REPORT OF THE ROUNDTABLE DISCUSSION ON
THE IMPLEMENTATION OF PILIR IN THE PUBLIC
SERVICE

DECEMBER 2013
LIST OF ACRONYMS

AGSA    Auditor General of South Africa
DPSA    Department of Public Service and Administration
EEA     Employment Equity Act
HOD     Head of Department
HPCSA   Health Professions Council of South Africa
HRM     Health Risk Manager
IHR     Ill-Health Retirement
LRA     Labour Relations Act
PILIR   Policy on Incapacity Leave and Ill-Health Retirement
PSA     Public Service Act
PSC     Public Service Commission
PSCBC   Public Sector Coordinating Bargaining Council
SLA     Service Level Agreement
TIL     Temporary Incapacity Leave
1. INTRODUCTION

1.1 Background
The management of sick leave and incapacity leave in the Public Service is a key management responsibility which supervisors across the board should be capacitated to handle. The management of sick and incapacity leave has a direct bearing on the capacity of the State to deliver on its mandate. Therefore the Public Service should recognise that its primary source of delivery is its human capital. In terms of applicable legislation, public servants have the right to be treated with fairness, this includes accommodating their absence from duty due to chronic illness, incapacity leave or ill-health retirement. Similarly, decisions pertaining to the management of employees’ applications for incapacity leave and ill-health retirement should be consistent and in line with applicable legislation and policy frameworks.

The Public Service Commission (PSC) has over the years continued to execute its constitutional mandate of monitoring the performance of the Public Service. It has been able to achieve this objective by, among other things, conducting research and producing reports that are presented to the Executive. In addition, the PSC has also facilitated workshops, roundtable discussions and other public participation processes aimed at creating a platform to engage on various policies and practices that hamper or enhance the performance of the Public Service.

In 2011 the Public Service Commission published a report on the “Evaluation of the impact of the Policy and Procedures on Incapacity Leave and Ill-Health Retirement (PILIR) on Sick Leave Trends in the Public Service”. Numerous findings and recommendations were made in the report, including the observation that the introduction of PILIR has resulted in a reduction in the use of sick leave by Public Service employees. Since the publication of the Report, it has emerged that there are specific legal and practical challenges that affect the manner in which departments implement PILIR. There is also an increase in the number of grievances submitted to the PSC that relate to the implementation of PILIR. Departments find themselves in an ethical dilemma when medical practitioners working for public hospitals recommend sick leave for employees and such leave is declined by departments based on the recommendation of Health Risk Managers.

In light of the legal and practical challenges experienced in the implementation of PILIR, the PSC identified a need to host a PILIR roundtable in order to create a platform through which a panel of experts, delegates from departments and the Department of Public Service and Administration could deliberate on the challenges experienced and propose viable solutions.
1.2 Objectives of the PILIR roundtable

The objectives of the PILIR roundtable discussion were:

(a) To create a platform that would enable discussions by experts and delegates on the challenges experienced by departments in the implementation of PILIR;
(b) To share best practices and identify strategies that should be implemented by departments; and
(c) Propose possible solutions to persisting challenges that are experienced in the implementation of PILIR.

1.3 Methodology

The methodology adopted was as follows:

- Data was gathered from the Department of Public Service and Administration (DPSA) in terms of prevalent illnesses that were observed in the applications assessed by Health Risk Managers for temporary and permanent incapacity leave and ill-health retirement in the previous leave cycles;
- Additional data was gathered from the grievances received by the PSC on the outcomes of incapacity leave applications and the PSC PILIR report; and
- A roundtable discussion was convened to discuss the preliminary findings.

1.4 Scope of the PILIR roundtable discussion

The roundtable discussion included all government departments, national and provincial. Each department had two delegates, that is, the PILIR champion and the Labour Relations officer. The participation of the Department of Public Service and Administration (DPSA); Thandile Health Risk Manager; expert medical practitioners in the fields of psychiatric, neurological and respiratory system diseases; human resource management and labour relations experts were secured as panel members.

The selection of medical practitioners was based on the top three categories of illnesses that were found to be prevalent in previous leave cycles up to 2012.
1.5 Structure of the Report

The report is divided into three sections, inclusive of the introductory section. The remainder of the report is structured as follows:

- Section 2 presents the analysis of findings of the PILIR roundtable discussion; and
- Section 3 provides the recommendations and conclusion.

An overview of the applicable legislative and policy framework is presented in Annexure A of the report.
2. ANALYSIS OF THE FINDINGS OF THE PILIR ROUNDTABLE DISCUSSION

This section analyses the key findings emanating from the presentations and follow up discussion in relation to concerns and challenges raised by delegates around the implementation of the PILIR. The need for the roundtable discussion was prompted by an increase in the number of grievances received by the PSC that are related to the outcomes of employees’ incapacity leave applications lodged with HRMs. The practical and legal challenges identified by the PSC’s grievance adjudication panel required that all concerned parties should come together and deliberate on these matters. In addition, the roundtable discussion served as an information sharing platform.

2.1 Structure of the discussion

The PSC opened the session by outlining the purpose of the PILIR roundtable discussion. Thereafter nine presentations were delivered by panel members. The presentations focused on prevalent illnesses and highlighted practical and legal implementation challenges which were identified from the grievance processes and the PSC’s PILIR report. After each presentation, delegates were given the opportunity to comment and seek clarity on issues raised in the presentations. Discussions on departmental concerns and challenges in relation to specific themes covered in the presentations commenced later. The detailed programme for the roundtable discussion is attached as Annexure B at the end of the report.

2.2 Overview of the PILIR framework

The DPSA, as custodian of the Public Service Human Resource Management Framework, developed the PILIR framework with the aim of managing uniformly incapacity leave and ill-health retirement in the Public Service. The objectives of PILIR as set out in the policy document are: to set up structures and processes, which will ensure-intervention and management of incapacity leave in the workplace to accommodate temporary or permanently incapacitated employees; and where appropriate facilitate the rehabilitation, re-skilling, re-alignment and retirement, where applicable, of temporarily or permanently incapacitated employees. This policy has been in existence since 2003 with amendments being effected according to latest collective agreements as concluded in the PSCBC chambers and presented as resolutions. The policy is implemented by all government departments, nationally and provincially. Some of the concerns raised by delegates include the fact that the policy:
• Does not cover illnesses associated with ancestral ‘witchdoctor’ calling that employees may be experiencing; and
• It is silent on who bears the extra cost that employees have to incur to complete incapacity leave application forms by the treating medical practitioners.

The concerns raised have financial implications for and create emotional strain on employees, which may result in employees beginning to suffer from neurological diseases such as stress, migraine headaches and etc. When an employee is sick, the likelihood of absenteeism or under performance is high. Therefore it becomes crucial for the custodian of the PILIR framework to reflect on these concerns and see how best to accommodate employees without opening the window to abuse of the policy by those who are not genuine in their actions.

2.3 Implementation of PILIR by departments

Representatives of implementing departments raised a number of concerns and challenges during the discussion. The following are some of the key concerns and challenges raised:

2.3.1 The first challenge relates to timeframes for the whole incapacity leave assessment process. It appears that there is non-adherence to the timeframes as set out in the policy by all parties involved in the application for incapacity leave, the assessment and approval process. This challenge has also been observed by the PSC during its grievance adjudication committees. The non-adherence to timeframes has a more negative impact on employees than the employer and the Health Risk Managers. In some cases the outcome of the application is negative (meaning the application is not approved) and the employee is required to reimburse the employer for the days of absence if the employee had taken leave and does not have annual leave days to convert. In other cases by the time the outcome is finalised, the applicant has passed on. With the latter, the challenge was observed in a case where a negative outcome was given and the department must now deduct what is owed from the pension fund of the deceased.

2.3.2 The second challenge relates to grievances that emanate from the outcomes of the assessment of applications for incapacity leave. Departments are unable to handle grievances that have differing medical opinions from employees’ medical practitioners and the Health Risk Managers. As a result, the grievances are forwarded to the PSC unresolved at departmental level. During
the 2012/13 financial year, the PSC observed an increase in the number of such grievances. Delays in resolving such grievances impacts on the employer and employee alike. The employer could be deemed as incapable of resolving labour relations matters, which may be viewed as a risk in terms of labour harmony. The employee might be despondent about the employer’s conflict resolution processes which could affect the moral, commitment and attitude of the employee and other employees within the department. This situation is likely to result in underperformance and/or more absenteeism.

2.3.3 The third challenge relates to the cumbersomeness of the application forms for incapacity leave, which may result in some employees not being assisted by medical practitioners to complete the forms. In some cases, employees have to pay extra to get the forms completed. The implication of the cumbersome application process is that timeframes to submit applications for incapacity leave are not met by employees. This could result in the employee’s application being automatically disqualified even if there are medical grounds for the application to be considered given that Health Risk Managers must operate strictly within the parameters of the policy.

2.3.4 The fourth challenge relates to the treatment of information provided by medical practitioners who do not provide a full report of the diagnosis in the medical certificate. The employee therefore has to consent to the information being divulged to a third person. Failing to give that consent, the employee runs the risk of his/her application for incapacity leave not being recommended for approval on the basis of insufficient information. Departments need to inform employees on the risks of submitting medical certificates with inadequate information. However, Health Risk Managers have an obligation to contact the treating medical practitioner to request such information or take the employee for further assessment by their specialist. Where a medical practitioner, despite the consent from the employee, refuses to give the information, then the medical practitioner can be reported to the Health Professions Council of South Africa (HPCSA).

2.3.5 The fifth challenge relates to the management of leave in general where it is alleged that managers are not managing this aspect of the conditions of service. There are cost and service delivery implications when leave is not managed by officials assigned to do so. The government incurs millions of cost on leave, money that could have been diverted to other priorities of government. The levels of productivity become affected as fewer officials are
present at work and many are on unmanaged leave. The effects of this are also felt by those employees who are present at work, who have more workload as a result of the absentees. If leave is not continuously managed even those that are present at work might start experiencing health problem and the implications for service delivery become dire.

The PSC in its PILIR evaluation report alluded to some of these challenges and made recommendations to try to resolve them. It would seem that the PSC’s recommendations were not considered or have not been implemented as yet.

2.4 DPSA support

DPSA is responsible for developing and monitoring implementation of the PILIR framework in the Public Service. It is also responsible for appointing a Panel of Accredited Health Risk Managers to be utilised by national and provincial departments. The role of the Health Risk Managers is to render consultancy services as required in terms of PILIR. Departments have an expectation that where there are challenges with implementation of the policy and operational relations with Health Risk Managers, the DPSA will provide guidance and support. During the discussion, delegates posed several questions and a number of concerns. Delegates wanted to know if:

2.4.1 The DPSA is going to assist and give guidance on the backlog of applications for incapacity leave that was created due to delays in the appointment of the new panel of accredited HRMs;
2.4.2 The DPSA is going to engage the Auditor General (AG) to grant condonation in terms of PILIR turn-around times as a result of the backlog;
2.4.3 The DPSA has a plan to interact with Health and Wellness officials in departments in order to develop a plan that seeks to address employee health and wellness issues;
2.4.4 The issue of timeframes (including adherence thereto) in the master Service Level Agreement (SLA) is going to be reviewed by the DPSA;
2.4.5 As per previous meetings of the DPSA with departments, the PILIR framework will be reviewed in order for the newly contracted HRMs to operate within a reviewed policy.

The above concerns seem valid and the DPSA should consider them as they have audit implications for departments. The questions and concerns raised allude to the fact that there is still a potential for HRMs to struggle to adhere to timeframes in assessing applications for incapacity leave. With the Labour Court judgment [Public Servants Association & Another v PSCBC & Others (D751/09) [2013]}
that was presented focusing on the 30 days’ timeframes for departments to investigate applications for incapacity leave, departments might find themselves having to entirely approve a backlog of incapacity leave applications. Failing which, departments could be challenged by employees on the basis of failure to adhere to timeframes given the precedent set by the Labour Court judgment.

2.5 Provision of assessment services by Health Risk Managers

A Panel of Accredited Health Risk Managers (HRMs) are appointed by the DPSA to provide assessment services for applications of incapacity leave for all government departments, nationally and provincially. Clusters of National Departments & Provincial Administrations select and contract a Health Risk Manager from the Panel to render the consultancy service required in terms of PILIR. The HRM then signs a Service Level Agreements (SLA) with each department that selected it. The implication of this setup is that, the Head of Department becomes accountable and responsible for the management of that particular Health Risk Manager’s SLA.

The Health Risk Manager (HRM) is an independent natural or juristic person appointed by the employer to provide advice on the granting of incapacity leave and ill-health retirement of employees. The HRM comprises of a multidisciplinary team of medical experts specialising in occupational health (e.g. Occupational Therapists), Occupational Doctors, and etc. The role of the Health Risk Manager as stipulated in the PILIR policy is to assess applications for incapacity leave and make recommendations to the department on whether to approve/partially approve or not to approve the application. These recommendations are based on a thorough assessment of documentation which is provided by the applicant. In exceptional cases, with the consent of the employee, the treating doctor gets contacted to verify the information where necessary. The Health Risk Manager further sources the services of specialists to make contact with the applicant for further examinations or an occupational therapist to conduct a workplace and/or functional capacity assessment and thereafter provide a detailed medical report. Also, the HRM ascertains the impact that the employee’s medical condition has on his/her work performance and work attendance.

In response to the issues raised through various presentations, delegates asked questions and sort clarity on a range of issues related to the HRMs’ services. A summary of the questions and issues raised is provided below.
2.5.1 Are HRMs in a position to give trends on cases and propose wellness intervention programmes to prolong the working lives of employees?

2.5.2 Is it possible for HRMs to participate in investigations of grievance cases emanating from incapacity leave application outcomes that HRMs recommend to the departments?

2.5.3 HRMs experience problems because departments submit applications late with stale medical information or applications without medical content and in some instances incomplete applications.

2.5.4 In some instances, the advice that is given by Health Risk Managers is often not implemented by departments due to varied reasons.

2.5.5 Medical practitioners who treat employees are not well-informed on the PILIR requirements.

2.5.6 Employees submit relevant clinical evidence only after they have lodged a grievance.

The issues mentioned above, indicate that there is a need for intense advocacy in as far as PILIR and its processes are concerned. Departments, with the support of the DPSA, need to conduct information sessions again on the implementation of PILIR. The DPSA might need to consider engaging the Public Sector medical practitioners on PILIR to enable them to adhere to the PILIR requirements and to cooperate with HRMs when necessary.
3. RECOMMENDATIONS

This section outlines the recommendations based on the discussion that took place during the PILIR roundtable session. The recommendations are also informed by the suggestions made by stakeholders who participated in the roundtable discussion and the PSC’s previous report. PSC advises that these recommendations be implemented as a matter of urgency to enable the smooth implementation of PILIR.

3.1 Review of the PILIR framework should be conducted as a matter of urgency by DPSA taking into consideration, amongst others, issues of timeframes, culture (i.e. ancestral ‘witchdoctor’ calling), bulkiness of the forms and who bears the cost if forms are not considered for review and involvement of HRM in investigating grievances.

3.2 Leave management should be part of the performance agreements of managers and be assessed accordingly. Heads of Departments should put in place a monitoring mechanism for this. DPSA should play an oversight role on leave management by departments.

3.3 Medical practitioners who refuse to provide departments with the full medical report even though the employee has consented should be reported to the HPCSA for non-compliance.

3.4 Departments must conduct incapacity hearings as soon as they observe a need and not wait until leave is exhausted before instituting disciplinary processes.

3.5 DPSA should arrange training, which must be facilitated by an experienced and reputable Labour Relations specialist, on implementation of PILIR and the handling of Ill-Health grievances for Labour Relations officers in departments.

3.6 DPSA should address the backlog issue with departments, HRMs and the AG.

3.7 DPSA should develop a plan to provide support to health and wellness officials in departments.

3.8 Each department should liaise with its HRM to get trends on cases and engage their health and wellness officials on a plan to address the issues identified in the trend report.

3.9 DPSA and departments should conduct information sessions for all employees again on the implementation of PILIR.

3.10 DPSA should engage with the Public Sector medical practitioners on PILIR to enable them to adhere to the PILIR requirements.

3.11 Due to lack of time to address all concerns and questions raised, the PSC should organise a follow up roundtable discussion that will only involve HRMs, DPSA and the PSC for the purposes of finding strategic and sustainable solutions to all the challenges associated with the implementation of PILIR.
4. CONCLUSION

In conclusion, the PILIR roundtable discussion has succeeded to create a platform for delegates from all departments and the panel of experts to engage on the challenges and dilemmas experienced when implementing PILIR. It has emerged during the discussions that gaps in the policy need to be addressed. The support of DPSA to departments needs to be strengthened and a more hands-on approach is required. HRMs need not only play a policing role but also an advisory role on health and wellness issues as per the trends identified. If this is done the ultimate aim of having a workplace that is well and healthy and ready to serve communities will be realised.

Disclaimer

All care has been taken to present a true reflection of what transpired during the PILIR roundtable discussion.
ANNEXURE A: OVERVIEW OF APPLICABLE LEGISLATIVE AND POLICY FRAMEWORK

The applicable legislation for temporary and permanent incapacity leave and ill-health retirement in the Public Service is stated in Table 1 below:

Table 1

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<tr>
<th>SOURCE</th>
<th>PROVISION</th>
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<tbody>
<tr>
<td>Labour Relation Act (LRA), 1995¹ as amended.</td>
<td>Schedule 8- Code of Good Practice: Dismissal</td>
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<tr>
<td>Item 10 - Incapacity: Ill health or injury</td>
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<td>1) Incapacity on the grounds of ill health or injury may be temporary or permanent. If an employee is temporarily unable to work in these circumstances, the employer should investigate the extent of the incapacity or the injury. If the employee is likely to be absent for a time that is unreasonably long in the circumstances, the employer should investigate all the possible alternatives short of dismissal. When alternatives are considered, relevant factors might include the nature of the job, the period of absence, the seriousness of the illness or injury and the possibility of securing a temporary replacement for the ill or injured employee. In cases of permanent incapacity, the employer should ascertain the possibility of securing alternative employment, or adapting the duties or work circumstances of the employee to accommodate the employee's disability.</td>
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<td>2) In the process of the investigation referred to in subsection (1) the employee should be allowed the opportunity to state a case in response and to be assisted by a trade union representative or fellow employee.</td>
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<td>3) The degree of incapacity is relevant to the fairness of any dismissal. The cause of the incapacity may also be relevant. In the case of certain kinds of incapacity, for example alcoholism or drug abuse,</td>
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counselling and rehabilitation may be appropriate steps for an employer to consider.

4) Particular consideration should be given to employees who are injured at work or who are incapacitated by work-related illness. The courts have indicated that the duty on the employer to accommodate the incapacity of the employee is more onerous in these circumstances.

Guidelines in cases of dismissal arising from ill health or injury

Any person determining whether a dismissal arising from ill health or injury is unfair should consider-

a) whether or not the employee is capable of performing the work; and

b) if the employee is not capable-
   • the extent to which the employee is able to perform the work;
   • the extent to which the employee’s work circumstances might be adapted to accommodate disability, or, where this is not possible, the extent to which the employee’s duties might be adapted; and
   • the availability of any suitable alternative work.

SUMMARY

Labour Relations Act, 1995 guides dismissal:

(a) Prevents unfair dismissal and labour practices
(b) Provides mechanisms of a fair dismissal if incapable of performing job due to poor health or injury, Schedule 8.
(c) Dismissal must be:
   • Substantively fair: Dismissed for a fair reason
   • Procedurally fair: Dismissal followed a fair procedure

Dismissal solely on the grounds of disability is automatically unfair. If permanent incapacity, ascertain possibility of:
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<tr>
<td>PSCBC Resolution 7 of 2000, read with Resolution 5 of 2001&lt;sup&gt;2&lt;/sup&gt;</td>
<td>This resolution, provides for:</td>
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**Temporary incapacity leave:**

a) An employee whose normal sick leave credits in a cycle have been exhausted and who, according to the relevant practitioner, requires to be absent from work due to incapacity which is not permanent, may be granted sick leave on full pay provided that:

- her or his supervisor is informed that the employee is ill; and
- a relevant registered medical and/or dental practitioner has duly certified such a condition in advance as temporary incapacity except where conditions do not allow.

b) The employer shall, during 30 working days, investigate the extent of inability to perform normal official duties, the degree of inability and the cause thereof. Investigations shall be in accordance with item 10(1) of Schedule 8 in the Labour Relations Act of 1995.

c) The employer shall specify the level of approval in respect of applications for incapacity leave.

**Permanent incapacity leave:**

a) Employees whose degree of incapacity has been certified as

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permanent shall, with the approval of the employer, be granted a maximum of 30 working days paid sick leave, or such additional number of days required by the employer to finalise the process set out in (b) and (c) below.

b) The employer shall, within 30 working days, ascertain the feasibility of:
   - alternative employment; or
   - adapting duties or work circumstances to accommodate the incapacity.

c) If both the employer and the employee are convinced that the employee will never be able to perform any type of duties at her or his level or rank, the employee shall proceed with application for ill health benefits in terms of the Pension Law of 1996.

**Section 17 – Termination of employment**

S17 (1) (a) reads, “subject to paragraph (b), the powers to dismiss an employee shall vest in the relevant executive authority and shall be exercised in accordance with the Labour Relations Act.

S17 (2) (a) reads, “An employee of a department, other than a member of the services, an educator or a member of the Intelligence Services, may be dismissed on account of incapacity due to ill health or injury.

**SUMMARY**

**Public Service Act, 1994:**

(a) Discharge of an employee on account of ill health
(b) Medical examination may be required
(c) Due regard to item 10 of Schedule 8 of the LRA must be given.

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**Employment Equity Act, 1998**

**EEA promotes employment:**
(a) Prohibits discrimination on grounds of disability.
(b) Requires employers to take affirmative actions to promote employment of the disabled.

**Disability according to the EEA:**
(a) Focus is on effect of disability in relation to the working environment and not on the diagnosis of impairment

(b) Must satisfy the following criteria:
- Long term or recurring
- Physical or mental impairment
- Substantially limiting

**Substantially limiting:**
- Totally unable or significantly limited to do a job without reasonable accommodation by the employer.
- Must consider if medical treatment or devices would control or correct impairment

**Requires employers to take affirmative actions to promote employment of disabled**
(a) Retaining people with disabilities
- If disabled during employment, re-integrate into work
- Encourage early return-to-work
- Offer alternative work, reduced work, flexible work
ANNEXURE B: PROGRAMME

Roundtable Discussion on the Implementation of the Policy and Procedure on Incapacity Leave and Ill-Health Retirement (PILIR) in the Public Service

Date: 14 October 2013
Venue: Birchwood Hotel - OR Tambo Conference Centre, BOKSBURG
Time: 07h00 – 16h30
### Programme Director: Ms Phelele Tengeni, PSC Deputy Chairperson

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Facilitator, Rationale</th>
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<tr>
<td>07h30 – 08h40</td>
<td>Registration and Arrival Tea &amp; Coffee</td>
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<td>08h40 – 09h00</td>
<td>Welcome and Purpose of the Roundtable</td>
<td>Mr Ben Mthembu, PSC Chairperson</td>
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<tr>
<td>09h00 – 10h30</td>
<td><strong>Panel Discussion One</strong></td>
<td><strong>Facilitator: Commissioner Phumelele Nzimande</strong></td>
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<td><strong>DPSA</strong></td>
<td>Ms Christa Brink, Mr James Cornwall</td>
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<td><strong>Health Risk Managers</strong></td>
<td>Ms Nadine Pienaar, Dr Louis Mokwena, Dr Jaco Folmer</td>
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<td><strong>Psychiatric Diseases</strong></td>
<td>Prof Robin Emsley and Prof Sean Kaliski</td>
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<td>10h30 – 11h00</td>
<td><strong>QUESTIONS &amp; DISCUSSIONS</strong></td>
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<td>11h00 – 11h15</td>
<td><strong>TEA BREAK</strong></td>
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<td>11h15 – 12h45</td>
<td><strong>Panel Discussion Two</strong></td>
<td><strong>Facilitator: Commissioner Moira Marais-Martin</strong></td>
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<td><strong>Neurological Diseases</strong></td>
<td>Dr Mikateko R Mokabane</td>
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<td><strong>Respiratory System Diseases</strong></td>
<td>Prof Charles Feldman</td>
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<td>12h45 – 13h00</td>
<td><strong>QUESTIONS &amp; DISCUSSIONS</strong></td>
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<td>13h00 – 14h00</td>
<td><strong>LUNCH</strong></td>
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<td>14h00 – 15h30</td>
<td><strong>Panel Discussion Three</strong></td>
<td><strong>Facilitator: Commissioner Lulu Sizani</strong></td>
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<td><strong>Labour Relations</strong></td>
<td>Mr Meshack Ravuku</td>
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<td><strong>Human Resource Management</strong></td>
<td>Ms Brenda Magqwaka</td>
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<td><strong>PSCBC</strong></td>
<td>Adv. Luvuyo Bono</td>
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<td>15h30 – 16h00</td>
<td><strong>QUESTIONS &amp; DISCUSSIONS</strong></td>
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<td>16h00 – 16h15</td>
<td>Consolidated Recommendations from Panels : Commissioner Gavin Woods</td>
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<td>16h15 – 16h30</td>
<td>Vote of Thanks and Closure: Commissioner Singata Mafanya</td>
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