Chapter 18

After Apartheid: Decay or Reconstruction? Transition in a Public Hospital

Karl von Holdt and Bethuel Maserumule[1]

This chapter investigates the impact of the triple transition on the workplace in South Africa's biggest hospital, Chris Hani Baragwanath Hospital in Soweto. It explores the paralysis and internal decomposition of the workplace regime as it is crushed between two forces – budget cutbacks and the concomitant staff shortages on the one hand, and the breakdown of managerial structures and disciplinary relations on the other. Lacking robust and effective managerial structures and systems, the institution is subject to a slow unravelling of workplace relations and practices, and a deterioration in the quality of both health care and working life. The chapter also documents a trade union initiative to reconstruct workplace order on a new basis.

Public service workplaces have been relatively invisible in the evolution of progressive industrial sociology research in South Africa, with its focus on private-sector manufacturing and mining. This study of the health sector constitutes a first step towards attempting to understand the specific character of the workplace regime in the public service and to facilitate a comparison with the changing workplace regime in industry. What was the character of the apartheid workplace regime in the public service, specifically in hospitals? In what ways did it resemble or differ from the apartheid workplace regime in the private sector (Von Holdt 2003b)? Has it been affected by the transition in similar ways? To what extent is the nature of workplace order subject to contestation? Is a distinct post-apartheid workplace regime emerging?

This study

The research for this study developed out of a trade union initiative for the transformation of Chris Hani Baragwanath Hospital into a 'People's Hospital' which would improve the quality of health-care service as well as the quality of working life for union members. In

2000, officials of the National Education Health and Allied Workers Union (NEHAWU) approached the National Labour and Economic Development Institute (NALEDI)[2] to assist with this project. After a series of workshops and discussions with NEHAWU shop stewards, NALEDI drew up an initial report on behalf of the union with broad proposals for change (NEHAWU 2001). This was presented to management, the hospital Board and the other trade unions at the institution, and finally adopted as a framework document by all stakeholders at the beginning of 2002 (*Towards a People's Hospital* 2002). The Surgical Department was chosen as a pilot project for the implementation of change, and NALEDI was commissioned to undertake in-depth research into the functioning of this department. Interviews and focus groups were arranged with all levels of staff, from cleaners to doctors, and proposals for change were designed based on the results. The research and proposals were then presented to the trade unions and management at a Transformation Forum – itself established as an element of the stakeholder agreement (NALEDI 2002). –There, agreement was reached that the proposals would be implemented as a pilot project for change in the Surgical Department. The process of creating the conditions for implementation began early in 2003.

This study is based on the research into shop stewards' views undertaken for the initial report in 2000, the interviews and focus groups conducted for the research into the Surgical Department in 2002, and the research information gathered through a process of participant observation. NALEDI was a participant in trade union, shop steward and management meetings by virtue of its role as adviser in the transformation project – a role which also entailed numerous information-rich informal discussions with all parties. The authors of this chapter are NALEDI researchers. The researchers' location in the institution as active protagonists – as advocates for a more participatory, democratic and co-operative workplace environment – obviously colours the research as well as the arguments put forward in this chapter; indeed, the substance of the chapter constitutes an argument for specific policy changes in order to reconstruct the institution. However, both the research findings and the arguments for change have been tested by robust exchanges within the institution as well as with senior officials in the national and Gauteng departments of health, as well as in the arduous process of attempting to implement change.Indeed, there is nothing like the practice of grappling with the challenges and difficulties of institutional change for generating rich knowledge about the workings of institutional structures and practices.

The hospital

Baragwanath Hospital – the name of assassinated Communist leader Chris Hani was added in 1997 to signify the reorientation of the hospital in the new democratic era – was established as a military hospital with 1 500 beds during World War II, and later converted into a civilian hospital for the African residents of the Witwatersrand. After the war, the African section of Johannesburg General Hospital, consisting of 480 beds, was transferred to Baragwanath. When Soweto was established around the site of Baragwanath by the apartheid government during the 1950s, the hospital became the main health-care facility serving the residents of the vast African township. Indeed, it was something of a showcase project for successive white governments to demonstrate that they did indeed care for blacks.

By the 1990s the hospital had grown to accommodate over 3 000 beds (reputedly the biggest in the world), although by the end of the decade only 2 600 were in use because of financial constraints. Chris Hani Baragwanath is a vast institution, consisting of 429 buildings spread out over extensive grounds. Most of the wards are long, low, barrack-like structures. In 2003 there were some 5 000 people working there, including 2 000 nurses and 600 doctors. It is one of four tertiary hospitals – that is, a specialist hospital with links to an academic teaching and research institution – in Gauteng province, and is the site for the greater part of the teaching and clinical research of the University of the Witwatersrand medical faculty (www.chrishanibaragwanathhospital.co.za).

The Department of General Surgery consists of eight wards with a total of some 250 beds. Specialist surgical departments add another eight wards. The staff complement for the surgical departments consists of roughly 200 nurses, 40 ward attendants, 25 clerks and 30 cleaners. There are 80 doctors in the General Surgical Department. The wards are big – most have 32 beds, while the biggest has 60-odd beds – and are arranged on either side of a long sloping corridor, the Surgical Corridor. The busiest ward is the Surgical Admissions Ward, which admits patients from Casualty. From here patients are distributed to the male and female wards. In the wards, patients are prepared for surgery, and post-trauma and post-operative recovery is managed.

The nursing staff consist of a distinctive hierarchy. At the bottom are the ward attendants who carry out non-nursing duties – operating the kitchen (warming and dishing up food, making and serving tea), cleaning lockers, working in the sluice room, packing the clean linen distributed from the laundry and collecting soiled linen for return to the laundry. Nursing

auxiliaries, who have a year of practical and theoretical training, wash patients, make beds, record patients' vital data, distribute certain levels of medication, apply dressings, and escort patients to other parts of the hospital or to other hospitals. Staff nurses, with an additional year of training, have additional tasks – accompanying ward rounds, writing a daily patient report, administering medication up to schedule-five drugs, preparing patients for theatre, and so on.

Professional nurses have completed a four-year training programme and are accountable for health care. They manage the other nursing staff, administer scheduled drugs, and can apply ventilation and resuscitation equipment. They also have a range of administrative and managerial tasks such as planning staff allocations and ordering stock. After three years of practical work, professional nurses are generally promoted to become senior professional nurses, and after a further three years to chief professional nurses (CPN).

Currently, most wards are expected to have four professional nurses, two auxiliary nurses and two ward attendants on day shift, each working four days on and four days off per week. This means that on six days per week there are half this number actually on duty. Night shifts are generally expected to operate with a smaller number of staff – a professional nurse and an auxiliary nurse, with a ward attendant shared between two wards.

Each ward also has a number of support workers – one or two cleaners managed by a supervisor and foreman located in offices far from the wards, and a ward clerk managed by a supervisor in the corridor outside the ward.

The ward is managed by the most senior chief professional nurse on duty on each shift. She is accountable to the corridor supervisors or matrons, who are stationed in an office in the Surgical Corridor, and each of whom oversees four wards. The corridor supervisors in turn are managed by a nursing assistant director for the surgical wards, stationed in the administration block. The surgeons are managed by the surgical chief clinician, and apart from actually conducting operations they prescribe the clinical dimension of health care on ward rounds and on individual visits to their patients.

An overview of the democratic transition and change at the hospital

First, a word of caution: the primary purpose of this study was to understand the current dynamics of workplace order and disorder, rather than to probe the nature of workplace practices before the democratic breakthrough (1990-94). The precise nature of control and

authority and the dynamics of compliance and resistance during the period of apartheid require further research. Nonetheless, certain characteristics can be gleaned from interviews and conversations with those who have worked at the hospital for many years. One aspect is worth remarking on – many, if not all, interviewees expressed a certain nostalgia for the time when Baragwanath functioned effectively as a hospital, a time when supervisors knew how to supervise and discipline was discipline.

Because Baragwanath hospital was a 'black' hospital, the transition to democracy did not imply a reorientation to serve a new community, as it did for 'white' hospitals such as the Johannesburg General Hospital. The impact of the transition was felt far more in terms of internal institutional relations and dynamics – changes in the racial division of labour, the recognition of trade unions, and changing attitudes towards and practices of discipline.

As in the private sector, the institution was characterised by a rigid racial division of labour during the period of apartheid. During the 1980s virtually the entire senior and middle management layers were white, including clinical, administrative and financial management. Most doctors and paramedical professional staff – radiologists, physiotherapists, and so on – were also white. Most nursing and clerical staff, and all support workers such as cleaners, porters, ward attendants and security guards, were black. What distinguished the workplace regime at Baragwanath, as a hospital serving black communities, from workplaces in the private sector was that the biggest contingent of professional workers, the nursing staff, was almost entirely black. This constituted a highly skilled group, including significant supervisory layers.

Apart from the somewhat distinctive racial division of labour, the apartheid workplace regime at Baragwanath was characterised by a hierarchical and disciplinarian managerial style, and a strict, even despotic, disciplinary regime for black workers.[3] By the end of the 1980s the industrial relations regime in the public service still resembled the classical apartheid workplace regime as it had existed in the private sector at the beginning of the 1970s, before the resurgence of black trade unionism and the labour reforms of 1980. Public service workers had no trade union, collective bargaining or dispute resolution rights. The Labour Relations Act (1981) specifically excluded public service employees. White public service trade unions engaged in practices of consultation with a white government which was sympathetic to their concerns (Nyembe 1992). Black public service workers had little job security and no recourse against unfair dismissals. Public service institutions such as

Baragwanath Hospital were characterised by personnel administration departments rather than industrial relations or labour relations functions, mirroring the situation in industry at the beginning of the 1970s.

In the late 1980s, trade union organisation of black workers in the public service was in its infancy. NEHAWU was launched in 1987 as an affiliate of the Congress of South African Trade Unions (COSATU), but in 1988 had only 6 000 members drawn mostly from support workers in the health sector (Baskin 1991: 217, 282). The situation among nurses was somewhat different. All nurses were obliged to belong to the South African Nursing Association (SANA), a statutory organisation dominated by white nurses and bureaucrats. With its strong professional and elitist ideology, and its hostility towards any form of trade unionism for nurses, SANA served more as an institution for the control of black nurses than a vehicle for negotiating workplace conditions and practices (Gwagwa and Webber 1995). Indeed, nursing had 'long been one of the few paths for training and better paid employment open to African women', and many nurses, particularly the older generation, internalised the hierarchical, disciplinarian and status-driven values of the profession. (Keet 1992: 51; see also Gwagwa and Webber 1995) Thus, in contrast to industry, black trade unionism in the public service, and specifically in the health sector, only flourished after 1990 – that is, it was more a phenomenon of the transition than of the anti-apartheid struggle.

By the time this study was undertaken (2001-4) much of this had changed. Public service workers had full collective bargaining and organisational rights regulated by the Labour Relations Act (1995). NEHAWU had become the second-biggest affiliate of COSATU, and there were several other public service unions affiliated to the National Council of Trade Unions and the Federation of Trade Unions of South Africa. SANA had been disbanded and absorbed into the Democratic Nurses Organisation of South Africa (DENOSA), which affiliated to COSATU in 2003 and competes with other health sector unions for nurses' membership.

In the institution itself, white senior management had been largely replaced by black managers (two out of three directors, both senior clinical executives, and three out of five deputy directors), although there remained a larger contingent of white middle managers, particularly in administrative, financial and personnel functions (www.chrishanibaragwanathhospital.co.za). Relations between management and the four recognised trade unions – NEHAWU, DENOSA, the Hospital and Other Services Personnel

of South Africa (HOSPERSA), and the National Union of Public Service Workers (NUPSW) – were characterised by regular consultative meetings and elaborate disciplinary procedures. However, as will be shown below, these changes had ushered in a process of decomposition of workplace order, rather than the formation of a new post-apartheid workplace order.

Dysfunctional management

All staff expressed extreme frustration at what can only be called a general managerial failure at the institution. While for most staff this was most immediately apparent in the failure of supervisors and managers to exert disciplinary control – discussed below – many saw this as simply one aspect of a broader managerial vacuum in the institution. This was articulated most forcefully by a group of CPNs with years of accumulated experience between them:

> We are doormats for everybody. We are running this hospital for the hospital's management. When we go to meetings with our supervisors we complain about the shortage of staff, the linen, the cleaners. They tell us, "Try your best!" They come with no solutions. It is a waste of time, problems remain unresolved. Who do we cry to? We never see the managers.

A group of nursing auxiliaries endorsed this:

> Problems like staff shortage, low morale, discipline, the resignation of nurses, are not dealt with The matrons are from the wards, but as soon as they go into their offices it is as if they are in a totally different world.

There are several reasons for this – the silo system of management, an administrative and authoritarian managerial culture, and a straightforward lack of managerial capacity.

The silo system refers to the traditional health-care structure of management in which different occupational categories are managed in parallel but separate lines of managerial authority. Thus the nursing line of authority extends all the way up from the wards to the nursing director, while the clinical line of authority extends from the doctors up to the clinical director, and the support workers are managed by a branched logistics line of authority which culminates with the Human Resources and Logistics director. This means that no single manager has accountability for the effective functioning of a specified operational area such as a ward or the Surgical Department as a whole, or the authority to manage it. Effectively, virtually every level of supervisor and management is disempowered.

The chief clinician described his frustration and his inability to implement new working

practices which required the co-operation of the nursing management. Nurses complained that doctors arranged ward rounds at the busiest times of the day, when understaffed nurses were battling to complete their tasks; doctors complained that nurses failed to accompany them on ward rounds. Nurses and doctors both complained about the behaviour of cleaners and clerks, and their inability to get any response from their supervisors. Underlying such problems was the elusive nature of authority divided between different silos and without clear lines of accountability between them.

Instead of an integrated operational management, the fragmentation of managerial structures into silos generates an administrative, hierarchical and authoritarian managerial culture. Managers and staff are acutely aware of status, hierarchy and the demarcations that define the limits to the authority of themselves and others. They tend to focus on paperwork, administering rules, regulations and personnel, rather than managing operations, people or strategies. Managers are isolated in the nine-floor administration block, and according to staff are seldom seen at the sites of health-care delivery. We came across several examples of 'management by memo' – managers circulating memoranda announcing decisions that were unworkable in the wards or that generated all kinds of new problems and tensions.

To the general hierarchical and authoritarian characteristics of this kind of bureaucratic culture must be added the specifically hierarchical, status-conscious and disciplinarian culture of the nursing profession (Gwagwa and Webber 1995). When we met a group of nursing auxiliaries they made a point of refusing to give us their names:

> We go to meetings and raise issues, and then they write our names down. We are ruled autocratically. We cannot make suggestions – they will kill you. It is like this even if there are unions.

The Assistant Director for nursing unwittingly reinforced their complaint when she said, 'The nursing auxiliaries are not a happy group. They cannot understand, they argue. I sometimes feel I should call in Security'.

The chief professional nurses responsible for running wards articulated the same complaint: 'The problem is that we who are in the working situation are never consulted. There is no consultation by management; to consult with us would show that they honour us'.[4] We came across numerous incidents of this type throughout the institution. The dysfunctional management structures and practices that characterise Chris Hani Baragwanath Hospital give rise to poor decision making with all kinds of unintended consequences,

aggravating workplace inefficiency, conflict and frustration.

Finally, there is the problem of management capacity. A 2003 organogram of the management structure on the hospital's web site indicates that thirteen out of 30 management positions were vacant. Even if they were filled, the 'management resources and expertise' would be 'less than adequate' for managing such a large and complex institution, with the result that the institution lacked a strategic plan, according to a consultant report commissioned by NALEDI (Tapson and Baker 2002: 3, 16).

The same report found that the human resources (HR) function was 'under resourced, poorly structured and is focused on administration as opposed to service'. The HR director was also responsible for information technology (IT) and logistics – that is, the entire support workers silo, including the laundry, the kitchens, security, and so on. His deputy director was essentially a payroll administrator. Staffing levels had been reduced from 84 to 47 over the previous decade, and their main function was payroll and personnel administration. There was to all intents and purposes no proactive labour relations or human resources development function, no skills training for non-professional staff, no career development, career paths or functioning skills development plan, and no internal communications capacity. In short, the institution lacked a human resources strategy or the capacity to develop one.

Although the NALEDI investigation did not examine financial management in any detail, it is clear that the institution lacks financial management capacity and systems. The silo structures of management and the absence of financial systems produces a very low level of financial control, with concomitant high levels of wastage, theft and corruption. Likewise, there are no quality control systems at the hospital. In the surgical wards quality control would entail monitoring patient recovery rates, wound sepsis rates and similar indicators of the effectiveness of health-care management, so that trends could be established and health-care strategies implemented improve results. In the absence of clear accountabilities and systems, such monitoring cannot take place.

The lack of management capacity is exacerbated by the centralisation of control over many aspects of hospital functioning in the hands of the provincial health department. There is some controversy and a great deal of tension over this issue, but it is clear that there are very significant constraints on the scope for the hospital management to take full accountability or adopt innovative strategies. The result is 'frustration and justifiable feelings of disempowerment' so that it 'is not surprising that the capacity to promote transformation

and reorganisation is largely absent' (Tapson and Baker 2002: 3).

Budget cuts and staff shortages

There has been a substantial reduction in tertiary hospital budgets over the decade of democratic transformation in South Africa. This is not directly or only because of the macro-economic orthodoxy with its attendant fiscal discipline adopted as policy by the ANC government in 1996.—Indeed, the overall budget for health has remained fairly constant in financial terms over this period. More directly, it is due to a shifting emphasis within the health budget which has redistributed resources from tertiary-level to primary-level health care, and from well-resourced provinces to the poorer and more rural provinces. Nonetheless, the resulting fiscal discipline, which has been internalised by government in the form of an outer limit on the total government budget of 24 percent of GDP, does impose constraints on the resources available for health-care transformation.

This general trend probably provides an explanation for the failure to address the budget discrepancies that have their origins in the apartheid structure of the health services. Black hospitals were significantly under-funded in comparison to white hospitals. Chris Hani Baragwanath Hospital still suffers from this legacy. Thus, it fares worse on all measures in comparison with the formerly white Johannesburg General Hospital. While the former has almost two and a half times the beds of the latter, its expenditure is only 14 per cent more. This translates into personnel expenditure per bed, personnel expenditure per patient day, and total expenditure per bed that are 34 per cent, 70 per cent and 58 per cent, respectively, of the comparable expenditures at the formerly white hospital. (Department of Health 2003b)

The shortage of funds has placed enormous pressure on all aspects of Chris Hani Baragwanath operations. Over 1 000 of the 3 000 nursing posts specified by the 'staffing establishment' for the institution are vacant because of insufficient funding – a staff shortage of some 30 per cent.[5] (In comparison, both Johannesburg General and Cape Town's Groote Schuur have nursing staff shortages of 10 per cent.[6]) Similar reductions seem to hold for other categories such as ward attendants and cleaners.

According to the chief surgical clinician the nursing shortage amounts to a 'crisis'. A nursing auxiliary described what this meant for his working day:

> I am the Atlas carrying the ward. I must skip my tea. I have to jump, to rush time. I must stop

> washing and serve tea. If there are no ward attendants I must go and make tea myself. There is no point in washing the patient and giving medications, but failing to feed him. Again, how can you leave a sick person in a wet bed, and go for lunch? In our training we were taught that you cannot wash the patient alone, but must always be two. Patients require regular turnings, and again, according to the rules, there should be two nurses to do this. At present we wash alone, we turn alone, we make beds alone, irrespective of how obese or how ill the patients are.

The CPNs described their day in similar terms:

> You do not have linen today; you must phone the laundry. The dietician wants information about certain patients. Then a relative of the patient phones; there is no clerk to take the call and she wants the sister, so you have to deal with it. Then a doctor arrives and wants me. The supervisor of the cleaners does not respond to a complaint, so you end up sweeping the ward. If you do not have a ward attendant you must also go to the kitchen. The injections and medications are waiting. There is a patient to prepare for surgery. Then there are the reports and other paperwork. Where do you find time? At the end of the day your head is so big . . .

The result is that they have to 'prioritise ruthlessly – those being prepared for theatre, and then the critically ill and very ill. The others must just wait'. Sometimes nurses just 'top and tail' patients instead of giving them a full wash. Forfeiting tea and lunch, working overtime, working extra weekends – the workload and stress are 'unbearable'. Nurses respond to the stress by avoiding work – through resigning, coming late or absenteeism – by becoming irritable, aggressive and uncaring at work, and in some cases turning to alcohol.

The workload and stress have exacerbated relations between the different occupational categories in the wards as workers, overwhelmed by their own tasks, refuse to assist others. The result, according to the chief clinician, is 'work fragmentation'. 'The focus is not service to the patient,' he said; 'It's "I do my job, you do yours".This attitude has emerged in response to staff shortages. It was the impact of budget cuts'. The CPNs agreed. During a focus group they said, '. . . posts were frozen; the most important change is the shortage in staffing levels'.

A further consequence of short staffing is daily staffing crises, as the absence of a nurse or cleaner through illness or leave necessitates reshuffling staff from other hard-pressed wards. The constant reshuffling of staff prevents the building of stable working relations and creates new conflicts. The shift patterns for night staff entail regular overtime, but because of financial constraints management has issued instructions that this overtime will not be paid; instead, staff can take an equivalent amount of time off when they return to day shift. However, the staff shortages on day shift prevent this, with the result that staff have accumulated unmanageable amounts of overtime.

The shortage of managers, itself related to financial constraints, in turn constrains the

ability of management to approach these and other problems in a strategic manner.

Discipline

All staff, from cleaners to doctors, complain that a significant minority of workers in every category are ill-disciplined, lazy, absent without cause, drink at work, or are guilty of theft and corruption. All likewise blamed supervisors for failing to implement disciplinary measures. The result was demoralisation and cynicism among honest and hard-working staff.

A nursing auxiliary expressed his moral outrage vividly:

> There are no disciplinary measures from top to bottom. Who is to discipline whom, when? Someone comes on duty drunk but he will never be disciplined. Are we not supposed to be disciplined? Where is this discipline? A known habitual loafer is never disciplined. Someone steals a patient's clothes. They know exactly who is responsible, but there will be no disciplinary action. They call a meeting of everyone and give a lecture on how to conduct ourselves.

A group of professional nurses also complained bitterly:

> There is a disease in management of not acting. Management knows the rotten potatoes and leaves them alone. If you report, you are regarded as a culprit. Then we all keep mum. You cannot trust anyone.

The worst disciplinary problems are found among the cleaners, as one of them confirmed:

> Now we have corruption. Some do not work, others do. People are ungovernable. They just disappear; there is no discipline. They sign in for work and then go out, and at 3 p.m. they come back just to sign out. Their supervisors know and do nothing. Some of them do their washing and ironing on the premises – even supervisors to this. Some of them are taxi owners and go to drive their taxis; others sell cassettes on the bridge.

Certain terms that have entered into the common discourse at the hospital reflect the pervasive culture of flouting discipline and of supervisory apathy. Workers who cannot be found at their workstations are said to have gone 'over the bridge' – a reference to a bridge at the entrance to the hospital on top of which some 'loafers' join the throngs of hawkers selling a variety of goods, and over which others cross to reach the shebeens. *Uyaziwa* – He is known – refers to the attitude supervisors adopt in the face of habitual offenders; they are known to be lazy or drinkers, so there is no point in disciplining them. A 'banana' is a bribe, something that clerks in particular are reputed to be guilty of demanding from patients. Many workers complained that they were known as 'donkeys' who work hard, and that supervisors would pair a lazy worker with a donkey in order to ensure that the job is done.

One reason for the disciplinary paralysis at the hospital is the bureaucratic disciplinary procedures which have to be ratified by the provincial department of health. This example of the excessive centralisation of control results in endless delays and disciplinary failures. This undermines managerial authority, and many supervisors prefer to take the easy route and simply avoid trying to exert discipline (Tapson and Baker 2002: 4, 9-11)

More important, however, is the collapse of the old apartheid disciplinary regime in the face of worker resistance and democratic expectations, and a failure on the part of the institution to establish a new disciplinary regime. Virtually all interviewees referred to the NEHAWU strike in 1992 as a turning point. The strike began in June of that year when general assistants at Baragwanath staged a wildcat walkout. It spread rapidly to other hospitals, with some 8 000 workers on strike. The strike centred on wage demands and the absence of collective bargaining rights for public service workers. It dragged on for four months in the face of a hostile and intransigent old-order management, and was characterised by escalating levels of worker violence. Twelve people were killed during the strike, with intimidation, assaults and arson directed against strikers and strike breakers alike, particularly black nurses who continued working. The union mobilised daily pickets and demonstrations outside Baragwanath, while management employed large numbers of scabs (Fenichel 1992: 11-3).

When the strike was settled and the strikers returned to work at Baragwanath, they found they had to work side-by-side with the scabs whose services management refused to terminate. Both strikers and scabs had armed themselves in response to the violence of the conflict, and several of them continued to carry firearms at work. Supervisors were often afraid to discipline workers. The institution was left with a legacy of deep tension between workers. The strike had destroyed the harsh and anti-union disciplinary regime characteristic of the apartheid workplace in the public service, but nothing was established to take its place. A cleaner described the change:

> The hospital has been a mess since 1992. Workers used to fear their supervisors and run to do their work. When we came back after the 1992 strike we found cleaners and ward attendants without discipline, without training. We found trolleys everywhere. The ones who were employed as strike breakers are the problem – there is tension between them and other workers, and they are uncontrollable. They bring guns and alcohol to work. Now discipline is applied in a discriminatory way.

Speaking with indignation from within their status-conscious and authoritarian nursing culture, the CPNs associated this situation with the broader changes brought about by

democratisation:

> When the ANC took over, everything became relaxed; you could do anything in the new dispensation . . . The lowest categories control the hospital. Since the unions were introduced the shop stewards have been running the hospital, but they cannot even write their names! They get out of hand and it is difficult to handle. Management is scared to discipline and control. The shop stewards confront and victimise the nurses. We also belong to a union but we do our job. Everyone barks at us. We have no dignity; we are degraded. There is supposed to be democracy, but not in the manner of Baragwanath.

The 1992 strike occurred at a watershed moment in the shift from the apartheid industrial relations order to a new democratic industrial relations order in the public service. Soon afterwards, trade unions were recognised, collective bargaining for the public service took place in the newly established Public Service Bargaining Council, and formal disciplinary and grievance procedures, including the right to trade union representation, were put in place. These changes have not facilitated the resolution of workers' problems, and a further unravelling of workplace order was manifested in an explosive and controversial countrywide series of wildcat strikes by nurses in 1995. While their immediate demand was for a fair pay increase, nurses also voiced grievances over shifts, grading, lack of workplace consultation and poor working conditions. They expressed an across-the-board hostility to all official worker organisations for failing to represent them adequately (Forrest 1996a, 1996b; see also Gwagwa and Webber 1995; Mantashe 1995; NEHAWU 1996).

By the time of our research, the trade unions at Chris Hani Baragwanath were meeting regularly with management to consult on issues of mutual concern. Each trade union had offices, and the majority trade union, NEHAWU, had three full-time shop stewards. However, despite the institutionalisation of trade unionism and workers' procedural rights in the institution, no proactive strategy has been established to build a new workplace regime, based on a new consensus about roles, rights and responsibilities. Thus discipline has been highly contested, with a minority of workers flouting any disciplinary control and backing this up with threats of violence, supervisors abdicating disciplinary responsibility, and the majority of workers highly frustrated and resentful.

In this fragmented and conflictual terrain, the trade unions themselves, particularly NEHAWU with its more militant traditions and base among the support workers, find themselves locked into a negative role, using bureaucratic procedures to defend wrongdoers. A group of NEHAWU members expressed this concern forcefully:

> The union is defending those who are wrong. It must educate its members and shop stewards.

> There should be clear rules. What is the point of having lots of members while they are rotten? We are the real NEHAWU members. More are rotten, and they dominate. They like NEHAWU because when it says, "No, that is final". NEHAWU delivers, but some people take advantage.

As the nurses observe, the broader transition from apartheid to a democratic order has plunged the workplace regime into crisis. A similar process of decomposition occurred in the manufacturing sector during and after the transition, but there market pressures tended to impel managers to adopt proactive strategies for establishing a new workplace order (Von Holdt 2003b: 238-40). At Chris Hani Baragwanath Hospital, in contrast, market pressures do not play a role, and neither management nor the Department of Health have the capacity or the expertise to develop a more strategic response. Indeed, the institution has what is essentially a personnel administration department which was designed for the apartheid-era workplace instead of a genuine human resources department with the strategic capacity to envisage and work towards a new workplace order. This does not seem to disturb ANC politicians such as the Minister of Finance who routinely continue to denounce the behaviour and ethics of public service workers rather then grapple with the structural causes of workplace disorder (Von Holdt 2003a).

Work organisation and skills formation

The silo structures of management, reinforced by a general lack of managerial capacity, create a fragmented work organisation which generates tremendous inefficiencies and frustration at the site of actual health care delivery – the wards. While the most senior CPN is in charge of the ward, she has no authority over ward clerks, cleaners and ward attendants. This leads to frequent conflict over who is supposed to do what and who has the authority to issue instructions.

A nursing supervisor explained that the demarcation between different categories of worker creates 'grey areas' which have to be negotiated. For example, if blood is required the doctor may have to fetch it himself if a ward attendant or nursing auxiliary refuses, because it is not strictly part of their job description.

The CPNs described the difficulties of trying 'to work with those who are managed from far away'. Non-nursing staff such as cleaners, ward clerks and ward attendants responded to their requests 'with the refrain that "I do not fall under a nurse"'.

Ward clerks experienced their separation from the nursing function as a form of isolation. One said, ‘We are isolated from daily ward life, and only do the boring repetitive paperwork for the wards’. Like other categories of staff, they described tensions over supervision, claiming that nursing supervisors provoked and interfered with them ‘by always talking in a sarcastic way to us’. Virtually all levels of staff complained about a lack of respect between categories. As one CPN acknowledged, ‘We call the ward attendants uneducated, whereas we know the reasons why someone lacks the education; it is no fault of their own’.

As far as the ward attendants, ward clerks and nursing auxiliaries were concerned, their reluctance to co-operate was a response to the excessive workload, their frustration that their skills were not recognised, and the lack of opportunities for training and advancement. They all expressed keenness to expand their jobs by taking on more skilled tasks. This might open up prospects for training and advancement and end their current frustration. As a ward clerk explained, ‘I find my routine work very boring and demotivating. I have been in my post for ten years. I need change. There is no career path for us’.

Yet the hospital was pursuing the opposite strategy, cutting down on its training. For example, the training of nursing auxiliaries had stopped, and the hospital was recruiting from the ranks of those who had already paid for their own training externally. Likewise, the nursing college attached to Chris Hani Baragwanath was training professional nurses by taking ‘new students from the location, but they do not take us, they do not appreciate our contribution’. As with the ward attendants, the nursing auxiliaries were required to orient auxiliaries who came from outside as well as train the student nurses, ‘but tomorrow she is my senior, telling me what to do’.[7] This problem was aggravated by the fact that staff shortages made it impossible to release staff for training.

These inefficiencies, frustrations and conflicts experienced in the wards were replicated at the broader level, in the relationship between the wards and other departments and activities in the institution. Thus nurses complained about shortages of vital equipment. Equipment that was sent away for repair, or orders for new equipment, would disappear with no explanation about what was happening. Linen shortages were a perennial problem. The pharmacy was inefficient so nurses had to repeat their trips to it. The IT system was a shambles so ward clerks spent much of their time as messengers, taking forms from one point to another. All of these problems made the workers in the wards feel that there was a managerial vacuum.

Impact on morale and work culture

The overwhelming impression, from the CEO who explained that he was unable to get the hospital clean to the cleaners who complained that they were never consulted, was a sense of disempowerment, a sense that nothing could change. A nursing auxiliary spoke with deep bitterness about his sense of alienation from his calling:

> I have served with every energy I have got. I feel neglected. When I wake up in the morning my soul is not up-to-date; I feel sick and I do not want to come to work. We do the dirtiest jobs of all. That is fine, that is our training. But the worst is the salary. The last resort is to resign from hospital and sell vegetables in the township.

Frustration about the declining quality of health care delivery at Chris Hani Baragwanath, and their own inability to perform their jobs well, was felt to be profoundly undermining. As one nurse explained, 'We used to be proud to work at Bara; even the way you walked to work showed your pride. Now you are just ashamed'.

The union project for reconstruction

It was in this context of extreme frustration and demoralisation that NALEDI worked together with the trade unions and staff in the Surgical Department to develop a set of proposals to transform the way in which work was organised. Given that the over-riding problem articulated by staff was the managerial vacuum that they experienced, and that without an effective management structure there was no prospect of implementing any changes, the proposals devoted considerable attention to developing more effective management structures and practices. The underlying assumption was that more effective management and work organisation would enable better use to be made of existing resources and staff; staff shortages could be accurately assessed and strategies developed to address them. The key elements in the Business Plan (2003) were:

- The silo structures of management were to be replaced with an integrated and accountable managerial structure. A general manager for the Surgical Department would be responsible for the effective functioning of the entire department. A ward manager for each ward would be responsible for managing all operations within the ward.
- Human resources management should be brought out of the administration block and into the workplace by establishing a new position of human resources officer for the Surgical

Department, whose role would be to manage the implementation of many of the processes described below.

- The fragmented work organisation in the wards would be replaced with an integrated work organisation. This would be based on a team-working approach where working relationships and joint problem-solving processes would be established, and then assessing staff shortages.
- A joint management-labour process would be implemented, to establish a new disciplinary regime with mutually understood roles and codes of conduct to which supervisors, shop stewards and staff would be held accountable.
- New business systems would be implemented so that cost centre and quality audit accountabilities could be put in place.
- Once the new system of ward management and integrated work organisation was functioning properly, more advanced work organisation would be developed and implemented. It would be based on the recognition of skills and multi-skilling of the ward attendants, nursing auxiliaries and ward clerks, whose numbers would ultimately be increased so as to relieve the pressures on the professional nurses. Training and career pathing would be developed.

These proposals were adopted by the management of the hospital and accepted by the provincial Department of Health at the beginning of 2003.[8] One of the hospital superintendents was appointed to fill the surgical general manager position (without reducing any of his other responsibilities!). The new management team consisting of the superintendent, the chief clinician, the nursing assistant director and the nursing and clerical corridor supervisors started meeting regularly to put in place the conditions for implementing the proposals. It took the entire year to draw up the job descriptions for the new positions, win departmental approval, advertise, interview and fill them – a measure of how cumbersome and under-resourced these procedures are. Nonetheless, in the context of the general institutional paralysis and disempowerment, this progress is counted by all involved as a genuine success for the project. In the course of the year, the management team also began to grapple with operational issues, providing a forum for beginning to empower managers and holding them accountable.

The key drivers of the project have been NEHAWU, NALEDI, and specific individuals in the surgical management team. While all the trade unions at Chris Hani Baragwanath Hospital

have played a significant role in developing the proposals and providing the project with credibility, NEHAWU has played a particularly important role in putting political pressure on the Gauteng Department of Health to take the project seriously, using meetings with the Premier, the MEC for Health, and departmental managers to good effect. This has been critically important, since while health officials have given full verbal support, in practice – particularly in relation to securing financial support – their support has been somewhat ambiguous.

NALEDI has played a central role in conceptualising and winning support for the project among staff and managers, as well as at provincial level. Indeed, the lack of managerial capacity in the institution has led NALEDI to provide ongoing support and advice not only to labour but also to management. NALEDI advisers, for example, attend the Surgical Department managerial team meetings as full participants. At the same time, individual managers in the managerial team have been key change agents in their contribution to shaping the proposals, their commitment to implementation, and their role in persuading the institutional management to adopt and support them.

The modest progress so far has therefore depended on the leadership provided by key managers and trade unionists, as well as on the capacity for innovation which NALEDI represents within the trade union movement. Future progress will depend on the continued support of these actors. In the view of NALEDI, when it comes to the concrete implementation of change in the work process, the indignation and frustration of the health care workers – which is an index of their commitment to good quality health care – will be a vitally important driving force for new ways of working.

Conclusion

The apartheid workplace regime at Chris Hani Baragwanath Hospital was both similar to and different from the workplace regime in private-sector industry. It was characterised by racial domination, the absence of worker and trade union rights, and managerial despotism. However, it was a more bureaucratic, administrative and rules-based system of management. The composition of the workforce was more complex and differentiated along racial and skills lines, which created particular challenges and tensions for black trade unionism. Most distinctive was the fact that the biggest contingent of professional workers, the nursing staff,

was almost entirely black. The hospital was completely dependent on their labour, yet their ideology of professionalism and self-improvement, and tight control by SANA, made them less susceptible to trade union organisation or militant action. During the 1992 strike, for example, they continued working in the face of militant pressure and intimidation from striking support staff. It was only in 1995 that nurses themselves went on strike in utter desperation at their working conditions. A final distinguishing feature was that widespread trade unionism and the winning of trade union rights came a decade later than in the private sector, making them phenomena of the transition rather than of the struggle against apartheid.

With the transition came the rapid growth of public service trade unionism, frequent consultation with government and highly centralised collective bargaining. As a result of this and other factors, there was a weak tradition of workplace organisation and engagement with management, in contrast to the long-established private-sector trade unions. Further contrasts are also noticeable at Chris Hani Baragwanath Hospital – the workforce composition makes for more pluralistic and fragmented trade unionism, which reproduces professional tensions (for example, between nurses and cleaners); at the same time there is a less antagonistic relationship between trade unions and management, as they are united by an ideology of public service, however fractious their relations may be.

The triple dimensions of the South African transition (Von Holdt 2003b) have therefore had a contradictory impact on the Chris Hani Baragwanath workplace. Democratic rights have been firmly established: workers have trade union rights and access to disciplinary and grievance procedures, the minimum wage has increased, and the wage gap between bottom and top has diminished dramatically – from 62:1 in 1989 to 16:1 in 1998 (Adler 1998). On the other hand, the racist, bureaucratic, hierarchical and authoritarian management of the apartheid era has changed much less. Much of the racial tension and despotism of the old order may have been eroded, and the racial structure of management has shifted more substantially than in the private sector. However, most staff are still administered as disempowered objects, as they were under apartheid, rather than as human agents who have emotional lives and ideas about work, and the capacity to negotiate and consult with managers. The apartheid legacy is also felt in the financial differentiation between previously black and previously white hospitals. The result is poor working conditions and poor service for the generally poorer residents of black townships next to which the previously black hospitals are located, compared to the racially mixed urban and suburban population served by the previously white hospitals.

The economic transition has reinforced these results. While the public service workplace is relatively insulated from market pressures, the budgetary constraints that accompany a rigid commitment to macro-economic 'stability' have, when combined with the restructuring of the health budget, placed the institutional fabric under enormous pressure. Workers now labour under an impossible workload – far greater than private sector workers who labour under market pressures – which severely compromises both their own health and the quality of health-care delivery to the working-class communities they serve.

The combined impact of apartheid remnants and the reduction of budgets has produced a decomposition of the workplace regime, characterised by a profound disorder and paralysis, which management lacks any kind of strategy or capacity to address. There is much evidence that this situation is not unique, but is widespread in public hospitals, particularly those formerly classified as black (IMMSA 1995; Commission of Inquiry 1999; Landman, Mouton and Nevhutalu 2001; Baker and Tapson 2003).

This situation raises broader questions about the legacy of apartheid in the health sector. Chris Hani Baragwanath Hospital in particular, and the public hospitals more generally, are overwhelmingly the providers of health services to those who are not covered by private medical aid – that is, to the poor and mostly black majority of our society. Even if the restructuring of the health budget improves the delivery of health clinics and district hospitals as is intended, this is unlikely to reduce the pressure of patient numbers on the tertiary hospitals (Department of Health 2003a: 5-6). Indeed, there are strong arguments to be made that improving primary health care results in increased rather than reduced referrals to the specialist health care provided by such institutions. Yet current government policy is leading to the destruction of their institutional capacity, and starving them of the managerial resources they need in order to respond innovatively. The apartheid bifurcation of health service provision into different levels of care for white and black is being replicated in the new South Africa, not only in the form of lower levels of funding for previously black hospitals but also in the form of radically different levels of care for those who can afford private medical aid and those who cannot.

At Chris Hani Baragwanath Hospital, the only sign of an innovative response to this crisis is the transformation project initiated by the trade unions. As this book was going to publication, the Gauteng MEC for Health mandated NALEDI to facilitate a strategic planning process for the institution as a whole – hopefully a sign that the broader crisis of hospital

services will be addressed.

[1] We would like to acknowledge the contribution of our colleague in the Chris Hani Baragwanath transformation project, Mike Murphy, to the research and thinking that have shaped this chapter.
[2] NALEDI is a research and policy institute established by COSATU. Although NALEDI has a high degree of autonomy, its primary role is to provide advice and research analysis for trade unions.
[3] Anecdotal evidence of the racist and despotic behaviour of white matrons and doctors can be found in the memoirs of a black nurse, Nosoaki Senokoanyane (1995).
[4] Indeed, at the end of this group interview with highly experienced CPNs, which left us overwhelmed by their insights and indignation, as well as exhilarated by their energy, knowledge and commitment, they apologised for the unruly way they had poured out their views: 'When you find a listening ear you feel relieved, you want to air your problems because you feel so victimised'.
[5] It is difficult to establish with certainty what the staff establishment ought to be, since it depends on the patient load, which changes over time, as well as on the specific nursing intensity required by different kinds of health-care provision. The Department of Health has not yet established these kinds of guidelines. At Chris Hani Baragwanath, the patient load in the Surgical Department has been declining somewhat, and the chief clinician estimates that the nursing shortage is closer to 20 per cent than 30 per cent. In the Medical Department, in contrast, the patient load has increased dramatically because of the HIV/AIDS pandemic.
[6] Personal communication, surgical chief clinician.
[7] It is a serious indictment of government as employer that the lack of recognition of skills and the reduction of training by the hospital – and these practices appear to be widespread in the public service – contradicts the skills strategy of government as laid down in the Skills Development Act.
[8] Similar proposals for replacing silo with integrated management, decentralised management and cost centres are adopted in the national Department of Health's (2003a: 13) discussion document on the modernisation of tertiary hospitals.