumptions.

Chapter 2 reviews the construct of incapacity in the workplace. It focuses on the concepts of organisational justice in relation to incapacity management, incapacity and well-being, the impact and management thereof.

Chapter 3 examines applicable international conventions, the statutory and regulatory obligations in managing incapacity in the workplace with an attempt to provide clarity on the legal, fair and best practices – internationally, nationally and institutionally, to be followed by employers when managing incapacity.

Chapter 4 explores the phenomenon of reasonable accommodation of an incapacitated employee. It examines aspects such as workplace adjustment and return-to-work strategies from an international, national, the broader higher education sector in South Africa, and the ODL institutional perspective.

In chapter 5 a complete description of the research design and methodology, inclusive of the research approach, population and sampling, data collection, and data management and analysis are explained.

Chapter 6 reports on the research findings. The chapter provides the findings of the study based on rich descriptions of participants' responses regarding the management of incapacity in the ODL institution.

In chapter 7 a comprehensive incapacity management framework for the ODL institution is proposed.

Chapter 8 provides conclusions, limitations, and recommendations for future research.

A diagrammatic representation of the thesis structure is depicted in Figure 1.1.

CHAPTER DIVISION
Chapter 1: Research orientation
Chapter 2: Organisational justice and incapacity management in the workplace
Chapter 3: Conventions and regulatory framework on incapacity management
Chapter 4: Reasonable accommodation
Chapter 5: Research design and methodology
Chapter 6: Research findings
Chapter 7: Incapacity management framework for the ODL institution
Chapter 8: Conclusions, limitations and recommendations

Figure 1.1: Structure of the thesis (own compilation)

1.12 SUMMARY OF CHAPTER

Chapter 1 provides insights into the ongoing transformation that HEIs around the world are facing mainly due to reduced state funding, increased student numbers, new governance structures due to a heightened demand for compliance and accountability, and new technology. At the heart of this continuous transformation are the institutions' employees. This transformation wave impacts on the employment relationship (employment contract) and psychological contract between the employee and the institution and is likely to lead to an increase in incapacity cases.

The chapter provides a brief overview of the research problem, research questions, and overall research paradigm and approach.

The next chapter focuses on organisational justice and how it relates to incapacity management in the workplace.

CHAPTER 2: ORGANISATIONAL JUSTICE AND INCAPACITY MANAGEMENT IN THE WORKPLACE

Wellness is the complete integration of body, mind and spirit – the realisation that everything we do, think, feel, and believe has an effect on our state of well-being.

Greg Anderson

2.1 INTRODUCTION

As outlined in chapter 1, the theoretical foundation of this study is anchored in three foci, namely incapacity management in the workplace, the statutory and regulatory obligations regarding incapacity management, and lastly, reasonable practices to accommodate incapacitated employees. All of these should result in perceived fairness and organisational justice.

The aim of chapter 2, as diagrammatically depicted in Figure 2.1, is to provide a comprehensive literature review on the notion of incapacity and the associated best management practices thereof in the workplace. In this chapter, organisational justice is conceptualised in relation to incapacity management. The chapter also provides an overview of what is defined as incapacity in the workplace. In addition, the chapter explores the impact of incapacity on the workplace in relation to the employer, line managers, and co-employees. Best practices in terms of incapacity management are also investigated. The current incapacity management practices in the ODL institution were compared to these incapacity management best practices, and the shortcomings of the current practices are highlighted.

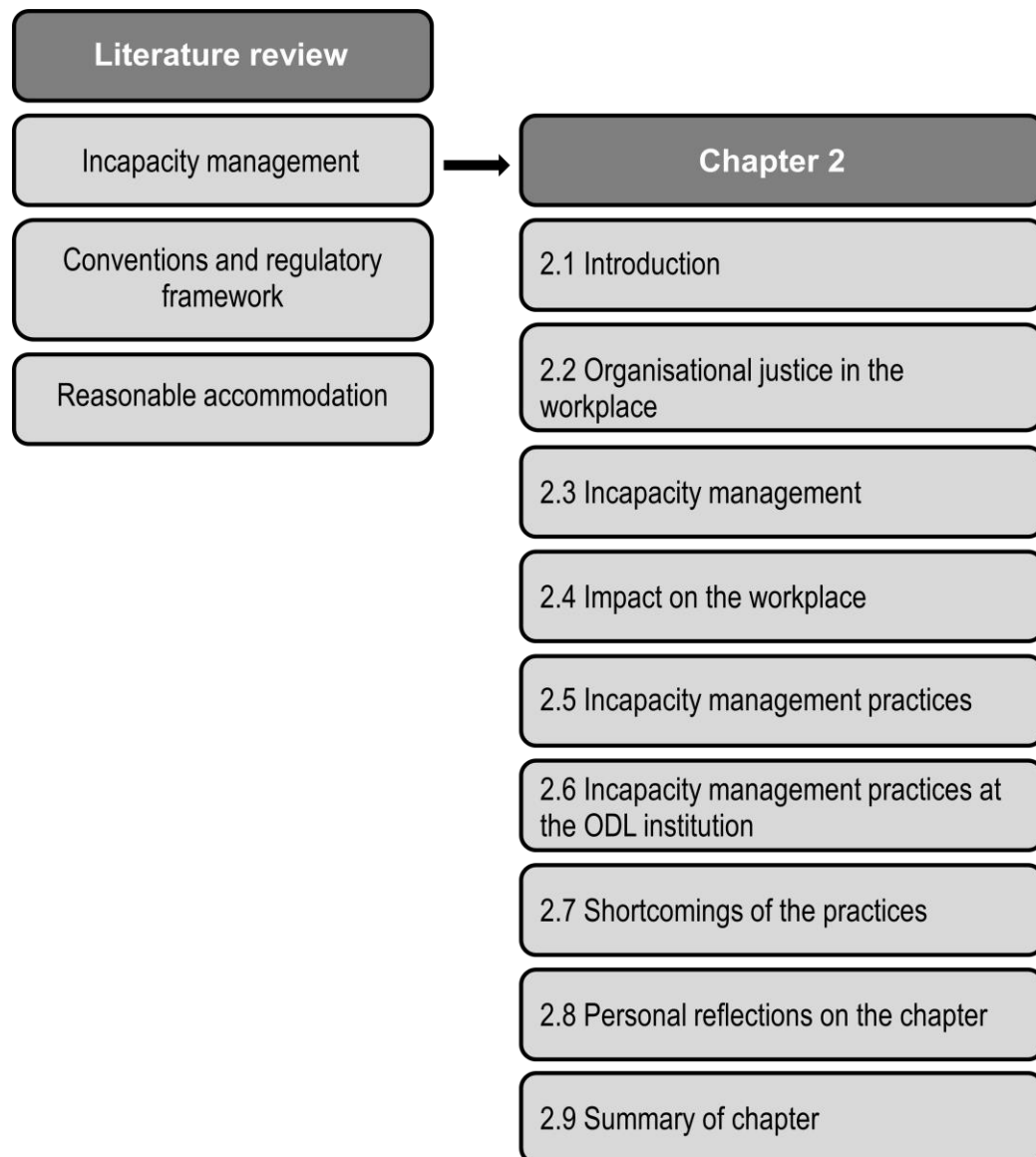


Figure 2.1: Conceptual framework of the literature review on incapacity management (own compilation)

2.2 ORGANISATIONAL JUSTICE IN THE WORKPLACE

The research on organisational justice was originally done to test propositions about the distribution of payment and other work-related rewards derived from the equity theory. Since then, fairness was expressed in various other human resource practices such as wage negotiations, selection, and labour disputes, resulting in a proliferation of approaches to organisational justice emerging (Coetzee, 2004, p. 4.2; Greenberg, 1987, p. 9). These approaches to

organisational justice were categorised by Greenberg (1987, p. 9) around a taxonomic scheme. Greenberg (1987, pp. 9-10) combined two conceptually independent dimensions, namely a reactive-proactive dimension and a process-content dimension to organisational justice:

- **Reactive-proactive dimension.** A **reactive** theory of justice focuses on people's attempts to either escape from or avoid perceived unfair states. It examines the reactions to injustices, whereas **proactive** theories focus on the behaviours attempting to promote justice.
- **Process-content dimension.** A **process** approach to justice focuses on the way in which various outcomes are determined, concentrating on the fairness of the methods and procedures used to make and implement organisational decisions. In contrast, **content** approaches address the relative fairness of the resulting decision or outcome.

The intention of the taxonomy is to clarify conceptual interrelationships, track trends in organisational justice research, and identify needed areas of research and conceptual development (Greenberg, 1987, p. 15). This resulted in a taxonomy of four theories. Table 2.1 provides a summary of the four theories and the representative questions asked in organisational research.

Table 2.1: Organisational justice theories and related research questions

Type of theory	Research question
Reactive content	How do workers react to inequitable payments?
Proactive content	How do workers attempt to create fair payments?
Reactive process	How do workers react to unfair policies or legal procedures?

Proactive process	How do workers attempt to create fair policies and procedures?
-------------------	--

(Adapted from Greenberg, 1987:16).

To contextualise the research questions presented in Table 2.1, the word “payment” should be read as “treatment” in the workplace.

The **reactive content theory** focuses on the reaction by employees to unfair treatment, whereas the **proactive content theory** focuses on how employees attempt to create fair decisions. The **reactive process theory** focuses on the fairness of the policies and procedures used in making decisions. In contrast, the **proactive process theory** concentrates on what policies and procedures people will use to achieve justice (Greenberg, 1987, pp. 11-15). Since the original conceptualisation of the taxonomy of the organisational justice theories, there was a shift from reactive to proactive theories and a shift from the content to process theories (Greenberg, 1987, p. 16).

As research on organisational justice expanded, perceptions of organisational justice have been categorised into three main components: distributive justice (outcomes), procedural justice (decision-making processes), and interactional justice (interpersonal treatment). **Distributive justice** is defined as the perceived fairness of the outcomes or allocations that an individual receives (Cropanzano & Molina, 2015, p. 380; Folger & Cropanzano, 1998, p. xxi). Distributive justice is promoted when the outcome of decisions, or the distribution of resources are viewed to be satisfactory, equitable, and fair (Colquitt, 2001, p. 386; Cropanzano & Schminke, 2001, p. 144). According to Coetzee (2004, p. 4.6), equitable or fair treatment of employees will benefit the institution as it will lead to increased job satisfaction, improved relationships between line managers and employees, and will encourage organisational citizenship behaviour. **Procedural justice** refers to the perceived fairness of the decision-making process and the policies and procedures that were utilised to achieve the outcome (Coetzee, 2004, p. 4.6; Cropanzano &

Molina, 2015, p. 380; Cropanzano & Schminke, 2001, p. 149; Folger & Cropanzano, 1998, p. 26). **Interactional justice** is the interpersonal treatment people receive when policies and procedures are applied (Bies & Moag 1986, p. 44; Colquitt, 2001, p. 386). When decision-makers treat people with dignity, respect, and sensitivity, and explain the rationale for their decisions, interactional justice is promoted (Colquitt, 2001, p. 386; Cropanzano & Molina, 2015, p. 381). The phenomenon of incapacity management permeates these main components of organisational justice.

Perceived organisational justice is positively associated with employee well-being. Procedural and interactional justice have a stronger impact on the well-being of employees (Ajala & Bolarinwa, 2015, p. 57, 65; Kivimäki, Elovainio, Vahtera & Ferrie, 2003, p. 31; Lawson, Noblet & Rodwell, 2009, p. 230; Le, Zheng & Fujimoto, 2016, p. 958). It is therefore important, for an institution to ensure perceived fair distributive, procedural and interactional justice to employees, that policies and procedures are designed to support fair workplace decisions and interactions on incapacity management. This will result in the engagement and retention of employees, and will guarantee their well-being (Ajala & Bolarinwa, 2015, pp. 57, 67; Ghosh, Rai & Sinha, 2014, p. 641; Ledimo & Hlongwane, 2014, p. 10). Organisational justice theory offers a structure against which the literature for this study was reviewed and the proposed incapacity management framework can be implemented and evaluated to ensure fairness and justice at the ODL institution.

2.3 INCAPACITY MANAGEMENT

Incapacity in the workplace is the inability of an employee to perform his or her obligations as contained in the employment contract either due to ill health, poor work performance, incompatibility or unsuitability for the position (Slabbert, Prinsloo, Swanepoel & Backer, 2006, p. 5-323). To fully understand incapacity management due to ill health, the concepts of health and wellness, disability, sick absence, and presenteeism were explored, as these provide a narrative of

what a capacitated or healthy employee ought to be like, as opposed to an incapacitated or unhealthy employee.

2.3.1 Health and wellness

Widely differing points of view exist on what constitutes an employee's health and wellness. It is narrowly conceptualised as a very specific physical or mental condition and broadly defined as a concept that also includes the social, emotional, financial and spiritual wellness of the employee (Sieberhagen, Pienaar & Els, 2011, p. 5).

Du Preez (2010, p. 14) distinguishes between the concepts of health and wellness in the workplace. In his opinion, health refers to the physical wellness of an employee and wellness refers holistically to the physical, psychological, and emotional wellness of the employee.

In contrast with Du Preez's (2010, p. 14) definition, the World Health Organisation (WHO) does not distinguish between health and wellness. It provides a broad definition that includes the physical, mental, or psychological and social wellness of an employee. As set out in the preamble to its Constitution, the WHO defines health as "a state of complete physical, mental and social wellness and not merely the absence of disease or infirmity" (World Health Organisation, 2002, p. 2). Jacobs (2012, p. 160) argues that although the WHO's definition includes physical and psychological health, the focus in the workplace is more on the physical health of an employee, which leaves the psychological health at risk. This may be attributed to the fact that employers need to comply with the relevant occupational health and safety legislation to not be in contravention of the law.

In defining health, Thompson and Bates (2009, p. 119) further argue that a workplace is not an emotion-free zone, and, to fully understand workplace health, the emotional factor should also be considered. Should emotion be

excluded in the management of incapacity, a crucial dimension will be lacking, and this may breed perceptions of injustice in the organisation.

Woods (2010, p. 172) supports the view of Thompson and Bates (2009) by stating that in conferring status and resources, income and life chances, workplaces can be very significant emotional arenas, especially when employees perceive distributive injustice. Woods (2010, p. 172) further argues that the workplace represents a major source of pain, pleasure, frustration, and fulfilment, yet when studies are conducted about stress and wellness in the higher education sector, the emotional dimension of working life is almost invariably inferred, rather than being the main focus of the research. The term “emotion” in the context of wellness in the workplace differs distinctly from the common usage (Woods, 2010, p. 172). In the wellness paradigm it has a specific technical meaning in that it is conceived as having a physiological dimension and therefore impacts on the health of an employee via the body’s neurochemistry (Woods, 2010, p. 176). An explicit focus on the phenomenon of emotion in researching the higher education context, as opposed to stress or attitudes in the workplace, may offer a richer and finer distinction of real-life experiences in the workplace and the impact thereof on employees’ wellness (Woods, 2010, pp. 172, 175).

The ODL institution conceptualises the health and wellness of their employees in the broad context in that the concepts are separately defined, and they cover the physical, mental, and social well-being of the employee. The draft Integrated Health and Wellness Framework of the ODL institution (University of South Africa, 2014d, p. 5) provides the same definition for health as that of the WHO. It defines health as a complete state of physical, mental, and social wellness and not merely the absence of disease or infirmity. It encompasses physiological, psychological and behavioural symptomology within a medical context. Equally important, the framework defines wellness as the experience of optimal health, good relationships with others, being emotionally and cognitively well stimulated, and experiencing significance and purpose in life; it considers

the total humanness of people, and conceptually includes life experiences such as happiness and life satisfaction (University of South Africa, 2014d, p. 5).

It is evident that health and wellness is a complex phenomenon and it includes the biological, psychological or mental, and sociological dimension of an employee, as well as the emotions associated with these factors within the workplace. The concept of health and wellness becomes even more complex when the notion of mental illness is included. The complexity is not a result of the denial or disregard of the existence of a mental condition, it is rather a debate of disputing the validity of mental conditions as an incapacity. This debate creates the assumption that the most appropriate response is a medical one, predominantly through medication and the adoption of a sick role (Thompson & Bates, 2009, p. 119). This brings the discussion to the concept of disability.

2.3.2 Disability

Favalli and Ferri (2016, p. 6) argue that despite the expansion of disability studies and the surge of interest across various strands of legal literature, there is still no shared understanding of what constitutes a disability in the normative sense. Countries define disability in different ways in their national legislation. In exploring the concept of disability for this study an all-embracing approach was followed.

When considering the ability of the employee to perform his or her functions, it is possible that the physical or mental condition of the employee may be of such a nature, or may develop to such an extent, that the employee does not have the full capacity to perform the functions. The incapacity may be temporary (short-term) or permanent (long-term) (Republic of South Africa, 1995, Schedule 8, s 10(1)). Short-term incapacity is likely to last less than a few days and does not necessarily require a medical certificate. Common short-term illnesses include colds, flu, stomach upsets, headaches, migraines, ear or eye

infection, or tooth ache. There is no generally accepted definition for long-term incapacity. In the South African context, long-term incapacity may be defined as more than two days, because this is the time after which an employee is required to obtain a medical certificate from the treating medical practitioner (Republic of South Africa, 1997, s 23). Long-term or chronic conditions are health conditions that last over a longer period. These may require ongoing care and support and have an impact on an employee's performance. Common long-term conditions may include diabetes, hypertension, cancer, lung diseases, respiratory and heart problems.

If the length or seriousness of the incapacity (curable or incurable) is taken into consideration, it may result in physical or mental impairment. A physical impairment is a physiological disorder or condition, cosmetic disfigurement, or anatomical loss impacting one or more body systems such as the neurological, musculoskeletal, respiratory, cardiovascular, digestive, lymphatic, and endocrine systems. Mental impairment is defined as a clinically recognised condition or illness that affects an employee's thought processes, judgement, or emotions (Republic of South Africa, 2015b, s 5.1.1(iii)). The impairments may cause a limitation which may hinder the employee's capacity to fully and effectively perform his or her key performance areas as contained in the employment and performance contracts.

Spicker (2003, p. 36) contends that long-term incapacity, both physical and mental, may shade into disability, as duration is one of the principal characteristics defining disability. The International Labour Organisation's (ILO) Convention 159 of 1983 defines disability as a duly recognised physical or mental impairment that reduces an employee's ability to retain and advance in suitable employment (International Labour Organisation, 1983a, s 1.1). Similarly, article 1 of the Convention on the Rights of Persons with Disabilities (United Nations, 2007), view a long-term physical, mental, intellectual or sensory impairment which, in interaction with various barriers, may hinder an

employee to fully and effectively participate in employment on an equal basis with others, as a disability (United Nations, 2007, s 1).

Christianson (2004, p. 894) indicates that although in an era where disability has a very specific meaning for purposes of equity in the workplace, incapacity and disability may lie together along a continuum for the purposes of deciding whether an employee is indeed capable or not of performing the required work to the standards set by the employment and performance contracts. Christianson (2004, p. 889) points out that the use of the term “disability” in sections 10 and 11 of the Code of Good Practice: Dismissal in the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995), would suggest that disability and incapacity can be used interchangeably or synonymously. Although the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995) and the Employment Equity Act 55 of 1998 (Republic of South Africa, 1998) make a distinction between the two concepts, the overlap comes in the assessment of the employee and the accommodation that an employer has to make in certain circumstances due to the employee’s health condition (Christianson, 2004, p. 889).

Spicker (2003, p. 40) agrees that although disability and incapacity are not synonyms, where disability is a functional limitation of an ordinary activity, such as work, the concepts of disability and incapacity become equivalent. Burkhauser, Daly, McVicar and Wilkins (2014, p. 23) confirm this argument by pointing out that although disability is frequently thought of as an indisputable, health-based condition that limits functionality and prevents the performance of socially expected tasks such as attending work, modern notions of the productive capacity of all people is at odds with this characterisation. Burkhauser et al. (2014, p. 23) argue that a more accurate description of the concept of disability is the product of an interactive process between an employee’s health conditions and the social and physical environment. Only when an employee cannot perform the contractual obligations, once

rehabilitation and reasonable accommodation have failed, should it be regarded as disability.

What is apparent, is that the illness of an employee, while in employment, can exacerbate to such a serious nature or duration that the employee may become incapacitated and unable to fully perform his or her job functions, and this situation will have to be dealt with in terms of a country's laws dealing with employment and disability matters. It is therefore evident that an in-depth exploration of the phenomenon of disability will also contribute to the understanding of incapacity management in the workplace.

For the purpose of this study it was assumed that the concepts of incapacity and disability are synonymous in the context where disability relates to an employee who acquired a long-term physical or mental illness during his or her working life. The reason for this assumption is that for both concepts, incapacity and disability, the employer has a legal obligation to assess the medical condition of the employee, and to consider the possible alternative arrangements that can be made to reasonably accommodate the employee's incapacity or disability.

2.3.3 Sick absence

In general, when an employee is incapacitated due to ill health, he or she may decide to attend or not to attend work. If the decision is not to attend work, it will be recorded as sick absence. It then follows that the phenomenon of incapacity in the workplace can further be explored by also analysing literature on sick absence. One should keep in mind that, although sickness itself is a relatively objective concept that can be assessed by a medical practitioner, the decision by the employee to be absent due to the sickness can be highly subjective. Employees with similar illnesses may make different choices in their determination to be present in the workplace or to be absent due to sickness. This determination is based on a wide and complex set of bio-psychosocial

factors and circumstantial variables unique to the individual employee. This decision is influenced by advice, financial circumstances, and decisions of the employer and the State, as well as the employee's health (Black & Frost, 2011, p. 16; Duff, Podolsky, Biron & Chan, 2015, p. 61; Thompson & Bates, 2009, pp. 118-119).

These bio-psychosocial and circumstantial factors are similar to the elements of the definition of health as suggested by the WHO, namely physical, mental and social wellness (World Health Organisation, 2002, p. 2) and may include, but are not limited, to the following:

- **Biological or physical factors:** These relates to injury or fear of re-injury, infection, physical pain intensity, and other biological factors the employee may experience (Frederiksen, Karsten, Indahl & Bendix, 2015, pp. 713-714; Thompson & Bates, 2009, pp. 118-119). Life style choices by an employee such as consumption of alcohol, smoking and lack of exercise may cause or exacerbate the factors (Thompson & Bates, 2009, pp. 118-119).
- **Psychological factors:** These entail factors such as level of motivation, commitment, and self-esteem. It may include the presence or absence of emotions such as anger, resentment, pride, loyalty, and enthusiasm. An employee who feels unappreciated and exploited may be more inclined not to report to work at the first sign of any biological or physical symptoms (Thompson & Bates, 2009, pp. 118-119).
- **Sociological factors:** These include factors such as the level of income, gender, culture, religion and so on (Thompson & Bates, 2009, pp. 118-119). In contrast, Frederiksen et al. (2015, p. 713) found that factors such as age, gender, education, and so forth do not significantly impact on an employee's decision to stay home due to sickness. Furthermore, Frederiksen et al. (2015, pp. 713-714) also found that the social climate at work, such as job strain within teams and intimate relations with co-employees play a role in employees' decision to stay at home. The higher the work pressure, the less an employee will decide to stay at home in order to support the work team.

Similarly, the manner in which managers conduct return-to-work interviews may also have an impact (Frederiksen et al., 2015, pp. 713-714).

Thompson and Bates (2009, pp. 120-121) identify six main ways in which sick absence can manifest:

- **Incapacity:** The employee is unable or feels unable to work due to genuine reasons as determined by a medical practitioner.
- **Excuse:** This is commonly known as malingering. This is when an employee decides to be absent from work although the employee is not genuinely sick.
- **Escape:** The employee has a need to be absent from time to time to cope with the pressure. This is in situations characterised by stress, bullying and harassment, conflict, aggression, and the threat of violence and/or high levels of emotional pressure. The absence does not have biological reasons, but is also not malingering, it is only to escape from the unhealthy workplace.
- **Last straw:** It is similar to the aforementioned way of escape, although less deliberate in that the employee may have a minor ailment, but as a result of the negative workplace characteristics, decides to be sick, whereas if the environment were healthy, the employee would in all probability have attended work.
- **Embodiment of distress:** This is regarded as an extreme version of “last straw”. It refers to environments in which levels of stress reach such a point that they manifest either in physical symptoms (intense headaches, stomach aches) or mental health problems (depression or anxiety), and therefore the employee will decide to be sick or decide to be absent.
- **Balance shifting:** In this way, employees take additional time off, although not sick, because they have family responsibilities to take care of and view it as more important than attending to work.

It is evident that sickness is a relatively objective concept, but the employee's decision to be absent or present due to the sickness, can be highly subjective

based on various factors (Black & Frost, 2011, p. 16; Duff, Podolsky, Biron & Chan, 2015, p. 61; Thompson & Bates, 2009, pp. 118-119). I now focus on presenteeism.

2.3.4 Presenteeism

Another phenomenon related to the incapacity of an employee is sick presenteeism as opposed to sick absence. Taloyan et al. (2012) argue that if an employee is affected by any form of sickness such as acute, episodic or chronic illness, it reduces the capacity of the employee to work. The employee must then decide how he or she will act in relation to the illness or the reduction of work capacity. Taloyan et al. (2012) point out that the employee can choose to attend work despite feeling incapacitated, which is known as sick presenteeism.

There are many reasons why employees are unwilling or hesitant to recuperate at home and instead show up for work. Some of the possible contributory factors are job security, excessive accumulation of uncompleted work, tight deadlines, and understaffed environments with insufficient numbers of available replacements for absent employees. It may also be to spend time away from home to avoid ugly encounters with relatives or in-laws living under the same roof (Today, 2017).

Incapacity is thus not limited to the physical absence from the workplace. Sickness presence can be a risk factor for future suboptimal general health and sick absence, particularly through mental health problems. An employee who attends work despite being ill does not take the required time to recuperate, which may lead to the exacerbation of the medical condition and subsequently may reduce the employee's capacity to stay at work in the long run (Taloyan et al., 2012).

Studies in countries such as the United States and Australia have shown that the cost associated with presenteeism run into billions of dollars and are greater

than absenteeism. Presenteeism also carries the potential risk of the transmission of infectious diseases in the workplace, resulting in more employees becoming sick, than would have been the case if the ill employee decided to rather stay at home (Today, 2017).

Timely interventions of sickness presence could decrease future incapacity. Janssens, Clays, De Clercq, De Bacquer and Braeckman (2013, p. 140) confirm that presenteeism is related to future sick absence. They argue that management strategies dealing with absenteeism should consider the phenomenon of presenteeism, as high rates of presenteeism may have possible consequences on future sick absences. In this study the phenomenon of presenteeism was not explored in detail, as it falls outside the scope and boundaries of the current investigation.

2.4 IMPACT OF INCAPACITATED EMPLOYEES IN THE WORKPLACE

An employee provides a service to an employer in a specific workplace as contained in the employment and performance contracts (Bendix, 1996, pp. 115-116; Davidov & Eshet, 2015, p. 173; Grogan, 2009, p. 29; Grogan, 2014, p. 17; Slabbert et al., 2006, p. 5-71; Van Zyl, 2011, p. 8). A workplace is a physical location with a formal or informal social system wherein the employer is represented by a manager and the employee interacts with co-employees and, in certain workplaces, with customers as well. Incapacity impacts on the total workplace.

2.4.1 Generic global impact

Mishra and Inda (2014, p. 72) point out that absenteeism, irrespective of the reason, has a negative impact on both the institution and the employee. The employee loses pay and the institution loses production and sometimes even incurs additional costs due to an increase in overtime payments. Furthermore, the management of incapacitated employees has a direct impact on managers

as they perceive it as a balancing act. On the one side the managers must meet the productivity and economic needs of the employer, while on the other hand the manager must take care of the affected employees' needs, for example, by providing workplace adaptations, reduced working hours and re-assigning of duties. In addition, the line manager experiences additional stress as he or she needs to balance the reaction of the co-employees in relation to the accommodations provided for the employee with a long-term health condition (Bramwell, Sanders & Rogers, 2016).

In Australia 7,8% of the work force are depressed and as a result, the effect of absenteeism and presenteeism alone, costs the Australian economy approximately \$8 billion (R84 billion) per annum. Over and above the personal effects of depression on individuals, such as sleep deprivation, smoking, poor nutrition and so forth, it also affects organisations through the loss of productivity, decreased decision-making, and high turnover (Tooma & Beach, 2016, pp. 497-498).

Poor workforce health can lead to various negative consequences such as reduced productivity, premature withdrawal from the labour market, reduced tax revenue and increased health care costs (De Vroome et al., 2015, p. 675). Over a five-year period (2007–2011) approximately 37% of the Dutch working population reported some type of chronic physical or psychological disease with a mean number of 7,7 days sick leave in a 12-month period (De Vroome et al., 2015, p. 678). The absenteeism cost per employee, based on the various individual physical and psychological complaints and diseases, is estimated at a cost of €1484 (approximately R24 161 per annum) per absent employee. The prevalence of psychological complaints and diseases, cardiovascular disorders, and life-threatening diseases among the Dutch working population may increase due to an ageing population, particularly with the proposed rise in the retirement age to 67 in the year 2021 (The Organisation for Economic Co-operation and Development, 2017, p. 1). Factors such as an increase in an

inactive lifestyle and obesity may result in an even higher proportion of employees with chronic diseases (De Vroome et al., 2015, p. 682).

In 2012, the average days lost per employee per annum in the United Kingdom (UK), was 7,7 days with a median cost of absence per employee of £600 (approximately R13 200) (Quazi, 2013, p. 37). More than 60% of all absenteeism in the UK was due to gastrointestinal ailments, infection, non-medical, and musculoskeletal reasons. However, in terms of productive time lost due to sick absence, it was found that musculoskeletal and mental health problems are the top two conditions contributing to the loss (Quazi, 2013, pp. 37-38). Black and Frost (2011, p. 15) point out that for employers in the UK, the financial cost of sick pay and other indirect costs of managing absence, is estimated at £9 billion (approximately R156 billion) per year. It is estimated that 2,2% of all working time is lost every year equating to 4,9 days for each worker each year, and is broadly comparable to many other developed countries such as the USA and the Netherlands (Black & Frost, 2011, p. 19). It was found that longer-term absence (of more than four weeks), which accounts for 40% or more of working time lost, tends to be due to musculoskeletal disorders, common mental health problems and medical conditions such as cancer, diabetes, heart disease or stroke (Black & Frost, 2011, p. 45). In a recent study it is estimated that workforce sickness and absence cost the UK £29 billion (approximately R638 billion) per year (Lewis, 2016, p. 103).

It is argued that sick absenteeism in South Africa should be approximately 1,5% for every 250 working days per year, or 3,75 working days per year per employee. Most South African companies have an overall absenteeism rate of between 3,5 and 6%, which actually equates to between 8 to 15 working days per employee per year. This amounts to an estimated absenteeism cost of around R12-16 billion per year. The highest annual absenteeism incidents are for influenza (14,1%) and gastroenteritis (6,09%). It is contended that the cost of presenteeism may be four times more than that of absenteeism, resulting in an

additional cost of R48 billion. The loss in productivity due to absenteeism and presenteeism in South Africa in 2015 equated to approximately 2% of the Gross Domestic Product (GDP) and it is estimated that it may rise to 2,1% of GDP in 2030. The monetary value of the 2015 loss was an estimated \$6,3 billion (approximately R80 billion) (Leblond, 2017; Rasmussen, Sweeny & Sheehan, 2017, p. 2).

Over and above the financial impact of sick leave in an organisation, the incapacity and the subsequent return-to-work process can have a detrimental physical or mental impact on co-employees. This detrimental impact can also result in the deterioration of the social environment in the workplace (Dunstan & MacEachan, 2013, p. 50).

The physical impact is on scenarios where co-employees are expected to carry out the ill employee's duties, either during the absence or in the return-to-work period, or sometimes both, without any apparent compensation. This puts additional pressure on the remaining staff and may result in work overload for them. The mental impact relates to the co-employee not knowing how to interact with the returning employee who may be emotionally fragile. The co-employee is afraid that he or she cannot respond appropriately if a problem arises or is nervous that he or she may impact on the returning employee's mental condition. This may then lead to tensions and conflict (Dunstan & MacEachan, 2013, p. 50; Thompson & Bates, 2009, p. 120).

In terms of the social environment in the workplace, the redeployment of a returning worker to a new work environment may cause the disruption of workplace social relationships. It may have the result that the new co-employees could feel uncomfortable about the redeployment, and abandon usual social interactions, as they had no existing relationship with the returning employee and no information on the returning employee's condition was supplied. In certain cases the return-to-work process had such an extreme effect on co-employees that it resulted in emotional distress or illness, including

personal injury where a co-employee had to carry heavy equipment, and in a worst case, a co-employee leaving his or her job. (Dunstan & MacEachan, 2013, p. 50-51).

However, the opposite is also true in that the return-to-work process is not always a negative experience for co-employees. Under optimal conditions such as in a supportive working culture with pre-existing relationships with the returning employee, a well-organised environment and relatively short duration of required support can give co-employees a sense of achievement. In an extreme case it was found that the return-to-work process gave a co-employee an opportunity to learn new skills and earn extra money, as the co-employee had to take over his manager's managerial duties (Dunstan & MacEachan, 2013, pp. 50-51).

Thompson and Bates (2009, p. 120) argue that as fewer staff members are available due to sick absence, such absence may result in reduced quality of service (quantitative and qualitative) to internal and external role players. The possibility exists that deadlines may be missed or even a potential lack of service continuity where an employee is not present. This may damage the reputation of the company.

From the above, it is evident that absence due to ill health does not only have an impact on the incapacitated employee but affects the workplace and the broader economy. I now focus on the impact of ill health in the higher education sector.

2.4.2 Impact in the higher education sector

In their annual sick absence benchmarking report for the higher education sector in the United Kingdom, the Universities and Colleges Employers Association (UCEA) found that in 2012–13 the average number of days lost to sick absence within the higher education sector was five and a half days

(Universities and Colleges Employers Association, 2014, p. 7). Academic employees only took an average of three days of sick absence, but this may be attributed to an under-reporting of short-term absences due to the flexibility and autonomy of working patterns enjoyed by academic employees (Universities and Colleges Employers Association, 2014, pp. 8-9, 19). This means that being sick as an academic employee does not necessarily mean absent from work, as they may already be working from home when they become ill. UCEA also argues that academic employees may be able to re-arrange work to honour commitments, in a manner not available to non-academic employees (Universities and Colleges Employers Association, 2014, p. 9).

The UCEA found that 48,2% of sick absence was for periods of longer than 20 days, with academic employees recording the highest levels of long-term sickness (Universities and Colleges Employers Association, 2014, p. 12). According to the survey the major cause of sick absence was psychiatric illnesses (anxiety, stress, depression, and other psychiatric illnesses). The second most common cause of illness resulting in sick absence was colds, coughing and/or flu related ailments. It is estimated that the cost of absence per employee ranged from £314 to £1 245 (approximately R6 900 to R27 300) in the 2012–13 period (Universities and Colleges Employers Association, 2014, p. 14).

The challenge of increased student numbers causes academic employees to experience high levels of stress relating to overload and work-life balance. The high levels of stress experienced by academic employees contribute to their ill health and incapacity. Academic employees experience moderate to high levels of burnout (Barkhuizen, 2005, pp. 101, 103, 135-136; Bezuidenhout & Cilliers, 2010), which may lead to increased absenteeism (El-Amin, 2015, p. 65).

The literature reviewed reveals that limited research has been conducted on employee absenteeism trends in the South African higher education sector,

hence the knowledge gap that this study seeks to close. I now focus on the impact of ill health in the ODL institution.

2.4.3 Impact in the ODL institution

The ODL institution implemented an absenteeism management pilot programme in 2011 (University of South Africa, 2011) among 11% of the institution's permanent employees, both from the academic and administrative sectors (University of South Africa, 2011, p. 11). It was found that the unplanned absenteeism rate (sick leave and family responsibility leave) for the period October 2009 to September 2011 was 2,29% compared to the South African benchmark rates of 1,5 to 1,8% (University of South Africa, 2011, p. 17). The direct cost of sick leave (incapacity) was calculated at just above R3 million, and indirect cost at R6 million, thus a total cost of R9 million (University of South Africa, 2011, p. 17). Absenteeism and the accompanying cost have a direct impact on the institution's funding, in that for the salary cost paid, the concomitant service delivery was not received. Indirect cost relate to the assignment of other employees to cover the work of the absent employee, administrative and managerial time used to manage the absence, reallocation of work and the general deflection from the productive demands of work. Indirect cost is double that of direct cost (University of South Africa, 2011, p. 17). If it is presumed that the 89% of the workforce who did not participate in the pilot project had approximately the same absenteeism profile for sick leave (temporary incapacity), then the total direct and indirect costs of absenteeism could have been approximately R86 million over the period.

As a result of the pilot study, the ODL institution has implemented an absenteeism rollout programme with the intention of reducing absenteeism at the institution – especially for unplanned absences such as sick leave. An analysis of the sick leave taken by permanent employees (employees with tenure until retirement) in the subsequent years since the pilot project and the implementation of the rollout programme (University of South Africa, 2015d) has

been conducted. Table 2.1 provides a summary of the outcome and the subsequent years' sick leave taken. The cost is based on the actual salary average per job grade of the employees who took sick leave for the specific period.

Table 2.2: Sick leave taken over a five year period at the ODL institution (own compilation)

SICK LEAVE TAKEN OVER FIVE YEARS		
Period	Number of working days	Direct cost
1/7/2012 – 30/6/2013	34 390	R51 million
1/7/2013 – 30/6/2014	36 044	R63 million
1/7/2014 – 30/6/2015	37 254	R77 million
1/7/2015 – 30/6/2016	35 210	R74 million
1/7/2016 – 30/6/2017	28 090	R72 million

Should the indirect cost associated with unplanned absence be added to these numbers, then the estimated total cost for the respective years would be as follows: R154 million (2012–2013); R187 million (2013–2014); R230 million (2014–2015); R223 million (2015–2016); and R216 million (2016–2017). This estimation does not include the indirect cost of a lack of student support, failure, and the risk to the institution's reputation, caused by the absence of academic employees.

This pilot study and the subsequent analysis of sick leave should be viewed in the context that absenteeism, and the subsequent costs thereof, may increase due to the increased stress experienced in the higher education sector (Barkhuizen, Rothmann & Van de Vijver, 2014; Bezuidenhout, 2015; Kenny & Fluck, 2014). The above-mentioned cost of absenteeism confirms Bezuidenhout's (2015, p. 13) statement that it may not be presumptuous to

assume that the negative outcomes of the changing work role of distance educators, resulting in increased stress and absenteeism, may have a negative effect on the sustainable financial survival of ODL institutions.

To complicate matters, Mogobe (2011, p. 26) opines that even if only a few employees are absent, the impact is felt across the entire organisation due to the interdependency between units at the ODL institution. If one person in a team is absent, it often hampers productivity as the team must deliver according to the commitment in a service level agreement. The effect of the absence of an employee is that the co-employees should automatically take on the extra responsibility of the absent employee for the work to be done. Resentment is often high, especially where line management takes the co-employees' extra efforts for granted. This negative experience results in different reactions:

- Voluntary unscheduled absences as employees decide to rest following the extra work they had to perform on behalf of an absent employee.
- Negative client service by the affected employees.
- Escalating client complaints due to the unplanned increase in the workload.
- Increase in overtime work (Mogobe, 2011, p. 26).

The foregoing discussion shows that employees' incapacity impacts organisations in multiple ways. However, what remains important is what organisations could do to manage incapacity effectively.

2.5 INCAPACITY MANAGEMENT PRACTICES

Incapacity management practices refer to the basic principles, policies, procedures, systems and interventions to fairly manage and reasonably accommodate the incapacity of employees due to ill health. It includes the roles and responsibilities of the employer as represented by managers, human resource specialists, employees, co-employees, unions, and health professionals (Mellor & Webster, 2013, p. 134; Pronk, 2014, pp. 44-45).

2.5.1 Purpose and benefit of an incapacity management programme

An absenteeism or incapacity occurrence, irrespective of the reason, has a negative impact on both the employer and the employee. Therefore, it is important that incapacity management practices should be beneficial to both the employer and the employee (Melnik et al., 2016, p. 309). Incapacity management practices should preferably contribute to organisational justice, the employment relationship, and the psychological contract between the parties.

The overarching purpose of incapacity management practices should be to provide a positive return on investment (profitability) and enhanced productivity by reducing absenteeism with an altruistic benefit of creating a healthier workforce (Mathlape 2003, p. 31; Melnik et al., 2016, p. 309). The characteristics of the practices will vary from organisation to organisation, but the key purpose will be to create an environment wherein employees feel supported and are influenced in a positive way (Tooma & Beach, 2016, p. 499).

The benefits of having human resource systems to manage absence will result in an improvement in the absence rate with resultant cost reductions. Employers may also begin to understand why absences are taking place by identifying the root causes and then, if necessary, introduce policies to manage the patterns of sick absence (Lewis, 2016, p. 103). Notenbower, Roelen, Van Rhene and Groothoof (2016, p. 8) share this view and argue that in environments where the management of sick absence is poor, employees feel no need to improve on their frequent absences.

In 2005 the South African Public Service introduced a Policy and Procedure on Incapacity Leave and Ill Health Retirement (PILIR) (Republic of South Africa, 2009). The objective of PILIR was to provide a holistic approach to health risk management by intervening and managing incapacity leave in the workplace to accommodate temporarily or permanently incapacitated

employees and where appropriate, facilitate the rehabilitation, re-skilling, re-alignment or retiring of the affected employees (Republic of South Africa, 2009, p. 5; Republic of South Africa, 2010, p. 3). In a study the Public Service Commission found that the PILIR was successful in reducing absenteeism and the abuse of sick leave. The implementation of PILIR resulted in an average of almost four percent reduction of sick leave days taken in national government departments and a three percent deduction in provincial government departments (Republic of South Africa, 2010, p. viii). The Public Service Commission (2010) concluded that PILIR has made a positive impact in the reducing of absenteeism and the abuse of sick leave.

Although it is acknowledged that having incapacity management practices in place will benefit both the employer and the employees, only a limited number of higher education institutions in South Africa have a formal policy, procedures, or guideline in place. Even at the few institutions where such exists, the documents refer to the provisions for incapacity and reasonable accommodation of the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995) and the Employment Equity Act 55 of 1998 (Republic of South Africa, 1998). The other institutions follow the provisions of these acts in conjunction with the provisions of their insurance policies for incapacity (Mr Manoko, personal communication, 11 April 2018; Ms Mercuur, personal communication, 5 April 2018; Ms Tainton, personal communication, 12 April 2018; Rhodes University, 2014; Stellenbosch University, 2017; University of the Witwatersrand, 2015). The limited number of policies and procedures for incapacity management in the South African higher education sector contributes to a knowledge gap in the management of incapacity in the sector.

2.5.2 Key elements of an incapacity management programme

Thompson and Bates (2009, p. 119) are of the opinion that when an employer wants to take steps to address incapacity, a simplistic approach with a focus only on biomedical factors cannot be followed, but it should also include

psychological, sociological, and emotional factors. One of the key elements to be incorporated in an incapacity management programme to manage sick absence is the development of an organisational culture premised on a genuine commitment to workplace wellness. Such organisational culture will not necessarily heal the sick employee, but will rather assist to minimise the problem of sick absenteeism by

- keeping workloads at realistic levels
- addressing conflicts constructively and not allowing them to fester
- promoting dignity at work
- being responsive
- providing confidential support services
- offering appropriate training
- keeping the channels of communication open (Thompson & Bates, 2009, pp. 124-125)

The essence of PILIR is a holistic approach to health risk management. PILIR seeks synergies with wellness and disease management programmes provided by the employees' medical schemes and by implementing sick leave management as well as a rehabilitation and re-skilling structure (Republic of South Africa, 2009, p. 5). In addition, it adopted a scientific approach based on sound medical, actuarial, and legal principles, and involves various role players in the health risk management processes and structures. This was achieved by the utilisation of an independent health risk management company, consisting of multi-disciplinary medical experts that assess and provide advice to the employer in respect of an employee's incapacity (Republic of South Africa, 2009, p. 6).

From the limited number of incapacity management practices and information available from South African higher education institutions, the following key elements stood out:

- retention of employees (Rhodes University, 2014, p. 1; University of the Witwatersrand, 2015, p. 1)
- promoting dignity at work (Rhodes University, 2014, p. 2)
- reasonable accommodation (Mr Manoko, personal communication, 11 April 2018; Ms Mercuur, personal communication, 5 April 2018; Rhodes University, 2014, p. 6; Stellenbosch University, 2017, p. 7; University of the Witwatersrand, 2015, pp. 5-7)
- involvement of multiple role players such as the incapacitated employees, human resources, employee relations, employee wellness, line managers, external experts and the insurers (Mr Manoko, personal communication, 11 April 2018; Ms Mercuur, personal communication, 5 April 2018; Rhodes University, 2014, p. 6; Stellenbosch University, 2017, pp. 5, 7; University of the Witwatersrand, 2015, pp. 11-14)
- ensure confidentiality (Rhodes University, 2014, p. 4; University of the Witwatersrand, 2015, p. 11)
- compliance to labour legislation (Mr Manoko, personal communication, 11 April 2018; Ms Mercuur, personal communication, 5 April 2018; Ms Tainton, personal communication, 12 April 2018; Rhodes University, 2014, p. 2; University of the Witwatersrand, 2015, pp. 5, 12)
- advice/education/guidance and training on incapacity management (Ms Tainton, personal communication, 12 April 2018; Rhodes University, 2014, pp. 3,7; Stellenbosch University, 2017, p. 1; University of the Witwatersrand, 2015, p. 13)
- regular feedback/communication (Stellenbosch University, 2017, p. 7; University of the Witwatersrand, 2015, pp. 11, 13, 17)

Various best practices were identified through the literature review. These practices can be summarised in eight key elements as in Figure 2.2 and discussed below.

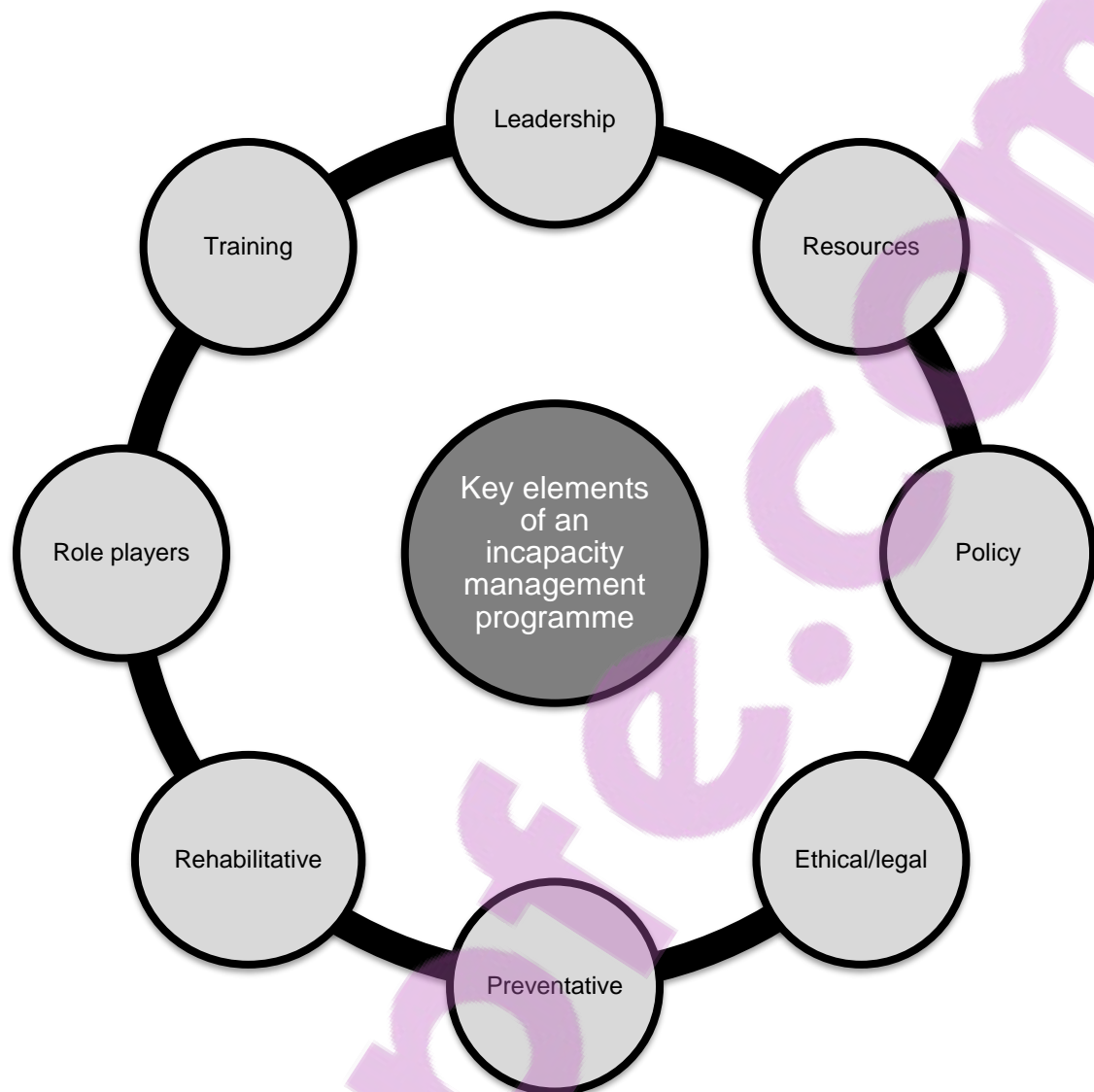


Figure 2.2: Key elements of an incapacity management programme (own compilation)

Incapacity management in an institution requires a supportive institutional culture supported by ethical and legally compliant policies and adequate resources (both human and financial). Human resources (all role players) need to be trained in the management of the incapacity processes and to understand which reasonable (preventative and rehabilitative) accommodations may be provided to an incapacitated employee. Each of the key elements gained from the literature is presented in more detail below.

2.5.2.1 *Supportive executive leadership and management*

One of the key factors to ensure effective and efficient incapacity management practices is leadership support and commitment for a comprehensive health and wellness programme (Mellor & Webster, 2013, p. 134). It is crucial that higher education leadership, over and above support and the provision of organisational policies and evidence-based programmes, encourages employees to adopt healthy lifestyle behaviours, and to make investments in developing and sustaining a culture and environment of wellness (Melnik et al., 2016, p. 320). Management needs to actively participate in and promote these wellness initiatives. This requires a holistic approach whereby wellness programmes go beyond the physical and mental health initiatives and include effective tools to

- explore, understand and assess the existing incapacity (physical and mental) policies
- continuously audit the work environment or mental or physical health
- make remedial adjustments based on the results to ensure that the ultimate objectives of a healthy workforce and work environment by means of preventative and educational interventions are achieved (Harder, Wagner & Rash, 2014, pp. 275-283; Mishra & Inda, 2014, p. 90; Pronk, 2014, pp. 44-45; Tooma & Beach, 2016, p. 49)

Executive management needs to set the vision and show support for the incapacity management programme. They should design an implementation plan with measurable performance indicators that is supported by all role players. Executive management must assume accountability and ensure that management at all levels throughout the organisation, is committed to and engaged in the programme (Harder et al., 2014, pp. 275-283; Higgins, O'Halloran & Porter, 2012, p. 330; Pronk, 2014, p. 44).

In *Nehawu and another v South African Institute for Medical Research* (1997) and *SAMWU obo Solomons v City of Cape Town* (2009) it was confirmed that in managing an employee's incapacity, a supporting, sympathetic and compassionate approach is required from an employer. There should also be a continuous engagement throughout the incapacity management process, even if the employee is recovering at home or in hospital (*Dorris Maharaj v Northern Health*, 2017; *EEOC v Kohl's Department Stores, Inc.*, 2014; *EEOC v LHC Group, Inc.*, 2014; *Jacobs v N.C. Admin Office of the Courts*, 2015; *Rorrer v City of Stow*, 2014).

Employees view all levels of management in the organisation's support and commitment to the workplace health programmes as a motivation for them to fully participate in the programmes (Dickson-Swift, Fox, Marshall, Welch & Willis, 2014, p. 146). Line managers play an important role in the implementation of incapacity management policies because they are the first contact point for an incapacitated employee (Anema, Prinz & Prins, 2013, p. 370; Haafkens et al., 2011, p. 105). It is found that when employees receive clear communication from their line manager, they are likely to experience quality feedback and experience better health. In today's workplace certain important interpersonal skills for managers such as listening, goal setting and clarifying expectations, effective conflict management, appropriate and effective meeting practices, enabling environments, team building and endorsing of change are required (Jacobs, 2012, p. 184).

Woods (2010, p. 181) suggests that, specifically in a higher education institution, a healthy and satisfying emotional experience of the workplace can be built and maintained by ensuring convergence between the employees' individual goals and the expectations of the employer. As the employer's and employees' expectations may change over time, it will require regular discussions with the employees in terms of their values, pre-occupations, motivation and concerns and, on the other hand, the values and priorities of the employer. This may impact the performance management practices of an

institution, such as the formal review and assessment discussions, in that it will require regular, informal interaction between the manager and the employee in addition to the formal performance management processes (Woods, 2010, p. 182). Regular and informal engagements between the manager and the employee may have a positive impact on the wellness of the employee. The concept of emotion is relevant to health and wellness over time, rather than observable, short-lived emotional experiences. This suggests that the manager should be alert to signs of gradual long-term changes in the affective state of an employee (Woods, 2010, p. 182).

Personalised and unexpected rewards given by management (preferably top management) play a significant role in promoting a healthy organisation. Attributes such as respect, trust, caring, being approachable, and the ability to develop personal relationships with different levels of management are important for employees, and foster a healthy workplace (Dickson-Swift et al., 2014, pp. 147-148).

2.5.2.2 Sufficient resources to support the incapacity management programme

Management must ensure that the incapacity management programme is sufficiently endowed with dedicated resources, both financially and structurally. The programme requires designated employees with clearly delineated accountabilities, including an overall wellness champion (Higgins et al., 2012, p. 330; Mellor & Webster, 2013, p. 133; Pronk, 2014, p. 44). Ideally, an incapacity management programme should have company-located return-to-work or disability case managers and, if possible, onsite physical rehabilitation services (Gensby, Labriola, Irvin, Amick & Lund, 2014, p. 235).

As the employer has an obligation to investigate the extent of the incapacity and may not have the expertise within the institution, sufficient financial resources for the use of external service providers such as medical specialist and

occupational therapists should be available (Standard Bank of South Africa v CCMA and others, 2007; Wylie v Standard Executors and Trustees, 2006).

2.5.2.3 Incapacity management policies and procedures

An effective incapacity management programme requires an appropriate organisational policy with clear and detailed rules and standards that are applied fairly and consistently (Ashley, Cashdollar, Etchevvery & Magill 2017, p. 22; Haafkens et al., 2011, p. 113; Kristman et al., 2017, p. 124; Mogobe, 2011, p. 83; Pomaki et al., 2010, p. 22). The policy should ideally provide for the integration of various programmes, such as health, safety, and wellness (Mellor & Webster, 2013, p. 133; Pronk, 2014, p. 44). The policy should also provide for a return-to-work strategy, including a compulsory return-to-work interview (Gensby et al., 2014, p. 235; Mogobe, 2011, p. 83). It is of importance that the policy is well communicated (Mishra & Inda, 2014, p. 90; Pomaki et al., 2010, p. 22).

Employers in the higher education sector should know and understand the impact of the higher education challenges such as the additional workload due to the increased number of students, the changing role of academic employees, and reduced resources. The employers must design policies that will be congenial for the higher education workplace to minimise the impact of challenges and to maximise the satisfaction level of the academic community (Yusoff & Khan, 2013, p. 95).

In the specific area of sick absence it is advisable that guidance should be as clear as possible. In the absence management policy employers should set out and explain clearly the processes they intend to follow, and ensure that employees are familiar with the process (Black & Frost, 2011, p. 43; Mogobe, 2011, p. 83). The incapacity management policy should include how absence will be recorded to ensure that absenteeism trends and patterns can be identified and monitored (Mogobe, 2011, p. 83).

2.5.2.4 *Compliance to ethical and legislative requirements*

The cornerstone of an effective incapacity management programme is compliance with the ethical and legal requirements (Pronk, 2014, p. 44). Following judgements in several legal cases, employers should, in consultation with the incapacitated employee, investigate or assess the following minimum requirements to ensure a fair incapacity process:

- the nature and cause of the incapacity
- the capability of the employee to perform his or her duties
- the likelihood of recovery, improvement or recurrence of the incapacity
- the possibility of adjusting the duties or workplace of an employee to accommodate the incapacity of the employee
- if it is not possible to adjust the duties or workplace, the possibility of suitable alternative employment to accommodate the incapacity of the employee
- the period of absence and its effect on the employer's operations
- the effect of the employee's disability on other employees
- the employee's work record and length of service

After complying with the above minimum requirements and if it is not possible to accommodate the incapacity of an employee, a dismissal may be fair (Ali v Torrosian and Ors t/a Bedford Hill Family Practice, 2018; Butterworth v Independence Australia Service (Human Rights), 2015; Hendriks v McIntyre and General Insurance Company of S.A. Ltd, 1994; Hilditch v AHG Services (NSW) t/a Lansvale Holden, 2017; Huntley v State of NSW, Department of Police and Justice (Corrective Services NSW), 2015; IMATU obo Anton Strydom v Witzenburg Municipality, The South African Local Government Bargaining Council v Van Staden NO, 2012; McCall v City of Philadelphia, 2015; Mitchell v Marks and Spencer plc, 2017; MTN Service Provider (Pty) Ltd v Matji NO & Others, 2007; Nehawu obo Lucas v Department of Health Western Cape, 2004; NUMSA obo Josias v Tedelex Trading (Pty) Ltd., 2007; O'Brien v

Bolton St Catherine's Academy, 2017; SAMWU obo Solomons v City of Cape Town, 2009; Standard Bank of South Africa v CCMA and others, 2007; Taylor-Novotny v Health Alliance Med. Plans, Inc., 2014; Walz v Ameriprice Fin. Inc., 2015; Withers v Johnson, 2014; Wylie v Standard Executors and Trustees, 2006).

Employers need to demonstrate core human values, such as being compassionate with employees throughout all phases of the incapacity process, from as early as the diagnosis. The employer should allow the employee to decide on the amount of information on the incapacity that he or she wants to provide (employee's privacy), and be respectful of the employee's needs. Employers need to be honest about what they can offer to assist the employee, and about the employer's constraints and expectations of the employee (Dewa et. al., 2016, pp. 2, 8-9; Dorris Maharaj v Northern Health, 2017; Nehawu and another v South African Institute for Medical Research, 1997; SAMWU obo Solomons v City of Cape Town, 2009).

The opportunity to be able to talk to his or her manager is viewed as a significant aspect of an employee's job satisfaction. This communication is about a two-way, easy, frequent, and respectful process, whereby the employee feels valued, able to express his or her ideas with confidence, and is well supported by the manager (Dickson-Swift et al., 2014, p. 147).

2.5.2.5 Preventative incapacity management practices

Preventative incapacity management practices are interventions that employers may introduce or provide to pro-actively create awareness on incapacity or to detect and prevent incapacity due to ill health. Various best practices were identified and include the following preventative interventions:

- Employees need to be made aware of and educated on the availability of wellness services. The advocacy programme requires a formal branding for

visibility, ongoing communication using multiple methods, and targeted or tailored messages to reach certain target groups (Bezuidenhout, 2015, p. 13; Mellor & Webster, 2013, p. 134; Mishra & Inda, 2014, p. 90; Pronk, 2014, pp. 44-45). The services should preferably include self-care/management, easy accessibility, and tailored solutions for individual employees and illnesses (Pronk, 2014, pp. 44-45).

- Employees need to be made aware of and educated on health risks. HEIs need to train and support academic employees to understand the environment they operate in, especially regarding, inter alia, occupational stress and general health. It is recommended that as a minimum standard, academic employees should be sensitised to the symptoms of stress and regular monitoring of their wellness and the impact on their work performance. A need also exists for academic employees to be educated on the health risks associated with being constantly available, fading boundaries between home and work life, working seven days a week, and coping with the environment for them to be able to function optimally in order to support the institutional goals (Bezuidenhout, 2015, p. 13; Setati, 2014, p. 161; Yusoff & Khan, 2013, p. 95).
- Work-life balance. As a preventative intervention, an employer needs to consider flexible work arrangements to assist employees. Employees value organisations that have family-friendly policies which allow them to have flexible working hours that promote work-life balance (De Vroome et al., 2015, p.683; Dickson-Swift et al., 2014, pp. 146-147).
- Employers need to provide a physical work environment that supports the health and well-being of employees. The physical environment mainly refers to ergonomically and comfortable work stations (Dickson-Swift et al., 2014, p. 148; Pronk, 2014, p. 45). In certain instances, physical aspects such as parking, showers, family-friendly infrastructure such as separate rooms for employees' children to do homework and for mothers to breast-feed, contribute positively to a health-promoting workplace (Dickson-Swift et al., 2014, p. 148).

- Counselling and support service need to be provided for affected employees. Due to the changing work-role expectations distance educators perceive, it is possible that they may, inter alia, suffer from high stress levels and mental health problems such as anxiety and depression. HEIs need to provide counselling and support for educators who are medically incapacitated due to the challenging workload (Bezuidenhout, 2015, p. 13). Employee assistance programmes have an important role to play in minimising sick absence by creating a healthy and congenial work environment (Black & Frost, 2011, p. 48; Mishra & Inda, 2014, p. 90; Mogobe, 2011, p. 83).

2.5.2.6 *Rehabilitative incapacity management practices*

In general, rehabilitative incapacity management practices can be described as the reasonable accommodation of employees' incapacity due to ill health. Employers need to be flexible in terms of the requested work accommodation and be clear in terms of the assistance they can offer. The provision of reasonable accommodation should be based on a workplace assessment through job analysis and, if required, suitably tailored job modifications made (Ali v Torrosian and Ors t/a Bedford Hill Family Practice, 2018; Butterworth v Independence Australia Service (Human Rights), 2015; Dewa et. al., 2016, pp. 8-9; Gensby et al., 2014, p. 235; Hilditch v AHG Services (NSW) t/a Lansvale Holden, 2017; Huntley v State of NSW, Department of Police and Justice (Corrective Services NSW), 2015; IMATU obo Anton Strydom v Witzenburg Municipality, 2012; McCall v City of Philadelphia, 2015; Mitchell v Marks and Spencer plc, 2017; MTN Service Provider (Pty) Ltd v Matji NO & Others, 2007; NUMSA obo Josias v Tedelex Trading (Pty) Ltd., 2007; Pomaki et. al., 2010, p. 22; Standard Bank of South Africa v CCMA and others, 2007; Taylor-Novotny v Health Alliance Med. Plans, Inc., 2014; Walz v Ameriprice Fin. Inc., 2015; Withers v Johnson, 2014; Wylie v Standard Executors and Trustees, 2006).

Effective return-to-work programmes positively contribute to job satisfaction and morale of both the incapacitated employee and their co-employees. It also has a positive effect on the physical health of the employee (Buys et al., 2016, p. 6). Van Oostrom and Boot (2013, p. 335) point out that timely return to work is of great benefit for both the employee and the employer. The longer an employee is unable to work, the higher is the probability that he or she will not return to work at all. Interventions that are initiated early, within the first six weeks of the sick absence, have a positive effect and facilitate return to work (Hoefsmit, Houkes & Nijhuis, 2012, p. 471). Employers should focus their efforts on trying to help sick employees return to work sooner, due to the indication that at least 80% of employees suffering from musculoskeletal injuries and back pain return to work, while for those with stress and other mental health problems the return rates are slightly lower (75–80%) (Black & Frost, 2011, p. 46).

Hoefsmit et al. (2012, p. 474) found that generic interventions targeted at all employees on sick absence, irrespective of their specific medical diagnosis do not show a positive impact, whereas interventions that focus on specific medical conditions are somehow (in more than half of the cases) positive. Line manager autonomy for designing and providing reasonable accommodation for the specific illness is one of the factors that positively affect injured employees (Kristman et al., 2017, p. 124). In addition, Hoefsmit et al. (2012, p. 471) found that return-to-work interventions that include decisions on specific details as to when or how return to work will take place, have a positive impact on the return-to-work processes. Ideally return-to-work activities are performed according to a predefined schedule.

From the literature reviewed, it can be deduced that structured, systematic, and coordinated return-to-work practices improve return-to-work outcomes (Pomaki et. al., 2010, p. 22).

2.5.2.7 *Multiple role player partnerships*

Most research focuses mainly on the employer and the incapacitated employee as the key role players in managing incapacity in the workplace. However, effective collaborative relationships among employers, health care providers, and other relevant role players can provide a good foundation for an employee's return to work (Ashley et al., 2017, p. 22). Frank (2016, p. 21) confirms that for an employee to remain at or return to work, close cooperation is required between the employee, health or rehabilitation professionals, and supportive employers. In addition, the employer's obligation to assess the extent of the incapacity necessitates a multiple role player approach, which includes relevant experts such as medical specialist and occupational therapists (Chetcuti v Coles Group Supply Chain Pty Ltd, 2012; Duarte v The Paraplegic and Quadriplegic Association of NSW, 2017; O'Brien v Bolton St Catherine's Academy, 2017; Standard Bank of South Africa v CCMA and others, 2007; Wylie v Standard Executors and Trustees, 2006).

A fundamental factor that ensures that best practices are applied is that the incapacity management policy and procedures should stipulate the roles and responsibilities of the multiple role players, such as the employers (represented by the line managers), the incapacitated employees, the multi-disciplinary health service providers, co-employees and organised labour (Mellor & Webster, 2013, p. 134; Pronk, 2014, pp. 44-45). Co-ownership and a mutual understanding (if not a common purpose) of the incapacity management programme by all role players will be beneficial. In addition, participatory principles and employee participation in the decision-making will add value to the programme (Higgins et al., 2012, p. 330; Pronk, 2014, pp. 44-45).

Multi-disciplinary interventions for physical and psychological illnesses appear to be effective in supporting return to work (Hoefsmit et al., 2012, p. 471). It is recognised that the successful implementation of a health management programme, which seeks to assist the employee to become well again, also

requires, in addition to that of the line manager, the support of other role players, such as human resource practitioners, occupational health experts, a joint labour-management committee and active employee participation (Anema et al., 2013, p. 370; Gensby et al., 2014, p. 235; Haafkens et al., 2011, p. 105; Mogobe, 2011, p. 83; Perski, Grossi, Perski & Niemi, 2017, p. 557). Employees must accept responsibility for work adaptations (Haafkens et al., 2011, p. 113; Perski et al., 2017, p. 557). This suggests that it is important that care professionals, case managers, employers and/or employees should cooperate to enhance the medical recovery processes (Ashley et al., 2017, p. 22; Hoefsmit et al., 2012, p. 474).

The negative effects of return-to-work processes may be offset by appropriate workplace planning and organisation. Incapacity management practices, with particular reference to return-to-work processes should provide for the specific roles and functions of co-employees and the provision of training and incentives to the assisting co-employee. The following may assist in ensuring less impact on the co-employee when an incapacitated employee returns to work:

- clarity and understanding of the roles and responsibilities
- clarity on expectations, timelines and workload as part of the return-to-work arrangements
- the line manager's acknowledgement of the co-employees' efforts to assist reintegration of the returning employee.
- the organisation's recognition of the co-employees' contributions to the success of the return-to-work outcomes
- compensation, monetary or in kind, for the personal cost of supporting an employee returning to work (Dunstan & MacEachan, 2013, p. 51)

Return-to-work or stay-at-work interventions require planned, structured, coordinated, and close communication between employees, employers, trade unions, healthcare service providers, and any other relevant role players (Pomaki et. al., 2010, p. 22). Medical practitioners also play a critical role in the

recovery and return to work of an employee (Mazza et al., 2015, p. 1). In Australia, in contrast to the United Kingdom, there appears to be a dissonance between the health benefits of returning to meaningful work and the general practitioner certification practice (Mazza et al., 2015, p. 1.) Mazza et al. (2015, p. 7) and Cotton (2014, p. 11) argue that general practitioners should be encouraged to issue employees with “fit notes” rather than “sick notes”. Fit notes provide recommendations on what people can do in the workplace, despite the illness or injury, by accommodating the medical condition. Cotton (2014, p. 11) points out that return to work is still commonly viewed by treating medical practitioners as an action that occurs after their treatment, not as something that should occur concurrently and be integrated into their treatment. Mazza et al. (2015, p. 7) argue that the first step to be implemented is to clarify the role of the general practitioners in return-to-work practices. This requires evidence-based education to the general practitioner to communicate directly to their patients the benefits of early return to work. Early return to work contributes to a shorter recovery period. Similarly, through continuous training of general practitioners and medical students about return to work and ill health benefit compensation systems could assist in reducing the number of unfit-to-work medical certificates. Grobler (2018, p. 65) is of the view that medical practitioners should show leadership in the matter of return to work after sick leave, by adopting a prevention model of thinking to avoid permanent disability as an outcome.

There should be a balanced focus on employee lifestyle risks and workplace risks. In workplaces with limited social and line manager support, heightened physical and psychological demands, and poor leadership, the risk for disability is likely to increase (White et al., 2013, p. 489). Managers should not only propagate healthier lifestyles to employees but should also ensure that the workplaces are not creating ill health through job design without regard for the wellness policy (Mellor & Webster, 2013, p. 134).

2.5.2.8 *Adequate training of role players*

Another fundamental best practice for incapacity management is the training of role players. Provision of adequate training to managers in particular, may curb absenteeism. This includes training on how managers should engage with employees when they were absent and have returned to work (Mishra & Inda, 2014, p. 90; Mogobe, 2011, p. 83). The role of a line manager is a critical aspect to be addressed as it was found that conflict between an employee and a line manager after returning to work from sick absence due to common mental disorders increases the odds to be sick again within six to twelve months (Arends, Van der Klink, Van Rhenen, De Boer & Bültman, 2014, p. 198).

Managers should understand their roles and responsibilities in the implementation of the interventions, from promoting the programme to monitoring employees' health-related needs. They should be equipped with the right advice and tools for assessment and monitoring of health-related needs on both the individual and team levels (Mellor & Webster, 2013, p. 134).

Employees need to be made aware of and educated on health risks due to occupational factors, and the availability of the wellness services (Bezuidenhout, 2015, p. 13; Mellor & Webster, 2013, p. 134; Mishra & Inda, 2014, p. 90; Pronk, 2014, pp. 44-45; Setati, 2014, p. 161; Yusoff & Khan, 2013, p. 95). To achieve co-ownership and a mutual understanding (if not a common purpose) of the incapacity management programme by all role players, the implication is that role players such as health service providers, co-employees, and organised labour should also be trained on the incapacity management policy and procedures (Higgins et al., 2012, p. 330; Mellor & Webster, 2013, p. 134; Pronk, 2014, pp. 44-45).

2.6 INCAPACITY MANAGEMENT INSTRUMENTS IN THE ODL INSTITUTION

The ODL institution's Policy on the Employee Assistance Programme (University of South Africa, 2015c) recognises that the institution's employees are its most valuable asset. The Policy aims to provide a work-based intervention programme to improve the quality of life of employees by identifying and resolving both the work and personal problems that may adversely affect the work performance of employees. It attempts to ensure employee wellness and workplace effectiveness. The draft Integrated Health and Wellness Framework (University of South Africa, 2014d, p. 3) seeks to support the ODL institution's goal of promoting the optimal wellness of employees while being cognisant of the relevant legislation, risks, and compliance.

The Policy on Leave of the ODL institution (University of South Africa, 2014a) provides for 68 working days' sick (incapacity) leave, in a three-year cycle, with full salary, with half salary and with no salary respectively (a total of 204 working days). It does not provide for temporary sick leave for periods exceeding the sick leave provision, as contained in the Policy on Leave (University of South Africa, 2014a). However, a small portion of the ODL institution's permanent employees (approximately 328 out of 5 600 employees) retained a temporary pre-merger disability risk benefit (with full salary) as provided for in the rules of the retirement fund to which they belong. The ODL institution only has insured risk benefits for its permanent employees in the case of permanent disability due to ill health.

The Policy on the Employee Assistance Programme (University of South Africa, 2015c) and the Integrated Health and Wellness Framework (University of South Africa, 2014d, p. 3) provide a theoretical and philosophical explanation of the wellness of employees. It does not elaborate on detailed incapacity management practices that may be implemented by the institution.

2.7 SHORTCOMINGS IN THE INCAPACITY MANAGEMENT INSTRUMENTS OF THE ODL INSTITUTION

The Policy on Leave (University of South Africa, 2014a), Policy on Employee Assistance Programme (University of South Africa, 2015c), and the draft Integrated Health and Wellness Framework (University of South Africa, 2014d) of the ODL institution do not provide guidance on how a non-healthy or incapacitated employee should be managed or accommodated. These instruments lack details on the roles and responsibilities of the various role players, potential reasonable accommodation practices, and training for the various role players. These shortcomings result in a knowledge gap at the institution on the management of incapacity, hence the need for this study.

2.8 PERSONAL REFLECTIONS ON THE CHAPTER

Any organisation needs healthy employees to excel and remain competitive and sustainable. Incapacity due to illness is not exclusively a biomedical condition. Incapacity is a complex phenomenon and it includes the biological, psychological, sociological factors of an employee and the emotions associated with these factors within the workplace. When an employee's prolonged or serious incapacity results in a situation where he or she cannot honour his or her employment or performance contract, even after a rehabilitation period and reasonable accommodation have been provided, the incapacity may be re-defined as a disability. This complexity requires a strategic, sophisticated, and holistic understanding of incapacity in the workplace. It requires that incapacity must be managed in such a manner that employees will perceive that organisational justice, especially procedural and interactional justice, have prevailed.

The definition of Landis and Grosset (2014, p. 237) provides a good summary of incapacity in the context of this study. Incapacity is defined as "the supervening of performance, an interruption in the ability to perform, either

permanent or temporary, partial or absolute, by an employee in relation to his or her employment obligations” (Landis & Grosset, 2014, p. 237).

It is evident that incapacity (sick absence) not only impacts the individual employee, but also affects the employer in terms of direct salary costs. It is also possible that the incapacity of employees may have a negative impact on the services rendered to the employer’s internal and external clients. It also impacts on the co-employees as they need to carry the extra workload, sometimes without any additional compensation. In addition, the co-employees can be affected both physically and mentally, not only during the absence of the incapacitated employee, but also during the phasing in when the employee returns to work after a period of absence.

It is also evident that an organisation should have an incapacity management framework to support the employer and employees in order to enhance global competitiveness, reduce or control costs associated with incapacity, and protect the employability of employees. Firstly, the framework should have the full support of the leadership of an institution. The management should ensure that the incapacity management practices are sufficiently resourced, both monetary and personnel-wise (either in in-house, outsourced or co-sourced capacity). Secondly, such a framework requires a clear policy and procedures on incapacity management practices. Thirdly, it requires defined preventative and rehabilitative accommodation consideration to assist employees while at work as well as to return to work after a period of sick absence. Fourthly, the roles and responsibilities of line managers, the incapacitated employee, human resource practitioners, employee assistance professionals, health practitioners, co-employees, and the labour unions should be defined, and they all should be trained on their roles and responsibilities.

2.9 SUMMARY OF THE CHAPTER

The chapter focuses on organisational justice in the workplace, incapacity management and its general impact. Furthermore, the chapter focuses on incapacity management practices in higher education, and more specifically, in the ODL institution. In the next chapter I explore the legislative requirements for fair and just management of incapacity in the workplace.

CHAPTER 3: CONVENTIONS AND REGULATORY FRAMEWORK ON INCAPACITY MANAGEMENT

Generally, labour legislations are constructively fortified with the goal of revitalising the socio-economic fabric of the country through their malleable yet firm provisions, which hypothetically works its way through harmonising the relationship between employer and employee.

Henrietta Newton Martin

3.1 INTRODUCTION

This chapter provides an overview of the conventions and regulatory framework applicable to incapacity management in the workplace. In addition, the employer's obligations, prior to the termination of the employment contract due to incapacity, are also addressed.

The aim of chapter 3, as diagrammatically depicted in Figure 3.1, is to provide a comprehensive literature review on the conventions and regulatory framework applicable to the management of incapacity due to ill health in the workplace. The chapter provides an overview of the essence of an employment relationship including the common law obligations of both the employer and employees. As the transformed South African higher education sector model is largely drawn from developed countries such as the United States of America, the United Kingdom, the Netherlands, and Australia, their applicable legislation and selective case law were investigated. The South African legislation was also compared with international conventions. In addition, the practical application of the legislation by the South African employers, as contained in South African case law, was investigated. The current incapacity management policies and procedures in the ODL institution were compared to the national legislative requirements and the applicable judgements or awards by the South African dispute-resolution forums, to determine its compliance. Any shortcomings of the current policies and procedures for incapacity management were explored.

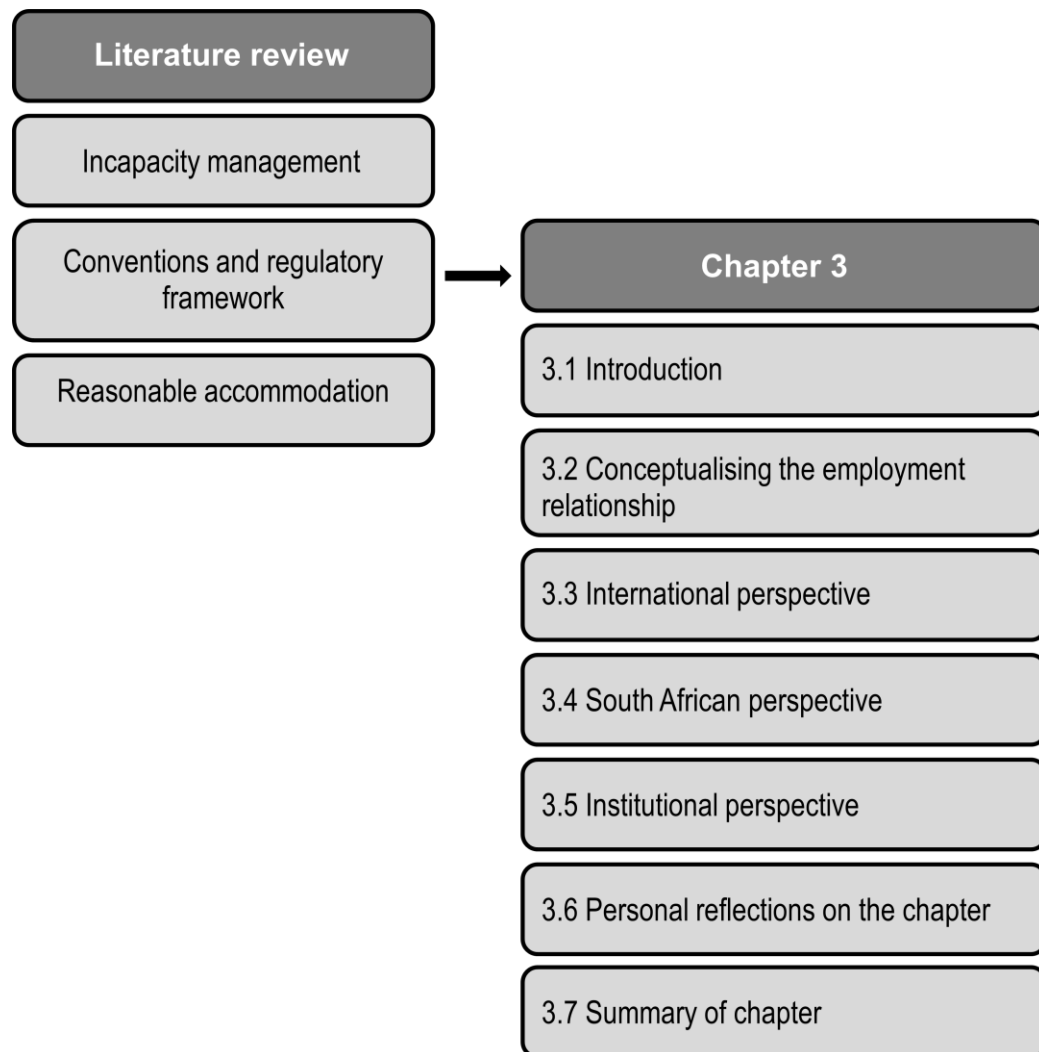


Figure 3.1: Conceptual framework of the literature review on incapacity management legislation and policy (own compilation)

3.2 CONCEPTUALISING THE EMPLOYMENT RELATIONSHIP

It must be appreciated that the employment relationship is influenced by international and local factors and should be understood within this context. The employment relationship is a sub-system of an organisation, which in turn is a sub-system of a wider environment (Slabbert et al., 2006, p. 1-37). In addition, an employment relationship provides for various role players that also have an impact on the relationship. As a key role player, the employee is dependent on

the employment relationship for economic, social, and psychological needs (Davidov & Eshet, 2015, p. 173). Figure 3.2 provides a schematic representation of the employment relationship.

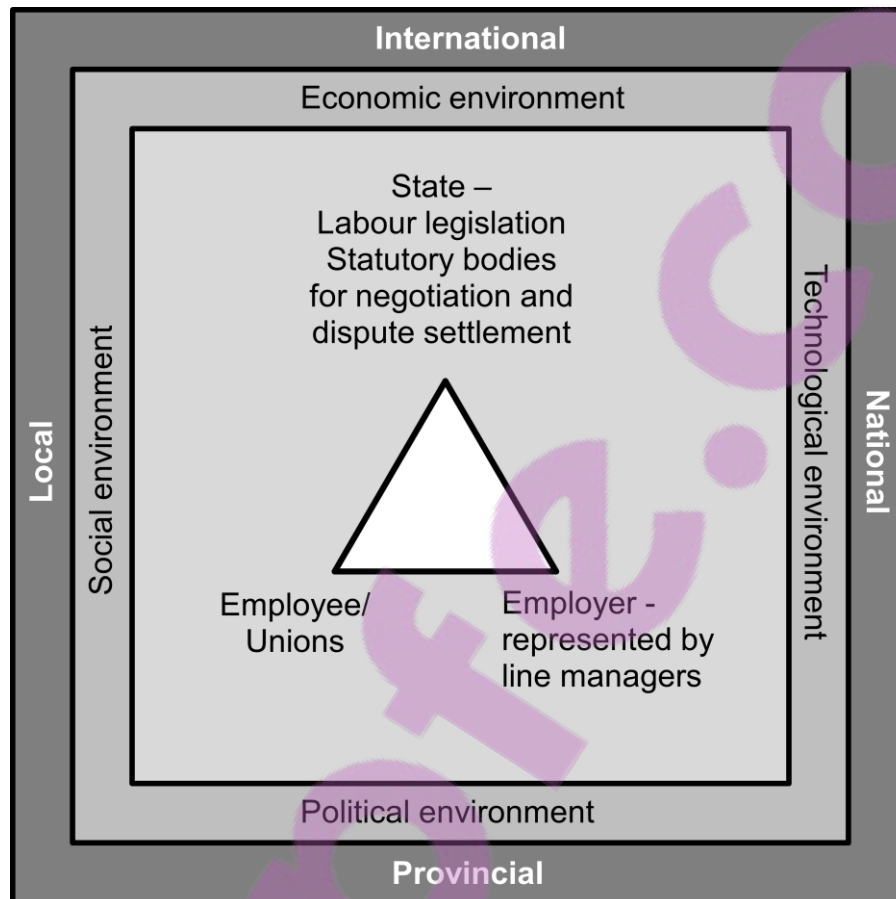


Figure 3.2: Context of the employment relationship (own compilation)

The employment relationship is generally regulated through employment legislation, collective agreements, and an employment contract. An employment contract may not have less favourable conditions than what is provided for in the legislation or an applicable collective agreement. Where no employment legislation exists, the employment relationship is governed by the employment contract, enforceable in terms of common law (Bendix, 1996, p. 107; Grogan, 2009, p. 2). Common law refers to the rules and principles from the Roman, Roman-Dutch, and English law that South Africa inherited during the colonial era. These common law rules and principles have been further

developed by the South African courts since South Africa became a fully sovereign state to bring the rules and principles in line with the new constitutional dispensation (Grogan, 2009, p. 2). Furthermore, common law does not cater for the conditions of modern commerce and industry, more specifically, for the fundamental human rights principles and their entrenchment in countries' constitutions (Grogan, 2009, p. 3). Common law does not provide sufficient protection of employees in the employment relationship. Its rules and principles do not adjudicate on the concept of fairness or equity, which is crucial in the employment relationship (Bendix, 1996, p. 107). In the South African context, the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995) defines, in addition to unfair dismissal, the following four main categories of unfair practices in the employment relationship:

- the employer conducting unfair practices in terms of promotion, demotion, probation, training of an employee or providing of benefits to employees
- the unfair suspension of an employee or any other unfair disciplinary sanction short of dismissal imposed on an employee
- an employer refusing to reinstate or re-employ an ex-employee in terms of any agreement
- the employer disadvantaging an employee as a result of whistle blowing (Republic of South Africa, 1995, s 186(2), 187, 188)

The essence of the employment contract is that the employee voluntarily places his or her labour potential or personal services at the disposal of and under the control of the employer, in return for remuneration for a continuous period (Bendix, 1996, pp. 115-116; Davidov & Eshet, 2015, p. 173; Grogan, 2009, p. 29; Grogan, 2014, p. 17; Slabbert et al., 2006, p. 5-71; Van Zyl, 2011, p. 8). The contract should preferably be in writing, but even if it is not, the verbal understanding between the employer and employee is still binding (Grogan, 2014, p. 17). In contrast to this view of Grogan (2014, p. 17), section 29 of the Basic Conditions of Employment Act 75 of 1997 (Republic of South Africa, 1997) stipulates that an employer must furnish an employee with written

particulars of the employment. However, the non-reducing of an employment contract in writing does not render it void, meaning that the verbal understanding between the employer and employee will be accepted as a valid contract (Grogan, 2009, p. 30). Cohen (2012, p. 84) points out that while the employment contract is invariably concretised through a written contract of employment, the rights and obligations of the parties evolve over time and extend well beyond the confines of the written agreement. This evolvement is as a result of commitments that the employer makes to employees, over the course of the relationship, the development of workplace practices and the development of expectations that may give rise to a sense of entitlement.

The reciprocal nature of the employment contract implies that an employer can expect reasonable efficient, diligent and faithful performance from an employee. In addition, the employee shall not deal dishonestly with the property of the employer, and not compete with the business of the employer. In return, the expectation exists that the employer shall compensate the employee fairly and provide a safe and healthy working environment (Bendix, 1996, p. 116; Grogan, 2009, pp. 47-57; Slabbert et al., 2006, pp. 5-99–5-101). The implied obligation is that the parties will conduct themselves in a manner that is not likely to damage or destroy the employment relationship. This is known as the obligation of mutual trust and confidence or fair dealing (Cohen, 2012, p. 94).

Should an employee not be able to fulfil his or her contractual obligations it can be viewed as a breach of the employment contract (Van Zyl, 2011, p. 8). Consequently, the employer has a duty to determine the reasons for the non-performance according to the contract and allow the employee an opportunity to remedy the situation. If an employee then fails to fulfil his or her obligations of the employment contract, the employer may elect to terminate the employment contract (dismiss the employee) on the terms provided for in the contract (Grogan, 2014, p. 2; Slabbert et al., 2006, p. 5-72). In terms of common law the termination of an employment relationship must be lawful, which means that the termination of the contract must be in terms of the termination

conditions as stipulated in the employment contract (Grogan, 2014, p. 2). This argument supports Bendix's view (1996, p. 107) that common law does not support fairness and equity, but purely compliance with the contractual duties.

In terms of the South African employment legislation the termination of an employment contract should be for a fair reason and in accordance with a fair procedure (Bendix, 1996, p. 116; Grogan; 2014, p. 11; Republic of South Africa, 1995, s 187,188; Van Zyl 2011, p. 15). Grogan (2014, pp. 2-4) points out that, particularly with the enactment of the Labour Relations Act 28 of 1956 and its successor, the Labour Relations Act 66 of 1995, the termination of the employment relationship is no longer merely adjudicated on the contractual entitlement (common law) in terms of lawfulness, but also on whether the employer acted fairly in doing so. Fair dismissal depends on two requirements. Firstly, the employer must present a fair reason to terminate the employment contract. A fair reason in the South African context is misconduct, incapacity (due to ill health or poor performance) or operational requirement (retrenchment). Secondly, the employer must follow a fair procedure prior to terminating the employment contract. The procedure followed would be judged differently according to each of the aforementioned reasons for dismissal (Grogan, 2009, pp. 165-167; Republic of South Africa, 1995, s 188). It is important that an employer should be able to deal with the termination of a contract with confidence, as a botched termination can be costly, both in time and money, and may impact negatively on the employment relationship and productivity of the organisation (Grogan, 2014, p. 1). Over and above the time spent during appearances at the relevant dispute resolution structures, such as the Commission for Conciliation, Mediation and Arbitration (CCMA) or a Bargaining Council, the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995) provides that the remedy for an unfair termination of a contract can be an order for reinstatement, re-employment, or compensation to be paid to the employee (Republic of South Africa, 1995, s 193(1)). Current legislation states that compensation may not be more than 12 months remuneration

calculated at the employee's date of dismissal or 24 months' remuneration for an automatic unfair dismissal (Republic of South Africa, 1995, s 194(1)).

3.3 INTERNATIONAL PERSPECTIVE

As the employment relationship exists in a global world and is influenced by international trends (Figure 3.2), it is imperative to explore the international legislative regime. Bendix (1996, p. 108) points out that in drafting employment legislation, governments need to be guided by globally accepted employment standards that are supplied by the various conventions and recommendations of the International Labour Organisation (ILO). These ILO conventions are explored later in this chapter.

As the transformed higher education model of South Africa is largely drawn from developed countries such as the United Kingdom (UK), the Netherlands, Australia and the United States of America (USA), a summary is provided on these countries' employment legislation pertaining to the management of incapacity in the workplace and the termination of an employment contract (Setati, 2014, p. 1). In addition, the Netherlands and Great Britain played an important role in the history and legislation of South Africa due to their colonisation of certain parts of South Africa (Grogan, 2009, p. 2). To a large extent the principles of the Roman-Dutch, and specifically the English laws still form part of the current South African legal system.

3.3.1 International Labour Organisation

The International Labour Organisation (ILO) was founded on 28 June 1919 after the end of the First World War as part of the Peace Treaty of Versailles (Bendix, 1996, p. 108; Burger, 2013, p. 55; Smit, 2010, p. 41). The ILO attempts to assist in establishing protective values for profit and social peace through equal working conditions. In terms of a dismissal of an employee, the

Termination of Employment Convention, 1982 (International Labour Organisation, 1982) sets the preferred standards for member states.

As the study focuses on incapacity and the potential termination of an employment contract due to ill health, the discussion is limited to only the relevant articles of the Convention as briefly outlined below.

Article 1 determines that the provisions of the Convention shall be given effect by laws or regulations if it is not contained in collective agreements, arbitration awards, or court decisions (International Labour Organisation, 1982, s 1). Member countries of the ILO are expected to subscribe and adhere to the international employment standards set by the ILO.

Article 4 of the Convention (International Labour Organisation, 1982, s 4) stipulates that the employment of a worker shall not be terminated unless there is a valid reason. The valid reason for termination is similar to the fair reason prescribed to by South Africa as mentioned in the previous section, namely incapacity, misconduct, or the employer's operational requirements. Incapacity relates to the inability of the employee to perform the job. Misconduct refers to an employee's action or behaviour that is not acceptable within the employment relation, such as dishonesty, fraud, and gross insubordination. Termination due to operational requirements is based on the economic needs of an organisation and is not an employee's fault.

In terms of article 6 of the Convention (International Labour Organisation, 1982, s 6) temporary (short-term) absence from work because of illness or injury shall not be a valid reason for the termination of the employment contract. It stipulates that the definition of what temporary absence from work constitutes, whether a medical certificate shall be required, and other requirements need to be provided for in a member state's laws, regulations, court decisions, arbitration, or collective agreements (International Labour Organisation, 1982, s 6).

Article 7 states that an employee must be given an opportunity to defend him- or herself against the allegations made by the employer prior to the termination of the employment relationship for reasons related to the employee's conduct or performance (International Labour Organisation, 1982, s 7). In addition, article 8 provides that an employee shall be entitled, within a reasonable period of time after the termination, to appeal against the termination of the employment contract if he or she considers the termination as unjustified (International Labour Organisation, 1982, s 8).

Smit (2010, p. 47) opines that the following three core principles in terms of the Termination of Employment Convention, 1982 (International Labour Organisation, 1982) should at least be complied with when termination of an employment relationship is considered:

- A fair and valid reason or just cause must exist for the termination of the employment contract (dismissal) (Davidov & Eshet, 2015, p. 167).
- An employee must have an opportunity to defend him- or herself against the allegations made by the employer.
- The employee should have the right to appeal the decision of the employer to an impartial body.

As the intention of the ILO is to set preferred standards for member states, the international and South African legislative frameworks are compared with the principles as contained in the ILO Convention for compliance. Legislation of the United Kingdom, the Netherlands, Australia and the United States of America is highlighted, as the transformed South African higher education system was influenced by the technical assistance of these countries.

3.3.2 United Kingdom

The United Kingdom (UK) was a founding member of the ILO (Smit, 2010, p. 41). In the spirit of article 1 of the Termination of Employment Convention, 1982 (International Labour Organisation, 1982, s 1), being a founding member of the ILO, the UK could reasonably be expected to comply with the principles contained in the ILO convention.

3.3.2.1 UK legislative framework for termination of an employment contract

In the UK collective agreements regulated the employment relationship for decades. However, when the Conservative government headed by Ms Margaret Thatcher came into power in the late nineteen seventies, a number of employment legislative reforms were introduced curtailing the freedom of trade unions to regulate their own conduct, resulting in a decrease in trade union membership and a reduction in strike action (Hardy, 2011, p. 54; Smit, 2010, pp. 60-61).

In 1996 the UK introduced the Employment Rights Act of 1996, which contains sections on disciplinary enquiries, including the rights of an employee during a disciplinary hearing. The Employment Act of 2002 expands on the disciplinary procedures as contained in the Employment Rights Act of 1996 (Smit, 2010, p. 61).

The general spirit of the English legislative framework is that employees have the right not to be unfairly dismissed after they have worked for more than two consecutive years. Defining unfair dismissal in this context is a major issue in termination disputes (Estreicher & Hirsch, 2014, p. 435; Hardy, 2011, p. 181; Hyams-Parish, 2013, p. 12). Section 94(1) of the Employment Rights Act of 1996 states that a fair reason must exist for termination and sections 98(2)(a)–98(2)(d) provides examples of fair reasons for the termination of an employment contract (United Kingdom, 1996). One of the reasons for the termination of an

employment contract is the capability of an employee to perform work of the kind he or she was employed for (Hardy, 2011, p. 188; United Kingdom, 1996, s 98(2)(a)). In terms of the Employment Rights Act of 1996, the capability of the employee is assessed by, inter alia, the health or any other physical or mental quality of an employee. Hardy (2011, pp. 150-151) points out that a long period of absence due to ill health may bring an employment contract to an end through the supervening impossibility of performance. This means that the incapacity of the employee was of such nature or duration that the further performance of the obligations of the employee would either be impossible or radically different from what was originally contracted on.

For a general termination of an employment contract to be judged as fair the following three steps should at least be followed:

1. An investigation into the alleged reasons for termination of the employment contract should be held.
2. The Employment Rights Act of 1996 (United Kingdom, 1996) and Employment Act of 2002 (United Kingdom, 2002) provide that a hearing should take place affording the employee an opportunity to state his or her case before any action is taken against him or her.
3. The employee should be provided a right to appeal (Estreicher & Hirsch, 2014, p 435; Hardy, 2011, pp. 186-187; Smit, 2010, p. 64).

Jackson and Banerjee (2013, pp. 96-98) point out that the factors to be considered when judging whether the termination of an employment contract due to ill health is fair, are:

- the nature of the illness
- the prospect of the employee's return to work
- the likelihood of recurrence of the illness
- the employer's need for someone to do the work
- the effect of the employee's absence on co-employees

- the extent to which the employee is aware of the position and has been consulted
- the employee's length of service
- whether ill health is the true reason for the dismissal
- whether a reasonable investigation was carried out by the employer

3.3.2.2 *Evaluation of the termination of employment process of the UK in terms of the ILO principles and case law*

If the above legislation is compared with the ILO Termination of Employment Convention of 1982, the UK, as a member of the ILO complies with the core principles of the convention. In addition, the legislation provides specifically for the termination of an employment contract based on the capacity of an employee, however, the appropriate legal steps need to be followed. The Equality Act of 2010 provides that when an employee has a physical or mental impairment that will have a long-term adverse effect on an employee's ability to perform his or her contractual duties, the employer needs to reasonably accommodate the medical condition (United Kingdom, 2010, s 20). The principle of reasonable accommodation was confirmed in a number of legal cases, where it was argued that an employer will be in violation of the Equality Act of 2010, if such is not provided for (Ali v Torrosian and Ors t/a Bedford Hill Family Practice, 2018; Mitchell v Marks and Spencer plc, 2017). Should it not be possible to accommodate the employee's condition, the employment contract may be terminated (United Kingdom, 1996, s 98(2)(a)). In O'Brien v Bolton St Catherine's Academy (2017) the Court of Appeal ruled that throughout the incapacity management process employers must assess the employee's medical condition. Even at the end of the process, when new medical information is provided indicating that the employee may now be fit to work, the employer has an obligation to take it into consideration, prior to terminating the employment contract. In this case the employer even had access to their own occupational health advisers that could have assisted them (O'Brien v Bolton St Catherine's Academy, 2017).

3.3.3 The Netherlands

The Netherlands was also a founding member of the ILO (Smit, 2010, p. 41). Being a member of the ILO and the European Union, the Netherlands could reasonably be expected to respect the labour standards regarding the termination of an employment contract as contained in the ILO convention and the directives of the European Union (Smit, 2010, pp. 53-54).

3.3.3.1 *The Netherlands legislative framework for termination of an employment contract*

Dutch employment and labour law is elaborate and relatively complex. It is divided into individual and collective law and is closely related to their social security law. In 2015 the Work and Security Act (“Wet Werk en Zekerheid”) was introduced. The Work and Security Act of 2015 brought fundamental changes to the employment and dismissal law of the Netherlands.

Although generally a fixed-term employment contract or a contract for a specific project ends upon expiration of the term or completion of the project, the Work and Security Act of 2015, introduced a duty of notification. As from 1 July 2015 an employer was obliged to notify the employee at least one month before the ending of a fixed-term contract, or six months or more in cases where the employment contract will be extended and, clarify to what terms and conditions the contract will be subjected (BarentsKrans Employment Law Department, 2015, p. 14; Bos, Van Dijk, Van Lammeren & Wallast, 2015, p. 14).

Since the introduction of the Work and Security Act of 2015, a permanent contract can be terminated in the following instances:

- The employer giving notice of termination of employment after receiving permission from a governmental organisation (Labour Office or Cantonal Court). Prior to the implementation of the Work and Security Act of 2015 there was little transparency regarding termination of an employment contract and this resulted in unequal consequences for employees, as it was often the employer who determined which procedure was followed, either through the Labour Office or the Cantonal Court. The Work and Security Act of 2015 abolished the system whereby an employer desiring to terminate an employment contract could choose between two different procedures (BarentsKrans Employment Law Department, 2015, p. 3; Bos et al., 2015, p. 28).

The amendments in terms of the Work and Security Act of 2015 dictate which one of the two procedures (Labour Office or Cantonal Court) should be followed. The decision will depend on the reasons for the termination of the contract and is no longer determined by the employer. The Labour Office will deal with terminations related to business economic circumstances or prolonged incapacity for work (minimum of two years). Permission will only be granted if there is reasonable ground for dismissal and redeployment within a reasonable period is not possible (even after training) or reasonable. A possible appeal provision exists against the permission of the Labour Office (BarentsKrans Employment Law Department, 2015, p. 17; Bos et al., 2015, p. 28). Dekkers-Sánchez, Wind, Frings-Dresen and Sluiter (2015, p. 577) explain that, in the Netherlands, insurance physicians are responsible to evaluate the work ability of employees on long-term sick leave. In terms of the legislation, employers are financially responsible for the employee on sick leave during the first two years; thereafter the sick employees may apply for disability benefits. After the two years the employees need to be assessed in terms of their ability to work or not to work, before they can qualify for disability benefits.

The Cantonal Court will deal with intended terminations due to:

- frequent and disruptive absence due to illness
- alleged unsatisfactory performance (other than as a result of illness)
- serious misbehaviour
- refusal to work due to a serious conscientious objection
- a disturbed working relationship as a result of which the employer cannot reasonably be expected to continue the working relation (BarentsKrans Employment Law Department, 2015, p. 17; Bos et al., 2015, pp. 28-29)

In the Cantonal Court proceedings, reasonable grounds for dismissal should exist and redeployment within a rational period must not be possible (even after training) or reasonable. The possibility of appeal against the Cantonal Court's decision exists (Bos et al., 2015, pp. 28-29).

- Secondly, the employee may give consent for the termination of the employment contract after the employer has given notice of the termination without the abovementioned permission from the Labour Office. Even after the implementation of the Work and Security Act of 2015, it remains possible to terminate the employment contract by mutual consent through the conclusion of a settlement agreement with a cooling-off period of 14 days. This means that if the employee has agreed to a settlement agreement, the employee can change his or her mind within 14 days. The cooling-off period has the objective of preventing the employee from agreeing to his or her dismissal hastily and without thinking matters through (Bos et al., 2015, p. 31).
- Thirdly, the employer may summarily dismiss an employee. It requires that the situation is of such a serious nature that the employment relationship needs to be terminated summarily. It appears that it is normally in cases of misbehaviour or gross misconduct. An urgent reason must exist and it should be communicated to the employee immediately after which the employment agreement is terminated without notice (Bos et al., 2015, p. 32).

- Fourthly, the employee may give notice to terminate the employment contract (resignation).
- Lastly, the employment contract will terminate when the employee reaches the normal pensionable age (BarentsKrans Employment Law Department, 2015, p. 16; Bos et al., 2015, p. 32).

3.3.3.2 *Evaluation of the termination of employment process of the Netherlands in terms of the ILO principles*

From an overview of the labour legislation of the Netherlands it is evident that the country generally complies with the core principles of the ILO's Termination of Employment Convention of 1982 (International Labour Organisation, 1982) in terms of fair and valid reasons for termination, following a specific procedure. The employee may present his or her case at the Labour Office or the Cantonal Court. The Netherlands' labour legislation provides for a framework to manage ill health (incapacity) with a distinction between long-term (two years and longer) and frequent and disruptive absence due to illness. An employee has a right to appeal the decision of the Labour Office or the Cantonal Court.

3.3.4 **Australia**

As with the UK and the Netherlands, Australia is also one of the founding member states of the ILO. Similarly, being a member, Australia could reasonably be expected to endorse the principles of the ILO.

3.3.4.1 *Australia's legislative framework for termination of an employment contract*

The Fair Work Act 22 of 2009 (Australian Government, 2009) provides for primary protection against unjust dismissals (Estreicher & Hirsch, 2014, p. 358;

Ndobela, 2012, p. 2; Ronalds & Raper, 2012, p. 225). Southey (2015, p. 150) argues that Australia's current nationally regulated unfair dismissal system as contained in the Fair Work Act 22 of 2009 (Australian Government, 2009) offers the widest range and accessible employee protection in the history of the country. The Fair Work Act 22 of 2009 protects an employee from dismissal for temporary absence due to ill health, unless the ill health extends for more than three months or if the total absence exceeds three months within a year (Ronalds & Raper, 2012, p. 230; Weir, 2012, p. 1). An employee's employment contract may be validly terminated based on the employee's illness or incapacity when the employer can demonstrate that reasonable adjustments to the employee's role had been made, but that it still has an adverse impact on the employee's ability to perform the inherent or adjusted requirements of the job (Ronalds & Raper, 2012, p. 232; Weir, 2012, p. 2).

The Fair Work Act 22 of 2009 states that an employer has the burden to prove that a termination of the employment relationship was not harsh, unjust or unreasonable. The following are some of the key questions that determine whether a dismissal was harsh, unjust or unreasonable:

- Was there a valid reason for the dismissal related to the employee's capacity or conduct?
 - Was the employee notified of the reason for termination of the contract?
 - Was the employee provided with an opportunity to respond to the allegations related to his or her capacity or conduct?
 - Was the employee represented at any discussions relating to the dismissal?
 - Was the employee warned about his or her poor work performance prior to the dismissal in order to have a chance to improve it?
- (Donaghey, 2013, pp. 302, 350; Estreicher & Hirsch, 2014, pp. 358-359; Ndobela, 2012, pp. 15-16; Ronalds & Raper, 2012, p. 225; Southey, 2015, p. 160).

A summary dismissal can occur without notice provided that the employer has reasonable grounds to believe that the employee has committed serious misconduct, such as criminal activity or serious breaches of health and safety procedures (Estreicher & Hirsch, 2014, p. 360).

3.3.4.2 Evaluation of the termination of employment process of Australia in terms of the ILO principles

The provisions of the Fair Work Act 22 of 2009 (Australian Government, 2009) give effect to the core principles of the ILO Termination of Employment Convention, 1982 (International Labour Organisation, 1982), in that a valid reason for the dismissal must exist, the employee will get an opportunity in defence, and has a right to appeal. In terms of the termination of an employment contract due to incapacity the employer needs to prove that the termination is reasonable and that a proper procedure was followed. The Australian employee can also claim that the termination of the employment contract is a discriminatory practise in that he or she is disabled, and the employer did not attempt to provide reasonable accommodation for the employee. Should the impact of the reasonable accommodation be unreasonable for the employer, the employment contract may be terminated (Australian Government, 2009, s 385; Ronalds & Raper, 2012, p. 232; Weir, 2012, p. 2).

A number of cases confirmed the aforementioned legal position in that an employer has an obligation to obtain a comprehensive assessment of the capacity of the employee to perform the inherent requirements of his or her work. In addition, if the employee cannot perform the job, the employer has an obligation to thoroughly consider reasonable adjustments to the job, to accommodate the capacity of the employee (Butterworth v Independence Australia Service (Human Rights), 2015; Hilditch v AHG Services (NSW) t/a Lansvale Holden, 2017; Huntley v State of NSW, Department of Police and Justice (Corrective Services NSW), 2015).

The employer has an obligation to engage with an employee, even while the employee is incapacitated. During this engagement, the employer should assess the employee's capacity and recovery as well as what reasonable accommodation(s) the employee may need in order to return-to-work. Similarly, an employee has a duty to communicate with the employer when away from work due to incapacity (Dorris Maharaj v Northern Health, 2017; Laviano v Fair Work Ombudsman, 2017).

In addition, an employer should have solid evidence of the employee's incapacity to work, including obtaining independent medical assessments if necessary, before a final decision is made on the termination of the employment (Chetcuti v Coles Group Supply Chain Pty Ltd, 2012; Duarte v The Paraplegic and Quadriplegic Association of NSW, 2017). In a case where the employer requested the employee to undergo an independent medical assessment and the employee refused, it was found that a dismissal was justifiable as the request from the employer was reasonable and lawful (Grant v BHP Coal Pty Ltd, 2014).

3.3.5 The United States of America

Although the United States of America (USA) has been a member of the ILO since its inception in 1919, they do not have a constitutional, statutory or public policy provision restricting the grounds for termination of an employment relationship. They subscribe to a doctrine called employment-at-will, which means that an employee or the employer has the right to terminate the employment contract at any time, lacking protection of employees against an unjust dismissal (Davidov & Eshet, 2015, p. 168, Estreicher & Hirsch, 2014, pp. 347, 443; Smit, 2010, p. 66). Other member states of the ILO increasingly demand of the USA to reconsider this exceptional rule and the absence of comprehensive just-cause protection against arbitrary terminations of employment contracts. The employment-at-will doctrine differs from the

approach taken by most of the other ILO member states in terminating an employment contract. The USA argues that this at-will rule permits greater labour market flexibility and therefore a more efficient and productive economy (Estreicher & Hirsch, 2014, pp. 348–349; Harcourt, Hannay & Lam, 2013, p. 314).

3.3.5.1 USA legislative framework for termination of an employment contract

Harcourt et al., (2013, p. 314) argue that the employment-at-will rule means that an employment contract can be terminated without a reason or cause for dismissal. Even if a reason or cause exists, it does not have to be just. This doctrine of employment-at-will has been tested over time with an ever-growing number of federal, state and local authority statutory and common law exceptions. These exceptions mostly focus on wrongful terminations or terminations based on discriminatory practices as contained in the various USA discriminatory laws and court cases (Estreicher & Hirsch, 2014, pp. 349-351; Harcourt et al., 2013, p. 314; Smit, 2010, pp. 66-71). One of the grounds for discrimination may be disability. The Americans with Disability Act of 1990 prohibits employers from discriminating on the basis of disability and gives employees with disabilities a right to be reasonably accommodated in the workplace. Disability is defined as a physical or mental impairment that substantially limits one or more life activities of a qualified employee (United States of America, 1990, s 12102(1), s12102(2)). Work is defined as one of the major life activities (United States of America, 1990, s 12102(2)). A qualified employee is viewed as someone who, with or without reasonable accommodation, can perform the essential functions of the post that he or she holds. The judgement of the employer on what are essential functions, as contained in the job description, will be considered when evaluating a matter of reasonable accommodation (United States of America, 1990, s 12111(8)). However, if the employer can prove that reasonable consideration was given to accommodate the disability of the employee, but that it would create an undue hardship on the business, the termination, based on disability, may be lawful.

Undue hardship is when the reasonable accommodation may require significant difficulty or expenses in comparison with the overall operations of the employer (United States of America, 1990, s 12111(10)).

3.3.5.2 Evaluation of the termination of employment process of the USA in terms of the ILO principles and case law

In terms of the core principles of the ILO Termination of Employment Convention, 1982 (International Labour Organisation, 1982) it is evident that the USA employment legislation does not prescribe a fair reason for dismissal, as defined by the ILO. The legislation also does not provide for any procedural requirements prior to the termination of an employee's service, and lastly, no provision is made for an employee to appeal against a verdict of dismissal (Smit, 2010, pp. 71-72). An employment contract may be terminated due to ill health that impairs the employee's ability to perform the contractual duties, provided that the termination of the contract is not deemed discriminatory as defined in the discrimination legislation. If an employment decision, having a negative impact on an employee, was taken based on an employee's race, gender, religion, national origin or disability (physically or mentally), it may be regarded as discrimination and the employee is entitled to challenge the decision in terms of discriminatory practices as contained in various USA discriminatory laws and court cases (United States of America, 1990, s 12102(4)).

A number of legal cases confirm that an employer is expected to accommodate an employee's incapacity, if it is known to the employer. The employee has a duty to inform the employer, and if the employee fails to inform the employer and fails to indicate what accommodation is required, the employee is not entitled to reasonable accommodation and the dismissal of the employee for incapacity may be justifiable (McCall v City of Philadelphia, 2015; Taylor-Novotny v Health Alliance Med. Plans, Inc., 2014; Walz v Ameriprice Fin. Inc., 2015; Withers v Johnson, 2014).

The courts also found that there should be active engagement between the employer and the employee in accommodating the incapacity of the employee. The employer should show that an earnest attempt was made during the engagement by discussing all possible accommodations, even if no accommodation is eventually provided. Failure by the employer to actively engage in the process, although providing (a) reasonable accommodation(s), is a violation of the Americans with Disability Act of 1990. When an employee fails to engage in an interactive process, the employer may fairly dismiss the employee (*EEOC v Kohl's Department Stores, Inc.*, 2014; *EEOC v LHC Group, Inc.*, 2014; *Jacobs v N.C. Admin Office of the Courts*, 2015; *Rorrer v City of Stow*, 2014). The courts confirm that not providing reasonable accommodation for an employee with a medical condition, provided that the accommodation does not change the essential functions of the job or may cause undue hardship, is an unfair dismissal (*Davina v Department of Justice*, 2017; *Jacobs v N.C. Admin Office of the Courts*, 2015; *Pamala v US Postal Services*, 2017; *Spears v Creel*, 2015).

3.4 SOUTH AFRICAN PERSPECTIVE

South Africa was one of the founding members of the ILO. South Africa was, due to the political system of exclusion of certain race groups, expelled as a member of the ILO in the nineteen sixties, and was readmitted on 26 May 1994 (Bendix, 1996, p. 108; Burger, 2013, p. 56; Smit, 2010, p. 41). Being a member, the South African national employment laws and practices need to comply with the ILO Conventions.

Grogan (2014, p. 5) argues that the South African courts historically viewed the employment relationship as purely contractual one. The superior economic position of employers was reflected in the social and political structures of the society, where these structures were based primarily on race. As a result of the

political dispensation, white people occupied most of the managerial and skilled positions.

3.4.1 South African legislative framework

As in Australia and the Netherlands, the South African employment legislation has undergone frequent and dynamic amendments over the last two decades to redress the inherent inequality between employers and employees. The new employment legislation was agreed to by government, organised labour and business (Grogan, 2014, p. 7). The new legislation incorporated the principles of the conventions of the ILO.

Chapter 2 of the Constitution of the Republic of South Africa, 1996, contains several provisions that have a direct impact on the employment relationships in South Africa (Republic of South Africa, 1996, s 23(1)–23(6)). In section 23(1) the Constitution of the Republic of South Africa, 1996, provides that everyone has the right to fair labour practices (Republic of South Africa, 1996, s 23(1)). Section 23 of the Constitution of the Republic of South Africa, 1996 (Republic of South Africa, 1996), also provides that national legislation may be enacted to regulate collective bargaining between employers and employees. The Constitution of the Republic of South Africa, 1996 (Republic of South Africa, 1996) does not provide any provision on what is deemed to be fair or unfair labour practices. Various laws exist to regulate and govern specific areas of employment, such as conditions of employment, occupational health and safety, collective bargaining, dispute resolution and termination of service due to misconduct, operational requirements and incapacity. This study focuses on the employment legislation providing guidance on incapacity in the workplace, such as the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995) and the Employment Equity Act 55 of 1998 (Republic of South Africa, 1998).

Section 1 of the Labour Relations Act 66 of 1995 stipulates that the purpose of the Act is to give effect to, inter alia, the fundamental rights conferred in the

Constitution of the Republic of South Africa, 1996 (Republic of South Africa, 1995, s 1(a)) and the obligations incurred by South Africa as a member state of the ILO (Republic of South Africa, 1995, s 1(b)).

The spirit of section 23(1) of the Constitution of the Republic of South Africa, 1996 (Republic of South Africa, 1996), is confirmed in section 185 of the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995, s 185), wherein an employee has the right not to be unfairly dismissed and subjected to unfair labour practices. This right is further elaborated on in section 188 of the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995, s 188). Section 188 stipulates that for a dismissal not to be viewed as unfair, there should be a fair reason for the dismissal and a fair procedure should have been followed (Republic of South Africa, 1995, s 188(1)(a), 188(1)(b)). Section 188(1)(a)(i) of the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995), specifically provides for a dismissal based on incapacity as a fair reason. In section 192(2) the Labour Relations Act 66 of 1995 also provides that an employer bears the onus of proof to justify a dismissal as fair (Republic of South Africa, 1995).

The Labour Relations Act 66 of 1995, makes provision that codes of good practice can be prepared and issued to elaborate on sections of the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995, s 203). Section 188 of the Labour Relations Act 66 of 1995, in terms of fair labour practises for dismissals is further explicated in Schedule 8 of the Labour Relations Act 66 of 1995 that contains the Code of Good Practice: Dismissal (Republic of South Africa, 1995). Sections 10 and 11 of Schedule 8 deal with incapacity (Republic of South Africa, 1995). Sections 188(2) and 203 stipulate that any person interpreting or applying the Labour Relations Act 66 of 1995 must take into account any relevant code of good practice (Republic of South Africa, 1995).

3.4.2 South African legislative framework for termination of an employment contract

The following grounds are listed as fair or legitimate reasons for a dismissal in South Africa:

- the employee's conduct
- the employee's capacity
- the operational requirements of the employer's business (Republic of South Africa, 1995, Schedule 8, s 2(2))

To ensure a fair procedure prior to the termination of an employment relationship, the employer is required in terms of Schedule 8 to:

- conduct an investigation to establish whether there are any grounds for dismissal
- provide a notice with the allegations to the employee in a form and language that the employee can reasonably understand
- provide the employee with reasonable time to prepare a response
- allow the employee to be assisted by a trade union representative or fellow employee
- provide the employee an opportunity to state a case in response to the allegations
- inform the employee of the decision taken after the hearing, preferably in writing (Republic of South Africa, 1995, Schedule 8, s 4(1))

After the dismissal decision, the employer also has an obligation to remind the employee of the right to appeal (refer a dispute). The dismissed employee may appeal to a bargaining council with jurisdiction, the Commission for Conciliation, Mediation and Arbitration (CCMA) or any other dispute resolution procedure established in a collective agreement (Republic of South Africa, 1995, Schedule 8, s 4(3)).

The Code of Good Practice: Dismissal places various obligations on an employer, prior to the dismissal of an employee due to incapacity (Republic of South Africa, 1995, Schedule 8). The Code states that incapacity on the grounds of ill health may be temporary or permanent (Republic of South Africa, 1995, Schedule 8, s 10(1)). If the incapacity is of temporary nature, the employer should investigate the extent of the incapacity. This requires of the employer to determine the nature and the severity of the employee's incapacity and the employee's prognosis and establish the likely duration of the incapacity. The onus is on the employer to prove that the employee is in fact incapacitated.

If it is established that the employee is likely to be absent for a period that is unreasonably long, the employer should consider alternative arrangements, short of a dismissal, to accommodate the incapacitated employee. When alternative arrangements are considered, an employer must consider the following factors:

- the seriousness of the illness and the prospects of recovery
 - the nature and importance of the employee's job
 - the ease with which the incapacitated employee can be replaced
 - the financial capacity of the employer to make arrangements to temporarily replace the absent employee
 - the length of the employee's service
 - the effect of the employee's absence on the co-employees
- (Grogan, 2014, p. 400; Republic of South Africa, 1995, Schedule 8, s 10(1))

In the case of permanent incapacity the employer should consider the possibility of securing alternative employment for the employee or adjusting the duties or work circumstances of the employee to accommodate the incapacity (Republic of South Africa, 1995, Schedule 8, s 10(1)). Grogan (2014, p. 395) argues that the alternative employment can even be at reduced remuneration – with the employee's consent. If the incapacity was caused by a work-related incident,

the employer's obligation to accommodate the employee is more onerous (Republic of South Africa, 1995, Schedule 8, s 10(4)).

During the investigation into the incapacity of the employee, the employee should be afforded an opportunity to state his or her case (Republic of South Africa, 1995, Schedule 8, s 10(2)). It may require a proper consultation process with the incapacitated employee to mutually consider how the employee may be assisted to avoid recurrence of the illness in the future – with the aid of professional medical assistance, if necessary (Grogan, 2014, p. 399; Letlonkane, 2015, p. 2). This counselling or consultation discussion may also consider reasonable accommodation of the employee's illness to minimise the adverse effects on the employer's operations.

Grogan (2014, p. 402) contends that it will be a fair dismissal for incapacity if:

- the nature and cause of the incapacity, the likelihood of recovery and the improvement or recurrence were investigated
- the employee has been counselled and his or her medical condition and the problems associated with it have been discussed
- the employee's medical condition makes it impossible for the employee to perform the contractual duties
- the medical prognosis is poor in that the employee will in future not be able to perform the contractual duties
- the employee had a fair opportunity to contest the employer's conclusion about his or her medical condition and prognosis
- the employee cannot reasonably be accommodated by the employer

The Employment Equity Act 55 of 1998 aims to, inter alia, achieve equality in the workplace by promoting equal opportunity and fair treatment in the workplace, through the elimination of unfair discrimination (Republic of South Africa, 1998). The Employment Equity Act 55 of 1998 defines people with disabilities as people who have a long-term or recurring physical or mental

impairment which substantially limits their prospects of entry into, or advancement in, employment (Republic of South Africa, 1998, s 1). The Employment Equity Act 55 of 1998 places an additional duty on the employer to consider reasonable accommodation for persons with disabilities. However, the Code of Good Practice issued in terms of the Employment Equity Act 55 of 1998 stipulates that if an employer is unable to reasonably accommodate an employee with a physical or mental impairment, the employer may terminate the employment relationship (Republic of South Africa, 2015b, s 12.1). Where employment is terminated due to the inability to retain an employee with a disability, the requirements of the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995) should still be complied with to ensure fair and just termination. What is important in this kind of termination where the employee is disabled and not merely incapacitated, is that the employer's obligation to accommodate the employee is more onerous as the employer will have to prove that the dismissal is due to unreasonable hardship to the employer and not a mere inconvenience to the employer (Grogan, 2014, p. 148). Where the employment contract of an employee with a disability is terminated due to an inconvenience to the employer, the termination would be regarded as an automatically unfair dismissal in terms of the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995, s 187).

3.4.3 Evaluation of the termination of employment process of South Africa in terms of the ILO principles and case law

South African legislation provides for a valid reason for termination, a hearing whereby the employee can state his or her case, and if a dismissal is sanctioned, a right to appeal exists. Similarly, the legislation also elaborates on how incapacity and disability in the workplace should be managed. The South African labour legislation dealing with the termination of an employment contract can thus be judged to give effect to the principles of the Termination of Employment Convention, 1982 (International Labour Organisation, 1982).

The principles of the legislation, such as an investigation into the employee's capacity, providing the employee an opportunity to state his or her case, and alternative accommodation (including alternative employment or adjusting the duties or work circumstances), were reconfirmed in a number of South African cases (Hendriks v McIntyre and General Insurance Company of S.A. Ltd, 1994; IMATU obo Anton Strydom v Witzenburg Municipality, The South African Local Government Bargaining Council v Van Staden NO, 2012; MTN Service Provider (Pty) Ltd v Matji NO & Others, 2007; Nehawu obo Lucas v Department of Health Western Cape, 2004; NUMSA obo Josias v Tedalex Trading (Pty) Ltd., 2007; SAMWU obo Solomons v City of Cape Town, 2009; Standard Bank of South Africa v CCMA and others, 2007; Wylie v Standard Executors and Trustees, 2006).

It was also confirmed that if the incapacity was caused by a work-related incident, then the employer has a more onerous obligation to accommodate the incapacity of the employee (Tshaka v Vodacom (PTY) Ltd., 2005).

Although not specifically provided for in the conventions and national legislation, the South African labour tribunals ruled that in investigating the extent of the incapacity of the employee, an employer may need to engage external service providers, such as medical specialist and occupational therapists, should the employer lack such internal skills (Standard Bank of South Africa v CCMA and others, 2007; Wylie v Standard Executors and Trustees, 2006). It was also confirmed that an employer needs to be supportive, sympathetic and compassionate when managing the incapacity of an employee (Nehawu and another v South African Institute for Medical Research, 1997; SAMWU obo Solomons v City of Cape Town, 2009).

3.5 ODL INSTITUTION'S PERSPECTIVE

The ODL institution's Policy on Leave provides for temporary incapacity (sick leave) but does not provide a framework on how an employee's prolonged ill health that may affect the ODL institution's operations should be managed (University of South Africa, 2014a).

In addition, the ODL institution's Employee Disciplinary Code stipulates that cases of incapacity that do not result from fault (intent or negligence) on the part of the employee, cannot be dealt with in terms of the Code (University of South Africa, 2013, p. 4). This means that incapacity due to physical or mental illness cannot be dealt with via the ODL institution's Employee Disciplinary Code. No other formally negotiated policy and procedure that complies with the ILO convention or general fair labour practices, to manage incapacity is available. This result in a policy gap or limitation, as there is no policy or procedures to manage incapacity due to ill health, hence the need for this study, which seeks to develop a framework to serve this purpose.

3.5.1 Shortcomings in the ODL institution's policies and procedures

The ODL institution's Policy on Leave provides only for short-term incapacity through limited sick leave to a maximum of 68 working days' fully paid sick leave (University of South Africa, 2014a). The institution lacks a negotiated policy and procedures on incapacity due to ill health. No other formal policy and procedures exist that are compliant with both the ILO core principles, and the provisions of the South African employment legislation, with specific reference to the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995), the Employment Equity Act 55 of 1998 (Republic of South Africa, 1998), and applicable case law in regulating the management of incapacity.

3.6 PERSONAL REFLECTIONS ON THE CHAPTER

The ILO, through its conventions, provides minimum labour standards that should preferably be adhered to by its member states, and the national legislation of a member state should reflect the standards set by the ILO.

Three core principles stand out in the ILO's Termination of Employment Convention of 1982, namely: a valid reason (incapacity, misconduct or operational requirements) must exist for an employment contract to be terminated; the employee must be provided with an opportunity to state a case in defence to the allegations brought by an employer; the employee must have a right to appeal to an independent authority after the decision to terminate the employment relationship, if the termination is viewed as unjustified.

In terms of an employee's ill health or incapacity, the convention stipulates that temporary absence from work shall not be a valid reason for termination of the employment contract. However, it does provide that a member state's legislation should define what temporary absence from work implies, whether a medical certificate shall be required, and other possible requirements or limitations.

From an international perspective it is evident that the USA has a system that is totally unique in that employees are not protected against arbitrary dismissals – the so-called employment-at-will doctrine. However, employees are protected against unlawful dismissal if the termination of the employment contract relates to any of the USA's anti-discrimination laws.

The other member states of the ILO, Australia, the United Kingdom, and the Netherlands do have legislation on termination of employment that complies with the core principles of the ILO convention. In the last decade Australia and the Netherlands made some employment legislation reforms to align their legislation with the core principles of the ILO convention. They also provide for incapacity in their legislation.

As in the cases of Australia and the Netherlands, South African employment legislation has undergone drastic reforms in the last two decades. These reforms, agreed to by government, organised labour and business, comply with the core principles of the ILO convention on termination of employment. In their Codes of Good Practice the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995) and the Employment Equity Act 55 of 1998 (Republic of South Africa, 1998) provide guidelines on how an incapacitated employee should be managed to ensure a fair dismissal if eventually necessary. These principles have been confirmed through various cases in the South African labour tribunals.

The ODL institution does not have a formal policy or procedures complying with international conventions, national legal provisions or case law on incapacity management, except for short-term incapacity (sick leave), resulting in a knowledge and practice gap in terms of a policy and procedures on the management of incapacity due to ill health.

3.7 SUMMARY OF CHAPTER

The chapter provides a discussion on the employment relationship obligations of both the employer and employees. The applicable legislation and selective case law of the United States of America, the United Kingdom, the Netherlands; Australia and South Africa are compared with international conventions for compliance. Similarly, the current incapacity management policies and procedures in the ODL institution are compared to the national legislative requirements and subsequent judgements or awards by various South African dispute-resolution forums. Chapter 4 explores the concept of reasonable accommodation.

CHAPTER 4: REASONABLE ACCOMMODATION

Obviously, because of my disability, I need assistance. But I have always tried to overcome the limitations of my condition and lead as full life as possible. I have travelled the world, from the Antarctic to zero gravity.

Stephen Hawking

4.1 INTRODUCTION

As established in chapter 3 and confirmed by selective case law, an employer has a statutory obligation to provide reasonable accommodation, if justifiable, prior to the termination of an employment relationship due to incapacity. The aim of chapter 4 as diagrammatically depicted in Figure 4.1, is to comprehensively integrate literature pertaining to international and national reasonable accommodation regulatory requirements and the generic practices available to reasonably accommodate an incapacitated employee in the workplace. The current reasonable accommodation interventions implemented in the ODL institution are examined and compared to international and local regulatory regimes and best practices, and shortcomings of the current policies and procedures for incapacity management are highlighted.

The chapter concludes with an integration of the literature reviewed for the purposes of this study.

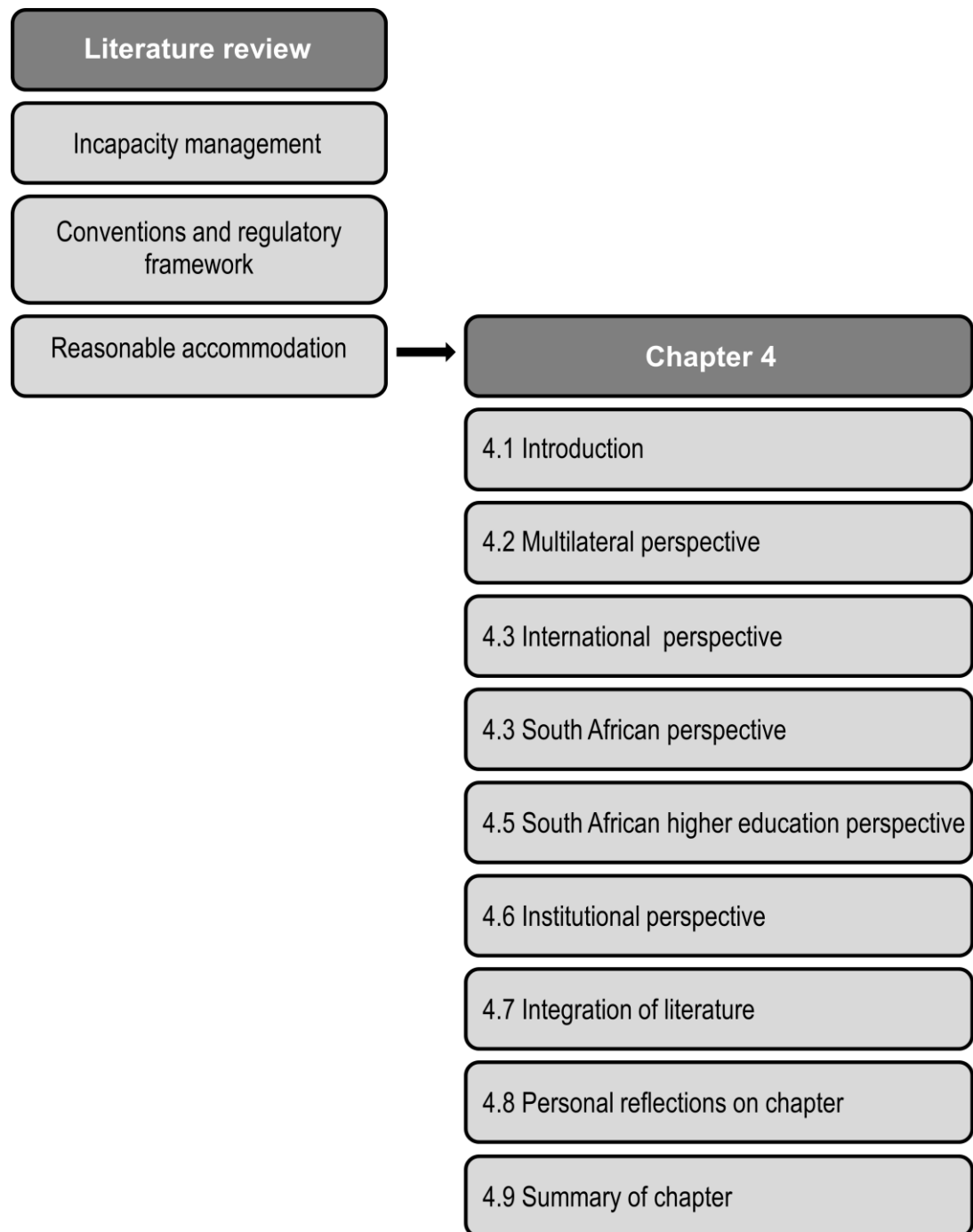


Figure 4.1: Conceptual framework of the literature on reasonable accommodation (own compilation)

4.2 PERSPECTIVES FROM GLOBAL MULTILATERAL INSTITUTIONS

Member states of international bodies such as the United Nations (UN) and the International Labour Organisation (ILO) often prepare legislation, policies and regulations to give expression to certain aspects of the conventions which affect the well-being of society, such as human rights and employment relations (International Labour Organisation, 1982; United Nations, 2007). The conventions of both the UN and ILO impact on the concept of reasonable accommodation.

4.2.1 United Nations (UN)

The concept of reasonable accommodation was explicitly recognised in the General Comment No 5 of 1994 in the United Nations' Committee on Economic, Social and Cultural Rights (Lawson, 2012, p. 847). This Comment formed the cornerstone for the Convention on the Rights of Persons with Disabilities (United Nations, 2007) that was adopted by the United Nations (UN) on 13 December 2006 (Favalli & Ferri, 2016, p. 12; Harpur, 2012, p. 4; Lawson, 2012, p. 847; Luo & Wang, 2017, p. 14). Reasonable accommodation in article 2 of the Convention on the Rights of Persons with Disabilities (United Nations, 2007) is defined as the necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure that persons with disabilities can enjoy or exercise all human rights and fundamental freedoms on an equal basis with others (United Nations, 2007, p. 4). In article 1 of the Convention on the Rights of Persons with Disabilities (United Nations, 2007) disability is defined as long-term physical, mental, intellectual or sensory impairments, which, in interaction with various barriers may hinder a person to fully and effectively participate in society on an equal basis with others (United Nations, 2007, p. 3).

Article 5(2) prohibits all discrimination on the basis of disability and article 5(3) stipulates that all appropriate steps should be taken to promote equality and

eliminate discrimination (United Nations, 2007, p. 7). Lawson (2012, p. 847) argues that these requirements of the Convention impose a definite duty on employers of the member states. In addition, article 4(1)(e) also places an obligation on a member state to take appropriate measures to eliminate discrimination on the basis of disability by any person, organisation or private enterprise, which includes employers (United Nations, 2007, p. 6). Article 27(1) stipulates that the right of persons with disabilities to work shall be safe guarded and promoted through legislation by member states. This article also caters for the right of employees', who have become incapacitated during employment, right to work. The legislation of member states should provide for reasonable accommodation of the incapacitated employees (United Nations, 2007, pp. 19-20). Article 27(1)(i) specifies that an employer should provide reasonable accommodation (United Nations, 2007, p. 19).

Lawson (2012, p. 848) contends that the reference to "a particular case" in article 2 of the Convention requires responses to the individual circumstances of a particular or specific person. This will necessitate consultation with the incapacitated employee to establish the nature of the incapacity and the intervention that may be necessary to accommodate the employee to ensure that he or she can fully operate. The burden to provide reasonable accommodation should not place undue pressure on the other party (in this study, the employer). The burden is not limited to financial costs but may include factors such as disruption to working arrangements or deterioration in the quality or nature of the services (Lawson, 2012, p. 848).

4.2.2 International Labour Organisation (ILO)

The ILO has two specific conventions that impact on reasonable accommodation in the workplace. These conventions are explored in more detail below.

4.2.2.1 Termination of Employment Convention (Convention 159 of 1983)

The primary goal of the Termination of Employment Convention (Convention 159 of 1983) (International Labour Organisation, 1983a) is to prepare and empower employees with disabilities to pursue their employment goals and facilitate access to work and job opportunities, while sensitising policy makers, employers, trade unions, and employees to this issue. In terms of article 1.1 of the Convention, the term “disabled person” means an individual whose prospects of securing, retaining, and advancing in suitable employment are substantially reduced as a result of a duly recognised physical or mental impairment (International Labour Organisation, 1983a). A member state has an obligation, through legislation and in accordance with national conditions, practice and possibilities, to formulate, implement and periodically review a national policy on vocational rehabilitation and employment that will enable a disabled person to secure, retain and advance in suitable employment and thereby further such person’s integration or reintegration into society (International Labour Organisation, 1983a, s 3-4, 6).

4.2.2.2 Vocational Rehabilitation and Employment (Disabled Persons) Convention (Convention 168 of 1983)

Article 11(a) of the ILO Vocational Rehabilitation and Employment (Disabled Persons) Recommendation No. 168 of 1983 (International Labour Organisation, 1983b) stipulates that one of the measures to be taken to promote employment opportunities for disabled persons who conform to the employment and salary standards applicable to employees in general, should include reasonable adaptations to workplaces, job design, tools, machinery, and work organisation (International Labour Organisation, 1983b).

4.3 PERSPECTIVES FROM INTERNATIONAL COUNTRIES

The reasonable accommodation practices of the United Kingdom (UK), the Netherlands, Australia and the United States of America (USA) were explored as the transformed higher education model of South Africa is largely based on their systems (Setati, 2014, p. 1).

4.3.1 United Kingdom

Section 94(1) of the Employment Rights Act of 1996 stipulates that a fair reason for the termination of an employment contract should exist (United Kingdom, 1996). Sections 98(2)(a)–98(2)(d) provide examples of fair reasons for the termination of an employment contract (United Kingdom, 1996). One of the reasons for the termination of an employment contract is the incapacity of an employee, due to his or her health or any physical or mental quality, to perform work of the kind he or she was employed for (United Kingdom, 1996, s 98(2)(a)). It is vital that the employer is fully aware of the medical condition of the employee and that reasonable grounds exist for the belief that the employee is incapable of performing his or her work.

4.3.1.1 Reasonable accommodation – policy regime

The provisions for the termination of employment due to incapacity in the Employment Rights Act of 1996 (United Kingdom, 1996) should be read in conjunction with the Equality Act of 2010 (United Kingdom, 2010). The Equality Act of 2010 provides for protected characteristics that include, but are not limited to age, race, gender, sexual orientation, religion, and disability. Disability is defined as a physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities (United Kingdom, 2015, s 6). Lockwood, Henderson and Thornicroft (2012, p. 182) point out that “substantial and long-term adverse effect” refers to

an effect that is more than minor or trivial and has lasted for 12 months, is likely to last at least 12 months, or is likely to last for the rest of the life of the affected person.

The Equality Act of 2010 stipulates that if the disability is known or a reasonable expectation to know exists, it will be discriminatory and unlawful if an employee with a disability is treated unfavourably by an employer. It will not be discriminatory or unlawful if it can be shown that the treatment is a proportionate means of achieving a legitimate aim and is objectively justifiable (Equality and Human Rights Commission, 2015, p. 10; United Kingdom, 2010, s 15).

Hanley (2014, p. 31) argues that even with the enactment of the Equality Act of 2010, the conceptual tensions around disability management are not resolved. Employees with disabilities have certain rights but the employer has the final say on the reasonable accommodation. Lockwood et al. (2012, p. 182) confirm this view by stating that the burden of proof is on the employee to show that he or she has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities and that it should be accommodated.

4.3.1.2 Reasonable accommodation – practices

The Equality Act of 2010 places a duty on an employer to make reasonable adjustments in order to accommodate the disability of the employee (United Kingdom, 2010, s 20). The duty to make reasonable adjustments implies that the status quo is reconsidered, and employers must be open to consider alternative arrangements in order to accommodate the disability of the employee with the underlying promise to retain an employee with a disability and improve his or her experience in the workplace (Bell, 2015, p. 201). Before the duty to provide reasonable accommodation becomes obligatory, it must be established whether the illness meets the definition of a disability as provided in

section 6 of the Equality Act of 2010 (Bell, 2015, p. 202). The aim of this duty is to ensure that, as is reasonable, a disabled employee has the same access to everything that is involved in doing and retaining a job as a non-disabled employee. The duty comprises of three requirements:

1. The first requirement is where a provision, criterion or practice of the employer puts a person with a disability at a substantial disadvantage in relation to a relevant matter in comparison with employees who are not disabled. In this case, the employer must make such reasonable adjustments to remove barriers for the disabled employee to avoid the disadvantage and thus avoiding discrimination arising from the disability (United Kingdom, 2010, s 20(3)). This requirement means that the employer needs to analyse its written or unwritten employment policies, procedures and/or practices, and amend these if necessary to remove or reduce the barriers that would place an employee with a disability at a substantial disadvantage. This includes criteria and assessment for promotion or training, benefits such as the availability of disability leave, working conditions in terms of altered working hours, and other contractual arrangements (Equality and Human Rights Commission, 2014, pp. 53, 60-62).
2. The second requirement is where a physical feature puts an employee with a disability at a substantial disadvantage in relation to a relevant matter in comparison with employees who are not disabled (United Kingdom, 2010, s 20(4)). According to the guidelines of the Equality and Human Rights Commission an employer needs to assess all its premises for physical barriers and make the necessary adjustments in order to remove or minimise the physical barriers that may cause a disadvantage to an employee with a disability (Equality and Human Rights Commission, 2014). Physical features may include steps, stairways, kerbs, exterior surfaces and paving, parking areas, building entrances and exits (including emergency escape routes), internal and external doors, gates, toilet and washing

facilities, public facilities (such as telephones, counters or service desks), lighting and ventilation, lifts and escalators, floor coverings, signs, furniture, and temporary or movable items (such as equipment and display racks). In addition, physical features also include the sheer scale of premises (for example, the size of a building) (Equality and Human Rights Commission, 2014, pp. 54, 59).

3. The third requirement is where an employee with a disability would be put at a substantial disadvantage in relation to a relevant matter if not provided with auxiliary aid, in comparison with persons who are not disabled. The employer must take reasonable steps to provide the auxiliary aid to avoid the disadvantage (United Kingdom, 2010, s 20(5)). This is not limited to auxiliary aids such as instructions or reference material being produced on audio CD or in Braille, but also auxiliary services, where someone else assists the disabled person, such as a reader, a sign language interpreter or a support co-employee. The kind of equipment, aid or service will largely depend on the needs of the individual disabled employee and the job he or she is doing or will be doing. The disabled employee may have experience of what he or she needs, or the employer may obtain expert advice on what is required to accommodate the disability of the employee (Equality and Human Rights Commission, 2014, pp. 55, 61).

The employer must provide the adjustments from the first point at which the duty to make reasonable accommodations arises, in other words, either when the employee starts working for the employer or for an employee already in service, once he or she becomes a disabled employee. This only applies if the employer knows or ought to have reasonably known that the employee is a disabled person (Equality and Human Rights Commission, 2014, p. 10; Lockwood et al., 2012, p. 183).

The employer must pay for reasonable adjustments. When deciding when an adjustment is reasonable the employer should consider the following:

- how effective the adjustments will be in avoiding the disadvantage the disabled employee would otherwise experience:
- the nature of the job
- the practicality of the adjustment
- the cost of the adjustment
- the institution's resources and size
- the availability of financial support (Equality and Human Rights Commission, 2014, pp. 57-58)

As part of the reasonable accommodation, if the employee is absent for a long period, the employer should stay in touch with the employee to find out how he or she is, and to inform him or her on what is happening at work. The employer should also plan for the employee's return to work and in consultation with the employee consider reasonable adjustments, if necessary, so that the employee can return to work (Equality and Human Rights Commission, 2014, p. 33).

An employer is not required to pay sick pay beyond what the employer would normally paid just because the employee's time off is related to a disability. The Equality and Human Rights Commission's guide (Equality and Human Rights Commission, 2014, p. 34) suggests that it may be a reasonable accommodation to extend the employee's sick pay, offer unpaid incapacity leave; or allow the employee to take the extra time off as annual leave.

Although mental illness is expressly included as a disability in section 6(1)(a) of the Equality Act of 2010, it is debateable whether the mental illness is having a substantial and long-term adverse effect on an employee's ability to carry out his or her contractual obligations as stipulated in section 6(1)(b), and therefore can be seen as meeting the definition of a disability as defined in the Equality Act of 2010 (United Kingdom, 2010). This debate provides uncertainty when deciding on discrimination due to mental illnesses and it requires professional

diagnosis and prognosis. To improve the handling of mental health issues in the workplace, it is recommended that an employer involves occupational health professionals in addition to human resources at an early stage, to prevent a period of sick absence with preventative accommodation interventions (Bell, 2015, p. 202; Lockwood et al., 2014, p. 179). Managers should be trained on mental health issues in order to minimise prejudice against mentally ill employees (Lockwood et al., 2014, p. 179).

4.3.2 The Netherlands

The Work and Security Act (“Wet Werk en Zekerheid”) of 2015 provides that an employment contract may be terminated due to the incapacity of an employee provided that redeployment within a reasonable period of time is not possible (even after training) or reasonable under the circumstances. The Labour Office deals with terminations related to prolonged incapacity for work (a minimum of two years) and the Cantonal Court deals with intended terminations due to frequent and disruptive absence due to illness (BarentsKrans Employment Law Department, 2015, pp. 3, 17; Bos et al., 2015, pp. 28-29).

Due to the shifting of the responsibility for the provision of employment incapacity benefits from the state to the employer in 2002, employers had to establish new programmes to promote job retention for employees who are ill (Haafkens et al., 2011, p. 105). One of the conditions identified that may facilitate job retention for incapacitated employees is work adaptations to accommodate incapacitated employees (Haafkens et al., 2011, p. 113).

4.3.2.1 Reasonable accommodation – policy regime

This shift in the responsibility of providing employment incapacity benefits to employers resulted in the Gatekeeper Protocol of 2002 (“Wet verbetering Poortwachter”) that specifies all the legal responsibilities of employers and their

incapacitated employees (Hullegie & Koning, 2015, p. 6). The Gatekeeper Protocol of 2002 forces employers to focus their attention from the start of an employee's incapacity period (Hullegie & Koning, 2015, p. 6), with the effect that employers cannot allow short-term sick absences to go unnoticed. In terms of the legislation the employers are financially responsible for the employee on sick leave during the first two years; thereafter the sick employees may apply for disability benefits. As in the United Kingdom (UK) employers are also responsible for facilitating an employee's return to work (Dekkers-Sánchez et al., 2015, p. 577; Vossen & Van Gestel, 2015, p. 171).

4.3.2.2 Reasonable accommodation – practices

The Gatekeeper Protocol of 2002 prescribes a series of actions that should be taken prior to an employee becoming eligible for disability benefits (Black & Frost, 2011, p. 105; Hullegie & Koning, 2015, p. 6). After six weeks of absence, both the employer and employee must make a first assessment on the medical cause of the absence and the functional limitations. The employer must pay for the independent occupational health physician to assess the employee's ability to do his or her own job. Based on the assessment the employer and employee should draft a reintegration plan detailing steps to be taken to allow the employee to resume work, and the accommodations required. This reintegration plan should be finalised in the eighth week of the sick absence. If the employee has not yet returned to work after three months since the start of the sickness period, the employee files a disability claim. Every six weeks, up to 91 weeks, the rehabilitation should be monitored. Insurance physicians are responsible to evaluate the ability to work of employees who are on long-term sick leave. The employees need to be assessed in terms of their ability to work or not to work, before they can, after two years, qualify for disability benefits (Dekkers-Sánchez et al., 2015, p. 577).

4.3.3 Australia

The Fair Work Act 28 of 2009 (Australia, 2009) provides that an employer has the burden to prove that a termination of the employment relationship was not harsh, unjust or unreasonable. In terms of the termination of an employment contract due to incapacity, the employer will need to prove that the termination was reasonable, and that the proper procedure was followed.

4.3.3.1 Reasonable accommodation – policy regime

In addition to stipulations of the Fair Work Act 22 of 2009 (Australian Government, 2009) the provisions of the Disability Discrimination Act of 1992 (Australian Government, 1992) should also be taken into consideration when an employer considers terminating an employment contract due to incapacity. It is, inter alia, unlawful for an employer to discriminate against an employee on the grounds of the employee's disability by dismissing the employee (Australian Government, 1992, s 15(2)(c); Scott, 2016, p. 129). In terms of section 4(1)(a) of the Disability Discrimination Act of 1992 (Australian Government, 1992) the definition of the term “disability” is very broad to ensure that the act applies to every person with a disability, and refers to:

- physical disability
- psychiatric disability
- the presence in the body of disease or illness - causing organisms
- intellectual disability or learning disability
- sensory disability
- neurological disability (Australian Government, 1992, s 4(1)(a))

While some people are born with disabilities, many people acquire disabilities throughout their lives, also while in employment. So, section 4(1)(a) of the Disability Discrimination Act of 1992 (Australian Government, 1992) protects

employees against discrimination on the basis of a disability, which employees may have, had in the past, may have in the future, or are believed to have.

In terms of section 5(2) of the Disability Discrimination Act of 1992 (Australian Government, 1992) it may also be seen as an act of discrimination if the employer does not make, or proposes not to make, reasonable adjustments for the employee; and the failure to make the reasonable adjustments has, or would have, the effect that the employee is, because of the disability, treated less favourably than an employee without the disability would be treated in circumstances that are not materially different (Australian Government, 1992; Scott, 2016, p. 129).

There is no obligation on the employer to accommodate the employee's disability if the reasonable accommodation may be unreasonable or cause undue hardship to the employer (Scott, 2016, p. 130). In determining whether the reasonable accommodation may impose an unjustifiable hardship on the employer, section 11 of the Disability Discrimination Act of 1992 (Australian Government, 1992) requires that all relevant circumstances of the particular case must be taken into account, including the following:

- the nature of the benefit or detriment likely to accrue to, or to be suffered by, any person concerned
- the effect of the disability on any person concerned
- the financial circumstances, and the estimated amount of expenditure required to be made, by the employer
- the availability of financial and other assistance to the employee (Australian Government, 1992, s 11)

4.3.3.2 *Reasonable accommodation – practices*

Social Firms Australia (2010, p. 10) contends that reasonable workplace adjustments are the changes on how the work is done or how the workplace is structured to accommodate the incapacity of an employee to overcome the difficulty to perform the functions of the position. Reasonable accommodations may include

- adjustment of the workplace, premises or equipment
- flexible working hours
- provision of a workplace mentor
- adjusting the manner of supervision
- interpreters, readers or other caregivers
- extra training for the incapacitated employee and/or the co-employees

The employer may require an assessment to determine what types of adjustments are needed to reasonably accommodate the employee (Social Firms Australia, 2010, p. 10). Adjustments that present too many demands on the workplace, cost too much, have a negative impact on co-employees or customers, or cause health and safety risks, may be viewed as unreasonable (Australian Government, 1992, s 11; Social Firms Australia, 2010, p. 10). The burden of proving that an accommodation will impose unjustifiable hardship lies with the person claiming the unjustifiable hardship (Ronalds & Raper, 2012, p. 154).

Financial assistance from the Australian Employment Assistance Fund is available to pay for the cost of workplace modifications that may be required to accommodate a worker with disability in the workplace. Assistance is available for a broad range of modifications including, but not limited to, physical and environmental workplace adjustments, computer software upgrades, vehicle modifications, communication technology devices, and specific items of

equipment an employee may require to do his or her job (Australian Government, 2018).

4.3.4 The United States of America

Over time the doctrine of employment-at-will in the USA, where an employee and the employer have the right to terminate the employment contract at any time without a reason or cause has been impacted by an ever-growing number of federal, state, and local statutory and common law exceptions. These exceptions mostly focus on wrongful terminations or terminations based on discriminatory practices as contained in various discriminatory USA laws (Estreicher & Hirsch, 2014, pp. 349-351; Smit, 2010, pp. 66-71). Disability as one of the grounds for discrimination is provided for in the Americans with Disability Act of 1990 (United States of America, 1990, s 102(5)(A)).

4.3.4.1 Reasonable accommodation – policy regime

The Americans with Disability Act of 1990 (United States of America, 1990) prohibits employers from discriminating on the basis of disability and gives employees with disabilities a right to be reasonably accommodated in the workplace. The Americans with Disability Act of 1990 (United States of America, 1990) defines disability as a physical or mental impairment that substantially limits one or more life or work activities of an employee (United States of America, 1990, s 12102(1), s 12102(2)). The Americans with Disability Act of 1990 (United States of America, 1990) requires of employers to reasonably accommodate the known physical or mental impairments of otherwise qualified employees, unless the employer can prove that the accommodation would create an undue hardship on the business. A qualified employee is viewed as someone who, with or without reasonable accommodation, can perform the essential functions of the post that he or she holds. The employer's judgement of what essential functions are, as contained in the job description, will be

considered when evaluating a matter of reasonable accommodation (United States of America, 1990, s 12111(8)). The Americans with Disability Act of 1990 (United States of America, 1990) does not define reasonable accommodation but provides examples of what may be deemed to be reasonable accommodation such as access to and use of facilities, job restructuring, changes to work schedules, provision of interpreters and modified equipment (United States of America, 1990, s 12111(9)). Undue hardship is when the reasonable accommodation may require significant difficulty or expenses in comparison with the overall operations of the employer (United States of America, 1990, s 12111(10)).

It is argued that since the implementation of the Americans with Disability Act of 1990 (United States of America, 1990), more than 28 years ago, employment issues facing people with disabilities remain challenging and little progress has been made towards equal employment opportunities for people with disabilities in that it has not lead to a significant reduction in the employment gap between employees with and without disabilities (Dong, Oire, MacDonald, & Fabian, 2013, p. 182; Pendo, 2013, pp. 143-144; Von Schrader, Malzer & Bruyère, 2014, p. 255). One of the reasons for this might be that the enactment of the Americans with Disability Act of 1990 (United States of America, 1990), had a positive impact on decreasing the physical barriers but has not done enough to change discriminatory attitudes towards disabilities (Pendo, 2013, pp. 143-144). Furthermore, the law defining reasonable accommodation has been described as underdeveloped. The imprecise nature of the concept can be due to the lack of guidance from the courts (Hickox & Guzman, 2014, p. 439). Even after various presentations by USA legal experts to the American Equal Employment Opportunity Commission in June 2011 to provide guidelines on what accommodations are reasonable to provide for more consistent determinations based on concrete, objective factors, no specific guidance has been provided to date (Hickox & Guzman, 2014, p. 439). Santuzzi, Waltz, Finkelstein and Rupp (2014, p. 205) question the viability of the legislation to adequately protect employees with invisible disabilities, or to equip

them and their employers to navigate the unique psychological challenges of disclosure in the workplace. They contend that invisible disabilities include a wide range of physical and psychological conditions such as sensory disabilities (low vision, hearing loss), auto-immune disorders (HIV/AIDS), chronic illness and pain, cognitive and learning challenges (ADHD), and psychological disorders (post-traumatic stress disorder or depression) (Santuzzi et al., 2014, p. 204).

4.3.4.2 Reasonable accommodation – practices

The obligation for requesting reasonable accommodation, invisible disabilities included, lies with the employee (Dong et al., 2013, p. 182; Santuzzi et al., 2014, pp. 205, 216; Von Schrader et al., 2014, p. 239). The obligation requires of the employee to disclose the nature of the condition, indicate how it interferes with performing essential job functions and suggest the types of accommodation that may mitigate the effects of the condition. Most employees with disabilities may either choose not to disclose or are reluctant to disclose their disabilities to the employer, even if they experience problems in the execution of their jobs due to their disabilities. This non-declaration may be due to stigmatisation, especially where employees conceal a highly stigmatised disability such as mental illness or past drug addiction (Dong et al., 2013, p. 183; Santuzzi et al., 2014, p. 205). Once an employer knows that the employee seeks or requires an accommodation for a disability, the employer should engage with the employee to:

- identify the essential functions of the job (Gold & Shuman, 2009, p. 213).
- determine the specific physical or mental limitations. This requires of employees to develop documentary trails of their formal medical and functional evaluations (Gold, Oire, Fabian & Wewiorski, 2012, pp. 34-35; Gold & Shuman, 2009, p. 213).

- propose or identify potential accommodations and assess the effectiveness of each accommodation, based on the medical and functional evaluations (Gold et al., 2012, pp. 34-35; Gold & Shuman, 2009, p. 213).
- select the accommodation that best serves the needs of the employer and the employee (Gold & Shuman, 2009, p. 213). In the event of leave as a reasonable accommodation, employers should rely on the reports from the employees' health care providers as well as factors related to the employees' job content to determine the reasonableness thereof and the potential hardship it may cause when requests for additional sick leave are considered (Hickox & Guzman, 2014, p. 487).
- regularly re-evaluate the impact of the accommodation on performance. Based on this evaluation, the employer may decide to retain, terminate and/or modify the accommodation (Gold et al., 2012, pp. 34-35).

To achieve a working environment in which employees can freely disclose their disability, employers should understand the experiences and perceptions of employees with disabilities (Von Schrader et al., 2014, p. 255). The employer must show considerate leadership through trust, respect, appreciation, and concern for the employees' welfare (Kristman et al., 2017, p. 124). It is also important that the employer has a workplace disability management policy and practice in place (Dwosken & Squire, 2013, pp. 20-21; Kristman et al., 2017, p. 124). The policy, as well as information for employers, employees and rehabilitation professionals on how to select and implement reasonable accommodation for affected employees, should be accessible (McDowell & Fossey, 2015, p. 201).

It should be understood that by accommodating all employees, not only will workplace productivity be promoted, and the pool of qualified job applicants expanded, but this will also help to establish a culture of openness and inclusion in the workplace and reduce any potential resentment towards employees with disabilities (Parry, 2011, p. 193; Schur et al., 2014, p. 614). This requires open communication between the employer and the employee on the reasonable

accommodation. Support from the affected employee's direct line manager is essential (Dong et al., 2013, p. 187). It may be necessary that an employer allows line manager autonomy for designing and providing workplace accommodations (Kristman et al., 2017, p. 124). In addition, it may require that co-employees should be engaged when negotiating the accommodation to obtain their buy-in and support (Gold et al., 2012, pp. 34-35).

It necessitates that employers and employees should creatively reframe the inevitable and unavoidable competing legal and financial demands of the employer, and the moral imperative to staff-inclusive workplaces. It requires aspirational developmental opportunities that simultaneously enhance the business operations and workplace inclusivity in which all parties can take pride (Gold et al., 2012, pp. 34-35).

As in the United Kingdom and Australia, the USA has the following generic interventions and other individualised workplace considerations to accommodate incapacitated employees:

- Flexible scheduling or reduced hours that may include working from home, time off for consultations with health service providers, or even relocation of employees closer to their homes and/or medical service providers to reduce their travel time and/or obstacles within the different transport modes. These kinds of accommodation may increase productivity and promote morale (Dwosken & Squire, 2013, pp. 8, 10, 12; McDowell & Fossey, 2015, pp. 197-200; Montagna, 2014; Gold & Shuman, 2009, p. 228; Parry, 2011, pp. 188-190).
- Equal opportunity to participate in all work activities through accessibility and transportation to and from an event, being able to communicate freely at the event, and having access to the documents that are associated with the event (Parry, 2011, p. 193).
- Short-term, extended or even flexible leave periods to obtain medical treatment, recover from an illness or receive disability training. This will be

determined by factors such as the employee's illness, the essentials of the employee's job and the leave credit available to the employee (Dwosken & Squire, 2013, p. 15; Gold & Shuman, 2009, p. 226; Hickox & Guzman, 2014, p. 439; Parry, 2011, p. 188).

- Modified training, including awareness, diversity and sensitivity training for co-employees and line managers of employees with disabilities so that they have the knowledge and understanding on how to interact with them and respect their privacy (McDowell & Fossey, 2015, p. 200; Parry, 2011, p. 192; Schur et al., 2014, p. 615; Von Schrader et al., 2014, p. 255). The training should also focus on the training of those employees responsible for emergency procedures to assist the employees with disabilities during evacuations (Parry, 2011, pp. 191-192).
- Modified supervision through, inter alia, job coaching and mentorship (McDowell & Fossey, 2015, p. 200; Montagna, 2014).
- Modified job duties and descriptions that are goal oriented (McDowell & Fossey, 2015, p. 200; Montagna, 2014). Placing employees with disabilities in jobs or reclassifying their positions to fit their competencies may also improve productivity. Additional time to complete tasks may also be considered (Chow, 2012, p. 60; Dwosken & Squire, 2013, pp. 5, 13; Gold & Shuman, 2009, p. 228; Parry, 2011, p. 189).
- Adjustments to the physical work environment, applying proper ergonomics principles, such as changes to buildings, noise or environmental solutions (including soothing music), lighting (provision of sun and other natural lighting), office layout, furniture, computers and all other equipment. The individual incapacitated employee's characteristics, needs and requirements should be taken into consideration when providing the required accommodation. Provision should also be made to accommodate support animals in the workplace and granting employees periodic breaks to walk or feed their animals during working hours (Montagna, 2014; Parry, 2011, pp. 180-192).
- Providing special devices, helpers and interpreters for employees with disabilities (Dwosken & Squire, 2013, pp. 21-22).

The Office of Disability Employment Policy (ODEP) argues that employers should not spend too much time analysing whether an employee meets the definition of disability, but should rather focus on whether, without causing undue hardships, reasonable accommodation can be provided to the affected employees. Employers can still request medical proof when an employee requests to be accommodated if the disability and/or need are not obvious (United States of America, 2013, p. 12).

4.4 SOUTH AFRICAN PERSPECTIVE

The Labour Relations Act 66 of 1995 (Republic of South Africa, 1995) places a statutory obligation on the employer to establish the permanency or temporary state of the incapacity and consider alternative arrangements short of a dismissal to accommodate the employee with incapacity due to illness or injury. When alternative arrangements are considered, it is required that an employer must consider factors such as the nature of the job, the seriousness of the illness, and the possibility of securing temporary replacement for the ill employee. In case of permanent incapacity, the employer should consider the possibility of securing alternative employment for the employee or adjusting the duties or work circumstances of the employee to accommodate the disability (Republic of South Africa, 1995, Schedule 8, s 10). The Employment Equity Act 55 of 1998 places a similar obligation on employers to reasonably accommodate employees who have a long-term or recurring physical or mental impairment, which substantially limits their prospects of entry into, or advancement in employment (Republic of South Africa, 1998, s 15(2)(c)).

4.4.1 Reasonable accommodation – policy regime

The Employment Equity Act 55 of 1998, defines reasonable accommodation as any modification or adjustment to a job or to the working environment that will enable a person from a designated group to have access to, participate in, or

advance in employment (Republic of South Africa, 1998, s 1). The adjustments in the context of the legislation can be any criterion used in the context of an employment policy or practice, or any aspect of the physical or psychological environment, which presents an unreasonable obstacle (Modise, Olivier & Miruka, 2014, p. 583). The Labour Relations Act 66 of 1995 (Republic of South Africa, 1995) does not define “alternative arrangement” but in the general aim and spirit of employment legislation in South Africa it can be deduced that the alternative arrangement should be reasonable and fair.

An employer should differentiate between the obligation to accommodate persons with disabilities in the workplace in terms of the Employment Equity Act 55 of 1998 (Republic of South Africa, 1998), and the employer’s obligations in terms of Schedule 8 of the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995) regarding incapacity management. Employees with disabilities may be adhering to the inherent job requirements, while incapacitated employees do not necessarily, due to ill health, adhere to the job requirements they were appointed for (Burger, 2013, p. 16). Although Grogan (2014, p. 395) supports the view that a distinction must be drawn between incapacity and disability, the view is qualified in that the treatment for persons with disabilities has its own code in terms of which employers should manage the disability. In addition, an incapacitated employee may also be disabled in a statutory sense when applying the definition as contained in section 15(2)(c) of the Employment Equity Act 55 of 1998 (Grogan, 2014, p. 395). Grogan (2014, p. 395) argues that while it is permissible to terminate the services of an employee with a disability in terms of the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995), the employer’s duty to accommodate the employee in terms of the Code of Good Practice (Republic of South Africa, 2015b, s 11.1) is more onerous than in the case of an incapacitated employee. The reason for this is that the reasonable accommodation must remove barriers, be accessible and cost effective (Republic of South Africa, 2002, p. 15), and it should take into consideration the overall objectives of the Employment Equity Act 55 of 1998 (Republic of South Africa, 1998) and the Constitution of the Republic of South

Africa, 1996 (Republic of South Africa, 1996). The reasonable accommodation should also not cause unjustifiable hardship to the employee (Republic of South Africa, 2015b, s 6.11, s 6.12). The Technical Assistance Guidelines on the Employment of People with Disabilities (Republic of South Africa, 2002, p. 15) explains that unjustifiable hardship is of a higher standard than in other countries, as employers in South Africa are required to make more efforts to accommodate incapacity. This involves an objective process whereby the employer must identify and determine the effectiveness of the accommodation, determine whether the implementation of such accommodation will create difficulty or expense that will seriously disrupt the operations of the institution. In addition, the assessment should also take into account the impact of providing, or failure to provide accommodation to the employee, and the systemic patterns of inequality in society. Ngwenya and Pretorius (2007, p. 768) argue that reasonable accommodation depends greatly on a fair balancing of competing considerations such as the nature of the risk involved, the extent of the duties that need to be reassigned, the effect of the reassignment on the normal operations of the business and the performance of other jobs, and the impact on other employees who will be assigned different or additional duties.

The Code of Good Practice, 2015 (Republic of South Africa, 2015b) issued in terms of the Employment Equity Act 55 of 1998 (Republic of South Africa, 1998) stipulates that when an employee becomes disabled during employment, the employer should, where reasonable, re-integrate the employee into the work situation and seek to minimize the impact of the disability on the employee (Republic of South Africa, 2015b, s 11.1). Disability in terms of the Employment Equity Act 55 of 1998 (Republic of South Africa, 1998, s 1) is viewed as a long-term or recurring physical or mental impairment of an employee, which substantially limits his or her prospects of entry into, or advancement in employment. The Code of Good Practice, 2015 (Republic of South Africa, 2015b, s 5.3) describes an employee as being disabled, if he or she meets all of the following criteria:

- having a physical or mental impairment
- the impairment is recurring or long term
- the impairment substantially limits his or her prospects of entry into or advancement in employment

The Code of Good Practice, 2015 (Republic of South Africa, 2015b) requires of the employer to engage with the employee to establish if there can be reasonable accommodation of the disability. This consultation may also, where reasonable and practical, include experts (general practitioners, specialists, psychologists, psychiatrists, occupational therapists, etc.) to advise on appropriate mechanisms to accommodate the employee (Republic of South Africa, 2015b, s 6.6, s 11.2). Reynolds (2015, p. 116) confirms this by stating that the involvement of a vocational practitioner may provide a greater depth of knowledge and understanding of the factors influencing the employment relationship. The author further argues that it may be necessary that these identified factors may need to be addressed by a multi-disciplinary medical team that can, for example, optimise the disease symptomatology that forms a barrier to be fully effective in the employ or to address the psychological distress associated with a chronic illness. The Code of Good Practise, 2015 further explains that if an employee is frequently absent from work due to incapacity, the employer should consult the employee to assess whether the reason for absence is a disability that requires reasonable accommodation (Republic of South Africa, 2015b, s 11.4). Reasonable accommodation may be temporary or permanent, depending on the nature and extent of the disability (Republic of South Africa, 2015b, s 6.8).

The Technical Assistance Guidelines on the Employment of People with Disabilities (Republic of South Africa, 2002, p. 13) further elaborates on the concept of reasonable accommodation. It states that the type of reasonable accommodation required would depend on the job and its essential functions, the work environment and the person's specific impairment. It will require that modifications or alterations should be made to such an extent that it will be

possible for a suitably qualified person with a disability to perform the job the way it is normally performed by everyone else. The Technical Assistance Guidelines on the Employment of People with Disabilities (Republic of South Africa, 2002, p. 15) provide criteria for reasonable accommodation and includes three interrelated factors:

1. Firstly, the reasonable accommodation must, where reasonably practical, remove the barriers to performing the job for a disabled person who is otherwise qualified, to enable him or her to play a full part in the workplace in order to achieve his or her full potential.
2. Secondly, the employer must take all reasonable steps to allow the person with a disability to enjoy equal access to the benefits and opportunities of employment and retain positions for which they are suitably qualified.
3. Thirdly, employers can adopt the most cost-effective means consistent with the above two factors.

If an employer is unable to reasonably accommodate and retain the employee in employment, then the employer may terminate the employment relationship (Republic of South Africa, 2015b, s 12.1).

4.4.2 Reasonable accommodation – practices

The following is a list of generic representative, but not exhaustive examples of reasonable accommodation interventions and other individualised workplace considerations to accommodate incapacitated employees:

- Flexible working time, regular or additional rest breaks and leave (Epilepsy South Africa, n.d., p. 26; Republic of South Africa, 2015b, s 6.9; Republic of South Africa, 2002, p. 20; Reynolds, 2015, pp. 99-101).
- Re-organising workstations to ensure that people with disabilities can work effectively, efficiently and safely (Epilepsy South Africa, n.d., p. 26; Republic of South Africa, 2015b, s 6.9; Republic of South Africa, 2002, p. 20).

- Adapting existing physical facilities to make them accessible, for example, for wheelchair access (Republic of South Africa, 2015b, s 6.9; Republic of South Africa, 2002, p. 20).
- Adapting existing, or acquiring new equipment including computer hardware and software, such as voice input/output software, to assist employees with sensory impairments or photosensitive epilepsy (Epilepsy South Africa, n.d., p. 27; Republic of South Africa, 2015b, s 6.9; Republic of South Africa, 2002, p. 20).
- Changing training and assessment materials and systems. This may include the provision of training materials in electronic format, Braille or on tape for people with visual and or hearing disabilities (Republic of South Africa, 2015b, s 6.9; Republic of South Africa, 2002, p. 20). It may also include educating co-employees on first aid for seizures and post-seizure care (Epilepsy South Africa, n.d., p. 26).
- Restructuring jobs so that non-essential functions are re-assigned, for example, assigning routine but physically demanding filing tasks, which may be non-essential duties of a person in a wheelchair, on a rotational basis to other employees (Republic of South Africa, 2015b, s 6.9; Republic of South Africa, 2002, p. 20; Reynolds, 2015, p. 100).
- Providing specialised supervision, training and support in the workplace. This may include interpreters for the deaf, readers for the blind, job coaches for people with intellectual disabilities or personal assistants for people with physical disabilities (Republic of South Africa, 2015b, s 6.9; Republic of South Africa, 2002, p. 20; Reynolds, 2015, p. 101).

In terms of **physical illness** or incapacity, it tends to be easier to accommodate an employee with a physical incapacity. An example is where an employee undergoes orthopaedic surgery such as a knee replacement or shoulder operation. The rehabilitation is normally six weeks and then the employee can gradually be reintroduced into the work environment with minimum adjustments. Reynolds (2015, p. 119) contends that although it may be easy to identify the physical barriers and accommodation required by an employee with a physical

condition, psychosocial factors play an important role in determining the eventual return to work.

However, the South African labour legislation does not provide clear guidelines on reasonable accommodation regarding **mental illness** as opposed to physical illness in the workplace. The Labour Relations Act 66 of 1995 (Republic of South Africa, 1995) uses the term “incapacity” for ill health and declares that the employer needs to establish the permanency or temporary state of the incapacity and should consider alternative arrangements, short of dismissal, to accommodate the employee (Republic of South Africa, 1995, Schedule 8, s 10). The Employment Equity Act 55 of 1998 (Republic of South Africa, 1998) only provides for the terms “physical” and “mental impairment”. Mental impairment is defined as a clinically recognised condition or illness that affects an employee’s thought processes, judgement or emotions (Republic of South Africa, 2015b, s 5.1.1(iii)). Reynolds (2015, p. 19) argues that one of the challenges coupled with reviewing disability and/or chronic illness in the workplace relates to the lack of consensus on the definition of disability. Some argue that mental illnesses, especially depression, should be recognised as a disability as contained in the Employment Equity Act 55 of 1998 (Republic of South Africa, 1998) and the Code of Good Practice on the Employment of People with Disabilities (Carvalho, 2011; Smit & Fourie, 2013). Burger (2013, pp. 65-66) adds to the argument by noting that it is evident that incapacity disputes are still rather vague, and many different opinions and legal positions on the matter exist. Illnesses such as depression and HIV/AIDS can be viewed as disability or incapacity. Burger (2013, p. 66) suggests that the legislators, due to the mentioned grey areas under incapacity, should address it in law. These conflicting points of view result in a knowledge gap, and it is therefore important that the various illnesses and possible reasonable accommodation interventions be further explored at the ODL institution, hence this study.

As a first step in accommodating psychological illnesses it is important to determine the basic cause of the illness. The cause may imply any of the following:

- poor employee and occupation compatibility
- lack of control by the employee over his or her workplace
- lack of social support to the employee
- unpleasant working conditions
- monotonous work
- shift work
- over and under load of work
- unexplained workplace change
- difficulties in handling co-employees (Coetzer, Botha & Huyser, 2002, p. 69)

The accommodation of a psychologically impaired employee is by nature a complex matter, and the following accommodation practices are suggested:

- amending workplace policies to cater for workplace accommodation practices such as flexible working hours accommodating the impact that medication may have on an employee, and allowing time off for an employee to visit the therapist
- developing guiding principles such as joint problem-solving with the affected employee and creating a culture of workplace accommodation
- providing human assistance by means of a job coach to assist the affected employee or individualised training
- allocating a sympathetic and supporting line manager for the affected employee and providing training programmes to equip the line manager with the necessary skill to be able to manage an incapacitated employee
- educating co-employees on the subject of psychological impairment to dispel the myths with regard to mental illnesses (Coetzer, Botha & Huyser, 2002, pp. 69-70)

Grogan (2014, p. 399) points out that counselling or consultation should take place with the incapacitated employee to mutually consider how the employee may be assisted medically to avoid the illness in the future, if necessary. This counselling or consultation discussion may also look at reasonable accommodation of the employee's illness to minimise the adverse effects on the operations of the employer.

4.5 SOUTH AFRICAN HIGHER EDUCATION PERSPECTIVE

Only a limited number of higher education institutions in South Africa have a formal policy, procedures or guideline in place to manage incapacity. Even at the few institutions where such instruments exist, limited reasonable accommodation practices are documented and the documents merely refer to the provisions for reasonable accommodation in the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995) and the Employment Equity Act 55 of 1998 (Republic of South Africa, 1998). Some of the institutions follow the accommodation options recommended by the insurance companies who assess claims for incapacity (Mr Manoko, personal communication, 11 April 2018; Ms Mercuur, personal communication, 5 April 2018; Ms Tainton, personal communication, 12 April 2018; Rhodes University, 2014; Stellenbosch University, 2017; University of the Witwatersrand, 2015).

The following reasonable accommodation practices are documented (Rhodes University, 2014, p. 6; Stellenbosch University, 2017, p. 7; University of the Witwatersrand, 2015, pp. 5-7):

- flexible working hours
- adjusting work duties or circumstances
- additional leave to recover
- providing special devices and equipment
- independent evaluations of the incapacity conditions

4.6 ODL INSTITUTION'S PERSPECTIVE

In a procedure approved by management (University of South Africa, 2014e, p. 3) the ODL institution only provides for the re-adjustment of the current job or if available, a transfer to an alternative job to accommodate the condition of the incapacitated employee. The procedure also allows for a referral to an independent medical practitioner for an evaluation or recommendation to guide the employer. In practice, line managers often use the obligation of the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995) to accommodate the incapacity. This has resulted in accommodations such as flexible working hours, and physical interventions such as specialised computer equipment, ergonomic chairs, and, in an extreme case, the installation of an air conditioner.

4.6.1 Shortcomings in the ODL institution

The institution does not have a formal, negotiated policy and procedures detailing the various potential workplace accommodations that may be reasonable and feasible in the institution's context, to thus comply with international and other best practices. This results in line managers being required to use their own discretion in accommodating the employee's incapacity.

4.7 INTEGRATION OF THE LITERATURE

The purpose of the study was to develop an incapacity management framework by exploring the incapacity management practices at an ODL institution. The central question was what elements should comprise an effective and comprehensive incapacity management framework suitable for an ODL institution in order to ensure that incapacity management is done fairly and equitably.

To address the research question, the theoretical foundation of this study was anchored in three thematic areas:

1. Organisational justice and incapacity management in the workplace. This focuses on the concept of organisational justice and how it relates to incapacity management in the workplace, and on different incapacity management practices that are available in the workplace.
2. Conventions and regulatory obligations that organisations must adhere to when managing incapacity in the workplace, and the associated implications thereof.
3. Requirements for accommodating incapacity, and the generally accepted reasonable accommodation practices available in the workplace.

An integration of the three focal areas of literature covered in this study is presented below.

4.7.1 Organisational justice and incapacity management in the workplace

Any organisation needs healthy employees to excel and remain competitive and sustainable. To determine what defines a healthy employee, the following concepts were explored in order to obtain a deeper understanding of an incapacitated employee or one that is not healthy:

- organisational justice in relation to incapacity management
- health and wellness
- disability
- sick absence
- presenteeism

Perceived fairness, especially in relation to procedural and interactional justice, has a positive impact on the health of an employee. Although sickness itself is a relatively objective concept in that an employee being sick can be assessed by

a medical practitioner, the decision by the employee to be absent due to the sickness, or present himself or herself at work, can be highly subjective. Employees with similar illnesses may make different decisions. The decision is based on a wide range of a complex set of bio-psychosocial factors and circumstantial variables unique to the individual employee, and is also influenced by advice, financial circumstances, decisions by the employer and the State, as well as the employee's health (Black & Frost, 2011, p. 16; Duff, Podolsky, Biron & Chan, 2015, p. 61; Thompson & Bates, 2009, pp. 118-119).

It is evident that health and wellness is a complex phenomenon and it includes the biological, psychological/mental, sociological dimensions of an employee, and the emotions associated with these factors within the workplace (Du Preez, 2010, p. 14; Thompson & Bates, 2009, p. 119; University of South Africa, 2014d, p. 5; Woods, 2010, pp. 172-176; World Health Organisation, 2002, p. 2). The health and wellness of an employee may be of such serious nature or may develop to such an extent that it results in physical or mental impairments, which may hinder the employee's capacity to fully and effectively perform his or her key performance areas as contained in the employment and performance contracts.

According to the International Labour Organisation (ILO) a physical or mental impairment that reduces an employee's ability to retain and advance in suitable employment is defined as a disability (International Labour Organisation, 1983a, s 1.1). Disability is frequently thought of as an indisputable, health-based condition that limits an ordinary activity, such as work, and has a very specific meaning for purposes of equity in the workplace. A notion exists that long-term incapacity and disability may appear together along a continuum and may become equivalent for the purposes of deciding whether an employee is indeed capable or not capable of performing the required work to the standards set by the employment and performance contracts. Only when an employee cannot perform the required obligation once rehabilitation and reasonable accommodation has failed, it should be regarded

as a disability. (Burkhauser et al., 2014, p. 23; Christianson, 2004, p. 894; Republic of South Africa, 2015b, s 5.1.1(iii); Spicker, 2003, p. 40).

Although South African legislation distinguishes between the concepts of incapacity and disability in sections 10 and 11 of the Code of Good Practice: Dismissal, the employer has in both cases an obligation to assess the medical condition of the employee (Republic of South Africa, 1995). After the assessment the employer needs to consider the possible alternative arrangements that can be made to reasonably accommodate the employee's incapacity or disability. In this study, due to the reasonable accommodation required of the employer for both incapacity and disability, the concepts are viewed as synonymous. Incapacity of an employee is thus defined as the supervening of performance, an interruption in the ability to perform, permanently or temporarily, partially or absolutely, in relation to the employee's employment obligations (Landis & Grosset, 2014, p. 237).

Incapacity not only impacts individual employees (sleep deprivation, smoking, poor nutrition, and other factors), but also affects the employer in terms of direct salary costs, reduced revenue, increased health costs, and a potential impact on the employer's capabilities to render an effective service. If the employer cannot render the expected service, it impacts the employer's internal and external clients (De Vroome et al., 2015, p. 675; Mishra & Inda, 2014, p. 72; Mogobe, 2011, p. 26; Thompson & Bates, 2009, p. 120; Tooma & Beach, 2016, pp. 497-498).

Managing incapacitated employees also has a direct impact on managers. On the one hand managers must meet the productivity and economic needs of the employer while, on the other hand, they need to take care of the needs of the affected employees. In addition, additional stress is created for line managers as they need to balance co-employees' reactions in relation to the accommodations provided for the employee with a long-term health condition (Bramwell et al., 2016).

It also impacts on the co-employees as they need to manage the extra workload, sometimes without any additional compensation. In addition, co-employees can be affected both physically as well as mentally, not only during the absence of the incapacitated employee, but also during the phasing in when the employee returns to work after a period of absence (Dunstan & MacEachan, 2013, pp. 50-51; Thompson & Bates, 2009, p. 120).

Absenteeism, the related cost thereof at HEI's may increase due to the increased stress experienced by higher education educators (Barkhuizen et al., 2014; Bezuidenhout, 2015; Kenny & Fluck, 2014). It may not be presumptuous to assume that the negative outcomes of the changing work role of distance-education educators, such as increased absenteeism, may have a negative effect on the sustainable financial survival of ODL institutions (Bezuidenhout, 2015, p. 13).

As absenteeism or incapacity, irrespective of the reason, has a negative impact on both the institution and the employee, it is important that incapacity management practices should be of such a nature that it is beneficial for both the employer and the employee. Incapacity management practices should preferably positively contribute to the employment relationship and psychological contract between the parties. The overarching purpose of workplace wellness programmes should be to provide a positive return on investment by reducing absenteeism with an altruistic benefit of creating a healthier workforce consisting of employees feeling supported and influenced in a positive way (Melnik et al., 2016, p. 309; Tooma & Beach, 2016, p. 499).

Eight key incapacity management elements that address the biomedical, psychological, sociological, and emotional factors of incapacity were identified. These elements are summarised as follows:

1. Creating a supportive institutional culture through the active support from executive management and leadership, and corporate accountability on all management levels throughout the organisation (Harder et al., 2014, pp. 275-283; Higgins et al., 2012, p. 330; Pronk, 2014, p. 44).
2. A sufficiently resourced incapacity management programme with dedicated resources and accountability, both financially and structurally (Gensby et al., 2014, p. 235; Higgins et al., 2012, p. 330; Mellor & Webster, 2013, p. 133; Pronk, 2014, p. 44).
3. An appropriate, well-communicated, incapacity management policy with clear and detailed rules and standards that are applied fairly and consistently. This policy should provide for the integration of various programmes, such as health, safety and wellness, and also provide for a return-to-work strategy including a compulsory return-to-work interview (Gensby et al., 2014, p. 235; Haafkens et al., 2011, p. 113; Mellor & Webster, 2013, p. 133; Mishra & Inda, 2014, p. 90; Mogobe, 2011, p. 83; Pomaki et al., 2010, p. 22; Pronk, 2014, p. 44).
4. Compliance with ethical and legal requirements (Pronk, 2014, p. 44).
5. Provision of preventative incapacity management practices such as:
 - awareness of and education on the availability of wellness services (Mellor & Webster, 2013, p. 134; Mishra & Inda, 2014, p. 90; Pronk, 2014, pp. 44-45)
 - awareness of and education on occupational and lifestyle health risks in particular (Bezuidenhout, 2015, p. 13; Setati, 2014, p. 161; Yusoff & Khan, 2013, p. 95)
 - work-life balance, allowing flexible work arrangements (De Vroome et al., 2015, p. 683; Dickson-Swift et al., 2014, pp. 146-147)
 - a physical work environment that supports the health and well-being of employees (Dickson-Swift et al., 2014, p. 148; Pronk, 2014, p. 45)
 - counselling and support service provided for affected employees (Bezuidenhout, 2015, p. 13; Black & Frost, 2011, p. 48; Mishra & Inda, 2014, p. 90; Mogobe, 2011, p. 83; Poalses & Bezuidenhout, 2018, p. 186)

6. Provision of rehabilitative incapacity management practices such as early return to work or reasonable accommodation interventions (Dewa et. al., 2016, pp. 8-9; Gensby et al., 2014, p. 235; Pomaki et. al., 2010, p. 22).
7. The incapacity management policy and procedures should stipulate the roles and responsibilities of multiple role players, such as the employer (represented by the line manager), the incapacitated employee, the multi-disciplinary health service providers, co-employees and organised labour (Mellor & Webster, 2013, p. 134; Pronk, 2014, pp. 44-45).
8. Training of all role players (Arends et al., 2014, p. 198; Mishra & Inda, 2014, p. 90; Mogobe, 2011, p. 83).

4.7.2 Conventions and regulatory framework on incapacity management

The employment relationship is generally regulated through an employment contract, employment legislation and collective agreements. Where no employment legislation exists, the employment relationship is governed by the employment contract, enforceable in terms of common law (Bendix, 1996, p. 107; Grogan, 2009, p. 2).

The reciprocal nature of the employment contract implies that an employer can expect reasonably efficient, diligent and faithful performance of an employee. In return the employer shall compensate the employee and provide a safe and healthy working environment (Bendix, 1996, p. 116; Grogan, 2009, pp. 47-57; Slabbert et al., 2006, p. 5-99–5-101).

Should an employee not be able to fulfil his or her contractual obligations it can be regarded as a breach of the employment contract (Van Zyl, 2011, p. 8), and employment contracts may be terminated when a breach exists.

Three core principles in the International Labour Organisation's Termination of Employment Convention of 1982, stand out:

1. A valid reason (incapacity, misconduct or operational requirements) must exist before an employment contract can be terminated.
2. The employee must be provided an opportunity to state a case in defence to the allegations brought by an employer.
3. The employee must have a right to appeal to an independent authority after the decision to terminate the employment relationship if the termination is regarded as unjustified (International Labour Organisation, 1982, s 6-8).

From an international perspective it is evident that the USA has a system that is totally unique in that employees are not protected against arbitrary dismissals – the so-called employment-at-will doctrine. However, employees are protected against unlawful dismissal if the termination of the employment contract relates to any of the USA's anti-discrimination laws (Estreicher & Hirsch, 2014, pp. 347, 349-351; Harcourt et al., 2013, p. 314; Smit, 2010, pp. 66-71).

Other international member states of the ILO, namely Australia, the United Kingdom and the Netherlands do have legislation that complies with the core principles of the ILO convention of termination of employment (Bos et al., 2015, pp. 28-32; Donaghey, 2013, pp. 302, 350; Estreicher & Hirsch, 2014, pp. 358-359, 435; Hardy, 2011, pp. 186-187; Ndobela, 2012, pp. 15-16; Ronalds & Raper, 2012, p. 225; Smit, 2010, p. 64; Southey, 2015, p. 160).

In terms of South African employment legislation, the termination of an employment contract should be for a fair reason and in accordance with a fair procedure (Bendix, 1996, p. 116; Grogan, 2014, p. 11; Van Zyl, 2011, p. 15). A fair reason in the South African context is misconduct, incapacity (due to ill health or poor performance) or operational requirements (retrenchment). A fair procedure differs according to the aforementioned reasons for dismissal (Grogan, 2009, pp. 165-167; Republic of South Africa, 1995, s 188). Section 4(1) of Schedule 8 of the Labour Relations Act 66 of 1995 provides for a basic

procedure that complies with the ILO convention (Republic of South Africa, 1995).

The employer has the right to terminate an employee's employment contract based on incapacity provided that certain prerequisites were complied with (Bos et al., 2015, p. 29; Republic of South Africa, 1995, Schedule 8, s 10; Ronalds & Raper, 2012, p. 230; Weir, 2012, p. 1; United Kingdom, 1996, s 98(2)(a)). One of the prerequisites is that the employer should consider all reasonable accommodation short of dismissal (Republic of South Africa, 1995, s 4(1)).

4.7.3 Reasonable accommodation

In article 2 the Convention on the Rights of Persons with Disabilities (United Nations, 2007), provides a good summary of reasonable accommodation – it is the “necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms” (United Nations, 2007).

The reference to “a particular case” in article 2 of the Convention requires responses to the individual circumstances of a particular or specific person. To give effect to this requirement, the following are required in this process (as confirmed in various court cases as cited earlier in chapters 2 and 3):

- Consultation with the incapacitated employee to establish the nature of the incapacity and how it interferes with performing of essential job functions (Gold & Shuman, 2009, p. 213; Grogan, 2014, p. 399; Lawson, 2012, p. 848; Republic of South Africa, 2015b, s 6.6, s 11.2).
- In consultation with the employee, explore interventions that may be necessary to accommodate the employee in order to ensure that he or she can fully operate, or that will mitigate the impact of the condition and serve the need of the employer (Coetzer et al., 2002, pp. 69-70; Gold &

Shuman, 2009, p. 213; Grogan, 2014, p. 399; Lawson, 2012, p. 848; Republic of South Africa, 2015b, s 6.6, s 11.2).

- If the employee is absent for a long period, the employer should stay in touch with the employee, to determine how he or she is, and to inform him or her of what is happening at work. The employer should also think about a plan for the employee's return to work and in consultation with the employee, consider reasonable adjustments, if necessary, for the employee to return to work (Equality and Human Rights Commission, 2014, p. 33).

The burden of proof is on the employee to show that he or she has a physical or mental incapacity that adversely affects his or her contractual obligations and requires accommodation (Dong et al., 2013, p. 182; Lockwood et al., 2012, p. 182; Santuzzi et al., 2014, pp. 205, 216; Von Schrader et al., 2014, p. 239).

The employer must provide the reasonable accommodation either when the employee starts working for the employer, or once the employee becomes disabled after having been in service for some time. The employer has no duty to provide reasonable adjustments if the employer did not know or could not reasonably be expected to know that an employee has a disability (Equality and Human Rights Commission, 2014, p. 10; Lockwood et al., 2012, p. 183).

When deciding when an accommodation is reasonable would depend on the following:

- the nature and essential functions of the job
- the specific physical or mental illness
- the working environment
- potential adjustments

- how effective the adjustments will be in avoiding the disadvantage that the disabled employee would otherwise experience
- its practicality
- the cost
- the institution's resources and size
- the availability of financial support (Equality and Human Rights Commission, 2014, pp. 57-58; Gold & Shuman, 2009, p. 213; Republic of South Africa, 2002, p. 13)

The following is a list of generic, representative, but not exhaustive examples of reasonable accommodation interventions and other individualised workplace considerations that employers and employees may consider:

- Flexible work scheduling, reduced working hours, more regular but shorter rest breaks, working from home or time off for consultations with health service providers (Dwosken & Squire, 2013, pp. 8, 10, 12; Equality and Human Rights Commission, 2014, pp. 59-60; Gold & Shuman, 2009, p. 228; McDowell & Fossey, 2015, pp. 197-200; Montagna, 2014; Parry, 2011, pp. 188-190; Republic of South Africa, 2002, p. 20; Reynolds, 2015, pp. 99-101; Social Firms Australia, 2010, p. 10; United States of America, 1990, s 12111(9)).
- An equal opportunity for all employees to participate in all activities, such as meetings or even social events (Parry, 2011, p. 193).
- Short-term, extended or even flexible leave periods to obtain medical treatment, recover from illness or receive disability training (Dwosken & Squire, 2013, p. 15; Equality and Human Rights Commission, 2014, p. 62; Gold & Shuman, 2009, p. 226; Hickox & Guzman, 2014, p. 439; Parry, 2011, p. 188).
- Utilisation of health care providers to advise employers. The employer should be responsible for the costs if external health care advisors are utilised (Dekkers-Sánchez et al., 2015, p. 577; Hickox & Guzman, 2014, p. 487).

- Awareness, diversity and sensitivity training for co-employees and line managers of employees with disabilities so that they have the knowledge and understanding on how to interact with them and respect their privacy. The training may also focus on the training of those employees responsible for emergency procedures to assist employees with disabilities during evacuations (Coetzer et al., 2002, pp. 69-70; Equality and Human Rights Commission, 2014, p. 61; McDowell & Fossey, 2015, p. 200; Parry, 2011, pp. 191-192; Republic of South Africa, 2002, p. 20; Schur et al., 2014, p. 615; Social Firms Australia, 2010, p. 10; Von Schrader et al., 2014, p. 255).
- Modified supervision through, inter alia, job coaching and mentoring (Equality and Human Rights Commission, 2014, p. 61; McDowell & Fossey, 2015, p. 200; Montagna, 2014; Republic of South Africa, 2002, p. 20; Social Firms Australia, 2010, p. 10).
- Modified or reclassified job duties and descriptions that are goal oriented, fit the competencies of the incapacitated employees, and even allow for additional time to complete duties (Chow, 2012, p. 60; Dwosken & Squire, 2013, pp. 5, 13; Equality and Human Rights Commission, 2014, p. 59; Gold & Shuman, 2009, p. 228; McDowell & Fossey, 2015, p. 200; Montagna, 2014; Parry, 2011, p. 189; Republic of South Africa, 2002, p. 20; United States of America, 1990, s 12111(9)).
- Physical work environment adjustments, ergonomical workstations to ensure that employees can work effectively and efficiently, provision for support animals in the workplace, and granting employees periodic breaks to walk or feed their animals during working hours (Equality and Human Rights Commission, 2014, p. 59; Montagna, 2014; Parry, 2011, pp. 180-192; Republic of South Africa, 2002, p. 20; Social Firms Australia, 2010, p. 10; United States of America, 1990, s 12111(9)).
- Providing special devices, helpers and interpreters for employees with disabilities (Equality and Human Rights Commission, 2014, pp. 61-62; Dwosken & Squire, 2013, pp. 21-22; Republic of South Africa, 2002, p. 20;

Social Firms Australia, 2010, p. 10; United States of America, 1990, s 12111(9)).

The employer has no obligation to accommodate the employee's incapacity if the reasonable accommodation may be unreasonable or cause undue hardship to the employer. All relevant circumstances of a case must be taken into account when determining whether the reasonable accommodation may impose unjustifiable hardship (Australian Government, 1992, s 5(2); Scott, 2016, p. 130). The hardship is not limited to financial costs, but may include factors such as:

- disruption to working arrangements or too many demands on the workplace
- deterioration in the quality or nature of the services
- a negative impact on co-employees or customers
- health and safety risks (Australian Government, 1992, s 11; Lawson, 2012, p. 848; Ngwenya & Pretorius, 2007, p. 768; Social Firms Australia, 2010, p. 10, United States of America, 1990, s 12111(10))

The burden of proving that an accommodation will impose unjustifiable hardship lies with the party claiming the unjustifiable hardship (Ronalds & Raper, 2012, p. 154).

Employees perceive organisational justice when employers manage their incapacity conditions within the parameters of the law, and when employers are considerate by offering different options to accommodate individual incapacity conditions. Equally, when different accommodation options are considered, the policy and procedures for incapacity management in an organisation should be aligned to legislative requirements to ensure that employees are treated fairly and in a just manner.

4.7.4 Synthesis of the literature

The literature shows that a generic incapacity management framework that will ensure organisational justice rests on four pillars. The first pillar is a supportive institutional culture. Organisational culture is generally defined as the beliefs or convictions and values shared by employees in an organisation (Smit & Cronje, 1999, p. 269). Over time organisational culture evolved from a purely narrative description to becoming linked with organisational improvement and accomplishment, which also applies to higher education (Kezar & Eckel, 2002, p. 438). Tierney and Lanford (2018, p. 3) argue that researchers need to have more than an intuitive understanding of culture. The higher education culture should be perceived from a socially constructed view (Tierney & Lanford, 2018, p. 2). I support Tierney and Lanford's view, as the ODL institution brings together employees with a wide range of backgrounds and disciplines. This means that the institutional culture does not entirely rely on agreement among these diverse groups of employees, although there must still be a certain level of commitment to shared beliefs, values, assumptions, and ideologies. From a conceptual point of view, the institutional culture is to be understood within a framework consisting of six elements, namely, mission, leadership, strategy, information, socialisation, and environment (Tierney & Lanford, 2018, pp. 3-6). The institutional culture requires full support and commitment from the leadership of the institution. The leadership should also ensure that the incapacity management practices are sufficiently resourced, both monetary and staff-wise (either in-house, outsourced or co-sourced).

Secondly, the framework requires a clear policy and procedures describing the incapacity management practices. The third pillar is the provision of reasonable preventative and rehabilitative workplace accommodations to benefit both the employer and employees while at work, and when an employee returns to work after a period of incapacity.

The fourth and the last pillar is the understanding that incapacity can best be managed through a multi-disciplinary team. The roles and responsibilities of the various role players, such as line managers, the incapacitated employee, human resource practitioners, employee assistance professionals, health practitioners, co-employees, and the labour unions should be detailed and these role players should be educated on their roles and responsibilities.

4.8 PERSONAL REFLECTIONS ON THE CHAPTER

The primary purpose of the obligation to reasonably accommodate an employee is to ensure that the incapacitated employee can firstly return to work as soon as possible, and secondly, retain and advance in employment as far as is practically possible. Both the UN and the ILO do not limit incapacity to employees with disabilities prior to employment, but reiterate that incapacity should also include employees who become incapacitated during employment. Furthermore, they expect from member states to incorporate the concept of reasonable accommodation in national legislation.

In the United Kingdom, the Netherlands, Australia and the United States of America their policy regimes do provide for reasonable accommodation for incapacity or disability experienced by employees. In South Africa reasonable accommodation is provided for in the Employment Equity Act 55 of 1998 (Republic of South Africa, 1998) and Labour Relations Act 66 of 1995 (Republic of South Africa, 1995, Schedule 8, s 10).

If the limitation impacts on the employee to fully fulfil his or her contractual obligations, the employer has a duty to investigate how the employee can be reasonably accommodated to comply with the obligations or that of an amended employment contract. In case of disability, the duty to accommodate an employee is more burdensome for the employer than in a matter of pure incapacity. If the employee cannot be accommodated without undue hardship to the employer, the employment contract may be terminated due to incapacity.

Of critical importance for employers in South Africa is that the guidelines for reasonable accommodation as contained in the codes issued in terms of the Labour Relations Act 66 of 1995 (Republic of South Africa, 1995) for incapacity, and the Employment Equity Act 55 of 1998 (Republic of South Africa, 1998) for disability, should be followed diligently, unless it may cause unjustifiable hardship for the employer.

Although an employer has an obligation to attempt to accommodate the incapacity of an individual employee, the following generic reasonable accommodation practices were identified:

- flexibility in terms of working time
- amendment or adjustment to the job or physical working environment
- gradual phasing in or return to work after illness
- physical or technological aids for visual, hearing and mobility impairments

The ODL institution does not have a formal, negotiated policy or procedures complying fully with either the international or national policy regimes or reasonable practices regarding accommodating employees. Although a limited number of higher education institutions in South Africa do have formal policies, procedures or guidelines in place that provide for reasonable accommodation, and certain generic reasonable accommodation practices exist, very limited research on such practices in the higher education sector exists, resulting in a knowledge gap on how to reasonably accommodate incapacity within the higher education sector.

4.9 SUMMARY OF THE CHAPTER

In this chapter I discuss perspectives from global multilateral institutions in relation to the concept of reasonable accommodation. I further discuss perspectives from selected countries with a focus on their policy regimes and

practices pertaining to reasonable accommodation. Perspectives from the South African higher education sector are also discussed. In the chapter I also integrate the literature reviewed for this study and present a personal reflection. In chapter 5 I discuss the research design and methodology followed in this study.

CHAPTER 5: RESEARCH DESIGN AND METHODOLOGY

The more important reason is that the research itself provides an important long-run perspective on the issues that we face on a day-to-day basis.

Ben Bernanke

5.1 INTRODUCTION

As stated in chapter 1, the aim of the study was to explore the real-life experiences and perspectives of the participants with regard to the management of ill health incapacity in the ODL institution. The central research question refers to the elements that should comprise an effective and comprehensive incapacity management framework suitable for an ODL institution to ensure fairly and equitable incapacity management. The sub-questions focus on the conceptualisation of incapacity in the workplace, the legal obligations of employers in managing incapacity and practices available to reasonably accommodate employees' incapacity.

In this chapter I present the philosophical position adopted for this study. I also describe the research methodology and design, and the justification thereof. Furthermore, I outline the research procedure, such as the sampling approach employed, the data collection method undertaken and the techniques applied for data analysis. I conclude the chapter with a discussion of the strategies applied to ensure trustworthiness and ethical reflections.

The structure and content of chapter 5 are depicted diagrammatically in Figure 5.1.

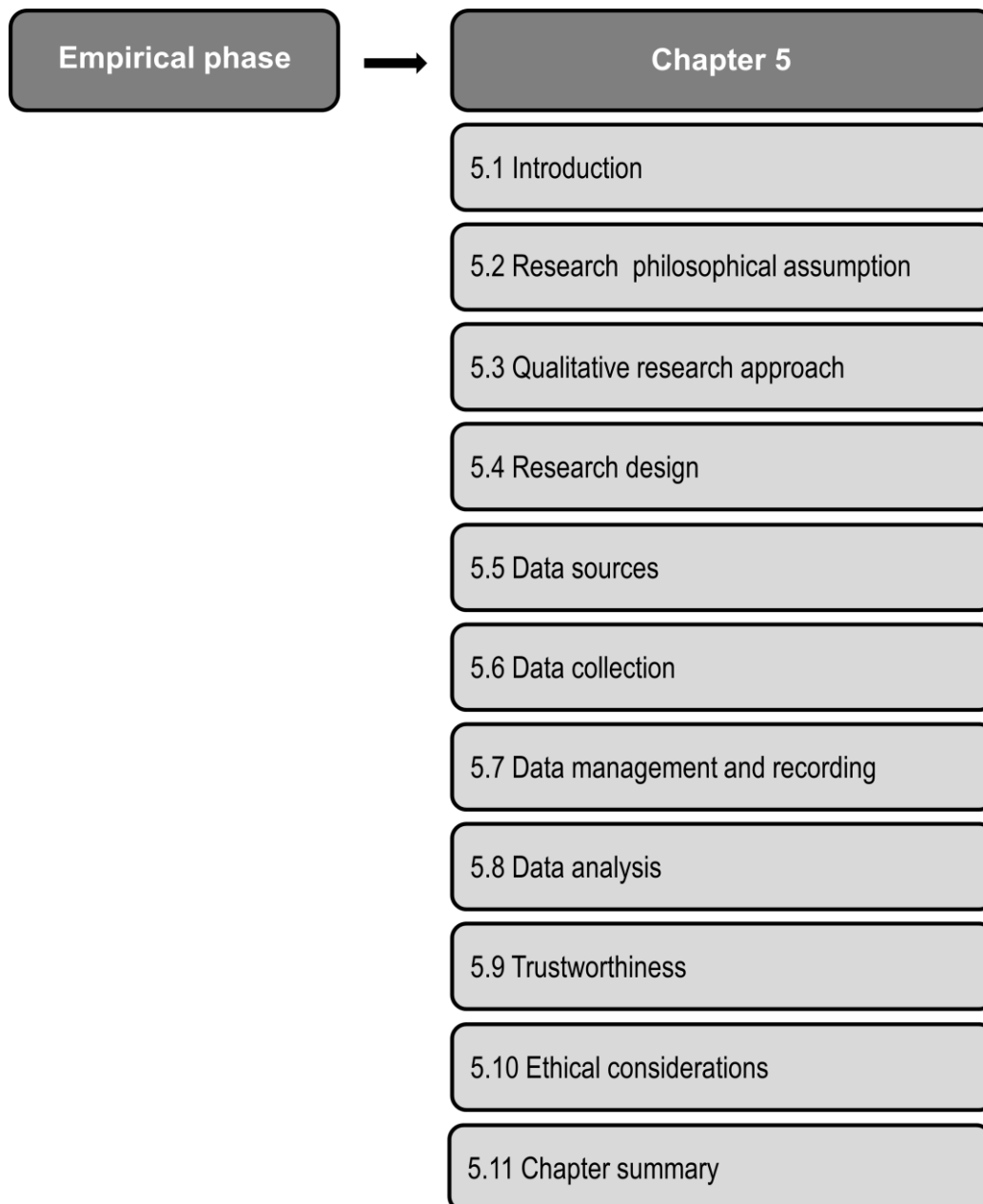


Figure 5.1: Conceptual framework of the research design and methodology (own compilation)

5.2 PHILOSOPHICAL RESEARCH ASSUMPTION

Creswell (2007, p. 15) argues that certain philosophical assumptions such as epistemology, ontology and axiology (as discussed in detail in chapter 1) underpin the researcher's design. The qualitative researcher chooses a position on each of these assumptions and the choices then have practical implications

for the manner in which the research is conducted and provides the basis for decisions on the research design, methodology, methods, and literature (Creswell, 2007, p. 15; Mackenzie & Knipe, 2006, p. 194).

In essence, with the **epistemological** assumption, a researcher attempts to get as close as possible to the participants within their natural settings, in order to explore and gain knowledge of their personal experiences (Creswell, 2007, p. 18; Creswell & Miller, 1997, p. 37; Elshafie, 2013, pp. 5, 7; Kivinja & Kuyini, 2017, pp. 27, 33; Mack, 2010, p. 8; Robson, 2011, p. 525; Rossman & Rallis, 2012, p. 7; Shah & Al-Bargi, 2013, p. 257; Wahyuni, 2012, pp. 69, 71). In terms of the **ontological** assumption, a researcher embraces the idea of multiple realities and intends to report on these multiple perspectives (Creswell, 2007, pp. 17-18; Creswell & Miller, 1997, p. 37; Denzin & Lincoln, 1994, p. 108; Elshafie, 2013, pp. 5, 8; Kivinja & Kuyini, 2017, pp. 27, 33; Mack, 2010, p. 8; Poggenpoel & Myburgh, 2003, p. 418; Robson, 2011, p. 525; Shah & Al-Bargi, 2013, p. 257; Wahyuni, 2012, p. 71). The **axiological** assumption reflects on the values or ethics the researcher brings to the study and must be made known (Creswell, 2007, p. 18; Elshafie, 2013, p. 5; Kivinja & Kuyini, 2017, p. 27; Robson, 2011, p. 525; Rossman & Rallis, 2012, p. 69; Wahyuni, 2012, p. 71).

After a researcher makes these assumption choices, he or she then further constructs the research by applying his or her paradigms or worldviews to the study. A research paradigm is a basic set of beliefs, principles and assumptions that guide the way in which a researcher views the world, and interprets and acts within that world (Creswell, 2007, p. 19; Kivinja & Kuyini, 2017, p. 26). Three main research paradigms are predominantly used in research, namely positivism, interpretivism and critical theory. A fourth research paradigm, the pragmatic paradigm, consists of a mix of the other three paradigms (Creswell, 2007, p. 19; Creswell & Miller, 1997, pp. 33-34; Elshafie, 2013, p. 5; Kivinja & Kuyini, 2017, p. 30; Shah & Al-Bargi, 2013, p. 253).

The interpretive research paradigm seeks to construct and clarify the research phenomena as experienced, interpreted and understood by the research participants in their natural world. It recognises that participants with their own background, experience and assumptions, contribute to multiple socially constructed realities. The knowledge of the phenomena is therefore inside the participant's mind, requiring the researcher to engage with the participants in their natural world to gather data about their lived experiences in their daily interactions (Creswell & Miller, 1997, p. 37; Elshafie, 2013, p. 7; Kivinja & Kuyini, 2017, p. 33; Mackenzie & Knipe, 2006, p. 195; McMillan & Schumacher, 2014, p. 14, 345; Rossman & Rallis, 2012, p. 8; Shah & Al-Bargi, 2013, p. 256; Thanh & Thanh, 2015, p. 24; Wahyuni, 2012, p. 71).

After careful analysis of the various research paradigms, I opted to conduct the research within the interpretive research paradigm, subscribing to its epistemological and ontological philosophies that informed my methodology. Below I present the research approach followed in this study.

5.3 QUALITATIVE RESEARCH APPROACH

The two major research paradigms, positivism and interpretivism, provide the basis for deductive versus inductive research, including quantitative, qualitative and mixed method research approaches. A mixed method research approach combines the quantitative and qualitative approaches within different phases of the research process, from a pragmatic paradigm perspective. The deductive, quantitative research approach emphasises objectivity in studying a phenomenon. Its objectivity is maximised by applying mostly numerical data and statistics. In contrast, an inductive, qualitative research approach represents a different epistemology than the deductive, quantitative research epistemology. The inductive, qualitative research approach is an interpretive research approach that does not test hypotheses based on predetermined theoretical frameworks, and according to this approach researchers cannot control aspects of the world that they are exploring. With qualitative research,

data are collected from participants based on their perceptions and understanding of the personal experiences in their natural environment, using in-person or observation methods (McMillan & Schumacher, 2014, pp. 4-5, 14, 29; Rossman & Rallis, 2012, pp. 6-7; Stake, 2010, pp. 1, 15).

Creswell (2007, p. 37) describes qualitative research as an investigation into the meaning that participants or groups ascribe to a social or human problem. The qualitative researcher collects data in a natural setting. The data analysis is inductive and establishes patterns or themes. The research report provides a detailed description and interpretation of the problem, includes the voices of the participants, the reflexivity of the researcher, and extends the literature.

Labuschagne (2003, p. 100) suggests that qualitative research is mainly concerned with the nature (properties, state and character) of the phenomena. It implies an emphasis on processes and meanings that are rigorously examined, but not measured in terms of quantity, amount or frequency. Instead, most of the data are in verbal form (participants' perspectives and understanding), rather than numbers, and the researcher needs to explore the data with a variety of methods to achieve an in-depth and detailed understanding of their participants' lived experiences, and how they interpret them (Bluhm, Harman, Lee & Mitchell, 2011, p. 1870; Bowen, 2005, p. 209; Hancock & Algozzine, 2006, p. 8; Kiliçoglu, 2018, p. 949; Labuschagne, 2003, p. 100; McMillan & Schumacher, 2014, pp. 31, 347; Stake 2010, p. 1).

The following are common characteristics of qualitative research:

- The research takes place in the participants' natural world where data are gathered about sensory experiences in their everyday lives.
- Researchers use multiple methods to collect the data through direct interaction with the participants.

- The data gathering happens in the field, such as the workplace, home or school, therefore, the research focuses on real-life contexts.
- The research is emergent as the conceptual research model alters or evolves when the research moves to fieldwork.
- It is fundamentally interpretive as it focuses on description, analysis and interpretation (Bluhm et al., 2011, p. 1871; Hancock & Algozzine, 2006, pp. 7-8; McMillan & Schumacher, 2014, pp. 345-347; Rossman & Rallis, 2012, pp. 8-9; Stake, 2010, p.15).

The investigation of incapacity management was set within the natural environment of the ODL institution based on participants' personal reports on their experiences, views and perceptions of incapacity management in the institution, therefore the qualitative research approach is highly appropriate in this case.

Qualitative researchers have a plethora of methods to follow, however Creswell (2007, pp. 6-9) identifies five methods that are frequently used in different disciplines (human, social and health science) namely, narrative, phenomenology, grounded theory, ethnography, and case studies. Whereas the interpretive research paradigm, and specifically the qualitative research approach, endeavours to understand a participant's point of view and lived experience within a certain context and natural setting, I opted for a case study method.

5.4 RESEARCH DESIGN

A research design is a set of guidelines and instructions or plan (road map) to be followed in addressing the research problem through the collection and analysing of data (McMillan & Schumacher, 2014, pp. 6, 28; Mouton, 1996, p. 107; Rossman & Rallis, 2012, p. 135). Figure 5.2 depicts a conceptual model of the research design that was used in this study.



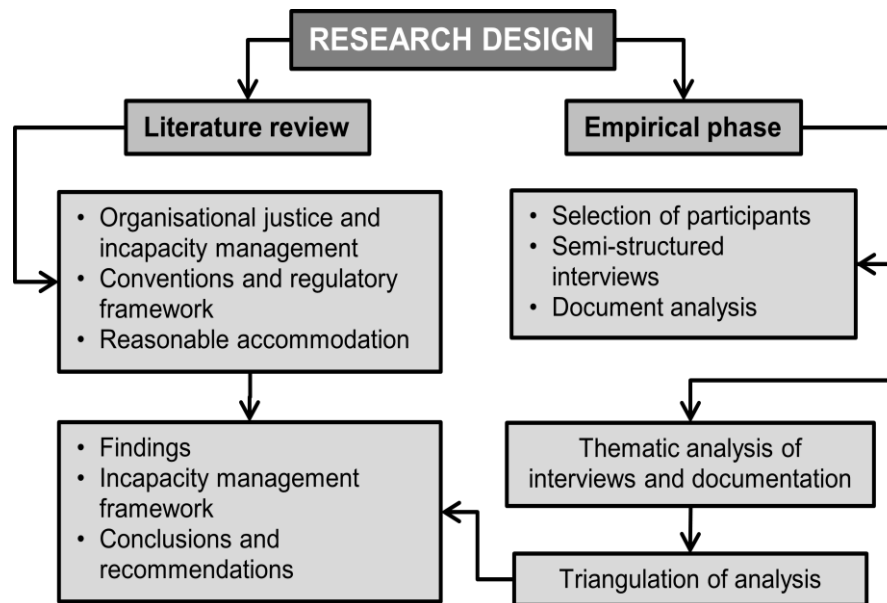


Figure 5.2: Research design and methodology (own compilation)

Figure 5.2 shows the thematic areas of literature review presented in chapters 2, 3 and 4. The empirical phase is discussed in detail in this chapter. The findings and recommendations are presented in chapters 6, 7 and 8.

5.4.1 Case study design

Yin (2012, p. 6) defines a case as a bounded entity, but the boundary between the case and its contextual conditions may be blurred. It is argued that the researcher needs to define the case to be studied and the boundaries of the study (McMillan & Schumacher, 2014, p. 32). Yin (2013, p. 331) contends that a case study should be expanded to also explore the probable interaction between the case and its context to ensure a reliable understanding of the case.

Abma and Stake (2014, p. 1150) agree that a case study can provide in-depth understanding of a single demarcated entity. However, in contrast with Yin (2012, p. 6), Abma and Stake (2014, p. 1150) argue that the case itself is central, and not the identification of general and universal patterns. Abma and Stake (2014, pp. 1150-1151) advocate for a naturalistic approach to a case

study, meaning that the research is performed with minimum intervention from the researcher to understand the particularity of the case in the normal and natural setting.

Merriam (1998, p. 27) argues that the defining characteristic of case study research is the delimitation of the case. She defines the case "... as a thing, a single entity, a unit around which there are boundaries." (Merriam, 1998, p. 27)

As this study was not intended to explore the various approaches to case studies, the following generic definition is accepted for this research. A case study is a qualitative, in-depth, empirical investigation of any social or contemporary phenomenon, relying on multiple sources of evidence within its real-life context bounded by space and time (Creswell, 2007, p. 73; Hancock & Algozzine, 2006, pp. 15-16; McMillan & Schumacher, 2014, p. 1; Robson, 2011; Rossman & Rallis, 2012; Shah & Al-Bargi, 2013; Yin, 2009, p. 18; Yin, 2013, p. 321). The case study could be a descriptive, explanatory or exploratory form of research inquiry. A descriptive case study attempts to present a complete description of a phenomenon within its context. An explanatory case study seeks to establish cause-and-effect relationships with the primary purpose to determine how events occur and which causes may produce particular effects. On the other hand, an exploratory case study normally explores any distinct phenomenon of interest to the researcher. The phenomenon is characterised by a lack of detailed preliminary data or is new. It opens the door for a subsequent examination of the phenomenon observed to add to existing experience and humanistic understanding (Blumberg, Cooper & Schindler, 2014, p. 302; Hancock & Algozzine, 2006, p. 33; Shah & Al-Bargi, 2013, p. 258; Stake, 2000, p. 24; Yin, 2009, p. 7).

Case study designs fall broadly in two categories, namely single or multiple case studies. Whether single or multiple, the researcher may also decide to keep the case holistic or have embedded sub-cases within an overall holistic case (Yin, 2009, pp. 19, 24, 50; Yin, 2012, p. 7). A single case study design is

structured around one case, whereas a multiple case study design investigates several cases. A single case may be considered if the real-life experiences contribute to the understanding of the phenomenon under investigation in a unique setting (Blumberg et al., 2014, p. 306; Yin, 2009, p. 47).

High quality case studies should at least reflect the following five methodological characteristics - problem definition, research design, nature of evidence, analysis and interpretation, and the manner of reporting on the findings (Yin, Bateman & Moore, 1985, pp. 252, 258). Yin (2009, pp. 79-81) contends that the use of a case study protocol is imperative and is a major way of increasing the trustworthiness of case study research. The intention of the case study protocol is to guide the researcher in carrying out the data collection. The case study protocol may consist of the following sections:

- an overview of the case study, the case to be studied, research questions and the broad data collection methodology
- field procedures (presentation of credentials, access to the participants, protection of participants and sources of data)
- case study questions
- a guide for the case study report (outline, format for the data, use and presentation of other documentation, and bibliographical information) (Yin, 2009, pp. 79-81)

Multiple sources of evidence can be used to collect data in a qualitative case study. Six commonly used sources of evidence are direct observation, interviews, archival records, documents, participant observation, and physical artefacts (Hancock & Algozzine, 2006, pp. 39-55; McMillan & Schumacher, 2014, pp. 375-390; Yin, 2012, p. 10). The findings of a case study are generally narrative in nature, consisting of a series of illustrative descriptions of key themes of the case (Creswell, 2007, p. 178; Hancock & Algozzine, 2006, p. 10; McMillan & Schumacher, 2014, p. 410; Stake, 2000, p. 24; Yin, 2007, p. 195).

As this study focuses on the phenomenon of incapacity management in the ODL institution, a qualitative and explorative case study research design deemed to be the most appropriate. The case study design offers the opportunity to gain an in-depth understanding of the participants' and their line managers' real-life experiences and perspectives on the management of ill health incapacity in an ODL context (Creswell, 2007, p. 73; Hancock & Algozzine, 2006, pp. 15-16; McMillan & Schumacher, 2014, p. 1; Robson, 2011; Rossman & Rallis, 2012; Shah & Al-Bargi, 2013; Yin, 2009, p. 18, Yin, 2013, p. 321). Limited knowledge was available on incapacity management in the natural context of ODL institutions. The exploratory phase allowed the utilisation of multiple methods of evidence and data collection such as interviews, documents and field notes (Hancock & Algozzine, 2006, pp. 39-55; McMillan & Schumacher, 2014, pp. 375-390; Yin, 2012, p. 10). The exploratory phase also included the analysis of literature, legislation and selective case law associated with the phenomenon of incapacity management.

In this study, a single case design was deemed most appropriate to provide a description of how a single organisation with employees incapacitated due to ill health, applies incapacity management practices within their usual operating contexts.

5.5 DATA SOURCES

The sources of data used in a case study may include direct observation, interviews, archival records, documents, participant observation, and physical artefacts (Hancock & Algozzine, 2006, pp. 39-55; McMillan & Schumacher, 2014, pp. 375-390; Yin, 2012, p. 10). The primary data source applied in this study was participants' interviews and selective documentation as a secondary source. Each of these data sources are discussed in more detail below.

5.5.1 Participants

It is incumbent on the researcher to clearly define the target population. Usually, the population is too large to survey all members. A small, but carefully chosen sample can be used to represent the population. According to the Merriam-Webster's online dictionary, "sampling is the act, process, or technique of selecting a representative part of a population for the purpose of determining parameters or characteristics of the whole population" (Merriam-Webster's Online Dictionary, 2018). In qualitative research, sampling may broadly be defined as the selection of specific data sources from which data are collected to address the research objectives (Gentles, Charles, Ploeg & McKibbin, 2015, p. 1775).

Sampling methods are classified as either probability (statistical) or non-probability (non-statistical). Probability sampling is scientific, and every member of the population stands an equal chance of being selected. It includes random sampling, systematic sampling and stratified sampling. In non-probability sampling, participants are selected from the population in some non-random or subjective manner based on accessibility. Convenience sampling, judgment sampling, quota sampling, snowball sampling, and purposive sampling are examples of non-probability sampling (Etikan, Alkassim & Abubakar, 2015, p. 1; McMillan & Schumacher, 2014, pp. 143-154).

The concept of purposeful sampling is widely used in qualitative research for the identification and selection of information-rich cases related to the phenomenon of interest. The rationale of purposeful sampling is not about probability sampling from which statistical inferences and generalisations can be made, but it is about selecting participants because they can purposefully contribute to the purpose of the study (Creswell, 1998, p. 110, Creswell, 2007, p. 125; McMillan & Schumacher, 2014, p. 152). Bowen (2005, p. 217) supports this view in that the emphasis of sampling should be on quality rather than quantity. In addition, it is important that the

sample ensures that a **variety of voices are represented** (Myers & Newman, 2007, p. 22). Sample sizes in qualitative studies are generally smaller than the samples required in quantitative research for generalisation. The sample can range from one to more than 40. Factors such as the size of the institution, the phenomenon, the scope, purpose, time frame of the study, and the availability of participants play a role in the sample size. A minimum of at least 15 participants is generally considered as appropriate for a case study (McMillan & Schumacher, 2014, p. 152; Pan & Tan, 2011, p. 169).

As the primary objective of this study was to explore the incapacity management practices in the ODL institution, the following inclusion criteria were used to define the population:

- employees who exhausted more than 30 sick leave days in their three-year sick leave cycle
- employees whose medical practitioners recommended that they be booked off for substantive rehabilitation periods exceeding the sick leave provisions of the ODL institution
- employees who had already applied for ill health retirement and were awaiting the decision of the insurer
- ex-employees who had already retired due to ill health

An original purposive sampling of not fewer than 16 participants was planned. Eight of the participants were employees and/or ex-employees that met the inclusion criteria and were selected because they could contribute relevant information and important insights into the phenomenon of incapacity management in the ODL institution. It was attempted to conduct interviews with these participants' immediate line managers to understand their real-life experiences of managing incapacity. Although the ideal was to interview the incapacitated employee and his or her direct line manager, not all the participants were in a direct employee-manager relationship. In two instances, one of the two participants (either the employee or a manager) declined to

participate, however, the interview continued with the other party. As a result, additional participants affected by incapacity (either a different line manager or another incapacitated employee) were approached to ensure that no fewer than 16 interviews were conducted. The 16 participants included male and female participants on various post grade levels and from different departments (academic and administrative) in the ODL institution to overcome bias and to ensure that a **variety of voices were represented** (Myers & Newman, 2007, p. 22). I used a participant information sheet that spelled out the purpose of the study, why the participant was selected, the rights of the participant and the confidentiality of the interview (Annexure A), to invite the participants to take part in the study.

5.5.2 Documentation

Only documentation that might have had a direct impact on incapacity management, with specific focus on temporary and permanent incapacity due to ill health, was included. To have a direct impact the documentation had to address aspects such as incapacity, reasonable accommodation and the management of the incapacity. The following documents, as secondary data sources, were included in the analysis:

- Employee Disciplinary Code (University of South Africa, 2013)
- Policy on Leave (University of South Africa, 2014a)
- Unisa's Integrated Health and Wellness Framework (University of South Africa, 2014d)
- Procedure for the Management of Ill Health (University of South Africa, 2014e)
- Policy on the Employee Assistance Programme (EAP) (University of South Africa 2015c)

5.6 DATA COLLECTION

Case study data collection involves a wide range of data sources to assist the researcher to build an in-depth picture of the case, such as documentation, archival records, interviews, direct observation, participant observation, and physical artefacts (Creswell, 2007, p. 132; Hancock & Algozzine, 2006, pp. 39-55; McMillan & Schumacher, 2014, pp. 375-390; Yin, 2012, p. 10).

Aligned to the case study design, the primary method of data collection for this study was semi-structured interviews and documentation used as secondary data. I was the key instrument in collecting the data. Before I discuss the two data collection processes, I need to reflect on my role as key instrument. I brought two major components to the data collection process, namely my prior experiences, beliefs, purposes, values, and subjective qualities that shaped how I conceptualised the study and engaged with it. The second component was the relationship that I had with the participants.

5.6.1 Researcher as key instrument

I am employed in the Department of Human Resources at the ODL institution. On numerous occasions, due to my position, I was directly or indirectly exposed to incapacity cases. I often directly engaged with the incapacitated employee and his or her line manager. The indirect exposure occurred when the section I manage participated in a multi-disciplinary team with employee wellness and/or employee relations colleagues in an attempt to manage the incapacity to the satisfaction of the employee and the ODL institution.

Being involved in the incapacity cases I observed the frustrations of both parties (affected employee and direct manager). The employee expected reasonable accommodation of his or her health condition and the employer expected to receive an acceptable service from the employee. This balancing act, or non-

convergence between expectations, led to frustration by both parties. Due to this unresolved frustration, I became interested in the topic of incapacity management and realised the importance of this research for both parties.

I observed that little research on the concept “reasonable accommodation” existed within the higher education sector, hence the interest in the study. Similarly, the ODL institution did not have a formal negotiated policy and/or procedure for the management of incapacity due to ill health.

I was aware of my own preconceived opinions on incapacity management and the importance to avoid potential bias, therefore relied on trustworthiness strategies as explained in section 5.10. I specifically used member checking and the community of practise whereby the colleagues at employee relations and employee wellness were engaged on a continuous basis. In addition, I realised that a research gap existed in terms of incapacity management and constantly reflected on how this study would contribute to the understanding of the phenomenon.

As I was the key person in obtaining the relevant data – either through participant interviews or analysis of relevant documents, I was regarded as the research instrument in describing and interpreting the phenomenon of incapacity (Denzin & Lincoln, 1994, p. 108; Poggenpoel & Myburgh, 2003, p. 418). Furthermore, I was instrumental in translating and interpreting the data into meaningful information (Poggenpoel & Myburgh, 2003, p. 418). In order to enhance the trustworthiness of the study, I ensured credibility by means of triangulation, member checking and peer evaluation interpretation (Baxter & Jack, 2008, p. 556; Creswell, 2007, pp. 45-46, 208; Hancock & Algozzine, 2006, p. 66; Kloppe, 2008, p. 69; McMillan & Schumacher, 2014, p. 3; Morrow, 2005, p. 252; Poggenpoel & Myburgh, 2003, p. 421; Robson, 2011, p. 158; Rossman & Rallis, 2012, p. 65; Shenton, 2004, pp. 65, 68; Yin, 2012, p. 13). Engaging an experienced thematic analyst to co-code a

sample of 12 interviews and assist with the defining of the themes, contributed to the consistency of the interpretation of data.

5.6.2 Interviews

In this single case study design, the primary method of data collection was semi-structured interviews. The reason for using semi-structured interviews was that I could narrow down the areas I wanted to cover, which were especially suitable for case study research (Dicicco-Bloom & Crabtree, 2006, p. 315; Hancock & Algozzine, 2006, p. 40; Rabionet, 2009, p. 564). In addition, semi-structured interviews had the advantage that, as the participants responded to pre-set open-ended questions, other questions emerged from the dialogue (Dicicco-Bloom & Crabtree, 2006, p. 315; Jamshed, 2014, p. 87). Interview guides were used with pre-set questions, based on the researcher's prior knowledge (Annexures B and C). The interview guides assisted in avoiding the risk of eliciting non-related topics and themes, ensured that the same issues were addressed in every interview, and increased the comparability of the multiple qualitative interviews (Blumberg et al., 2014, pp. 247-248; Percy, Kostere & Kostere, 2015, p. 79; Rabionet, 2009, p. 564).

The rationale of the semi-structured interviews was to understand the participants' real-life experiences and perspectives on incapacity management. It provided greater spontaneous responses that were rich and descriptive in nature, meaningful and within the context of the environment in which the research was undertaken (Bowen, 2005, p. 209; Rossman & Rallis, 2012, p. 176). The questions were open ended, and participants had the opportunity to respond in their own words, rather than having a set of pre-determined answers.

The following uniformed approach was followed for each interview to ensure that the interviews yielded data consistent with the study objectives (Dicicco-

Bloom & Crabtree, 2006, p. 316; Hennink, Hutter & Bailey, 2011, pp. 123-131; Rabionet, 2009, p. 564; Robson, 2011, p. 285; Whiting, 2008, p. 37):

- At the beginning of the interview, an attempt was made, through small-talk, to establish rapport with the participants and to make them feel comfortable.
- After establishing rapport, I verbally summarised the information contained in the participant's invitation letter (Annexure A), which they had received prior to the interviews. The research topic and purpose, the ethical clearance, the use of the audio-recording device and taking of field notes were explained. The participants were also reminded that their participation in the research project was entirely voluntary and that they could decline to participate, refuse to answer any question, ask questions, request a break or withdraw at any time without giving an explanation and without any fear of negative consequences to themselves. The participants were assured of confidentiality and anonymity in that their names and names of any other employees mentioned during the interview would be deleted from the interviews transcript and not included in the final report. Each participant was then asked whether he or she was still willing to participate in the interview, and was requested to sign the consent form (Annexure D). The participant retained the participant letter and was provided with a copy of the signed consent form.
- Key open-ended questions as per the theoretical assumptions of incapacity and reasonable accommodation as contained in the interview guide, were posed to the participants in an open and friendly conversational manner. The key focus was to elicit the participants' real-life experiences. Short prompting questions were asked to motivate the participants to further elaborate on their personal perceptions on the topics. In some interviews the participants became emotional (cried) and they were allowed to calm down before the interview proceeded. I also offered the participants access to employee assistance counsellors. None of them took up this offer as they regained their composure within a short period of time. In one interview a participant showed substantial aggression towards the direct line manager.

- At the close of the interview, the participants were asked whether they had any questions regarding the interview or the research project in general. Each participant was then thanked for their participation in the research.

The incapacitated employees and their managers were interviewed separately. The interviews were conducted in a private, natural and neutral setting of the participant's choice. None of the participants received any incentive for their participation.

Although I committed to the anonymity of the participants, certain individual participants indicated that they did not mind being quoted. However, to protect the participants and honour the ethical guidelines, it was agreed that pseudonyms would be used in the reporting of the findings for the following reasons. Firstly, the research, once published, would become a permanent record and with the ease of access through the internet, a participant's name may be found in a short space of time. When a participant's real name is used, any person directly related to the participant, such as a person with the same surname (husband, wife, parent or sibling) or other people that the participant referred to, such as a medical practitioner or colleagues, is easily identifiable. Secondly, the use of the participant's name may have unintended consequences on the current or future life or employment of the participant, such as a future employer searching a prospective employee's name on the internet (Lahman et al., 2015, pp. 450-451).

The average length of the interviews was 43 minutes with the longest 140 minutes and the shortest just under 10 minutes. The verbatim transcribed interviews totalled 125 pages.

Table 5.1 provides a summary of the data collection process for each participant.

Table 5.1: The data collection process through interviews (own compilation)

Participant and pseudonym	Interview context
Interviewee 1: Ryan Gender: Male Employee Age: 51	When I invited the participant to participate in the study, he agreed without hesitation. The participant was at ease during the interview. The participant dwelled upon historical career incidents that were not resolved and he was of the view that it might have contributed to his current ill health. Each question was considered carefully before responding.
Interviewee 2: Walter Gender: Male Age: 43 Employee	When I invited the participant, he was somewhat hesitant to agree. Only after two lengthy telephone discussions, explaining the rationale of the study and confirming anonymity, the participant agreed to participate. The participant was very nervous at the start of the interview and I realised that he focused too much on the voice recorder. I had to put him at ease and to assist I moved the voice recorder further away from him. As the interview progressed he became more relaxed. The participant shared several historical career incidents not related to his illness, such as job grading, work allocation and office space. I got the impression that he thought that through my research I would be able to resolve these historical issues.
Interviewee 3: Jack Gender: Male Age: 65 Employee	The participant agreed to participate immediately upon receipt of the invitation. At the beginning of the interview the participant was nervous, but as the interview progressed, he started to relax. The participant thought about each question before giving his response. At one stage the participant became emotional when he shared some perceived career injustices in his earlier career. After calming down, he continued of his own free will. The interview ended on a very positive note.
Interviewee 4: Abbey Gender: Female Age: 39 Employee	This participant had already retired due to ill health. When I invited the participant to participate in the study, she was very eager to participate. Due to her illnesses, the interview was conducted at the participant's mother's house upon her request. She considered each question thoroughly before responding. Although the participant was at ease during the interview, I observed that she was in constant physical pain.
Interviewee 5: Freda Gender: Female Age: 33 Employee	Originally the participant was hesitant to participate, but after a lengthy telephone discussion, explaining the rationale of the study and confirming anonymity, the participant agreed to participate. The interview was conducted in a coffee shop at a shopping mall close to the participant's house, upon her request. She had already retired due to ill health. The participant was at ease during the interview.
Interviewee 6: Zoe	When I invited the participant to participate in the study, she was

Gender: Female Age: 45 Employee	very excited and eager to participate. The participant was generally relaxed during the interview, although she became emotional on two occasions about certain incidents that had occurred in her earlier career. After overcoming her emotions, she voluntarily carried on with the same excitement and eagerness as when she agreed to participate.
Interviewee 7: Joana Gender: Female Age: 46 Employee	I experienced some problems contacting the participant, however once we established contact, she immediately agreed to participate. The participant was slightly nervous at the start of the interview but as the interview progressed, she relaxed. She pondered on the questions prior to her responses. At one stage the participant became aggressive when she shared an incident that she had with a line manager. She calmed down quickly and voluntarily continued, focussing on the purpose of the interview.
Interviewee 8: Moira Gender: Female Age: 41 Employee	After the insurer declined her application for retirement due to ill health and she had to return to work, the participant accepted the invitation to participate in the study. At times she was very emotional, and I had to allow time for her to recover. I offered that we could continue the interview at a later stage, but the participant voluntarily agreed that we should proceed. She considered each question carefully, but at certain times I had to repeat the questions to refresh the participant's mind on what I had originally asked.
Interviewee 9: Juan Gender: Male Age: 43 Manager Cases managed: 2	Initially I was unable to contact the participant, however once contact was established, he agreed to participate after I had explained the rationale for the study in detail. I had to reschedule the interview twice due to the participant's schedule. The participant was relaxed during the interview and provided quick responses to the questions.
Interviewee 10: Kenny Gender: Male Age: 64 Manager Cases managed: 4	I was unable to contact the participant directly - I had to make the appointment via his personal assistant. The challenge was to arrange a suitable time in his full schedule. The interview had to be rescheduled twice due to unforeseen circumstances. The interview was conducted in a conference room adjacent to the participant's office to avoid any disturbances. The participant was relaxed during the interview and could relate well to the topic of the study as he had dealt with numerous cases of incapacity due to ill health.
Interviewee 11: Rose Gender: Female Age: 59 Manager Cases managed: 1	When I invited the participant to participate in the study, she was eager to participate. The participant was generally at ease during the interview and comfortably shared her experience.
Interviewee 12: Clara Gender: Female Age: 52 Manager Cases managed: 3	The participant agreed to participate in the study. We had to reschedule the original interview due to unforeseen circumstances. The participant was generally at ease during the interview. Due to her vast experience on managing incapacity cases in her career, she participated eagerly.
Interviewee 13: Eva Gender: Female	Initially I struggled to contact the participant, however once contact was established, she was very keen to participate. My observation

Age: 51 Manager Cases managed: 5	was that this eagerness was a result of the frustration she experienced, as she had to deal with a number of incapacity cases due to ill health in a relatively short period. The participant was generally at ease during the interview.
Interviewee 14: Hilda Gender: Female Age: 55 Manager Cases managed: 1	When I approached her, the participant immediately agreed to participate in the study. The participant carefully considered each question prior to answering.
Interviewee 15: Greg Gender: Male Age: 47 Manager Cases managed: 2	It took some time to contact the participant to deliver the invitation letter for participation in the study. Thereafter, it took even longer for the participant to agree to take part in the study. Eventually we could agree on a time for the interview. I guess the time delays resulted from the stressful environment in which the participant was employed. The interview was interrupted twice by colleagues who had to engage with the participant on urgent matters. I offered that we could reschedule the interview, but the participant indicated that we should proceed as the work environment was such that even if we rescheduled, similar disruptions could occur. The participant was generally at ease during the interview, but carefully considered the questions before responding.
Interviewee 16: Grace Gender: Female Age: 45 Manager Cases managed: 1	The participant immediately agreed to participate in the study. She was generally relaxed and carefully considered each question prior to her response.

5.6.3 Documentation

Approval was obtained from the ODL institution to access and utilise the conditions of employment and risk benefit policies (Annexure E - Approval reference number: 2016_RPSC_049 dated 8 September 2016).

The following documents, as secondary data sources, were collected to be analysed:

- Employee Disciplinary Code (University of South Africa, 2013)
- Policy on Leave (University of South Africa, 2014a)
- Unisa's Integrated Health and Wellness Framework (University of South Africa, 2014d)

- Procedure for the Management of Ill Health (University of South Africa, 2014e)
- Policy on the Employee Assistance Programme (EAP) (University of South Africa 2015c)

5.7 DATA MANAGEMENT AND RECORDING

The primary and secondary data collected had to be stored, coded and interpreted in a trustworthy manner. The management and recording of the data are explained in more detail below.

5.7.1 Data from interviews

The voice recordings were copied to a computer with backup data stored on two memory sticks. After copying the recordings to the computer, they were deleted from the voice recorder. I transcribed the interviews. The transcribed interviews and field notes taken during the interviews were stored in Microsoft Word on a computer with backup data stored on two memory sticks. The documents were password protected. The computer and the memory sticks were locked in a steel cabinet at my home. The information for each participant was stored in a separate folder with unique identifier.

5.7.2 Data from documents

Documents for the research were retrieved electronically and manually (printed copies). Electronic documents were stored in a similar manner as the transcripts of the interviews. Manual documents were placed in arch lever files. The stored electronic documents and the arch lever files were also locked in a steel cabinet at my home. A directory of the documents was kept in a Microsoft Excel spreadsheet with appropriate key words. The spread-sheet included cross references

to where the documents could be retrieved - either on the computer, memory stick or in the relevant file.

5.8 DATA ANALYSIS

Although I immersed myself in the data, I support the view of Rossman and Rallis (2012, p. 264) that data analysis is ongoing and that it had already started when I prepared the research questions.

5.8.1 Data analysis interviews

In this study thematic analysis was chosen as a realistic method whereby the participants' experiences, meanings and realities were analysed and reported on (Robson, 2011, p. 474). Thematic analysis is a qualitative research method that can be widely used across a range of epistemologies and research questions (Nowell, Norris, White & Moules, 2017, p. 2). Braun and Clarke (2006, p. 79) describe thematic analysis as a method for identifying, analysing and reporting on themes in qualitative data. By having a defined sequence of analytical phases, thematic analysis provide the researcher with a clear and user-friendly method for analysing data (Vaismoradi et al., 2013, p. 403). A summary of the phases of thematic analysis followed is provided below (Braun & Clarke, 2006, p. 87; Percy et al., 2015, pp. 81-83; Robson, 2011, p. 476; Vaismoradi et al., 2013, pp. 401-402):

- Familiarising the data – this required listening to the recorded interviews, the verbatim transcribing of the recorded interviews, reading and re-reading of the transcribed interviews and documents to identify recurrent themes, topics and relationships that appeared meaningful, while keeping the literature and the research questions in mind.
- Preliminary codes or descriptors (concise labels) were allocated to data relating to the literature and research questions.

- Related data were clustered to identify themes. A theme is a coherent and meaningful pattern that emerges from the data, relevant to the research questions.
- An independent co-coder with no theoretical interest in the topic also read and analysed 12 of the interviews. The co-coder and I shared our findings and reached consensus on the themes.
- I reflected whether the themes were appropriate in relation to the coded extracts and the entire data set. It was necessary to combine two themes, and in a few cases, themes were discarded as they did not relate to the research questions.
- A detailed analysis of each theme was made, generating clear definitions and constructing an informative name for each.
- Finally, I needed to explore, describe, summarise and interpret the patterns to contextualise them in relation to the research questions and literature review. From this I developed conceptual generalisations, which were formulated as recommendations that the ODL institution may apply to improve incapacity management.

5.8.2 Data analysis documentation

Content analysis of documents is a commonly used method in case study research. The researcher needs to ensure that the documentary evidence would provide meaningful answers to the research questions. When combined with information from other sources of evidence, such as interviews, information gathered from documents provides the researcher with important information to address the research questions under investigation (Hancock & Algozzine, 2006, p. 52). The documentation was analysed based on the minimum criteria as explored in the literature, as well as using the themes that emerged from the thematic analysis of the interviews in order to enhance the rigour of the study through triangulation.

The following documentation were analysed:

- Employee Disciplinary Code (University of South Africa, 2013)
- Policy on Leave (University of South Africa, 2014a)
- Unisa's Integrated Health and Wellness Framework (University of South Africa, 2014d)
- Procedure for the Management of Ill Health (University of South Africa, 2014e)
- Policy on the Employee Assistance Programme (EAP) (University of South Africa 2015c)

5.9 STRATEGIES FOR ENSURING TRUSTWORTHINESS

Qualitative research, following from a variety of research paradigms, embraces multiple standards of quality, known as validity, credibility, rigor, or trustworthiness (Morrow, 2005, p. 250). Authors agree that to ensure a trustworthy qualitative study, the research should apply the four criteria as suggested by Lincoln and Guba (1985) in their book, *Naturalistic Inquiry*, namely credibility, transferability, dependability and conformability (Baxter & Jack, 2008, p. 555; Connelly, 2016, p. 435; Nowell, et.al, 2017, p. 3; Shenton, 2004, p. 65.)

5.9.1 Credibility

Credibility relates to the internal validity of the study. This is the extent to which the study measures what is intended, and that the researcher is confident that the findings are trustworthy and reliable (Klopper, 2008, p. 69; McMillan & Schumacher, 2014, p. 2; Shenton, 2004, p. 64). To enhance the credibility of this study to maintain acceptable standards of scientific enquiry, the following strategies were applied:

- Triangulation was used to establish converging themes of evidence. Triangulation is a valuable and widely used strategy involving the use of

multiple sources to provide corroborating evidence, therefore enhancing the rigour of the research. The ultimate convergence occurs when three or more sources of evidence all point to the same interpretation (Baxter & Jack, 2008, p. 556; Creswell, 2007, pp. 45-46, 208; Hancock & Algozzine, 2006, p. 66; Klopper, 2008, p. 69; McMillan & Schumacher, 2014, p. 3; Robson, 2011, p. 158; Shenton, 2004, p. 65; Yin, 2012, p. 13). As interviews and relevant documents were analysed, it added to the trustworthiness of the study, especially where corroboration occurred on the phenomenon. The involvement of an independent qualitative researcher to co-code 12 of the interviews also contributed to the triangulation.

- Prolonged engagement (“being there/insider perspective”) – being employed in the same environment and spending a substantial amount of time with the participants, I had more than a snapshot view of the phenomenon (Baxter & Jack, 2008, p. 556; Creswell, 2007, p. 207; Klopper, 2008, p. 69; McMillan & Schumacher, 2014, p. 345; Morrow, 2005, p. 252; Rossman & Rallis, 2012, p. 65).
- Participant validation (“member checking”) – this can be a very valuable means of guarding against researcher bias (Baxter & Jack, 2008, p. 556; Creswell, 2007, p. 208; Hancock & Algozzine, 2006, p. 66; Klopper, 2008, p. 69; Morrow, 2005, p. 252; Robson, 2011, p. 158; Shenton, 2004, p. 68). I negotiated with the participants to share a summary of my interpretation of the interview with the participant to check whether I had understood the participants’ responses correctly. All participants agreed with the correctness of the summary of their interviews.
- Community of practice (“peer review or debriefing”) – this provides an external check of the research process. It advocates that a researcher engages in critical and sustained discussion with valued colleagues to share emerging ideas, tentative interpretations and unsubstantiated ideas. It may even provide the researcher with an opportunity for catharsis by providing the researcher with a sympathetic ear (Baxter & Jack, 2008, p. 556; Creswell, 2007, p. 208; Hancock & Algozzine, 2006, p. 66;

Klopper, 2008, p. 69; Morrow, 2005, p. 252; Rossman & Rallis, 2012, p. 65; Shenton, 2004, p. 65). As the outcome of the study also benefitted the colleagues managing the employee relations and employee wellness programmes at the ODL institution, they were engaged as sound boards to me. One of the colleagues from employee wellness often had to provide a sympathetic ear as part of the debriefing. During these engagements the anonymity of the participants were ensured.

- Participants' honesty - this requires that a participant has the right to refuse to participate in the study to ensure voluntary and free offering of data. It also requires that the researcher should ensure rapport prior to the interview and that the participant may share data anonymously without fear of any form of intimidation or victimisation. The participant should also have the right to withdraw from the study at any given time (Shenton, 2004, p. 65).

These principles were contained in the participant invitation letter (Annexure A), which was distributed to the participants prior to the interviews. During the interviews, I reiterated the above principles to ensure that the participants shared the data of their own free will.

5.9.2 Transferability

Transferability deals with the external validity of the study. It is the degree to which the findings can be applied to other situations and populations. Due to small sample sizes and the absence of statistical analyses, the findings of qualitative research are not necessarily generalisable or transferable in the conventional sense. It is accepted that after examining the description of the context in which the study was undertaken, the reader must establish how far he or she can confidently transfer the findings and recommendations of the study. It is possible to increase the possibility of transferability by providing sufficiently thick descriptions of the phenomenon investigated so that the reader can compare the phenomenon in the study with what he or she sees emerging in his or her context. The description should provide sufficient information about

the researcher as instrument, research context, participants, and data collection processes (Baxter & Jack, 2008, p. 556; Morrow, 2005, p. 252; Shenton, 2004, pp. 69-70). Transferability of this study was increased by discussing the ODL institution, its challenges, and the context of incapacity management in the institution. In addition, the inclusion criteria for participants, the sample and type of participants are also described in detail. Detailed discussions on the data collection and analysis processes are also provided. Lastly, the results of the research are discussed in depth with supporting quotations from the interviews.

5.9.3 Dependability

Dependability considers whether the findings will be consistent if the study was replicated with the same participants, in the same context, and with the same methods. It deals with the reliability of the study. The ideal is that the process through which findings are derived should be explicit and repeatable as much as possible. One way of achieving dependability is by indirectly applying the strategies for credibility. To address the issue of dependability the researcher should provide a thick description of the methodology. This description should include detail of the research design and the implementation thereof, as well as the chronological detail of the research activities and the data collection and analysis processes (Klopper, 2008, p. 69; Morrow, 2005, p. 252; Shenton, 2004, pp. 71-72). An in-depth description of the methodology is provided to increase the dependability of this study. This description provides for an almost step-by-step replication of the processes followed. In addition, the co-coder and I reached consensus on the themes derived from the interview data.

5.9.4 Conformability

Conformability addresses the objectiveness of the study. This entails that the research process and findings are unbiased as far as is humanly possible, and reflects solely the views of the participants, rather than the characteristics or preferences of the researcher. Once more, the detailed description of the methodology adds to the conformability as the reader will be in a position to scrutinise the research results (Klopper, 2008, p. 70; Morrow, 2005, p. 252; Shenton, 2004, p. 72). Conformability for this study was achieved by applying objectivity during the data collection and analysis processes. The objectivity was enhanced by utilising an independent co-coder, who is viewed as an expert in thematic analysis, during data analysis. The independent co-coder did not, prior to the coding of the data, review the literature on which this study is based and thus had no interest in or bias about the study.

5.10 ETHICAL CONSIDERATIONS

The essence of ethical research in South Africa is found in section 12(2) of the Constitution of the Republic of South Africa, 1996 (Republic of South Africa, 1996), which stipulates that everyone has the right to bodily and psychological integrity, which includes, inter alia, the right not to be subjected to medical or scientific experiments without their informed consent (Republic of South Africa, 1996, s 12(2)(a)). Chapter 9 of the National Health Act 61 of 2003 (Republic of South Africa, 2003) provides for the statutory governance of health research. The Act defines in section 1 that health research may be understood to include, but is not limited to, research that contributes to knowledge of, inter alia, the biological, clinical, psychological, or social processes in human beings. The research on incapacity management falls within this definition as it investigates the social welfare of participants in the workplace.

The Guidelines on Ethics in Research (Republic of South Africa, 2015a) contain the national policy for conducting research responsibly and ethically. These guidelines are based on the Constitution of the Republic of South Africa, 1996 (Republic of South Africa, 1996) and the National Health Act 61 of 2003

(Republic of South Africa, 2003). The guidelines provide for a broad and narrow meaning of health research. In the broad sense it refers to research conducted outside a health care environment, usually not with patients (Republic of South Africa, 2015a, p. 7). The incapacity management case study fell within this broad definition as the research was undertaken in the workplace.

The guidelines on Ethics in Research (Republic of South Africa, 2015a) and the ethical guidelines and standards stipulated by the ODL institution were adhered to. The study was guided by the following ethical and moral principles:

- The autonomy, rights and dignity of participants were respected (Republic of South Africa, 2015a, p. 15; University of South Africa, 2014, p. 10).
- The study aimed to make a positive contribution towards the wellness of employees (Republic of South Africa, 2015a, p. 14; University of South Africa, 2014, p. 10).
- The research did not cause harm to any participant (University of South Africa, 2014, p. 10).
- The benefit of the study will be fairly distributed to both the employees and the ODL institution (Republic of South Africa, 2015a, p. 14; University of South Africa, 2014, p. 10).

In addition to the above moral principles the study complies with the following general ethics principles (Republic of South Africa, 2015a, pp. 15-17; University of South Africa, 2014, pp. 10-15):

- The research is essential and relevant in that it provides knowledge on incapacity management in the workplace for the good of employees, the ODL institution, and the public.
- The results and implication(s) of the research will be made public in an appropriate manner and time.
- I was personally qualified and committed to research incapacity management in the ODL institution.

- The dignity, privacy and confidentiality of the participants and the ODL institution were respected and protected. This was achieved by providing each participant with a pseudonym. Only the co-coder and I had access to the information provided by the participants. No participant was requested to supply any information that compromised his or her confidentiality (Robson, 2011, pp. 200-204; Rossman & Rallis, 2012, p. 73).
- The participants participated freely based on informed consent. Prior to providing written consent, the participants were informed of the purpose and the objectives of the study, and what their participation would entail to allow them to make a conscious and deliberate decision on whether to participate or not. They were informed that the participation was voluntary and that they should not feel coerced or unduly pressurised to participate. The participants had the right to withdraw from the study at any time (Rossman & Rallis, 2012, p. 74).
- The selection of the research participants was done by means of purposive sampling and easily accessible participants were not inordinately burdened.
- I was honest about my own limitations and belief system, and did not abuse his position or knowledge.
- I minimised the risk and ensured that the participants were subjected only to those risks that were necessary for the research.

As certain of the interviews revealed private and confidential medical conditions, I adhered to the ethical standards of the Health Professions Council of South Africa and the provision of the Protection of Personal Information Act 4 of 2013 (Republic of South Africa, 2013).

5.11 SUMMARY OF CHAPTER

The chapter describes the research design and methodology followed in this study. A qualitative research design, using a case study approach, was applied. A purposeful sampling strategy ensured that selected participants would have in-depth knowledge and understanding of the phenomenon of incapacity

management to provide data relevant to the research questions. Semi-structured interviews were used as primary data collection method, and secondary documentary evidence was used for triangulation purposes. The data analysis process drew on thematic analysis. Finally, the quality of the research was evaluated and ethical considerations were addressed.

Chapter 6 outlines and presents the analysis and interpretation of the findings based on the methodology outlined in chapter 5.

CHAPTER 6: RESEARCH FINDINGS

We live longer than our forefathers; but we suffer more from a thousand artificial anxieties and cares. They fatigued only the muscles; we exhaust the finer strength of the nerves.

Edward George Bulwer-Lytton.

6.1 INTRODUCTION

Chapter 5 focuses on the research design and methodology followed. The purpose of the research was to develop an incapacity management framework by exploring the incapacity management practices at an ODL institution. Chapter 6 presents the analysis and interpretation of the findings of the study. The analysis was based on the data collected from the interviews with the participants and the documentation in relation to incapacity management practices in the ODL institution.

The structure and content of chapter 6 are depicted diagrammatically in Figure 6.1.

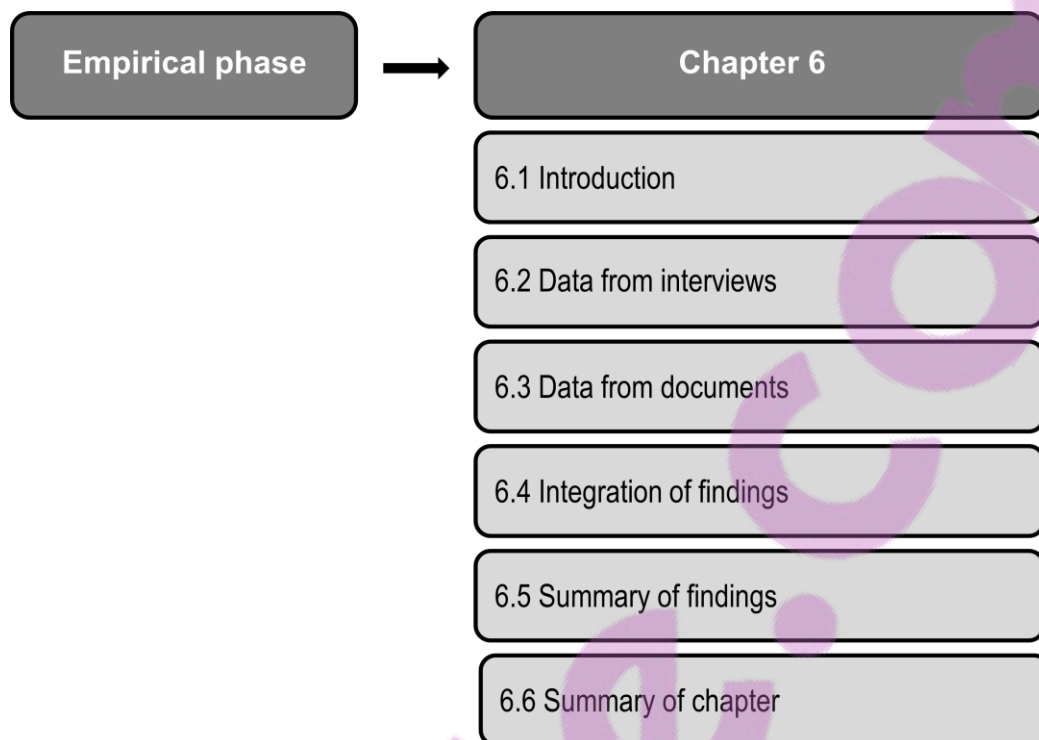


Figure 6.1: Conceptual framework of the research findings (own compilation)

6.2 DATA FROM INTERVIEWS

The overall research question of the study was what elements should comprise an effective and comprehensive incapacity management framework suitable for an ODL institution in order to ensure incapacity is managed fairly and equitably. To this effect, the opening interview question invited the participants to share their lived experiences or views on incapacity management in the ODL institution. Based on the answers provided, the participants were then prompted further on their own understanding and knowledge of the management of incapacity, as well as their perception of the understanding and knowledge of incapacity management by their managers or the incapacitated employee (whichever was applicable). Further probing questions explored how the incapacity was accommodated during and after the period of ill health when the employee returned to work (if any accommodation was necessary). Lastly, the

participants were asked about their perceptions on what factors, internal or external to the ODL institution, hindered or facilitated the accommodation of their ill health, and they were invited to offer suggestions on how the incapacity management in the ODL institution could be improved. These questions sought to also add value to the sub-questions of what acceptable incapacity management practices the ODL institution could put in place to ensure that incapacitated employees can be rehabilitated and retained, and recommendations that can be made to improve the management of ill health incapacity cases.

As indicated in chapter 5, a total number of 16 participants were interviewed for this study. Although the length of the interviews varied considerably, all participants contributed differing amounts of data to the questions. Some participants responded at length on one or two of the questions, however, they eventually contributed to all questions. The participants’ voices are fully represented in this study. Table 6.1 depicts the reference system used to report on the data from the transcribed interviews.

Table 6.1: Reference system used in reporting on data from interviews (own compilation)

Example:	Pseudonym, p. 5:1-9
In the example above, pseudonym represents the participant’s transcribed interview and not the participant	
p. 5 refers to the page number of the relevant document	
1 refers to the starting line	
9 refers to the ending line	

When a quotation reference to more than one page from the same interview is referred, the following reference was used:

Pseudonym, pp. 5:1-9, 5:20, 10:23-25. In this example the subsequent pages follow the comma (,) but the reference is the same as explained.

The data in the transcribed interviews were analysed through thematic analysis by both an independent, experienced qualitative researcher, acting as co-coder and I. At a consensus meeting we agreed on the following four themes and sub-themes that emerged from the interviews (Table 6.2):

Table 6.2: Themes and sub-themes (own compilation)

No	Themes	Sub-themes
1	Institutional culture	1.1. Perception of institutional culture 1.2. Views on management approach
2	Challenges regarding the managing of incapacity	2.1. Awareness, knowledge and understanding of policies and procedures 2.2. Understanding of the incapacity condition 2.3. Mismatched management/employee perceptions and expectations 2.4. Communication 2.5. Training
3	Reasonable accommodation	3.1. Perceptions on accommodation 3.2. Types of accommodation 3.3. Impact on the workplace
4	Multi-disciplinary approach	4.1. Holistic approach 4.2. Line managers 4.3. Co-employees 4.4. Human resources 4.5. Employee assistance 4.6. Occupational health 4.7. Unions 4.8. External service providers

The four themes are discussed in more detail below. The themes are underpinned by the sub-themes which were inductively derived from the data. Extracts from the semi-structured interviews formed a basis from which the themes and sub-themes were generated and established. The relevant literature evidence was integrated with the appropriate themes and sub-themes.

6.2.1 Theme 1: Institutional culture

To have good incapacity management practices, an institutional culture premised on a genuine commitment to workplace wellness and organisational justice is required. The institutional culture will not necessarily heal an incapacitated employee, but will keep the incapacity to a minimum (Thompson & Bates, 2009, pp. 124-125). It is acknowledged that the ODL institution brings together employees from a different number of countries and a wide range of disciplines. As explained in chapter 4, not all employees may necessarily be in total agreement about the organisational culture, but one can expect some level of common commitment to the organisational beliefs, values, assumptions and ideologies. Therefore, culture in this study was understood through the socially constructed cultural framework comprising of the six elements of mission, leadership, strategy, information, socialisation and environment (Tierney & Lanford, 2018, pp. 3-6).

Although not directly explored, a few of the participants voluntarily articulated a view on the broader culture of the ODL institution when they were asked about their lived experiences and views of incapacity management in the ODL institution. However, the participants held divergent views on the managerial approaches applied to incapacity management in the ODL institution.

6.2.1.1 *Sub-theme 1.1: Perception of institutional culture*

Participants perceived the general institutional culture as uncaring. The extracts shared below expressed the viewpoints of the participants (employees and managers):

- "... the institution was really horrible bad ..." (Eva, p. 3:35).
- "... I am really disappointed in the institution ..." (Zoe, p. 1:7).
- "... institution does not care for its people anymore" (Jack, p. 15:15).
- "... lack of empathy and compassionate ..." (Freda, p. 5:20).
- "... we have a problem at the institution ... running it in terms of business sense or are we running a rehabilitation centre? If we are going to continue to massage this problem ... not going anywhere, instead we are creating a culture whereby people will use it as a precedent. This makes it difficult for line managers to manage employees and subordinates" (Greg, p. 5:6-12).

None of the participants perceived the broader institutional culture as a caring culture.

The literature reveals that from an institutional culture perspective, the incapacity management practices should be positive or beneficial for both parties. The culture should be of such a nature that the employees can freely disclose their disabilities, feel supported and influenced in a positive manner, resulting in reduced absenteeism and cost reduction with a consequential higher return on investment for the employer (Lewis, 2016, p. 103; Melnyk et al., 2016, p. 309; Tooma & Beach, 2016, p. 499; Von Schrader et al., 2014, p. 255).

6.2.1.2 *Sub-theme 1.2: Views on management approach*

The participants expressed opposing views on the approach of management in dealing with participants' incapacity. A few participants regarded the experience as positive and caring, while most reported having had negative experiences. The following extracts provide the few positive perceptions of the participants' lived experiences:

- "... was accommodative, question of keep the staff happy" (Kenny, p. 4:28-29).
- "My Director is very supportive ..." (Greg, p. 4:18-19).
- "... received plenty of support ... they understood ... often enquired about my health ... was good to me ..." (Abbey, p. 1:10-11, 1:23).

The following extracts demonstrate participants' negative experiences with management's handling of their incapacity:

- "... do not care ... no empathy, no compassion ... no concern on the root cause ... is it something work related ... nobody asked me whether your illness was treated or was there something we can do as an employer ... subtle threats from line managers because you are off sick ... can be dismissed for incapacity ..." (Ryan, pp. 1:28, 4:31-34, 5:2-4).
- "... nonchalant, sometimes antagonistic ... shown me he is callous ..." (Jack, pp. 2:17, 3:10).
- "... does not ask me how I am ..." (Joana, p. 3:34).

- “... being harassed about sick leave, I mean where is the compassion ... comfort mostly was not in my management ... lack of empathy and compassionate in the workplace ...” (Freda, pp. 3:2, 3:13-14, 5:20-21).
- “... was bullied by a certain Dean up to the VP’s and VC’s office” (Joana, p. 3:13).
- “... Dean said I am unreasonable ... was picked on by top management ...” (Zoe, pp. 5:7, 5:20).

One participant suggested that, to improve the managing of incapacity, it should be incorporated in the performance agreement of managers and supervisors:

- “... incapacity management should be focused on and be part of the KPAs ...” (Juan, p. 5:16-17).

From the above, it can be deduced that the ODL institutional culture is not ideal for managing incapacity. It is crucial that higher education leadership make investments in developing and sustaining a culture and environment of wellness, as it provides a positive return through a healthier workforce and reduced absenteeism (Melnik et al., 2016, p. 320). Executive management need to set the vision and design an implementation plan with measurable performance indicators. In the plan, executive management must assign accountability and ensure that management on all levels, throughout the organisation, is committed to and engaged in the programme. Commitment by all levels of management motivates employees to fully participate in the programmes (Dickson-Swift et al., 2014, p. 146; Harder et al., 2014, pp. 275-283; Higgins et al., 2012, p. 330; Mellor & Webster, 2013, p. 134; Pronk, 2014, p. 44). The manager must show considerate leadership through trust, respect, appreciation, sympathy, and compassion for the incapacity of employees (Kristman et al., 2017, p. 124; Nehawu and another v South African Institute for Medical Research, 1997; SAMWU obo Solomons v City of Cape

Town, 2009). Management should be in constant contact with the incapacitated employee, even if the employee is in hospital or still recovering at home (Dorris Maharaj v Northern Health, 2017; EEOC v Kohl's Department Stores, Inc., 2014; EEOC v LHC Group, Inc., 2014; Jacobs v N.C. Admin Office of the Courts, 2015; Rorrer v City of Stow, 2014).

6.2.2 Theme 2: Challenges regarding the management of incapacity

Based on their individual views and real-life experiences the participants clearly articulated perceived challenges with the implementation and management of incapacity in the ODL institution. This theme deals specifically with the basic principles, policies, procedures and practices to fairly manage the incapacity of employees due to ill health. The theme is discussed under five sub-themes supported by verbatim quotes. As the interviews were analysed, it emerged that the understanding of and challenges identified by the participants were consistent with the literature on policy fundamentals required in terms of incapacity management to ensure the congruence of the perceptions and expectations of the employer and employees. This is elaborated on under each sub-theme.

6.2.2.1 *Sub-theme 2.1: Awareness, knowledge and understanding of policies and procedures*

The participants expressed disparate views on the sub-theme relating to an incapacity management policy and procedures of the ODL institution. Some of the participants were of the view that the institution had an incapacity management policy and procedures in place, whereas the other participants held opposing views. The following extracts reflect the views of those participants who were of the opinion that a policy and procedures were in place:

- “... it is on the system and the procedures are there ... procedures are all in place ...” (Walter, pp. 12:5, 13:22).
- “I think so” (Joana, p. 4:6).
- “... has a policy ...” (Hilda, p. 2:15).
- “... know the policy, does not support you 100% ...” (Clara, p. 2:23).

Some of the participants did not know whether a policy or procedures existed or not:

- “... have not come across any ...” (Juan, p. 1:14-15).
- “No. I think we need a policy and procedure” (Maira, p. 3:17).
- “We did not previously know about it” (Rose, p. 2:1).
- “... not aware off ... loose arrangement” (Grace, p. 2:9).

Two participants indicated that they never checked or searched for a policy. One participant indicated that he solely relied on his own discretion when managing incapacity and the other participant sought assistance from Employee Wellness:

- “I have never researched on a policy ... use your own discretion ...” (Greg, p. 2:32-34).
- “... asked for assistance from Employee Wellness ... have not checked whether there is a policy ...” (Kenny, p. 4:11-12).

Some participants were of the view that, although the policy and procedures may exist, the line manager was not familiar with or ignorant about it:

- “... my line manager was not familiar with the processes ... leave processes ... the extended leave processes ... had to constantly advise my line manager ... plays the ignorance card on the leave processes” (Ryan, pp. 1:9-12, 1:17-18, 1:32).
- “... do not think a lot have read it ...” (Juan, p. 3:15).

The participants were of the view that not only line managers were unfamiliar with the policy and procedures, but even certain executive managers:

- “... Executive Director not clear on that ... were not familiar with the processes ...” (Ryan, pp. 2:28, 3:2-3).
- “... a single Director ... none of them will be so au fait ...” (Juan, p. 3:10-11).

In one instance a participant indicated that he had to assist the line manager to understand the incapacity management policy and process:

- “... I constantly had to advise from sick bed ...” (Ryan, p. 1:13).

Three participants suggested that, as management was not necessarily regularly exposed to incapacity cases, it might have contributed to the limited knowledge and understanding of the incapacity management policy and procedures by management:

- “... do not think line management understood well, think was first one they had to work with ...” (Abbey, p. 3:15).
- “... was a rare case ... they had not experienced this ...” (Freda, p. 3:29-30).

- “... not plenty of knowledge ... only isolated cases ... not everyone works with it daily ...” (Hilda, p. 2:25-29).

Some of the employee participants also admitted that, as their line managers, they were also not familiar with the policy and procedures for incapacity management:

- “... myself was ignorant ... I was not clear ...” (Ryan, p. 2:25-28).
- “As time went on I had to read on it” (Jack, p. 3:16).
- “We did not previously know about it” (Rose, p. 2:1).

Some participants were of the view that the policy had some shortcomings that required amendment. The following extracts provide participants’ suggestions on policy matters that should be amended:

- “Policy to provide for unforeseen replacement” (Clara, p. 5:25).
- “... appoint an acting for three or four weeks ...” (Greg, p. 3:9).
- “... need to review the policy ... know we are lenient with all leave ... however there is the humanity factor ... if one has worked 40 years at a place and you are really sick, and you die ... what will the institution do” (Eva, p. 3:14-17).
- “Policy ... does not make provision for internal movements of employees ... more mandate for executive management ... provide me authority ...” (Eva, pp. 3:24-25, 3:28, 5:5).
- “... should be a policy for chronic diseases ...” (Freda, p. 1:23).

From the above verbatim evidence the importance of an appropriate institutional policy with clear and detailed procedures to be followed to address the challenges raised by the participants, is revealed. In addition, a policy should also stipulate the specific roles, responsibilities and authority of each of the multiple role players. These role players include at least, the employer (represented by the line manager), the incapacitated employee, human resource practitioner, employee assistance practitioner, employee relations practitioner, occupational health specialist, health service providers, co-employees, and the unions (Ashley et al., 2017, p. 22; Haafkens et al., 2011, p. 113; Kristman et al., 2017, p. 124; Mellor & Webster, 2013, p. 134; Mogobe, 2011, p. 83; Pomaki et al., 2010, p. 22; Pronk, 2014, pp. 44-45).

6.2.2.2 Sub-theme 2.2: Understanding of the incapacity condition

Another challenge identified was the poor understanding or insight regarding the nature of the incapacity condition. This was a concern for both the management and employee participants. The following extract from one of the semi-structured interviews provides a representative view of the opinions of the participants who shared their perceptions on the phenomena of incapacity conditions:

- “... we do not understand the incapacity ... it is a challenge ... if we can get information on the various illnesses, that will help ... to better understand what the conditions are ... room for improvement ... knowledge around all the possible disabilities” (Kenny, pp. 3:14-15, 3:28-29, 4:4-6).

This should be read in conjunction with the following quote, confirming that no clear understanding of the incapacity conditions existed:

- “... what I know broadly is what ill health is all about ...” (Juan, p. 1:11).

Several views were expressed of what should be done to ensure a better understanding of the incapacity condition:

- “... more involvement ... without my involvement or discussions, consulting ... without my participation or input or even my awareness ... there should be proper consultation with the relevant role players or affected parties ... one size does not fit all” (Ryan, pp. 8:19-26, 11:8).
- “... look at the circumstances per individual ... each one has an unique situation ... spot the person in the situation ... get the sick notes, what is cause ... analyse the doctor’s notes ... employee may obtain notes from different people ... at the end does not provide a true picture of the circumstances ... document all processes in writing ...” (Clara, pp. 1:8-9, 2:14, 2:36-3:1).
- “... it should be taken seriously ... get preferably information from the psychologist or doctor ... refer employees and stop matters before it goes wrong ...” (Jack, pp. 13:34-4:4).

The lack of understanding of the incapacity condition may be addressed through the education of managers on the essence of the incapacity conditions, so that tailored solutions, that focus on an individual employee’s incapacity is provided. Where the manager lacks expertise on a specific condition, the manager must consult with external service providers such as medical specialist and occupational therapists (Grogan, 2014, p. 399; Hoefsmits et al., 2012, p. 474; Letlonkane, 2015, p. 2; Lockwood, Henderson & Thorncroft, 2014, p. 179; Pronk, 2014, pp. 44-45; Standard Bank of South Africa v CCMA and others, 2007; Wylie v Standard Executors and Trustees, 2006).

6.2.2.3 *Sub-theme 2.3: Mismatched management/employee perceptions and expectations*

The participants shared their perceptions and expectations on the managing of the incapacity in the ODL institution. Opposing views from management and affected employee participants manifested in a mismatch of their perceptions and expectations, resulting in a challenge regarding the managing of incapacity.

The perceptions from management participants are expressed in the following extracts:

- “... impression that people abuse the incapacity ... you must make more and more concessions ... tend to push the boundaries ... do not see the employer as the person that should accommodate in every respect ... employer has given me a job to do ... must pull my weight in order to perform my responsibilities to the employer” (Kenny, p. 3:16-24).
- “... person required lot of support to improve his self-image ... drained us psychologically ...” (Rose, pp. 1:8, 2:24).
- “... one of the most challenging parts of my task as COD ...” (Clara, p. 1:7).
- “... required enormous commitment over a very long period ...” (Eva, p. 1:15).
- “... are not allowed to appoint someone whilst the sick person is still in his post ...” (Grace, p. 1:10).
- “... responsibility shifted to me to carry the load ... puts pressure on me ... less sleep ... need to extend my working hours ... more stress ... whole day taken by queries ...” (Grace, pp. 1:36-2:5).

The management perceptions indicate that the managing of incapacity is a taxing responsibility. In contrast, one of the management participants put forward the following view on what the purpose of incapacity management should be:

- “... you were good enough to be appointed ... what went wrong now ... how can we help you ...” (Clara, p. 5:3-5).

Despite the view of “how can we help you”, most expectations from management regarding incapacity management focus more on an employee performing according to the employment agreement obligations and on delivering the required services. This is evidenced by the following extracts:

- “... employer has given me a job to do ... must pull my weight in order to perform my responsibilities to the employer” (Kenny, p. 3:22-24)
- “... university to create climate ... easier to appoint marker ... system makes it virtually impossible ... one has a job from 8 to 4 and I need outputs ... not done, then I must confront you ... do not play games with me ...” (Clara, pp. 2:15-18, 5:5-7).
- “... prefer if something is in place to assist with quicker backup ... be able to quickly make a differentiation between the opportunists and the employees that are really ill ...” (Eva, p. 2:2-5).
- “... hit by particular scenario ... immediately implement the guideline ... should be supported by HR ... can I appoint an acting for three or four weeks ... must look in how we manage this individuals, not ill health per se, they are healthy but those with absenteeism of a sort ... not managing these people out quickly as possible. They drag their feet, you try to massage these problems for as long” (Greg, pp. 3:6-9, 4:30-33).

As indicated, the participating employees' perceptions were the opposite of that of the management participants. The perceptions of the manner in which a line manager deals with an employee's incapacity vary from being regarded as threatening to being subjective. The employee perceptions are encapsulated in the extracts below:

- "... subtle threats from line managers because you are off sick; you can be dismissed for incapacity ... subtle threats are extreme measures that should not be uttered to a staff member who is still recovering ... to insinuate ... you not here ... not performing ... will be disciplined ... do not come to work ..." (Ryan, p. 5:22-24).
- "... found more support from the union than my direct manager and supervisor ... couldn't understand ... harassed about sick leave ... more support from other colleagues and the union ..." (Freda, pp. 2:30-3:2, 3:14).
- "... nonchalant, sometimes antagonistic ... partially the personality of the person who dealt with it ... was outsider to the department ..." (Jack, pp. 2:17, 3:5, 14:22).
- "... every communication with the line manager ... when I was off sick, it came across as, it was not objective ... was more in that biased tone and biased manner ... medical certificates are looked at with a frown ... when medical practitioner says not fit to work, is seen in a bad light" (Ryan, pp. 7:12-19, 7:33, 10:27-29).
- "... procedures start from your direct supervisor ... this starting level is almost as it stifles ... you cannot get past it ... not only for medical conditions ..." (Walter, p. 12:6-9).

One participant was of the opinion management only assisted him with his incapacity, when management from outside his department, intervened:

- “... dealt with the Deputy Registrar directly ... was not done by my department ...” (Walter, pp. 1:20, 10:11).

Perceptions on the role of the Department of Human Resources and the Employee Assistance unit in managing incapacity were also raised:

- “... even HR, when medical practitioner says not fit to work, is seen in a bad light” (Ryan, p. 10:27-29).
- “... to assist alcoholics, people with AIDS, and assist employee relations with disciplinary measures ...” (Ryan, p. 10:7-10).

Some of the employee participants shared their expectations of what they expected from the incapacity management practices:

- “... first priority let see how we can get this staff member’s health where it is supposed to be ... try to assist ... from a medical point of view ... found out what is wrong ... get the support to assist ...” (Ryan, p. 7:12-19).
- “... maybe a policy should be in place ... accommodate chronic illnesses and diseases ... get shorter working hours or coming to work late ...” (Freda, pp. 1:33-34, 5:32-33).

The mismatch of perceptions and expectations can be minimised if the employer and employees understand that incapacity management refers to the policies, procedures, systems and interventions to fairly manage and reasonably accommodate incapacity of employees due to ill health (Mellor & Webster, 2013, p. 133). This also includes the understanding of their roles and responsibilities, as well as those of the other role players such as human resources specialists, co-employees, unions and health professionals. It is also important that managers are held accountable for the managing of incapacity

(Harder et al., 2014, pp. 275-283; Higgins et al., 2012, p. 330; Mellor & Webster, 2013, p. 134; Pronk, 2014, pp. 44-45). It is important that incapacity management practices should be beneficial and just for both the employer and the employee, contributing positively to the employment relationship and psychological contract between the parties. The intention should be to create a working environment wherein employees feel supported and dignified in order to retain their service. Retaining employees' services benefits the employer's return on investment (Melnyk et al., 2016, p. 309; Thompson & Bates, 2009, pp. 124-125; Tooma & Beach, 2016, p. 499).

6.2.2.4 Sub-theme 2.4: Communication

Participants identified communication as a challenge regarding the managing of incapacity. Participants desired involvement in the management process, consultation, and feedback. During the interviews the participants shared their concerns, evident from the extracts below:

- "... I was not even consulted" (Juan, p. 3:2).
- "... should be proper consultation with the relevant role players or affected parties" (Ryan, p. 8:26).
- "... communication is extremely important ..." (Clara, p. 5:12-13).
- "... over years I have not received feedback from my line management ..." (Walter, p. 1:13-14).
- "... does not help to phone ... no answer ... does not get answers with e-mails ..." (Abbey, p. 1:26-28).
- "... you can send e-mails, you can phone, you can walk there, people are just not available ..." (Hilda, p. 5:9-10).

- “... felt I should have received a little bit more feedback ...” (Grace, p. 2:35).
- “... very important, very quick feedback ... not line management to follow up ... system should flag it and then communication must go to both the employee and line manager ...” (Eva, p. 4:18-20).

The perceived insufficient consultation and communication with the incapacitated employee, and the various role players requires a continuous, two-way engagement. This communication should be upheld throughout the incapacity management process and should include regular feedback to the employee (Dickson-Swift et al., 2014, p. 147; Dorris Maharaj v Northern Health, 2017; EEOC v Kohl’s Department Stores, Inc., 2014; EEOC v LHC Group, Inc., 2014; Jacobs v N.C. Admin Office of the Courts, 2015; Rorrer v City of Stow, 2014; Thompson & Bates, 2009, pp. 124-125; Stellenbosch University, 2017, p. 7; University of the Witwatersrand, 2015, pp. 11, 13, 17). As the line manager is an incapacitated employee’s first point of contact, he or she plays an important role in the implementation of incapacity management policies (Anema et al., p. 370; Haafkens et al., 2011, p. 105). The manager should be alert to signs of gradual long-term changes in the affective state of an employee and should provide the employee with an opportunity to present his or her case through a proper consultation process. This requires that an employee should at least be able to present his or her incapacity case to the employer and make suggestions on how the incapacity may be accommodated (Grogan, 2014, p. 399; Letlonkane, 2015, p. 2; Republic of South Africa, 1995, Schedule 8, s 10(2); Woods, 2010, p. 182). During this engagement, the manager should respect the employee’s privacy and allow the employee to decide the amount of information he or she is willing to share (Dickson-Swift et al., 2014, p. 147; Dewa et. al., 2016, pp. 2, 8-9; Dorris Maharaj v Northern Health, 2017; Nehawu and another v South African Institute for Medical Research, 1997; SAMWU obo Solomons v City of Cape Town, 2009).

6.2.2.5 Sub-theme 2.5: Training

Participants, both managers and employees, were unanimous in their perception that they needed training on incapacity management. They were of the opinion that training would address several of the associated challenges:

- “... new COD ... they do not have years of experience ... some simulation programme ... training that add skills ...” (Clara, pp. 3:29-30, 4:22).
- “... refresher ... policy or new changes ... comprehensive training or information sharing ...” (Ryan, p. 1:15-16).
- “... need to provide more training ...” (Kenny, p. 5:1).
- “Training will work, even creating of awareness ... training in policy and processes ...” (Eva, p. 4:14-17).
- “...make them aware ... remind them, have sessions with them regularly as the departmental management ...” (Greg, p. 4:4-6).
- “... send once a month a newsletter, actions, what is available, where are people available when one requires assistance, a contact e-mail ...” (Hilda, p. 5:6-8).
- “... a booklet that indicate the possible route one will follow ... maybe a booklet ... type of FAQ ... actually want to say, make a framework” (Abbey, pp. 1:37-38, 2:17-22).
- “... definitely a need, especially for line managers ... a process started to compile a guide for line managers ... during sessions with COD’s there is a need from them to get guidelines ... will be handy to have a manual wherein it is contained ...” (Grace, p. 4:6-9).

The findings reveal a variety of thoughts on the modalities for training. Some argued that the training should be general training while others suggested it should take place during induction, and even that regular refresher sessions should be presented – especially when the policy or procedures are reviewed. A booklet or a framework that summarise the various incapacity management processes were also suggested. Any institution committed to workplace wellness needs to offer appropriate training on incapacity management (Rhodes University, 2014, pp. 3,7; Stellenbosch University, 2017, p. 1; Thompson & Bates, 2009, pp. 124-125; University of the Witwatersrand, 2015, p. 13). Employees need to be made aware of and educated on health risks due to occupational factors, as well as the availability of the wellness services (Bezuidenhout, 2015, p. 13; Mellor & Webster, 2013, p. 134; Mishra & Inda, 2014, p. 90; Pronk, 2014, pp. 44-45; Setati, 2014, p. 161; Yusoff & Khan, 2013, p. 95). Managers should be trained on their roles and responsibilities, from promoting the incapacity management policy and procedures to the managing of an employee's incapacity. This includes training on how managers should engage with employees when they were incapacitated, at work, absent from work or when returning to work (Lockwood et al., 2012, p. 183; Mellor & Webster, 2013, p. 134; Mishra & Inda, 2014, p. 90; Mogobe, 2011, p. 83).

By implication then, to achieve co-ownership and a mutual understanding (if not a common purpose) of the incapacity management programme by all role players (Higgins et al., 2012, p. 330; Mellor & Webster, 2013, p. 134; Pronk, 2014, pp. 44-45), the other role players like human resource practitioners, employee assistance practitioners, employee relations practitioners, occupational health specialists, health service providers, co-employees and the unions should all be trained.

6.2.3 Theme 3: Reasonable accommodation

The participants expressed their perceptions on the concept of reasonable accommodation. They also shared their real-life experiences on the manner in which reasonable accommodation was implemented or, in some cases, not implemented in the ODL institution. The impact of the reasonable accommodation on the workplace was also shared. Three sub-themes emerged as reflected in the extracts below.

6.2.3.1 *Sub-theme 3.1: Perceptions on reasonable accommodation*

The following extract from the interview with Juan provides almost an executive summary of the various perceptions shared by the participants and encapsulates the essence of the concept of reasonable accommodation:

“... organisation should be able to accommodate ... should release you ... if you are here for a prolonged period of time, your productivity suffers or you also suffer ... needs to be fair for both the employee and the organisation ...” (Juan, p. 1:21-31).

This was supported by the following view by Clara:

“The success story for me is that if you have managed them in the right manner ... get positive results ... it shows the institution created an environment within which it can be achieved” (Clara, p. 1:10-12).

Grace argued that reasonable accommodation was done haphazardly and should be done within a bigger framework:

“... it is for me a very loose arrangement in terms of how long a person must be accommodated. I do not know, is it three weeks, six weeks, two months, a month ... not only individual that requires support ... as

part of reasonable accommodation one must know what the bigger system entails ... if I know employee's problems ... make it easier to accommodate ..." (Grace, pp. 2:9-11, 4:13-16).

As the reasonable accommodation of an employee's incapacity condition will be beneficial to the employee and the institution, it then follows that reasonable accommodation should be contained in an incapacity management policy, as suggested by a number of participants. The following extracts portray their views:

- "In the policy there must be accommodation ... must have accommodation" (Clara, pp. 2:32-33, 3:33).
- "... any organisation should be able to accommodate ... the policy should spell out broadly what needs to be there ... should be flexible ... level of flexibility ... need a clear policy" (Juan, pp. 1:21, 1:30, 2:12-13, 5:7).

Concern was also raised about the fact that no time limits for accommodating an employee's incapacity were presented in the policy:

- "... something is missing in the policy ... must see what is cut-off date, we accommodate people relatively long, sometimes we play too long" (Clara, p. 3:12).

One participant expressed the view that reasonable accommodation might be one-sided as the employer was expected to accommodate whereas the incapacitated employee was not prepared to do the same:

- "... he wants the employer to do everything for him ... do not see the employer as the person that should accommodate me in every respect" (Kenny, pp. 2:9, 3:21-22).

A participant shared her frustration on the manner in which reasonable accommodation was taken away in a certain department:

- “... saw the past few years how the institution handled and managed it ... until last year, accommodation got positive attention ... attitude changed ... no more concessions regarding working hours, work from home ... all treated the same ... not an institutional change, unfortunately a change in the management incumbent ...” (Hilda, pp. 1:12, 2:5-10).

Reasonable accommodation is an internationally recognised right for incapacitated employees and may not be withdrawn, especially if the incapacity was evident and known to the employer for a number of years, unless it is not justifiable or may cause undue hardship. Reasonable accommodation is explicitly provided for in article 27(1)(i) of the Convention on the Rights of Persons with Disabilities (United Nations, 2007, p. 19) and article 11(a) of the ILO Vocational Rehabilitation and Employment (Disabled Persons) Recommendation No. 168 of 1983 (International Labour Organisation, 1983b). Member states of the United Nations (UN) and the International Labour Organisation (ILO), have a moral obligation to provide for reasonable accommodation in their national legislation (International Labour Organisation, 1983a, s 3-4, 6; Lawson, 2012, p. 847; United Nations, 2007, p. 6).

The United Kingdom (UK), the Netherlands, Australia and the United States of America (USA) have provided for reasonable accommodation in their legislation (Australian Government, 1992; Haafkens et al., 2011, p. 113; Scott, 2016, p. 129; United Kingdom, 2010, s 20). As a member state, South Africa has also provided for reasonable accommodation in its national legislation (Republic of South Africa, 1995, Schedule 8, s 10(1); Republic of South Africa, 1998, s 15(2)(c); Republic of South Africa, 2015b, s 11.1).

The obligation to reasonably accommodate an employee's incapacity was confirmed in international as well as South African legal cases. In the UK it was

found that an employer will be in violation of the Employment Equity Act of 2010 (United Kingdom, 2010) if reasonable accommodation is not provided (Ali v Torrosian and Ors t/a Bedford Hill Family Practice, 2018; Mitchell v Marks and Spencer plc, 2017). Similarly, in Australia the courts ruled that the employer has an obligation to thoroughly consider reasonable adjustments to the job to accommodate the capacity of the employee (Butterworth v Independence Australia Service (Human Rights), 2015; Hilditch v AHG Services (NSW) t/a Lansvale Holden, 2017; Huntley v State of NSW, Department of Police and Justice (Corrective Services NSW), 2015)). In the USA, the obligation to accommodate an employee's incapacity, if known to the employer, was reconfirmed by a number of legal cases (McCall v City of Philadelphia, 2015; Taylor-Novotny v Health Alliance Med. Plans, Inc., 2014; Walz v Ameriprice Fin. Inc., 2015; Withers v Johnson, 2014). The USA courts also ruled that active engagement should take place between the employer and the employee to show that an earnest attempt was made by discussing all possible accommodations, even if no accommodation is eventually provided. Failure by the employer to actively engage in the process, although providing (a) reasonable accommodation(s), is a violation of the Americans with Disability Act of 1990 (United States of America, 1990). If an employee fails to engage in an interactive process, the employer has no obligation to accommodate the employee (EEOC v Kohl's Department Stores, Inc., 2014; EEOC v LHC Group, Inc., 2014; Jacobs v N.C. Admin Office of the Courts, 2015; Rorrer v City of Stow, 2014).

In South Africa the statutory obligation to provide accommodation (including alternative employment or adjusting the duties or work circumstances) was also reconfirmed in a number of South African cases (IMATU obo Anton Strydom v Witzenburg Municipality, The South African Local Government Bargaining Council v Van Staden NO, 2012; NUMSA obo Josias v Tedexlex Trading (Pty) Ltd., 2007; SAMWU obo Solomons v City of Cape Town, 2009; Standard Bank of South Africa v CCMA and others, 2007; Wylie v Standard Executors and Trustees, 2006).

Both internationally and in South Africa, an employer has no obligation to provide reasonable accommodation if it is unjustifiable, unreasonable or may cause undue hardship (Australian Government, 1992, s 11; Equality and Human Rights Commission, 2015, p. 10; Lawson, 2012, p. 848; Republic of South Africa, 2015b, s 6.11, s 6.12; Scott, 2016, p. 130; Social Firms Australia, 2010, p. 10; United Kingdom, 2010, s 15; United States of America, 1990, s 12111(10)). In addition, the employer only need to provide for reasonable accommodation if the employer knew or ought to have reasonably known that the employee was incapacitated (Equality and Human Rights Commission, 2014, p. 10; Lockwood et al., 2012, p. 183).

6.2.3.2 *Sub-theme 3.2: Types of reasonable accommodation*

Management and employee participants had various experiences with the provision of reasonable accommodation. Management participants shared the following:

- “... got special screens and special keyboard for her ... special chair ... created an office for him and he has an air conditioner in there which only works in his office ... he can set and change the temperature as he will ... work from home ...” (Kenny, pp. 1;19, 2:3, 2:20-21, 2:31).
- “... allowed him to mark from home ... attempted to assist him ... was under psychiatric and psychological treatment and if he had appointments allowed him to attend ... if observed that he needs rest, told him to take leave ... distributed his work ...” (Rose, pp. 1:24, 2:2, 2:7-9, 3:2).
- “... quickly appoint a person on contract to do that person’s work ... arrange within the department to perform the extra work ... mark from home ...” (Clara, pp. 1:21-23, 2:4).

- “... I sent the people home ...” (Eva, p. 2:6).
- “... specific concessions in terms of working hours, work from home ...” (Hilda, p. 2:6-7).
- “... we are going to do rotation ... allocated supervisors every week or two weeks to take charge of the section” (Greg, p. 1:32-34).

Although management provided reasonable accommodation, such as special equipment, flexible working hours, and working from home, these needed to be applied within the actual needs of the employer. The following extract provides a perspective on this balancing need:

- “... nature of his work requires that he is here ... needs to be on campus ... needs to be able to do the work from here ... can make some concessions ... to work from home ... cannot do everything what is required from home” (Kenny, p. 3:8-12).

On the other hand, some employee participants indicated that no accommodation was provided or that facilities were not accessible:

- “There was none ...” (Ryan, p. 4:31).
- “... had not much reaction ... dates are predetermined ... need to comply ... no people to spare ... everybody is busy ... nothing was offered ... requested if a module can be taken away or allow me to work less hours ... do less work and gradually increase the work ... never happened ... know they could reduce my work, I know they did not want to” (Jack, pp. 1:24-26, 3:29, 4:32-5:3, 10:30).
- “No, it was not, it was either you take this or you out” (Freda, p. 6:3).

- “... line management never offered wellness ... management must be more involved with our problems ...” (Joana, pp. 4:14, 5:3).
- “... suffering from the beginning, with parking and that was a basic thing ... bathroom not accessible for employees in wheelchairs ... lifts did not recognise the chair ... newest building is inaccessible ...” (Zoe, pp. 1:13, 1:22, 1:27, 3:30-31).

Where reasonable accommodation was provided, the employee participants expressed different experiences as reflected in the extracts below:

- “I think I was accommodated well by the employer” (Moir, p 1:10).
- “... installed an air conditioner ... chair given to me ... flexible hours ...” (Walter, pp. 2:28, 10:3, 10:31).
- “... could see a psychologist ... helped a lot ...” (Jack, p. 5:25-27).
- “... worked from home ... one stage had permission from Dean to work from Florida campus ...” (Abbey, p. 3:10-11).
- “... get sent home ...” (Freda, p. 2:17).
- “When my ill health required additional days ... apply for conversion...when I came back, EAP provided me with assistance support from the external wellness service provider ... security offered their services ... picked me up for the bus stop ... work shorter hours ...” (Moir, pp. 1:26-28, 3:6).
- “... she is not my assistant, but admin officer, on her contract there is four things she must do for me, ridiculous things ... I was allowed to work from home ...” (Zoe, pp. 5:32-33, 6:8).

Some participants made suggestions on how to improve reasonable accommodation practices:

- “... at times I need a rest ... would like to request for a comfortable chair ...” (Walter, p. 10:24-28).
- “... there can be a resting room ... so that you recover ... maybe there is Wi-Fi there, you can use your laptop to do work ... maybe you can get shorter working hours or coming to work late ...” (Freda, pp. 2:18-20, 5:32-33).
- “... need for extended sick leave ...” (Ryan, p. 10:22).

Despite the fact that the ODL institution only provides for the re-adjustment of the current job or if available, a transfer to an alternative job in order to accommodate the employee's condition (University of South Africa, 2014e, p. 3), the verbatim evidence revealed that in reality, line managers provided reasonable accommodation interventions similar to some of the generic interventions, as explored in chapter 4, that the institution could consider:

- flexible work scheduling, reduced working hours, more regular but shorter rest breaks, working from home or time off for consultations with health service providers (Dwosken & Squire, 2013, pp. 8, 10, 12; Equality and Human Rights Commission, 2014, pp. 59-60; Gold & Shuman, 2009, p. 228; McDowell & Fossey, 2015, pp. 197-200; Montagna, 2014; Parry, 2011, pp. 188-190; Republic of South Africa, 2002, p. 20; Reynolds, 2015, pp. 99-101; Rhodes University, 2014, p. 6; Social Firms Australia, 2010, p. 10; Stellenbosch University, 2017, p. 7; United States of America, 1990, s 12111(9); University of the Witwatersrand, 2015, pp. 5-7)
- utilisation of health care providers to advise employers (Dekkers-Sánchez et al., 2015, p. 577; Hickox & Guzman, 2014, p. 487; Rhodes

University, 2014, p. 6; Stellenbosch University, 2017, p. 7; University of the Witwatersrand, 2015, pp. 5-7)

- physical work environment adjustments, ergonomically designed workstations to ensure employees can work effectively and efficiently, and provision for support animals in the workplace and granting employees periodic breaks to walk or feed their animals during working hours (Equality and Human Rights Commission, 2014, p. 59; Montagna, 2014; Parry, 2011, pp. 180-192; Republic of South Africa, 2002, p. 20; Social Firms Australia, 2010, p. 10; United States of America, 1990, s 12111(9))
- providing special devices, helpers and interpreters for employees with disabilities (Equality and Human Rights Commission, 2014, pp. 61-62; Dwosken & Squire, 2013, pp. 21-22; Republic of South Africa, 2002, p. 20; Rhodes University, 2014, p. 6; Social Firms Australia, 2010, p. 10; Stellenbosch University, 2017, p. 7; United States of America, 1990, s 12111(9); University of the Witwatersrand, 2015, pp. 5-7)

However, a plethora of reasonable accommodation interventions exist that are not yet offered at the ODL institution:

- short-term, extended or even flexible leave periods to obtain medical treatment, recover from an illness or receive disability training (Dwosken & Squire, 2013, p. 15; Equality and Human Rights Commission, 2014, p. 62; Gold & Shuman, 2009, p. 226; Hickox & Guzman, 2014, p. 439; Parry, 2011, p. 188; Rhodes University, 2014, p. 6; Stellenbosch University, 2017, p. 7)
- modified supervision through, inter alia, job coaching and mentoring (Equality and Human Rights Commission, 2014, p. 61; McDowell & Fossey, 2015, p. 200; Montagna, 2014; Republic of South Africa, 2002, p. 20; Social Firms Australia, 2010, p. 10; University of the Witwatersrand, 2015, pp. 5-7)
- modified or reclassified job duties and descriptions that are goal oriented, fit the competencies of the incapacitated employees and even allow for

additional time to complete duties (Chow, 2012, p. 60; Dwosken & Squire, 2013, pp. 5,13; Equality and Human Rights Commission, 2014, p. 59; Gold & Shuman, 2009, p. 228; McDowell & Fossey, 2015, p. 200; Montagna, 2014; Parry, 2011, p. 189; Republic of South Africa, 2002, p. 20; Rhodes University, 2014, p. 6; Stellenbosch University, 2017, p. 7; United States of America, 1990, s 12111(9); University of the Witwatersrand, 2015, pp. 5-7)

6.2.3.3 *Sub-theme 3.3: Impact on the workplace*

Reasonable accommodation has an impact on the workplace, especially on the manager and the incapacitated employee. The impact may be positive or negative.

The following extracts indicate how the management participants experienced the impact in the workplace:

- “... one case unbelievably emotional ... took a lot of cheer out of my day ... to daily engage with the person ... takes a lot from a manager ...” (Clara, p. 5:3-5).
- “... responsibility shifted to me to carry the load ... puts pressure on me ... less sleep ... need to extend my working hours ... more stress ... whole day taken by queries ...” (Grace, pp. 1:36-2:5).
- “... had to boost him ... keep him busy ... almost no time for oneself ... almost take over your life ... felt later you had no privacy ... the standard, quality of work deteriorates ... cannot concentrate ... often interrupted when he stormed in here ... I took leave to get away from him ... could not ... he will phone you at home ... his wife will send a SMS ... you do not get away from the situation ...” (Rose, pp. 1:9-15, 2:17-19).

The managing of incapacitated employees is a balancing act for managers. On the one hand the managers must meet the productivity and economic needs of the institution, while on the other hand they need to accommodate the needs of the incapacitated employees. The line manager experiences additional tension as he or she also needs to balance the reactions of co-employees in relation to the accommodations provided to the incapacitated employee (Bramwell et al., 2016).

Similarly, reasonable accommodation may have an exhaustive impact on an employee, as observed from the following experience when an employee was involved in return-to-work meetings:

- “... guys who had to manage the things did not manage all ... I still had a number of things not completed ... some people did help, but not all ... some were not of good quality as it is not their work ... had to redo it ... meetings were traumatic meetings ... when I walked out, I felt I was squashed ... the meetings was like fuel in the fire ...” (Jack, pp. 1:24-26, 4:18-27, 5:5-7, 11:31-33).

Although an employee might be accommodated, the accommodation interventions might have a negative impact on his or her co-employees. The perceived impact on the co-employees ranged from positive to negative. The following extracts demonstrate the impact on the co-employees as shared by both management and employee participants:

- “... in one case it was very positive ... other case had not the same reaction ... at first well, but later there was bitchiness under the women colleagues ...” (Clara, p. 2:1-7).
- “... on my floor, my colleagues, they accommodate me well ... if caretaker is not here ... other admin people should stand in for her ... they said they

cannot believe that I expect from them to wash my crockery ...” (Zoe, pp. 5:30, 6:1-3).

- “If it flows into team work it has an effect on other staff members ... general perception from co-employees this person is lazy, getting an unfair advantage, unfair treatment ... rather than understanding there is something seriously wrong” (Ryan, p. 8:22-32).
- “... not positive ... makes it difficult because it is extra responsibility for them as well ... had a case where one came to my office and said the person is at work, why should he still carry the responsibility ... initially people are accommodative, sympathetic, but as time goes on it wears off ...” (Grace, p. 2:18-23).
- “... if work is taken away from me ... will not be fair on the other people that are already overloaded ... problem is, very busy ... they are pressured for time ... think the people around me would have assisted if they could ... they are very nervous and tired ...” (Jack, pp. 11:1-2; 12:17-19, 13:14-23).
- “... asked other colleagues to jump in, in order to assist in keeping him busy ... drained everyone psychologically ...” (Rose, pp. 1:10-11, 2:24).
- “... send mail to colleagues to indicate what I am going through ... think only two responded ... everyone goes on ... it is pressure and not enough people ... they may have thought that I let them down, resulting in more work for them ... can appreciate if there is some sort of attitude ...” (Abbey, pp. 2:34-3:2).
- “... might take it, she is just doing what she wants ... she is not penalised ... without knowing the full story” (Freda, p. 8:16-18).

- “Initially there was some feelings ... little bit of antagonism from other employees ... think that feeling disappeared ...” (Hilda, p. 3:27-33).
- “Very positive and still is” (Moir, p. 1:33).

The verbatim evidence reveals that when an incapacitated employee was being accommodated, the co-employees were initially supportive, but as time went by, they became tired, then exhausted and then negative. Accommodating incapacitated employees impacts co-employees’ physical or psychological and social environment. The physical impact occurs when the co-employees who carry the extra responsibility experience work overload. The psychological impact relates to the peer being uncertain about how to interact with the incapacitated employee without affecting his or her incapacity condition. The redeployment of an incapacitated employee returning to work may impact the social relationships in the new workplace (Dunstan & MacEachan, 2013, p. 50; Mogobe, 2011, p. 26; Social Firms Australia, 2010, p. 10; Thompson & Bates, 2009, p. 120).

6.2.4 Theme 4: Multi-disciplinary approach

From the interviews it emerged that the managing of incapacity in the workplace should not be done in isolation. It requires the involvement of multi-disciplinary role players both from within the ODL institution and even from outside the institution. The multi-disciplinary approach, involving the various role players as identified by the participants, was consistent with the literature on a multiple role player approach as discussed in chapter 4. This is elaborated on under each sub-theme.

6.2.4.1 *Sub-theme 4.1: Holistic approach*

Participants identified that the management of incapacity necessitated a multi-disciplinary approach. This view is supported by the extracts below:

- “... multi-disciplinary problem ... get all the parties together ... forms basis to discuss the problem case ...” (Clara, p.2:23-25).
- “... institution needs to get together ... inclusive of medical and external wellness service provider ... all people ... determine what we can do ...” (Eva, p. 3:4).
- “... proper consultation with the relevant role players or affected parties ... should be the affected person and person in HR ... line managers ... to some extent the unions” (Ryan, pp. 8:26, 9:8-10).

Although a multi-disciplinary approach was propagated, one of the participants advocated for the privacy of the affected employee to be recognised:

- “... privacy to be respected ...” (Ryan, p. 8:21).

The success of incapacity management is anchored in a holistic approach which provides synergy between wellness and disease management programmes, appropriate sick leave management, accommodation of the incapacity condition, and effective collaborative relationships among all relevant role players (Ashley et al., 2017, p. 22; Frank, 2016, p. 21; Republic of South Africa, 2009, pp. 5-6).

Incapacity management requires a holistic approach with planned, structured, coordinated, and close communication between the incapacitated employees, employers (represented by the line manager), trade unions, multi-disciplinary healthcare service providers, co-employees and any other relevant role players

(Pomaki et. al., 2010, p. 22). What is important in the holistic approach is that the incapacity management policy and procedure should spell out the roles and responsibilities of the multiple role players (Mellor & Webster, 2013, p. 134; Pronk, 2014, pp. 44-45).

6.2.4.2 *Sub-theme 4.2: Line managers*

The participants indicated that their line managers were crucial role players in managing incapacity in the workplace, as they were the first point of contact for the incapacitated employees. The following extracts summarise these views:

- “... bottom-up approach should be adhered to line management ... they are the people spending time with the employees and know the employees better ... know if somebody is sick to the level of incapacity ... line management is quite critical ...” (Juan, p. 4:11-23).
- “... first line communicator ... have an understanding of all staff members and ask them if there is anything we can do ... to assist with your condition ... let us get the support to assist him ...” (Ryan, pp. 5:16-21, 7:23-24).

Although the view was that the line manager should be the first to know that an employee was ill and assisted the employee accordingly, a participant shared the following disturbing experience about her line management’s attitude or behaviour - in part due to them not understanding her condition, and in part due to the work pressure they experienced to deliver a service:

- “... may be the less understanding of what I had ... found more support from the union than my direct manager and supervisor ... from their part, that they also need their job requirements ... no compassion for me from my managers ... they were not really being supportive ...” (Freda, pp. 2:29-32, 3:3, 3:25).

The participants unanimously shared the view that training would assist managers to play an improved role in the multi-disciplinary team. These views are reflected below:

- “... new COD ... they do not have years of experience ... some simulation programme ... training that add skills ...” (Clara, pp. 3:29-30, 4:22)
- “... refresher ... policy or new changes ... comprehensive training or information sharing ...” (Ryan, p. 1:15-16).
- “... need to provide more training ...” (Kenny, p. 5:1).
- “Training will work, even creating of awareness ... training in policy and processes ...” (Eva, p. 4:14-17).
- “... make them aware ... remind them, have sessions with them regularly as the departmental management ...” (Greg, p. 4:4-6).
- “... definitely a need, especially for line managers ... a process started to compile a guide for line managers ... during sessions with COD’s there is a need from them to get guidelines ... will be handy to have a manual wherein it is contained ...” (Grace, p. 4:6-9).

The verbatim evidence reveals that well equipped line managers play a very important role within the multi-disciplinary approach to incapacity management, therefore their roles and responsibilities should be clearly spelled out in the incapacity management policy and procedures (Mellor & Webster, 2013, p. 134; Pronk, 2014, pp. 44-45). As they are the first point of contact with an incapacitated employee, managers should be alert to the capacity of the employee, show sympathy and compassion for the incapacity of the employee and stay in constant contact with the incapacitated employee (Anema et al., 2013, p. 370; Dorris Maharaj v Northern Health, 2017; EEOC v Kohl’s

Department Stores, Inc., 2014; EEOC v LHC Group, Inc., 2014; Haafkens et al., 2011, p. 105; Jacobs v N.C. Admin Office of the Courts, 2015; Kristman et al., 2017, p. 124; Nehawu and another v South African Institute for Medical Research, 1997; Rorrer v City of Stow, 2014; SAMWU obo Solomons v City of Cape Town, 2009; Woods, 2010, p. 182). They should also be trained on their role and responsibilities within the multi-disciplinary team (Lockwood et al., 2012, p. 183; Mellor & Webster, 2013, p. 134; Mishra & Inda, 2014, p. 90; Mogobe, 2011, p. 83).

6.2.4.3 *Sub-theme 4.3: Co-employees*

Although not directly involved in the managing of incapacity in the workplace, the attitude of the co-employees could impact on the process or the relationship with the incapacitated employee. Some of the participants suggested that the sharing of some information of the incapacity condition was necessary:

- “... other members of the team, should understand ... person is ill ... respect this person’s privacy ...” (Ryan, p. 9:24-26).
- “... colleagues played a huge role ... very, very supportive ... they need to know what is going on ... maybe there should be disclosure process as well to colleagues ...” (Freda, pp. 8:8-9, 8:15-19).

An incapacity management policy should provide for the specific roles of and expectations of co-employees. Co-employees should be trained on their roles and should be recognised and even compensated for standing in for or assisting the incapacitated employee (Dunstan & MacEachan, 2013, p. 51; Mellor & Webster, 2013, p. 134; Pronk, 2014, pp. 44-45). Co-employees may need to be consulted to obtain their buy-in and support for the intended accommodation intervention (Gold et al., 2012, pp. 34-35).

6.2.4.4 Sub-theme 4.4: Human resources

Participants identified the Department of Human Resources as one of the key role players although their views were divergent. The following extracts portray the participants' positive views:

- "... got full cooperation from HR ..." (Walter, p. 1:11-12).
- "... HR is very helpful ... if I asked, they were always there ... got all the support ... trust HR 100% ..." (Eva, pp. 1:20-21, 4:28, 5:14).

The following extracts shared the participants' negative experiences with the Department of Human Resources:

- "... HR not responsive enough that one must act in the capacity for the period that the employee is hospitalised ..." (Eva, p. 1:27-28).
- "... you can send e-mails, you can phone, you can walk there, people are just not available ..." (Hilda, p. 5:9-10).
- "... HR is seen more as a stumbling block than assistance ... perception is that HR does not play a very friendly role at the institution" (Hilda, p. 5:11-12).

One participant was of the view that the Department of Human Resources might not have the necessary skills to assist in the managing of incapacity:

- "... HR is quite broad ... not find a lot of people knowledgeable or expert enough in this field ... need specialised people ..." (Juan, pp. 3:33-4:1).

A number of participants expressed their perceptions on what they believed the Department of Human Resources should be doing to contribute to the proper

management of incapacity at the ODL institution. These suggestions are shared below:

- “... regular training ... refresher ... policy or new changes comprehensive training or sharing of information ... interaction with the line managers to advise on how the affected staff member can be assisted ...” (Ryan, pp. 4:1-16, 10:30-32).
- “... new CODs ... does not have years of experience ... interaction with some simulation programme ...” (Clara, p. 3:29-30).
- “... should be close consultation with line managers ...” (Juan, p. 4:7).
- “... HR can assist us ... know what the disabilities are ... what tools are available in all of those areas ... make the information available to managers ...” (Kenny, p. 4:9).
- “... HR can play a bigger role ... more visible role ... HR function is very important ...” (Hilda, p. 5:6-11).
- “... need to engage line managers ... make them aware on how do they function, how can they utilise them, have sessions with them regularly ...” (Greg, p. 4:3-6).
- “... HR has my records, maybe they can refer me to EAP ... start putting the therapeutic measures into place ... help person on journey ...” (Freda, p. 7:28-31).

Human Resources is a crucial role player in a multi-disciplinary approach towards managing incapacity (Anema et al., 2013, p. 370; Gensby et al., 2014, p. 235; Haafkens et al., 2011, p. 105; Mogobe, 2011, p. 83; Perski et al., 2017, p. 557). Their roles and responsibilities should be clearly spelled out

in the incapacity management policy. As Human Resources need to co-own the incapacity management practices - they need to be trained on the incapacity management policies and procedures (Mellor & Webster, 2013, p. 134; Pronk, 2014, pp. 44-45).

6.2.4.5 Sub-theme 4.5: Employee Assistance Section

Although the Employee Assistance Section is one of the sections in the Department of Human Resources, participants expressed different views on this section. Once again, positive and negative views were indicated. The following were some of the participants' positive experiences:

- "... got full cooperation from HR, Wellness ..." (Walter, p. 1:11-12).
- "... Occupational Health Nurse ... EAP ... assisted from their side ..." (Jack, p. 4:13-18).
- "... EAP did wonderful work, made him positive and motivated, introduced a work programme ... could see the positive impact EAP made on him" (Rose, p. 1:23-26).
- "... Wellness allocated someone, psychologist to talk to ... they were very helpful, got much support from them" (Abbey, p. 1:1-2).

A participant expressed both a positive and negative experience with the Employee Assistance Section. However, when analysed, it appears that the negative view could be ascribed to the non-cooperation of the incapacitated employee:

- "... one case where employee worked with EAP, good feedback ... in another case not ... suggested that person should see someone, but no ..." (Clara, p. 4:3-6).

Participants expressed the following negative perceptions:

- “EAP ... was biased ... people here lost their trust in EAP ...” (Eva, p. 4:28-30).
- “People do not trust internal EAP, prefer the external company ... carried me a lot ... made me calm ... if I have seen them more, could have assisted more ...” (Joana, p. 4:18-23).
- “... not very well ... did not see role EAP played ... is for me insufficient ...” (Hilda, p. 4:16-20).

Even when a participant had no experience with the Employee Assistance Section, he still expressed a negative perception. The extract below expands on this:

- “... no exposure ... a support body ... to find you incapacity, incapable of working, in order to take disciplinary measure rather than assisting measure to help you ... a tool for the institution ... to take disciplinary measures against you later on ... they are there to assist alcoholics, people with AIDS and assist employer relations with disciplinary measures” (Ryan, pp. 6:30-7:4, 10:8-9).

Another participant who had no exposure to the Employee Assistance Section observed the following:

- “... never engaged with EAP ... you do not know where to go as person...do not know the resources available to you ...” (Freda, p. 7:17-18).

Some participants raised certain expectations of the Employee Assistance Section:

- “... their role should be bigger ... role and functions should be properly communicated to staff members and play more active role than be seen as a tool of disciplinary measures” (Ryan, p. 10:7-10).
- “... EAP should be available for sick employees, you do need therapy ... (Freda, p. 7:17-18).

The Employee Assistance Section has an important role to play in helping to keep sick absence lower than it otherwise might be by creating a healthy and congenial work environment (Bezuidenhout, 2015, p. 13; Black & Frost, 2011, p. 48; Mishra & Inda, 2014, p. 90; Mogobe, 2011, p. 83). This necessitates that their role and responsibilities should be defined in the incapacity management policy and they should receive training as well (Mellor & Webster, 2013, p. 134; Pronk, 2014, pp. 44-45).

6.2.4.6 *Sub-theme 4.6: Occupational Health*

As with the Employee Assistance Section, the Occupational Health Nurse was suggested as an important role player in the multi-disciplinary approach, especially when it came to the matter of general health, safety and physical illnesses. Although not all participants had previous interactions with the Occupational Health Nurse, the following positive views were shared by those participants that interacted with her:

- “Occupational Health Nurse took it up with management” (Walter, p. 3:3).
- “... addressed letter directly to the Occupational Health Nurse, she referred it to the people working with it, got immediate feedback ...” (Walter, p. 9:32-34).

- “... Occupational Health Nurse and EAP assisted from their side ... Occupational Health Nurse had good plans that she wanted to implement ... she helped me a lot and gave practical advice ... she also engaged with my wife on how to manage me ...” (Jack, pp. 4:13-18, 11:20-23).

No negative comments were made or experiences with the Occupational Health Nurse reported.

As with Human Resources and the Employee Assistance Section, the occupational health specialist should be part of the multi-disciplinary team, with roles and responsibilities spelled out in the incapacity management policy. In addition, as co-owners of the incapacity management processes, the occupational health specialists need to be trained on the incapacity management programme like all other role players (Higgins et al., 2012, p. 330; Mellor & Webster, 2013, p. 134; Pronk, 2014, pp. 44-45).

6.2.4.7 *Sub-theme 4.7: Unions*

The ODL institution preferred that incapacitated employees were represented by a union representative during the incapacity management process. Despite this preference, it was evident that certain employee participants opted not to involve the union:

- “No” (Abbey, p. 3:6, Hilda, p. 4:1, Greg, p. 4:14, Joana, p. 4:27).
- “... never involved ...” (Rose, p. 3:30).
- “Unions not at all” (Grace, p. 3:24).

A management participant indicated that in the cases he had managed, the union was not involved as, in his opinion, they managed the cases to the satisfaction of the affected employee:

- “No, maybe because we were dealing with it, without them becoming involved” (Kenny, p. 4:23-24).

An employee participant indicated that she wanted to involve the union, but they could not assist her:

- “Had at one stage ... told me honestly they do not have an expert on it ... afraid to advise me ...” (Zoe, p. 7:18-19).

A number of positive experiences on union involvement were reported:

- “... found more support from the union than my direct manager and supervisor ... was helped by the union in terms of sorting it out ... they are well informed ...” (Freda, pp. 2:30, 5:6, 5:14).
- “... they reasonable accommodated me ... often enquired on my well-being ... had often contact with the Occupational Health Nurse and discussed my situation” (Jack, p. 11:17-19).
- “... one case union was always in the background to support the employee ... I believe employee should have coverage ... if union is involved, there is more freeness to talk ...” (Clara, p. 4:32-34).

A participant had a negative experience when he attempted to involve the union. The extract below expressed his lived experience:

- “Nothing ... bad experience with them ... in meetings with management ... sat there and wait for an hour ... they do not pitch ... next day bump into them ... they request I must send all my documents ... few days thereafter ... again hear nothing ... go to the offices there on top ... still nothing ...” (Walter, p. 13:27-34).

Some of the participants expressed ambivalent views on the role of unions:

- “... if you got a history of being a union member, they will tend to support your case ... unions are useful, and they are useless, it depends who you are” (Juan, pp. 4:28-5:3).
- “... are involved ... unions have sometimes perception that you favour someone ...” (Eva, p. 5:1-4).

The verbatim evidence provides a variety of perceptions on the role of the unions in the managing of incapacity. From the literature it is evident that unions should be one of the members of the multi-disciplinary team. Furthermore, unions play an important role in the reasonable accommodation and/or return-to-work interventions of their members (Pomaki et. al., 2010, p. 22). This requires that their roles and responsibilities, like those of other role players, should be spelled out clearly, and the unions also need to be trained on their roles and responsibilities (Higgins et al., 2012, p. 330; Mellor & Webster, 2013, p. 134; Pronk, 2014, pp. 44-45).

6.2.4.8 Sub-theme 4.8: External service providers

The institution co-sourced an external wellness service provider for additional capacity with employee assistance. Furthermore, the incapacity risk benefits are insured with two external insurance companies. This sub-theme explored the participants' views on these external service providers and their role in the multi-disciplinary approach.

The following extracts provided a synopsis of the views on the co-sourced employee wellness service provider:

- “People do not trust internal EAP, prefer the external company ... carried me a lot ... made me calm ... if I have seen them more, could have assisted more ...” (Joana, p. 4:18-23).
- “... institution has this health and wellness thing ... I could see this woman ... think she is a psychologist ... it helped a lot ... I welcomed it, it was rather good ...” (Jack, p. 5:25-29).
- “... thankful for the external wellness service provider ... feels much quicker when we manage these cases ... also safer ... if HR or people in the organisation are involved, there is serious resistance ... not to judge HR ... people appreciate it more if external people is involved ... lucky external service provider was there ... could have an external view on the matter ...” (Eva, pp. 1:31-36, 4:29-30).
- “... what helps us is the external wellness service provider that is available to assist those people in the process ... should be utilised more ... most cases people do not use it effectively ...” (Greg, p. 3:22-25).

The following extracts reflect the participants’ views on the external risk benefit insurance companies and the medical professionals they engaged with when assessing the level of incapacity of the affected employee:

- “... one insurer was ok ... have an issue with the other insurer ... have been to hell and back with them ...” (Freda, p. 6:21-26).
- “... occupational therapist, the first one was a difficult person ... got impression she did not believe me ... was forced to do things I could not perform ... second occupational therapist was more approachable ...” (Abbey, pp. 1:16-19, 4:9-10).

One of the participants said that engagement between the insurer and a line manager might add value to the assessment of the condition of an incapacitated employee:

- “... no direct contact ... if I was contacted ... could have sketched the background and picture ... maybe that could have assisted the insurer ...” (Clara, p. 4:26-28).

It was also suggested that external service providers could be useful in assisting the line manager regarding the incapacity condition and how it might be accommodated:

- “We had a group to come and see us, to explain the situation to us ... we have a better understanding of her challenges” (Kenny, p. 5:20-25).

In addition, a proposal was made that an incapacitated employee should be provided with an opportunity to obtain an opinion from an external service provider:

- “Should we provide or would you like an option to go to a service provider that can assist you with your condition” (Ryan, p. 5:22-23).

The verbatim evidence shows that the co-sourced wellness service provider made a positive impact in most cases. Although some negative feedback was provided on the impact of the risk benefit service providers, the impression was created that their liaison with the incapacitated employee and line manager may add value to managing the employee’s incapacity. The literature confirms that should the employer not have the necessary expertise to investigate the extent of the incapacity within the institution, the employer must use external service providers such as medical specialist and occupational therapists (Grogan, 2014, p. 399; Letlonkane, 2015, p. 2; Standard Bank of South Africa v CCMA and others, 2007; Wylie v Standard Executors and Trustees, 2006). The

external service providers' roles and responsibilities should also be described in the incapacity management policy (Mellor & Webster, 2013, p. 134; Pronk, 2014, pp. 44-45).

6.3 DATA FROM DOCUMENTS

To address the overall research question of what elements should comprise an effective and comprehensive incapacity management framework suitable for an ODL institution, and to ensure that incapacity management is done fairly and equitably, a number of documents were analysed. The documents selected either had a direct or should have had a direct impact on incapacity management at the institution. The documents were assessed for compliance with policy, procedural and juristic imperatives (where applicable), as evidenced by the literature. The analysis also sought to add value to the sub research questions of how incapacity management is conceptualised in the ODL institution, what incapacity management practices are implemented, compliance to the regulatory obligations regarding incapacity management, and recommendations that can be made to improve the existing policies.

The following documents were analysed and are discussed below:

- Employee Disciplinary Code (University of South Africa, 2013)
- Policy on Leave (University of South Africa, 2014a)
- University of South Africa's Integrated Health and Wellness Framework (University of South Africa, 2014d)
- Procedure for the Management of Ill Health (University of South Africa, 2014e)
- Policy on the Employee Assistance Programme (EAP) (University of South Africa 2015c)

6.3.1 Employee Disciplinary Code

The purpose of the Employee Disciplinary Code is to provide certainty and clarity about the content and consequences of misconduct, and the efficient and fair application of discipline (University of South Africa, 2013, p. 2). The Employee Disciplinary Code stipulates that cases of incapacity that do not result from fault (intent or negligence) on the part of the employee cannot be dealt with in terms of the Employee Disciplinary Code (University of South Africa, 2013, p. 4). This means that incapacity due to physical or mental illness cannot be dealt with via the ODL institution's Employee Disciplinary Code.

The literature reveals that a South African employer has several legal obligations when dealing with incapacity due to ill health. Firstly, it requires the employer to investigate the incapacity and secondly, the employer should consider reasonable accommodation of the incapacity (Grogan, 2014, pp.394-395, 397; Republic of South Africa, 1995, Schedule 8, s 10(1)). Thirdly, the employee should be able to present evidence on the incapacity condition (Nehawu obo Lucas v Department of Health Western Cape, 2004; Republic of South Africa, 1995, Schedule 8, s 10(2)). In the fourth place, proper consultation with the employee and involvement of professional medical assistance, if necessary, should take place (Grogan, 2014, p. 399; Letlonkane, 2015, p. 2; Standard Bank of South Africa v CCMA and others, 2007; Wylie v Standard Executors and Trustees, 2006).

If compared to the obligations discussed above, it is evident that the ODL institution's Employee Disciplinary Code does not provide for incapacity management at all.

6.3.2 Policy on Leave

The ODL institution's Policy on Leave provides for the following sick (temporary incapacity) leave in a three-year cycle: 68 working days with full remuneration,

68 working days with half remuneration and 68 days with no remuneration (University of South Africa, 2014a).

The literature reviewed suggests that an incapacity management policy should have clear and detailed rules and standards (Ashley et al., 2017, p. 22; Haafkens et al., 2011, p. 113; Kristman et al., 2017, p. 124; Mogobe, 2011, p. 83; Pomaki et al., 2010, p. 22). The policy should also stipulate the roles and responsibilities of the multiple role players and provide for the integration of various programmes, such as health, safety and wellness (Mellor & Webster, 2013, p. 133; Pronk, 2014, p. 44). The policy should provide for a return-to-work strategy, including a compulsory return-to-work interview (Gensby et al., 2014, p. 235; Mogobe, 2011, p. 83).

The Policy on Leave only deals with various leave types, including sick (temporary incapacity) leave. It does not provide for sick (incapacity) leave for periods exceeding the sick leave provision, nor guidance on how to manage an employee's prolonged ill health that may affect the operations of the ODL institution. The Policy on Leave provides a limited explanation on the role and responsibility of the manager and the employee and no integration with any other programmes exists nor is a return-to-work strategy included.

6.3.3 Unisa's Integrated Health and Wellness Framework

The draft Integrated Health and Wellness Framework (University of South Africa, 2014d, p. 3) seeks to support the ODL institution's goal of promoting employees' optimal wellness of while being cognisant of the relevant legislation, risks and compliance. The Framework (University of South Africa, 2014d, p. 3) provides a theoretical and philosophical explanation of the wellness of employees. It lists certain departments whose services need to be coordinated to provide an integrated approach to health and wellness at the ODL institution. It then describes the roles and responsibilities of various coordinating committees (University of South Africa, 2014d, pp. 10-12).

An institutional policy should have clear and detailed rules and standards, stipulate the roles and responsibilities of the multiple role players, such as the employer (represented by the line manager), the incapacitated employee, the multi-disciplinary health service providers, co-employees and organised labour, and provide for the integration of various programmes, such as health, safety and wellness (Ashley et al., 2017, p. 22; Haafkens et al., 2011, p. 113; Kristman et al., 2017, p. 124; Mellor & Webster, 2013, p. 134; Mogobe, 2011, p. 83; Pomaki et al., 2010, p. 22; Pronk, 2014, pp. 44-45).

The Framework (University of South Africa, 2014d) does not elaborate on detailed incapacity management practices that can be implemented by the institution. It does not provide guidance on how an employee's incapacity should be managed or accommodated. The Framework also lacks detail on the roles and responsibilities of the various role players.

6.3.4 Procedure for the Management of Ill Health

The Procedure for the Management of Ill Health provides for multiple role players such as the incapacitated employee, union representative, line manager, occupational health representative, Human Resources, employee wellness representative and employee relations specialist. The Procedure also defines some elementary processes as well as duties for some of the role players, such as line managers, employees and Human Resources (University of South Africa, 2014e).

From the literature it is evident that an incapacity management policy requires clear processes, definite roles and responsibilities for the multiple role players and the integration of various programmes (Ashley et al., 2017, p. 22; Haafkens et al., 2011, p. 113; Kristman et al., 2017, p. 124; Mellor & Webster, 2013, p. 134; Mogobe, 2011, p. 83; Pomaki et al., 2010, p. 22; Pronk, 2014, pp. 44-45).

Although the Procedure for the Management of Ill Health provides for multiple role players, it lacks in-depth guidance on processes such as reasonable accommodation practices and the integration of various wellness programmes. The procedure does not provide for all the role players of the multi-disciplinary team, nor are the roles and responsibilities of the role players described in the procedure well defined.

6.3.5 Policy on the Employee Assistance Programme (EAP)

The ODL institution's Policy on the Employee Assistance Programme (University of South Africa, 2015c) recognises that the ODL institution's employees are its most valuable assets. The Policy aims to provide a work-based intervention programme to improve the employees' quality of life of by identifying and resolving both the work and personal problems that may adversely affect an employee's work performance. It also attempts to ensure employee wellness and workplace effectiveness. The Policy on the Employee Assistance Programme (University of South Africa, 2015c) provides a theoretical and philosophical explanation of the wellness of employees.

A policy to manage incapacity, according to the literature, requires clear processes to be followed and stipulates the roles and responsibilities of the multiple role players (Ashley et al., 2017, p. 22; Haafkens et al., 2011, p. 113; Kristman et al., 2017, p. 124; Mellor & Webster, 2013, p. 134; Mogobe, 2011, p. 83; Pomaki et al., 2010, p. 22; Pronk, 2014, pp. 44-45). The policy should also provide for the integration of various programmes, such as health, safety and wellness, and should also provide for a return-to-work strategy, including a compulsory return-to-work interview (Gensby et al., 2014, p. 235; Mellor & Webster, 2013, p. 133; Mogobe, 2011, p. 83; Pronk, 2014, p. 44).

The Policy on the Employee Assistance Programme does not provide in-depth detailed information on incapacity management processes to be followed or on the roles and duties of the multiple role players. It does not provide guidance on how an employee's ill health or incapacity should be managed or accommodated.

6.4 INTEGRATION OF FINDINGS

Although the literature presupposes a healthy institutional culture to ensure well-managed incapacity in the workplace (Dickson-Swift et al., 2014, p. 146; Harder et al., 2014, pp. 275-283; Higgins et al., 2012, p. 330; Mellor & Webster, 2013, p. 134; Pronk, 2014, p. 44), the findings from the collected data indicate that the current institutional culture is perceived as negative. In order to address this perception, the executive management should take the lead by ensuring that a proper incapacity management plan is in place. This plan should assign accountability to management on all levels (Dickson-Swift et al., 2014, p. 146; Harder et al., 2014, pp. 275-283; Higgins et al., 2012, p. 330; Mellor & Webster, 2013, p. 134; Pronk, 2014, p. 44).

One of the key elements to be incorporated in an incapacity management plan is an incapacity management policy and procedures. The participants expressed different views on whether an incapacity management policy and procedures exist or not. Furthermore, the participants had displayed no common understanding of the purpose and content of the incapacity management policy, associated processes, and the expectations on the management of the incapacity, resulting in opposing views from management and affected employee participants. The policy and procedures need to spell out the roles, responsibilities and authority of each of the multiple role players (Ashley et al., 2017, p. 22; Haafkens et al., 2011, p. 113; Kristman et al., 2017, p. 124; Mellor & Webster, 2013, p. 134; Mogobe, 2011, p. 83; Pomaki et al., 2010, p. 22; Pronk, 2014, pp. 44-45).

In addition, all the management and employee participants indicated that they had a poor understanding of or insight into the nature of the incapacity condition as well as the related reasonable accommodation practices that could be applied. Management and employee participants were of the opinion that they would prefer to be consulted throughout the incapacity management process.

It can be deduced that the views expressed in the interviews are a direct consequence of the incomplete or limited provisions for incapacity management in the documents that were selected for analysis. The Employee Disciplinary Code does not provide for incapacity management at all (University of South Africa, 2013). From a generic perspective, the other documents analysed have limited provisions on incapacity management. They either lack details on the roles and responsibilities of the various role players, and do not provide in-depth guidance on reasonable accommodation practices and consultative processes (University of South Africa, 2014a, 2014d, 2014e, 2015c).

The participants unanimously agreed that training will address several of the challenges associated with incapacity management. Matters that should be covered include incapacity management policy and processes, duties and responsibilities of role players, and reasonable accommodation interventions (Bezuidenhout, 2015, p. 13; Lockwood, Henderson & Thornicroft, 2012, p. 183; Mellor & Webster, 2013, p. 134; Mishra & Inda, 2014, p. 90; Mogobe, 2011, p. 83; Pronk, 2014, pp. 44-45; Rhodes University, 2014, pp. 3, 7; Setati, 2014, p. 161; Stellenbosch University, 2017, p. 1; Thompson & Bates, 2009, pp. 124-125; University of the Witwatersrand, 2015, p. 13; Yusoff & Khan, 2013, p. 95).

From both the empirical findings and the existing literature, it emerged that incapacity management requires a multi-disciplinary approach with planned, structured, coordinated and close communication between the incapacitated employees, employers (represented by the line managers), trade unions,

healthcare service providers, co-employees and any other relevant role players (Pomaki et. al., 2010, p. 22).

6.5 SUMMARY OF RESEARCH FINDINGS

The central research question was what elements should comprise an effective and comprehensive incapacity management framework suitable for an ODL institution to ensure that incapacity management is done fairly and equitably. It is evident from the above empirical findings and literature (as discussed earlier in chapters 2, 3 and 4) that a strategic, sophisticated and holistic understanding of incapacity in the workplace is required. The ODL institution should have an incapacity management framework that supports managers and incapacitated employees to enhance global competitiveness, reduce or control the costs associated with incapacity, and protect the employability of employees.

To protect healthy employees' employability and engagement, the incapacity management framework should provide for a policy and procedures on incapacity management that employees will perceive as just. Similarly, the engagement process and the resultant decision(s), based on the incapacity management policy and procedures, should be perceived to be fair, and should respond to the first sub-question on how incapacity should be managed to ensure that organisational justice is achieved (discussed earlier in sections 2.2, 6.2.2.1 and 6.2.2.2).

Sub-question 2 dealt with the conceptualisation of incapacity in the workplace and the available incapacity management practices in a workplace. From a literature perspective, the concept of incapacity due to illness is not an exclusively biomedical condition, but it is a complex phenomenon that includes the biological, psychological, and sociological factors and the emotions associated with these factors that employees experience within the workplace. Incapacity does not only have an impact on individual employees, but may also affects the employer, line managers, client services and co-employees. The

literature on the conceptualisation of incapacity was discussed in detail in chapter 2. Section 6.2.2.3 of the empirical findings provides the participants' views on the understanding of the incapacity condition in the ODL institution and section 6.2.3.3 describes the impact of incapacity on the ODL workplace. In terms of the incapacity management practices, section 2.5 elaborates on the practices as contained in the literature. These practices were empirically confirmed by the participants' responses presented in this chapter.

Chapter 3, in response to sub-question 3, deals with the regulatory obligations of an employer in managing incapacity. The proposed incapacity management framework needs to comply with the minimum requirements contained in the legislation and case law discussed to ensure that incapacity is managed in a fair and just manner.

Sub-question 4 deals with reasonable accommodation employees' incapacity. Sections 2.5.2.5 and 2.5.2.6 deal extensively with the literature review on preventative and rehabilitative, reasonable accommodation practices. Section 6.3 provides an empirical perspective on reasonable accommodation. It is evident that the incapacity management policy should describe reasonable accommodation (both preventative and rehabilitative) intervention to assist employees while at work and when returning to work after a period of incapacity. The policy should also allow a manager autonomy in the design and provision of a tailored-made reasonable accommodation for a specific incapacity condition.

In response to sub-question 5 the real-life experiences of the participants (both the affected employees and managers) are well documented in this chapter.

The responses to sub-questions 6 and 7 regarding the acceptable incapacity management practices that the ODL institution may put in place and the recommendations to be made to the ODL institution are dealt with in chapters 7 and 8 respectively.

In summary thus, the research confirmed that the ODL institution needs an incapacity management framework. The framework should have the full support of management, be sufficiently resourced, requires a detailed policy and procedures that spells out the roles and responsibilities of all role players, and allows for applicable reasonable accommodation practices. Furthermore, all role players should be aware of and educated on the framework.

In chapter 7 a conceptual framework for the ODL institution to support the incapacity management practices, is proposed.

6.6 SUMMARY OF CHAPTER

The participants' lived experiences with regards to their perceptions of incapacity management practices in the ODL institution are presented, analysed and interpreted in this chapter. The literature review and extracts from the semi-structured interviews were used to support the findings. It was found that the phenomenon of incapacity management, as contained in the literature and experienced by the participants, was complex and multifaceted.

Chapter 7 presents the proposed incapacity management framework for the ODL institution.

CHAPTER 7: INCAPACITY MANAGEMENT FRAMEWORK FOR THE ODL INSTITUTION

We have the duty of formulating, of summarizing, and of communicating our conclusions, in intelligible form, in recognition of the right of other free minds to utilize them in making their own decisions.

Ronald Fisher

7.1 INTRODUCTION

The central research question of the research was what elements should comprise an effective and comprehensive incapacity management framework suitable for an ODL institution in order to ensure that incapacity management is done fairly and equitably. From the synthesis of the literature, as summarised earlier in section 4.7, it is apparent that a fair and just incapacity management framework requires four main pillars, namely a supportive institutional culture, an incapacity management policy and procedures, appropriate reasonable accommodation practices, and a multi-disciplinary team approach.

In chapter 6 it was found that the management of incapacity in the ODL institution is complicated and multifaceted. The empirical evidence depicts four themes, namely a supportive institutional culture, various challenges regarding the management of incapacity, reasonable accommodation, and a multi-disciplinary approach.

Chapter 7 presents the proposed incapacity management framework for the ODL institution based on the literature and empirical findings. The chapter elaborates on the purpose and design of the incapacity management framework. The meaning of and interaction between the parts of the framework are also presented in the chapter.

The structure and the content of chapter 7 are depicted diagrammatically in Figure 7.1.

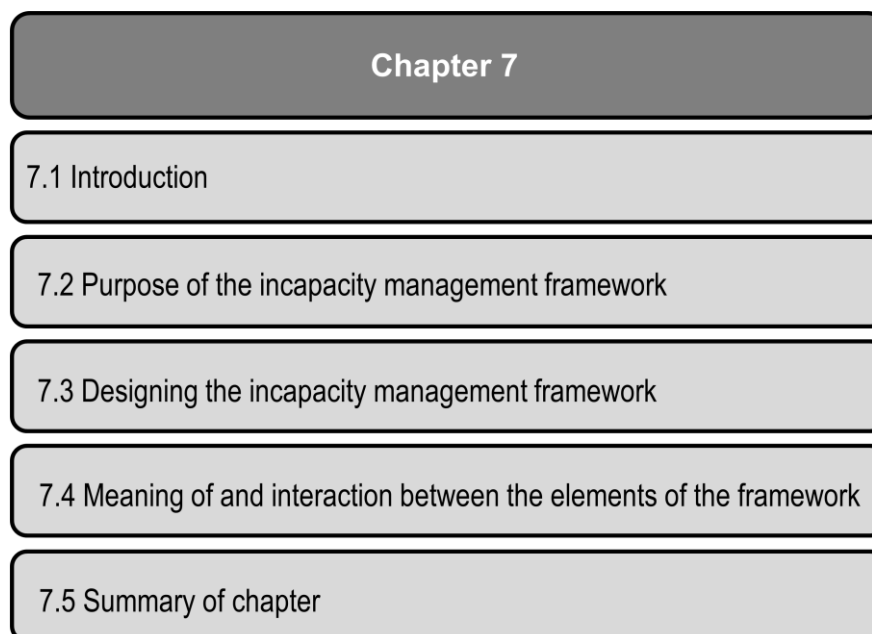


Figure 7.1: Conceptual framework of chapter 7 (own compilation)

7.2 PURPOSE OF THE INCAPACITY MANAGEMENT FRAMEWORK

As established in chapter 1, the global higher education landscape is, due to various challenges, in a constant process of transformation. To remain competitive, relevant, and sustainable, higher education institutions (HEIs), need to adjust to these challenges. Higher education employees are at the heart of this continuous transformation, and the literature indicates that the continuous institutional changes have a negative impact on employees' capacity.

The research literature (chapter 2) shows that having an incapacity management framework providing for the key elements of incapacity management practices (see section 2.5) benefits both the employer and the affected employee, in that it ensures healthy employees that assist the employer to remain competitive and sustainable. This is ensured when

employees perceive the incapacity management policy and procedures, as well as the application thereof, as fair, and hence contributing to procedural and interactional justice (see section 2.2).

South African legislation does not provide for a detailed incapacity management framework giving employers and employees clear guidance on the prescribed actions, specifically regarding the accommodation of the affected employee in the workplace (see section 3.4). Similarly, the ODL institution does not have a formally negotiated and approved policy and procedures dealing with the management of incapacity due to ill health, reasonable accommodation for incapacity, or fair termination of employment due to incapacity resulting from illness (see section 3.5). This resulted in a knowledge gap on how incapacity due to ill health should be holistically managed.

The empirical phase of the study (chapter 6) encapsulated by the participants' views and lived experiences, shows a number of challenges at the ODL institution regarding the general managing of incapacity, including but not limited to aspects such as policy, procedures, reasonable accommodation, communication, and training on incapacity management.

The purpose of the proposed incapacity management framework is thus to serve as a frame of reference for the multi-disciplinary role players, defining their duties and obligations in managing and reasonably accommodating incapacitated employees in order to address the above-mentioned issues presented in the literature and the empirical phase of the study.

7.3 DESIGNING AN INCAPACITY MANAGEMENT FRAMEWORK FOR THE ODL INSTITUTION

The central research question guided the design of the proposed incapacity management framework, including, for example, the elements that should comprise an effective and comprehensive incapacity management framework

suitable for an ODL institution to ensure that incapacity management is done fairly and equitably. Apart from the above, the outcome and findings of the literature review and empirical evidence were incorporated in the proposed incapacity management framework.

The literature review confirms that a supportive institutional culture owing to the active championing of all levels of management is a crucial element in managing incapacity. This must be supported by a well-communicated policy and procedures with sufficiently resourced support programmes. Furthermore, the duties and responsibilities of the multiple role players and the various reasonable accommodation practices should be spelled out in the policy and procedures. All role players should also be trained on the incapacity management regime (Arends et al., 2014, p. 198; Bezuidenhout, 2015, p. 13; Black & Frost, 2011, p. 48; De Vroome et al., 2015, p. 683; Dewa et al., 2016, pp. 8-9; Dickson-Swift et al., 2014, pp. 146-148; Gensby et al., 2014, p. 235; Haafkens et al., 2011, p. 113; Harder et al., 2014, pp. 275-283; Higgins et al., 2012, p. 330; Mellor & Webster, 2013, pp. 133-134; Mishra & Inda, 2014, p. 90; Mogobe, 2011, p. 83; Poalses & Bezuidenhout, 2018, p. 186; Pomaki et al., 2010, p. 22; Pronk, 2014, pp. 44-45; Setati, 2014, p. 161; Yusoff & Khan, 2013, p. 95).

Four themes, as discussed in chapter 6, supported by the literature, emerged from the empirical data. Firstly, the institutional culture, although perceived as negative, as well as the attitude of the line managers, were raised by the participants. Secondly, the knowledge and understanding of the incapacity management policy and procedures, understanding of the incapacity condition, and a lack of proper communication and consultation among the key role players were also identified. The third theme that emerged was that the reasonable accommodation practices needed to be defined in the policy and that a necessity for additional or better applied reasonable accommodations existed. The last theme was that incapacity management required a multi-disciplinary approach.

Integrating the outcome of the literature review in terms of the four pillars (see section 4.7) and the four empirical themes (see Table 6.2), I concluded that to respond to the central research question, a proposed incapacity management framework for the ODL institution should consist of three main elements:

- Overarching **enabling conditions** - this entails a supportive institutional culture, caring leadership, open and transparent communication, and trained and empowered role players.
- **Policy** - the policy should identify the role players and their roles and responsibilities. The policy should also elaborate on reasonable accommodation practices.
- **Procedure** - the procedure should explain the detailed stages to be followed to ensure a fair and just process when managing employees' incapacity.

The policy and procedures should also comply with the international conventions, South African legislation (as discussed in chapter 3), and should be designed in such a way that it promotes organisational justice, especially procedural and interactional justice (section 2.2).

The incapacity management framework would serve as a reference for multi-disciplinary role players when engaging in an incapacity case (due to ill health), at the ODL institution. The graphic presentation of the proposed incapacity management framework for the ODL institution is reflected in Figure 7.2.

A narrative describing the meaning of and interaction between the elements to elaborate on the structure of the proposed incapacity management framework follows.

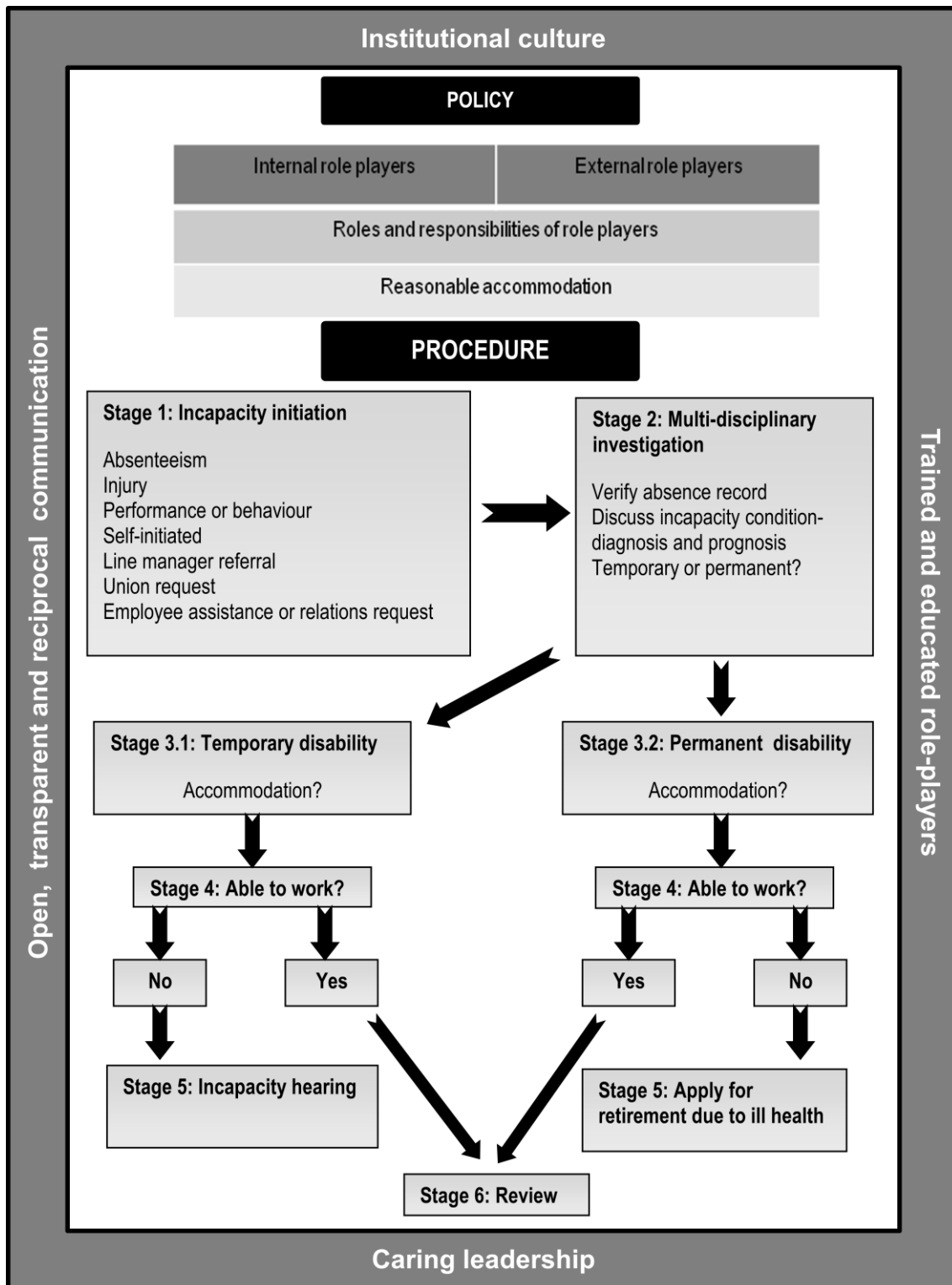


Figure 7.2 Proposed incapacity management framework for the ODL institution (own compilation)

7.4 MEANING OF AND INTERACTION BETWEEN THE ELEMENTS OF THE FRAMEWORK

The three main elements of the incapacity management framework: enabling conditions, policy and procedure, and their interconnectedness are discussed below.

7.4.1 Element 1: Enabling conditions

Incapacity management will only be effective if certain enabling conditions are introduced. It requires supportive **institutional culture and caring leadership** wherein employees will freely disclose their incapacity, feel supported and influenced in a positive manner (Lewis, 2016, p. 103; Melnyk et al., 2016, p. 309; Tooma & Beach, 2016, p. 499; Von Schrader et al., 2014, p. 255). This can be created through the active support of executive management, a sufficiently resourced incapacity management programme, and corporate accountability for incapacity management on all hierarchical levels of the institution (Gensby et al., 2014, p. 235; Harder et al., 2014, pp. 275-283; Higgins et al., 2012, p. 330; Mellor & Webster, 2013, p. 133; Pronk, 2014, p. 44). From an empirical point of view, it was even suggested that incapacity management should be included as a key performance area for managers in order to ensure accountability (Juan, p. 5:16-17). Caring leadership requires that a manager should provide a supporting, sympathetic and compassionate approach (Nehawu and another v South African Institute for Medical Research, 1997; SAMWU obo Solomons v City of Cape Town, 2009).

Training and education on incapacity management is another enabling condition (Rhodes University, 2014, pp. 3, 7; Stellenbosch University, 2017, p. 1; Thompson & Bates, 2009, pp. 124-125; University of the Witwatersrand, 2015, p. 13). In practice it would require that all role players (managers, employees, unions, co-employees, human resource practitioners and health service providers) are trained and educated on the elements of the

framework (Arends et al., 2014, p. 198; Bezuidenhout, 2015, p. 13; Mellor & Webster, 2013, p. 134; Mishra & Inda, 2014, p. 90; Mogobe, 2011, p. 83; Pronk, 2014, pp. 44-45; Setati, 2014, p. 161). A variety of modalities for incapacity management training exist, such as general training, training during induction of new employees, and regular refresher sessions for serving employees. The need for education may even be addressed in a booklet or framework documenting the various incapacity management processes.

The fourth enabling condition is the continuous, **open, transparent and reciprocal communication** or consultation throughout the incapacity management process. This requires consultation with the incapacitated employee to establish the nature of the incapacity and how it interferes with him or her performing essential job functions, what intervention is needed to accommodate the employee's incapacity condition, and regular review or feedback, until the employee is in a position to fully perform his or her job (Dickson-Swift et al., 2014, p. 147; Dorris Maharaj v Northern Health, 2017; EEOC v Kohl's Department Stores, Inc., 2014; EEOC v LHC Group, Inc., 2014; Jacobs v N.C. Admin Office of the Courts, 2015; Rorrer v City of Stow, 2014; Thompson & Bates, 2009, pp. 124-125; Stellenbosch University, 2017, p. 7; University of the Witwatersrand, 2015, pp. 11, 13, 17).

7.4.2 Element 2: Policy

The enabling conditions must be founded on an incapacity management policy with clear and detailed rules and standards that are applied fairly and equitably. The policy should provide for the integration of various programmes, such as health, safety and wellness, and also provide for a return-to-work strategy including a compulsory return-to-work interview (Gensby et al., 2014, p. 235; Haafkens et al., 2011, p. 113; Mellor & Webster, 2013, p. 133; Mishra & Inda, 2014, p. 90; Mogobe, 2011, p. 83; Pomaki et al., 2010, p. 22; Pronk, 2014, p. 44).

The policy ought to identify the **internal and external role players** and elucidate their **roles and responsibilities** (Mellor & Webster, 2013, p. 134; Pronk, 2014, pp. 44-45). Internal role players are the employees, employee representatives (union or fellow employees), line management, co-employees, relevant Human Resources sections (benefits, employee relations and wellness) and occupational health practitioners. The roles and responsibilities of the internal role players may include the following:

- Employee – ensures that the employee sets boundaries between work and private life. The employee has the co-responsibility to comply with the occupational health and safety requirements of his or her specific occupation and workplace, e.g. Print Production, Protection Services, and to timeously engage with the line manager in the event of incapacity.
- Union representative – acts responsibly on behalf of the employee represented during the incapacity management process.
- Line management – ensures that the workplace complies with occupational health and safety requirements. As first point of contact with the employee, the line manager should pro-actively engage with the employee at any sign of incapacity. Communication with the employee throughout the incapacity management process is key and reasonable accommodation for an incapacitated employee should be provided.
- Co-employees – ensure that they understand the incapacity of the employee (within ethical boundaries) and provide support to the employee on the agreed reasonable accommodation.
- Human Resources --ensures overall compliance to occupational health and safety requirements. Human Resources should train and educate all role players on the incapacity management policy and procedure, and advise and assist employees, union representatives and line managers with incapacity cases.
- Occupational health practitioners – support Human Resources in complying with occupational health and safety requirements, and provide specialist advice in terms of occupational illnesses.

External service providers may include the companies that insure the incapacity risk benefits, employee assistance practitioners (when the service is co- or outsourced), independent health professionals (when applicable). When their services are procured, external service providers' roles and responsibilities should be outlined in a service level agreement.

The policy must also explicate the employer's obligation to provide **reasonable accommodation**, the possible types of reasonable accommodation, and the line management's authority to provide such accommodation (Chow, 2012, p. 60; Dwosken & Squire, 2013, pp. 5-15, 21-22; Equality and Human Rights Commission, 2014, pp. 59-62; Gold & Shuman, 2009, pp. 226-228; Hickox & Guzman, 2014, p. 439; McDowell & Fossey, 2015, pp. 197-200; Mellor & Webster, 2013, p. 134; Montagna, 2014; Parry, 2011, pp. 188-193; Pronk, 2014, pp. 44-45; Republic of South Africa, 1995, Schedule 8, s 10; Republic of South Africa, 1998, s 15(2)(c); Republic of South Africa, 2002, p. 20; Reynolds, 2015, pp. 99-101; Social Firms Australia, 2010, p. 10; United States of America, 1990, s 12111(9)). In addition, the policy should provide for guidelines on when an accommodation will be regarded as unreasonable or cause undue hardship to the employer, which is not limited to financial costs, but may include factors such as:

- disruption to working arrangements
- too many demands in the workplace
- deterioration in the quality or nature of services
- a negative impact on co-employees or customers
- health and safety risks (Australian Government, 1992, s 11; Lawson, 2012, p. 848; Ngwenya & Pretorius, 2007, p. 768; Social Firms Australia, 2010, p. 10, United States of America, 1990, s 12111(10))

7.4.3 Element 3: Procedure

The incapacity management policy requires a detailed procedure. The procedure must explain the various stages of the incapacity management process in a simple, clear manner. The recommended six stages of the incapacity management process are discussed in detail below.

The initiation stage (**stage 1**), might be triggered by various events. The most common event is absenteeism. The employee, who might be off sick on a regular basis might request for an incapacity intervention. Alternatively, it may be that a health professional may view the employee unfit to work and either prescribes short-term incapacity or temporary incapacity leave, or may even view the employee as permanently incapacitated. Furthermore, an injury might have caused the employee's incapacity. Another manner of initiating the procedure might be that a line manager refers the employee to Human Resources based on his or her absenteeism or (poor) performance. After analysing the employee's absenteeism patterns, Human Resources might also intervene. Similarly, Employee Assistance or Employee Relations, might, as a result of counselling, realise that a capacity concern might exist. The last trigger might be when the union representing the employee requests for an incapacity intervention.

After the initiation of the procedure, **stage 2** will be initiated whereby the multi-disciplinary role players, such as the employee, union representative, line management, relevant human resources representatives and the occupational health practitioner meet. The purpose of the meeting will be to verify the employee's absenteeism record and to consult with the incapacitated employee to establish the nature of the incapacity and how it interferes with the performing of his/her essential job functions (Gold & Shuman, 2009, p. 213; Grogan, 2014, p. 399; Lawson, 2012, p. 848; Republic of South Africa, 2015b, s 6.6, 11.2). This requires a discussion of the diagnosis and prognosis of the condition, taking cognisance of privacy and confidentiality. In

this discussion, it should also be determined whether the incapacity condition is temporary or permanent (Republic of South Africa, 1995, Schedule 8, s 10; Republic of South Africa, 1998, s 15(2)(c)).

Stage 3 then necessitates that the multi-disciplinary team, which includes the employee, discusses and explores what reasonable intervention may be necessary to accommodate the employee. The team then makes a collaborative decision on a reasonable accommodation intervention that will allow the employee to operate fully, or that will mitigate the impact of the employee's condition and serve the employer's needs (Coetzer et al., 2002, pp. 69-70; Gold & Shuman, 2009, p. 213; Grogan, 2014, p. 399; Lawson, 2012, p. 848; Republic of South Africa, 1995, Schedule 8, s 10; Republic of South Africa, 1998, s 15(2)(c); Republic of South Africa, 2015b, s 6.6,11.2). The reasonable accommodation might be sick leave, adapted working hours or duties, special equipment, or even an alternative position. The multi-disciplinary team should take the following into consideration when determining then reasonableness of the accommodation (Equality and Human Rights Commission, 2014, pp. 57-58; Gold & Shuman, 2009, p. 213; Republic of South Africa, 2002, p. 13):

- nature and essential functions of the job
- the specific physical or mental illness
- the working environment
- potential adjustments
- how effective the adjustments will be in avoiding the disadvantage that the incapacitated employee might otherwise experience
- its practicality
- the cost
- the institution's resources and size
- the availability of financial support

Within an agreed period, the multi-disciplinary team will do a follow-up assessment to determine whether the reasonable accommodation supported the employee to perform his or her contractual obligations or not (**stage 4**). If this is not the case, **stage 5** would take effect.

For an employee with a temporary incapacity, **stage 5** would be the invoking of an incapacity hearing that may lead to the termination of the employee's employment contract (Republic of South Africa, 1995, s 188(1)(a), 188(1)(b), 192(2)). In case of a permanent incapacity, the employee would be advised to apply for retirement due to ill health to be considered by the insurer.

If the incapacitated employee (temporary or permanent) was able to perform his or her duties as a result of the reasonable accommodation intervention, a review of the situation should take place after an agreed period of time (**stage 6**). The review would focus on the continued necessity of the reasonable accommodation or the modification thereof.

7.5 SUMMARY OF CHAPTER

The chapter presents the proposed incapacity management framework for the ODL institution. The purpose and design of the framework is to serve as a frame of reference for the multi-disciplinary role players. The framework provides for three elements, an enabling environment, an incapacity management policy, and a procedure providing for a staged approach. The enabling environment requires a supportive institutional culture with caring leaders, trained and empowered role players and open and transparent communication. The policy should provide for internal and external role players, their roles and responsibilities, and reasonable accommodation interventions that may be implemented. The procedure provides for six stages, namely the initiation stage, multi-disciplinary team investigation, determining of the nature of the incapacity, reasonable accommodation, alternative options if the accommodation is not

feasible, and a review process. The meaning of and the interconnectedness of the elements are also discussed.

In chapter 8 the focus is on conclusions, limitations and recommendations.

CHAPTER 8: RESEARCH CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

Keep right on to the end of the road.

Harry Lauder

8.1 INTRODUCTION

In chapter 7 a proposed incapacity management framework to support the multi-disciplinary role players in order to ensure a holistic approach to incapacity management in the ODL institution is presented. The framework presupposes three main elements to ensure appropriate management of incapacity, namely an enabling institutional culture, a policy and procedures.

Chapter 8 concludes the study. The chapter provides concluding observations on the overview of the research and the findings. The research limitations and contribution of the study are also highlighted. The chapter concludes with a discussion on recommendations for the ODL institution, human resource practitioners in similar contexts, and possible future research.

The structure and content of chapter 8 are depicted diagrammatically in Figure 8.1.

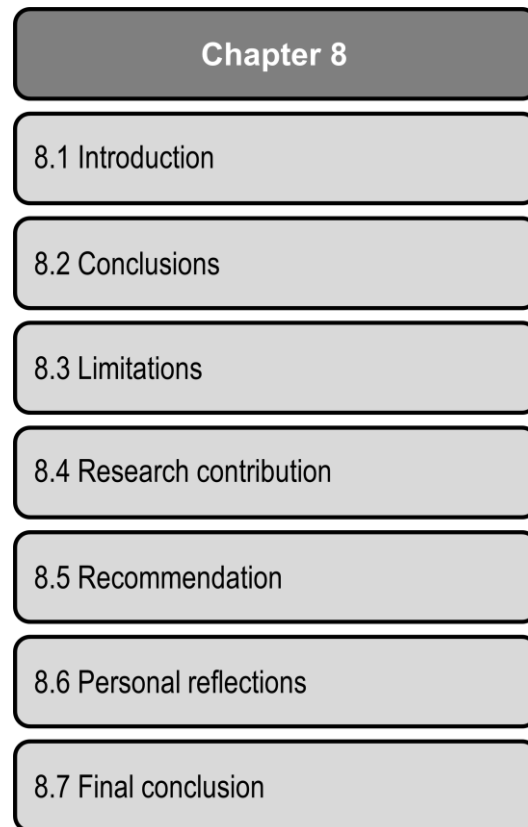


Figure 8.1 Conceptual framework of chapter 8 (own compilation)

8.2 CONCLUSIONS

The following section focuses on the conclusions, based on the literature and empirical studies in terms of the research questions as set out in chapter 1. The central research question was to establish what elements should comprise an effective and comprehensive incapacity management framework suitable for an ODL institution in order to ensure that incapacity management is done fairly and equitably. Conclusions were drawn on each of the specific research sub-questions.

8.2.1 Conclusions relating to the literature review

Response to the **first sub-question**, namely the achievement of organisational justice in relation to incapacity management, is presented earlier in chapter 2. The following conclusions were drawn: organisational justice is categorised into three main components: distributive, procedural and interactional justice. When people perceive the outcome of decisions as equitable and fair, and they perceive that they are treated with respect and sensitivity, and the rationale for the decisions is explained, the institution benefits. Such positive perceptions lead to increased job satisfaction, improved relationships between line managers and employees, and also encourage organisational citizenship behaviour (Coetzee, 2004, p. 4.6; Colquitt, 2001, p. 386; Cropanzano & Schminke, 2001, pp. 144, 149; Folger & Cropanzano, 1998, p. 26). Perceived organisational justice is also positively associated with employee well-being (Ajala & Bolarinwa, 2015, pp. 57, 65; Kivimäki et al., 2003, p. 31; Lawson et al., 2009, p. 230; Le et al., 2016, p. 958). It is therefore important for an institution to ensure organisational justice to employees, that policies and procedures are designed to support fair workplace decisions, and just interactions among the role players of incapacity management. This will result in improved engagement and employees' retention and well-being (Ajala & Bolarinwa, 2015, pp. 57, 67; Ghosh et al., 2014, p. 641; Ledimo & Hlongwane, 2014, p. 10).

The **second sub-question** is also answered in chapter 2. The question deals with the conceptualisation of incapacity and incapacity management practices in the workplace. From a literature perspective, the concept of incapacity due to illness is not an exclusively biomedical condition, but it is a complex phenomenon that includes the biological, psychological, and sociological factors and the emotions associated with these factors that employees experience within the workplace. Incapacity does not only have an impact on individual employees, but may also affects the employer, line managers, client services and co-employees (Bramwell et al., 2016; De Vroome et al., 2015, p. 675; Dunstan & MacEachan, 2013, pp. 50-51; Du Preez, 2010, p. 14; Mishra &

Inda, 2014, p. 72; Mogobe, 2011, p. 26; Thompson & Bates, 2009, p. 119-120; Tooma & Beach, 2016, pp. 497-498; University of South Africa, 2014d, p. 5; Woods, 2010, pp. 172-176; World Health Organisation, 2002, p. 2). Incapacity management practices require the full support of the management of the institution and should be sufficiently resourced (Gensby et al., 2014, p. 235; Harder et al., 2014, pp. 275-283; Higgins et al., 2012, p. 330; Mellor & Webster, 2013, p. 133; Pronk, 2014, p. 44). The incapacity management practices should be documented in a policy and procedure. The policy should provide for clarity and detail on the roles, responsibilities and training of the multiple role players (line manager, incapacitated employee, the multi-disciplinary health service providers, co-employees, and the unions). It is important that the policy is accessible and is well communicated to ensure that employees are familiar with the policy (Gensby et al., 2014, p. 235; Haafkens et al., 2011, p. 113; Mellor & Webster, 2013, pp. 133-134; Mishra & Inda, 2014, p. 90; Mogobe, 2011, p. 83; Pomaki et al., 2010, p. 22; Pronk, 2014, pp. 44-45). The incapacity management procedure needs to explain in detail the stages to be followed to ensure a fair and just process when managing the incapacity of the employee.

The following conclusions were drawn on **sub-question 3** relating to the regulatory requirements as described in chapter 3. The employment relationship is generally regulated through an employment contract, employment legislation, and collective agreements. Where no legislation exists the employment relationship is governed by the employment contract, which is enforceable in terms of common law. The employer can expect services from the employee in exchange for remuneration and a safe and healthy working environment (Bendix, 1996, pp. 107, 116; Grogan, 2009, pp. 2, 47-57; Slabbert et al., 2006, pp. 5-99–5-101). Should an employee not be able to fulfil his or her contractual obligations it can be regarded as a breach of the employment contract, and based on certain core principles, the employment contract may be terminated. The core principles are that a valid reason (incapacity due to ill health is a valid reason), a fair procedure allowing the employee an opportunity

to state his or her case, and a right to appeal the decision of termination, should be provided (Bendix, 1996, p. 116; Bos et al., 2015, p. 29; Grogan; 2014, p. 11, International Labour Organisation, 1982, s 6-8; Republic of South Africa, 1995, Schedule 8, s 10; Ronalds & Raper, 2012, p. 230; Van Zyl 2011, p. 15). One of the prerequisites for terminating the employment contract due to incapacity is that the employer should consider all reasonable accommodation short of dismissal (Republic of South Africa, 1995, Schedule 8, s 10(1)). The proposed incapacity management framework must comply with the minimum requirements as contained in the legislation and case law discussed in chapter 3, to ensure that incapacity is managed in a fair and just manner.

The **fourth sub-question** is answered in chapter 4. The question deals with the minimum requirements for accommodating an incapacitated employee and the reasonable accommodation practices available in a workplace. The following conclusions were drawn: the provision of reasonable accommodation is provided for in international conventions and South African legislation (Republic of South Africa, 1995, Schedule 8, s 10(2); United Nations, 2007). In considering the provision of reasonable accommodation, the employer needs to consult with an employee to determine the extent of the incapacity, and to explore suitable accommodation interventions (Coetzer et al., 2002, pp. 69-70; Gold & Shuman, 2009, p. 213; Grogan, 2014, p. 399; Lawson, 2012, p. 848; Republic of South Africa, 2015b, s 6.6, s 11.2). The burden of proof is on the employee to show that he or she has a physical or mental incapacity that adversely affects the employee's contractual obligations, and that it requires accommodation (Dong et al., 2013, p. 182; Lockwood et al., 2012, p. 182; Santuzzi et al., 2014, pp. 205, 216; Von Schrader et al., 2014, p. 239). The employer has no duty to provide reasonable adjustments if the employer does not know or could not reasonably be expected to know that an employee has a disability (Equality and Human Rights Commission, 2014, p. 10; Lockwood et al., 2012, p. 183). Several factors such as the nature of the incapacity, the nature of the job, and the impact of the accommodation on the workplace should be considered when deciding on the reasonableness of an

accommodation (Equality and Human Rights Commission, 2014, pp. 57-58; Gold & Shuman, 2009, p. 213; Republic of South Africa, 2002, p. 13). The employer has no obligation to provide reasonable accommodation if it is unreasonable or may cause undue hardship to the employer. The hardship is not limited to financial costs, but may include factors such as disruption to working arrangements or too many demands on the workplace, deterioration in the quality or nature of services, a negative impact on co-employees or customers, or health and safety risks (Australian Government, 1992, s 5(2), s 11; Lawson, 2012, p. 848; Ngwenya & Pretorius, 2007, p. 768; Social Firms Australia, 2010, p. 10, Scott, 2016, p. 130; United States of America, 1990, s 12111(10)). The burden of proving that an accommodation will impose unjustifiable hardship lies with the party claiming the unjustifiable hardship (Ronalds & Raper, 2012, p. 154). A plethora of reasonable accommodations exist. The more generic ones are flexible working hours, modified or adjusted work duties, physical work environment adjustments, and special devices.

8.2.2 Conclusions relating to the empirical findings

The **fifth sub-question** deals with the empirical aim to determine the real-life experiences of affected employees and managers in terms of the current incapacity management practices in the ODL institution. This is addressed in chapter 6 and the following conclusions were drawn: four themes emerged, namely an organisational culture, various challenges regarding the management of incapacity, reasonable accommodation, and the need for a multi-disciplinary approach. In terms of the **first theme**, organisational culture, the participants viewed the broader institutional culture as uncaring. They presented opposing views on the approach of management in dealing with the participants' incapacity, namely positive and caring versus negative. In terms of the **second theme** on challenges regarding incapacity management in the ODL institution, a number of conclusions were drawn:

- Not all participants were aware of the existence of an incapacity management policy and had limited knowledge thereof. The limited knowledge may be ascribed to the reality that managers are not always exposed to incapacity cases.
- An appropriate institutional policy with clear and detailed processes to be followed is of the essence. It should also determine the roles; responsibilities and authority of the multiple role players.
- There may be a lack of understanding of the incapacity condition that should be addressed through the education of line managers, in particular, on the essence of incapacity conditions. Where the manager lacks expertise on a specific condition, the services of external service providers such as medical specialist and occupational therapists may be used to advise him or her.
- There is no alignment of management and employee participants' perceptions and expectations on the manner in which the incapacity should be managed.
- Both management and employee participants desired involvement in the incapacity management process, consultation and feedback.
- Participants, both managers and employees, were unanimous in their perception that they needed training on incapacity management.

The **third theme** deals with reasonable accommodation and the following conclusions were drawn:

- Reasonable accommodation should be contained in an incapacity management policy and procedure.
- The reasonable accommodation should be linked to a specific time frame.
- Various forms of reasonable accommodation were provided, but the actual operational needs of the employer should also be taken into consideration.

- Managers and employees had positive and negative experiences regarding reasonable accommodation.
- The impact of allowing reasonable accommodation is not limited to managers and the affected employee, but also impacts co-employees. The verbatim evidence revealed that co-employees were initially supportive of the accommodation of an incapacitated employee, but as time went by the co-employees became negative.

The conclusion from the **fourth theme**, the multi-disciplinary approach is that the managing of incapacity in the workplace should not be done in isolation. It requires the involvement of various role players, internal and external to the institution.

Sub-questions 6 and 7, in terms of acceptable incapacity management practices that the ODL institution may implement, and recommendations made to the ODL institution, are answered in chapters 7 and 8 respectively.

8.2.3 Conclusions relating to the central research question

The research confirmed that the ODL institution requires an incapacity management framework. The framework should have the full support of the management, be sufficiently resourced, requires a detailed policy and procedure that describe the roles and responsibilities of all role players, as well as applicable reasonable accommodation practices. Lastly all role players should be aware of and educated on the framework.

8.3 LIMITATIONS

The following are limitations of this study:

- Research on the psychological well-being and physical wellness of higher education employees, especially in developing countries, is limited.
- Although studies were done on student absenteeism in the South African higher education sector, limited research is available on employee absenteeism trends in the sector.
- Although the participants were from an ODL institution, applicable research results on incapacity management at an ODL institution are not readily available.
- Policies and procedures for incapacity management in the South African higher education sector are limited.
- Very limited research was conducted on reasonable accommodation practices in the higher education sector, specifically the ODL environment.
- The South African legislation does not provide for clear guidance on incapacity management frameworks.
- The study was limited to absenteeism due to incapacity. Presenteeism was not explored.
- No generalisation of findings can be made to the higher education sector population as the sample (16 participants) in this study is relatively small. A larger sample with more participants from across the sector (including residential higher education institutions) would have made it possible to generalise the findings. However, the study provides a detailed insight into how participants experienced incapacity management in the ODL institution. It is not unreasonable to assume that the broad perceptions expressed by the participants would be reflective of a wider thinking by employees and management in a similar situation.
- The study presents a snap-shot description of the selected participant's lived experience at a specific point in time, which may differ at another point in time.
- The study was not intended to distinguish between academic and administrative employees or various post grade levels, nature of appointment (temporary/permanent), race, gender, and/or age.

8.4 RESEARCH CONTRIBUTION

Despite the above-mentioned limitations of the study, it may be concluded that the findings of the study offer original contributions to knowledge on incapacity management in the South African ODL environment. Four areas present themselves.

8.4.1 Theoretical contribution

Firstly, in terms of theory, the study makes a unique contribution to the management of incapacity in the higher education sector, but with specific reference to an ODL institution. On a general theoretical level, readers of the study, especially human resource practitioners, will develop a better understanding of what incapacity of employees, the impact thereof in the workplace, and international and national legal requirements in managing and accommodating incapacity due to ill health entail.

8.4.2 Applied contribution

The second valuable contribution of the study is that the incapacity management framework can be utilised in an ODL environment. The framework will assist line managers, incapacitated employees, human resource, employee relations and employee wellness practitioners, and unions to ensure that they collectively manage the incapacity fairly and justly. The human resource practitioners of the ODL institution could also use the framework to train and educate other role players of the multi-disciplinary team in the managing of incapacity. The framework could be used for analysing similar situations and has the potential to be developed further for application in a wider range of situations.

8.4.3 Methodological contribution

Thirdly, from an empirical perspective, the study offers a useful contribution to the thinking of participants employed in a real-world setting, thus adding to the existing body of knowledge. It offers a unique and rich insight into how the participants conceptualised incapacity management, contributing to a general sense of vagueness about the issue. From the data it became clear that incapacitated employees and the line managers viewed the incapacity management and reasonable accommodation practices in the ODL institution differently. The overall value thereof is that it adds to the understanding of the conceptual thinking that underpins the responses of two key role players in the multi-disciplinary group to incapacity management within the workplace.

8.4.4 Policy formulation contribution

Lastly, in terms of a policy contribution, the study offers information for developing policies and procedures for incapacity management that could be beneficial to the multi-disciplinary role players. The study also points to the need to strengthen the debate on incapacity management and provide clearer and more widely-accepted interventions for accommodating incapacitated employees in the workplace. This is of significance as it suggests that the current approaches to incapacity management are weakened by the absence of a negotiated policy and procedure which is acceptable to all role players.

8.5 RECOMMENDATIONS

The recommendations in this section are based on the findings, conclusions and limitations of this study. Recommendations are formulated for the ODL institution as well as for future research.

8.5.1 Recommendations for the ODL institution

The following recommendations are made for the ODL institution:

- The policy and procedure should be reviewed and negotiated with the unions. The policy should, inter alia, provide for the following:
 - Internal and external role players, including their roles and obligations. The role players should be multi-disciplinary and at least include the following: line manager, incapacitated employee, union representative (if employee is unionised), human resource practitioners (those responsible for employee relations, leave administration, and incapacity benefits), employee assistance and occupational health practitioners.
 - Guidelines on reasonable accommodation, with specific reference but not limited to, the authority of the line manager and time frames for the accommodation.
 - Provision for an immediate temporary replacement as soon as a medical practitioner declares the incapacitated employee unfit to work.
 - A return-to-work strategy, including a compulsory return-to-work interview.
- Conscious training of all role players on the policy and procedure for incapacity management should be enforced. This should not be a once-off occurrence, but should start at induction and then be regularly repeated as refresher courses thereafter. As and when an amendment to the policy, procedure or the risk insurance occurs, all role players should once again be enlightened about the changes. This should be the responsibility of Human Resources.
- Consideration should be given to the drafting of a booklet that would explain the policy and procedure, the expected time frames, as well as the benefits an employee is entitled to if an application for retirement due to ill health is approved. This may be drafted by Human Resources.

- As soon as role players become aware of an incapacity condition, continued open and transparent communication between the various role players should be established.

It is believed that if the ODL institution constantly trained and made role players aware of the policy and procedure, and ensured uninterrupted communication in the incapacity management process, it would go a long way to minimise the perception of a negative and unsupportive institutional culture.

8.5.2 Recommendations for future research

A number of areas for further research could be pursued on this basis of this case study. Further case studies could be undertaken to explore the generalisability of the findings from this study.

Firstly, as only participants from the ODL institution participated in this study, future research on the managing of incapacity at residential higher education institutions could be considered to determine a difference between the types of institutions due to the nature of their business.

Secondly, this study examined the conceptualisation of incapacity management for a purposive sample. Further research could be undertaken to explore whether findings may differ if the sample existed of employees from different categories, such as academic versus administrative staff, or differentiation based on other variables such as type of appointment (temporary/permanent), post grade levels, gender, race, age or culture.

Thirdly, this study's focus was mostly on employees' physical and psychological well-being. From the literature review it became evident that, as a workplace is not an emotion-free zone, a third dimension, namely emotional well-being, should be included in future research (Burger 2013, p. 14; Sieberhagen et

al., 2010, p. 5; Thompson & Bates, 2009, p. 119). Further researched could be done on the impact of emotional well-being on incapacity.

The impact of the phenomenon of presenteeism, whereby an employee may decide to attend work despite his or her incapacity, was not addressed in this study. This phenomenon justifies a fourth topic for research.

A fifth potential topic is to compare incapacity management with that at similar institutions within Africa or the BRICS countries (Brazil, Russia, India, China and South Africa). In this study the focus was on the legislation of countries that had an impact on the South African judicial system and those who advised on the post-democracy higher education institutions, namely the United Kingdom, the Netherlands, Australia and the United States of America.

Lastly, as this study focused more on how to manage the condition of the incapacitated employee, a need exists to explore the causes of incapacity, especially where it relates to the institutional culture.

8.6 REFLECTIONS

In this part I reflect on the doctoral journey as well as the doctorateness of my study.

8.6.1 Personal reflection on the journey

My study was born out of frustration when dealing with a specific incapacity case in which an employee with a treatable condition demanded unjust treatment for the incapacity condition. I could not find any formal policy or procedures on how to manage such a scenario, realising that there was a knowledge gap. As I completed my M Com (Labour Management) degree, which required limited research, an almost desk-top literature review and a mini-dissertation of no more than 50 pages more than 20 years ago, I was not sure

where to start. I met with one of my current promoters, who at that stage was a Chair of Department, who shared my enthusiasm for a possible study and advised me to narrow my topic down to only include incapacity management in the ODL institution.

I then started the journey by reading numerous articles and books on how to write a doctoral thesis. The book, *Stepping stones to achieving your doctorate: By focusing on your viva from the start* (Trafford & Leshem, 2008), guided me in understanding that “doctorateness” is like a “road map” that can only be fully appreciated when all the twelve components of “doctorateness” are in synergy. Yazdani and Shokooh (2018) define “doctorateness” as:

A personal quality, that following a developmental and transformative apprenticeship process, results in the formation of an independent scholar with a certain identity and level of competence and creation of an original contribution, which extend knowledge through scholarship and receipt of the highest degree and culminates stewardship of the discipline. (Yazdani & Shokooh, 2018, p. 42)

During this journey, I experienced additional frustrations with the bureaucratic processes of applying for ethical clearance, gaining permission to obtain data from the ODL institution, securing financial support and purchasing a voice recorder to record the participants’ interviews. The procuring of a voice recorder took almost two months due to all the red tape involved, resulting in personal negativity, which prevented me from doing hardly any studying during the third year. At the end of the third year I was seriously considering not to proceed with the study. However, having spent so much time on the study during the previous two years, I decided to forge ahead. As I am writing this, I have almost completed the study. It was a long and sometimes frustrating journey, not only for me, but also for my family, especially my wife, who could often not share her daily experiences with me, as I was forever behind the computer or reading, reading, and reading books and articles!

8.6.2 Personal reflection on the doctorateness of my study

Although I had to research various topics for numerous purposes during my career, this study taught me that academic research was not the same as the so-called research I did. To deliver a quality study that contributes to the knowledge of the phenomenon, one needs to meticulously follow the research road map. The journey started with identifying the topic or problem, known as the knowledge gap, that I wanted to study. Once this was done, I was required to formulate the overall research question and sub-questions that I thought would address the phenomenon under study – in this case incapacity due to ill health. The choice of the interpretive research paradigm influenced the research methodology in relation to the research questions, participant selection, data collection instruments, procedures and analysis. The last stretch of the journey was to present the findings in a clear and precise manner, and to provide definite recommendations that would contribute to knowledge on the phenomenon. Being a pragmatist and not being an academic, nor research oriented, I was but through the mill on this journey. However, with the assistance and guidance of my promotor I managed to succeed in this tedious research journey in which, in my opinion, I did justice to “doctorateness”.

I am optimistic that the findings of this study will provide a better understanding of incapacity management practices in ODL institutions. I am further optimistic that the findings will provide insights on what should be contained in a policy and procedure to ensure fair and just incapacity management at an institution. In addition, the research identified a plethora of reasonable accommodation interventions that may be implemented either in the ODL institution or any other employer, taking the incapacitated employee’s specific incapacity condition into consideration. The theory on incapacity management has been further expanded through the detailed literature analysis and findings on the importance of an approach which included multi role players. The proposed incapacity management framework for the ODL institution expands the general

body of knowledge in terms of incapacity management. The study makes a unique contribution to the management of incapacity in the higher education sector, but with specific reference to an ODL institution. Lastly, although the focus was on incapacity management at an ODL institution, I am optimistic that the study will contribute to the human resource management field.

8.7 FINAL CONCLUSION

Chapter 8 provides concluding explanations on the overview of the research and a summary of the findings. The research limitations are stated and discussed, and the research contribution is highlighted. The chapter concludes with recommendations for the ODL institution and future research.

With this study I attempted to create a balanced view on the realities regarding the incapacity condition faced by the ODL institution and its employees and ex-employees who experienced such a condition. Many debates exist around incapacity due to ill health in the workplace, what it means, and how the population of the institution should respond. I hope that this study will make a positive, unique contribution to the on-going narrative about the human resources function of managing incapacity due to ill health.

This concludes the study.

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ANNEXURE A: PARTICIPANT INFORMATION SHEET

THE DEVELOPMENT OF AN INCAPACITY MANAGEMENT FRAMEWORK FOR AN OPEN DISTANCE LEARNING INSTITUTION IN SOUTH AFRICA.

Dear Prospective Participant

My name is Nic van Staden and I am doing research towards obtaining a Doctoral degree under the supervision of Prof MC Mulaudzi and Prof A Bezuidenhout, both attached to the Department of Human Resource Management at the University of South Africa. I am inviting you to participate in my study entitled “The development of an incapacity management framework for an open distance learning institution (ODL) in South Africa”. Before you decide whether or not to participate, it is important for you to understand why the research is being done and what the study will involve. Please take time to read the information below carefully.

WHAT IS THE PURPOSE OF THE STUDY?

I am conducting this research to obtain the real life experiences of incapacitated employees (current and former) and their managers in order to establish how the ODL institution is managing or has managed incapacity cases reported. The study also seeks to determine the measures (and the effectiveness thereof) the ODL institution has implemented or is implementing to accommodate incapacitated employees. The outcome of the research will be an incapacity management framework that can be implemented in an ODL environment or a similar context.

WHY AM I BEING INVITED TO PARTICIPATE?

You have been invited to participate in this study either by being an employee who is or was affected by one or a combination of the following factors or you are a line manager who is or was managing an employee who is or was affected by one or a combination of the following factors:

- More than thirty days in a three year sick leave cycle have been exhausted;
- A medical practitioner recommended that an employee should be booked off for substantive rehabilitation periods exceeding the sick leave provisions of the ODL institution;
- An application for ill health retirement was lodged and is awaiting the decision of the insurer; or
- An application for ill health retirement was already approved.

Your experience and views relating to incapacity in the workplace and the management thereof is viewed valuable and would assist the researcher to gain an in-depth understanding of incapacity management at the ODL institution.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

The study involves a voice recorded, semi-structured interview that will last no longer than two hours. The interview will focus on the central question related to the legal obligation that South African legislation places on employers to ensure a fair and just management of incapacity in the workplace. The focus of this research is on incapacity management due to ill health. In terms of the legislative framework, fairness includes, inter alia, reasonable accommodation of the health condition of the employees. The nature of your participation involves you sharing with the researcher of your experience regarding how the incapacity situation in which you are or were involved, is or was managed. You will also have an opportunity to share your perspective on how the incapacity

could have been reasonably accommodated or managed to the benefit of both the employee and the employer.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Your participation in this study is entirely voluntary and you are under no obligation to consent to participation. You can decline to participate or withdraw at any time during the study, without giving any reason. Your withdrawal will not affect you in any way. If you do decide to take part, you will be given this information sheet to keep and be requested to sign a consent form.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

You will have the benefit of sharing your real life experiences regarding incapacity management practices at the ODL institution and your view on how incapacity should be managed, including potential reasonable accommodation practices that can be utilized to accommodate an incapacitated employee. The findings of this study will make a contribution to the management of incapacity in higher education, but specifically in the ODL institution. It may also result in the review of the human resource policies and procedures and/or conditions of employment of the ODL institution in order to support incapacitated (specifically temporary incapacitated) employees.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

The researcher does not foresee that you will experience any long term inconvenience and/or discomfort. There may be a minimal short term risk such as emotional discomfort that may transpire during or after the interview related to the personal nature of the information you may wish to share. You will be

required to invest your valuable time though participation in the research. The interview will take place at a time and place that is convenient to you in order to avoid disruption of your activities.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

Your name will not be recorded anywhere and no one, apart from the researcher will know about your involvement in this research. The recorded interview will be transcribed for data analysis and the transcribed interview will be anonymous. Pseudonyms will be used for ease of reference, e.g. Interview A, Interview B, etc.

HOW WILL THE RESEARCHER PROTECT THE SECURITY OF DATA?

After transcribing the interviews and combining these with the notes taken during the interviews or observation, it will be stored in Microsoft Word on a computer. Backup data will be stored on a memory stick. The documents will be password protected. The computer and the memory stick will be locked in a steel cabinet at the house of the researcher. The data will be managed through the recording of each case in a sequence of major events. Each case will have its own folder and unique identifier. The data collected will be stored for 5 years after completion of the study where after it will be permanently deleted from the hard drive of the computer and the memory stick through the use of relevant software.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

There is no payment or reward, financial or otherwise involved for participating in this study.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study has received ethical clearance from the Research Ethics Review Committee of the College of Economic and Management Sciences, Unisa. A copy of the approval letter (*Ref #: 2016_CRERC_014(FA)*) can be obtained from the researcher if you so wish.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact the researcher. As this research is being done to fulfil the requirements of a D Com degree, the findings may only be available at the earliest towards the end of 2018.

CONTACT DETAILS

Should you require any further information please contact the researcher about any aspect of this study. Should you have concerns about the way in which the research has been conducted, you may contact the Supervisor or co-supervisor of the researcher. Alternatively, contact the Chairperson of the Ethics Sub Committee in the Department of Human Resources Management.

Thank you for taking time to read this information sheet and for participating in this study.

ANNEXURE B: INTERVIEW GUIDE - EMPLOYEE PARTICIPANT

THE DEVELOPMENT OF AN INCAPACITY MANAGEMENT FRAMEWORK FOR AN OPEN DISTANCE LEARNING INSTITUTION IN SOUTH AFRICA

INTERVIEW GUIDE – EMPLOYEE/ILL HEALTH RETIREE PARTICIPANT

PARTICIPANT'S PSEUDO NAME:	
PLACE OF EMPLOYMENT:	
DATE OF INTERVIEW:	
TIME OF INTERVIEW:	DURATION OF INTERVIEW:
<p>Introduction: My name is Nic van Staden and I am doing research towards obtaining a Doctoral degree under the supervision of Prof MC Mulaudzi and Prof A Bezuidenhout, both attached to the Department of Human Resource Management at the University of South Africa. You have accepted the invitation to participate in my study entitled <i>"The development of an incapacity management framework for an open distance learning institution (ODL) in South Africa"</i>. Before we start with the interview I wish to reconfirm the essence of what is contained in the participant's letter you have received and consented to:</p> <ol style="list-style-type: none">1. The study has received ethical clearance from the Departmental Ethics Review Committee of the College of Economic and Management Sciences, Unisa.2. I am conducting this research to obtain your real life experience of how your incapacity or sick absence is or has been accommodated and managed. In addition I would like to obtain your view or perception on how it can or could have been accommodated or managed differently to the benefit of both you and the institution. The outcome of the research will be an incapacity management framework that can be implemented in an ODL environment or a similar context.3. The interview will be voice recorded and is semi-structured. It should not last longer than two hours. I may also make some field notes during the interview.4. Your participation is entirely voluntary and you are under no obligation to proceed with the interview. You can decline to participate, refuse to answer some of the questions or withdraw at any time during the interview, without giving any reason. Your withdrawal will not affect you in any way. Should you wish to have a break during the overview, you are welcome to request same. If so required, the interview can be completed at a future date.5. At any time, please feel free to request a clarification of the question when you do not understand.6. You are also welcome to ask me questions during the interview.7. Your name will not be recorded anywhere and no one, apart from I will know about your involvement in this research. The recorded interview will be transcribed for data analysis and the transcribed interview will be anonymous. Pseudonyms will be used for ease of reference, e.g. Interview A, Interview B, etc.8. After transcribing the interviews and combining these with the notes taken during the interview, the records will be stored in a safe place.9. When presenting the findings of the research, it will be anonymous so that nobody can identify you. <p>I wish to hereby confirm whether you are still willing to continue with the interview?</p>	

Opening question: Labour legislation in South Africa compels employers to fairly manage incapacity cases in the workplace. For this research the focus is on incapacity due to ill health. According to the legislation fairness includes, inter alia, reasonable accommodation of the health condition of the employees. How did you experience/view the accommodation of your illness by the employer?
Probing question 1: What is your opinion of the college/department management's understanding and knowledge of the management of incapacity due to ill health?
Probing question 2: What is your understanding and knowledge of the management of incapacity due to ill health at the university?
Probing question 3: How was your incapacity accommodated during the ill health period?
Probing question 4: How was your incapacity accommodated when returning to work after the ill health period?
Probing question 5: In your opinion, what alternative/different interventions could have been implemented to make the management of your incapacity more reasonable?
Probing question 6: Tell me more about what factors, internal or external, hindered or facilitated the accommodation of your ill health?
Probing question 7: In your opinion what changes can be made to the conditions of employment or risk benefits in order to accommodate similar illnesses in future?
Probing questions 8: Are there any other matters relating to the accommodation of your ill health situation you would like to share?
Closing remark: Thank you for participation. If you agree I would like to provide you with a summary of my interpretation of the interview or observation to verify if I have a correct understanding of the interview. As this is a doctoral study the earliest the results will be available is in 2018. Should you wish to obtain a copy of the results you can contact me at 012 429 4378 or alternatively at vstadpjn @unisa.ac.za.

ANNEXURE C: INTERVIEW GUIDE - MANAGEMENT PARTICIPANT

THE DEVELOPMENT OF AN INCAPACITY MANAGEMENT FRAMEWORK FOR AN OPEN DISTANCE LEARNING INSTITUTION IN SOUTH AFRICA

INTERVIEW GUIDE - EMPLOYER PARTICIPANT

PARTICIPANT'S PSEUDO NAME:	
PLACE OF EMPLOYMENT:	
DATE OF INTERVIEW:	
TIME OF INTERVIEW:	DURATION OF INTERVIEW:
<p>Introduction: My name is Nic van Staden and I am doing research towards obtaining a Doctoral degree under the supervision of Prof MC Mulaudzi and Prof A Bezuidenhout, both attached to the Department of Human Resource Management at the University of South Africa. You have accepted the invitation to participate in my study entitled <i>"The development of an incapacity management framework for an open distance learning institution (ODL) in South Africa"</i>. Before we start with the interview I wish to reconfirm the essence of what is contained in the participant's letter you have received and consented to:</p> <ol style="list-style-type: none"> 1. The study has received ethical clearance from the Departmental Ethics Review Committee of the College of Economic and Management Sciences, Unisa. 2. I am conducting this research to obtain your real life experience of how you manage/accommodate or have managed/accommodated the incapacity or sick absence of one of your employees. In addition I would like to obtain your view or perception on how it can or could have been accommodated or managed differently to the benefit of both the employee and the institution. The outcome of the research will be an incapacity management framework that can be implemented in an ODL environment or a similar context. 3. The interview will be voice recorded and is semi-structured. It should not last longer than two hours. I may also make some field notes during the interview. 4. Your participation is entirely voluntary and you are under no obligation to proceed with the interview. You can decline to participate, refuse to answer some of the questions or withdraw at any time during the interview, without giving any reason. Your withdrawal will not affect you in any way. Should you wish to have a break during the overview, you are welcome to request same. If so required, the interview can be completed at a future date. 5. At any time, please feel free to request a clarification of the question when you do not understand. 6. You are also welcome to ask me questions during the interview. 7. Your name will not be recorded anywhere and no one, apart from I will know about your involvement in this research. The recorded interview will be transcribed for data analysis and the transcribed interview will be anonymous. Pseudonyms will be used for ease of reference, e.g. Interview A, Interview B, etc. 8. After transcribing the interviews and combining these with the notes taken during the interview, the records will be stored in a safe place. 9. When presenting the findings of the research, it will be anonymous so that nobody can identify you. <p>I wish to hereby confirm whether you are still willing to continue with the interview?</p>	

Opening question: Labour legislation in South Africa compels employers to fairly manage incapacity cases in the workplace. For this research the focus is on incapacity due to ill health. According to the legislation fairness includes, inter alia, reasonable accommodation of the health condition of the employees. How did you experience/view the accommodation of the employee's illness by the employer?
Probing question 1: What is your understanding and knowledge of the management of incapacity due to ill health?
Probing question 2: What is your opinion of the employee's understanding and knowledge of the management of incapacity due to ill health?
Probing question 3: How did you accommodate the incapacity of the employee during the ill health period?
Probing question 4: How did you accommodate the incapacity of the employee when he or she returned to work after the ill health period?
Probing question 5: In your opinion, what alternative/different interventions could have been implemented to make the management of the employee's incapacity more reasonable?
Probing question 6: Tell me more about what factors, internal or external, hindered or facilitated the accommodation of the employee's ill health?
Probing question 7: In your opinion what changes can be made to the conditions of employment or risk benefits in order to accommodate similar illnesses in future?
Probing question 8: Are there any other matters relating to the accommodation of the employee's ill health situation you would like to share?
Closing remark: Thank you for participation. If you agree I would like to provide you with a summary of my interpretation of the interview or observation to verify if I have a correct understanding of the interview. As this is a doctoral study the earliest the results will be available in 2018. Should you wish to obtain a copy of the results you can contact me at 012 429 4378 or alternatively at vstadpjn @unisa.ac.za.

ANNEXURE D: CONSENT TO PARTICIPATE

I, _____ (participant name),
confirm that the person asking my consent to take part in this research has
told me about the nature, procedure, potential benefits and anticipated
inconvenience of participation. I have read (or had explained to me) and
understood the study as explained in the information sheet. I have had
sufficient opportunity to ask questions and am prepared to participate in
the study.

I understand that my participation is voluntary and that I am free to
withdraw at any time without an obligation to explain or any adverse effect.

I am aware that the findings of this study will be processed into a research
report, journal publications and/or conference proceedings, but that my
identity will be kept anonymous and my information will be kept
confidential.

I agree to the voice recording of the interview.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname:.....

Participant Signature:.....**Date**.....

Researcher's Name & Surname: PJN van Staden

Researcher's signature:.....**Date**.....

ANNEXURE E: ETHICS APPROVAL



COLLEGE OF ECONOMIC AND MANAGEMENT SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

05 July 2016

Ref #: 2016_CRERC_014(FA)

Name of applicant: Mr PJN van Staden

Student number #: 57649502

Dear Mr PJN van Staden

Decision: Ethics Approval

Name: Mr PJN van Staden, vsjadp@unisa.ac.za, 012 429 4378

Proposal: The development of an incapacity management framework for an open distance learning institution in South Africa

Qualification: Postgraduate Student Research

Thank you for the application for research ethics clearance by the College of Economic and Management Sciences Research Ethics Review Committee for the above mentioned research. Final approval is granted from **04th July 2016 to 03rd July 2018**.

For full approval: The revised application was reviewed in compliance with the Unisa Policy on Research Ethics by the CRERC on **04th July 2016**.

The proposed research may now commence with the proviso that:

- 1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*
- 2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology,*



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should be communicated in writing to the CRERC.

- 3) An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*
- 4) The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

Note:

The reference number **2016_CRERC_014(FA)** should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the CRERC.

Kind regards,



Prof JS Wessels

Chairperson of the CRERC, CEMS, UNISA
012 429-6099 or wesselsj@unisa.ac.za



Prof M.T. Mogale

Executive Dean: CEMS
mogalmi@unisa.ac.za



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