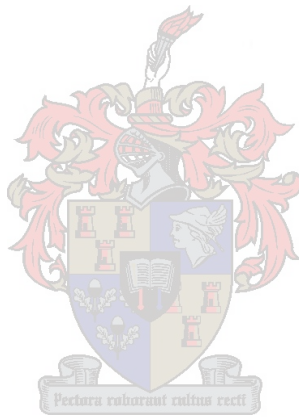# THE EXPERIENCE OF HOSPITAL MANAGEMENT AND EMPLOYEES IN TRANSFORMING THE PUBLIC HEALTH SYSTEM IN THE WESTERN CAPE 1996-2001

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Thesis presented in partial fulfilment of the requirements for the degree MPhil (Value Analysis and Policy Formulation) at the University of Stellenbosch

Study leader: Prof. B. C. Lategan

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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any other university for a degree.

Signature

Date

ABSTRACT

One of the main objectives of the new South African government who came into power in 1994 was to improve the daily living conditions of its citizens. *To what extent did the government succeed in this objective?* This is the basic research question informing the present study. In order to keep it within manageable proportions, the study investigated a very specific area of service delivery, namely the delivery of public health services. This was further narrowed down to the Western Cape and more specifically, to the role of public hospitals in the area. The Western Cape promised to be an interesting case, because although the government of national unity was dominated by the ANC, the Western Cape was ruled by a NNP dominated coalition. On the national level, the Province had to follow national policy guidelines, while on the provincial level it had more freedom to formulate and implement its own policies.

The study itself consists of two parts. The first concerns policy *formulation,* the second policy *implementation.* As far as policy formulation is concerned, a study was made of basic documents articulating the fundamental values, national priorities and main objectives informing government policy. These included the Freedom Charter, the Constitution, and the Reconstruction and Development Program. It was found that these values and priorities were in general well translated into policy options on both the national and provincial level, especially in the various documents aimed at transforming the national health system.

The second part of the study investigates the implementation of the broad policy guidelines in the area of public heath in selected public hospitals in the Western Cape. The main method of investigation was the use of structured interviews with representative employees from all different levels. The findings were therefore of a qualitative rather than a quantitative nature. The focal areas selected were personnel management issues, human resource planning, labour relation issues and human resource development issues.

The main findings were that the formulation of policy both from basic values to the level of health care policies and from the national to provincial level in general was quite successful. On the other hand, there were serious shortcomings in the implementation of these policies on various levels. The investigation revealed a mixed and often contradictory picture. Although some hospitals made good progress in some

respects, there is still a long way before quality health care will be delivered to all patients. A commitment to equity in the health services of the country implies a commitment to correcting the historical gender, class and racial imbalances in the development of human recourses for health care. Of necessity, a compassionate and caring health service will address the issue of corrective action. There is a real need to provide proper planning of those most disadvantaged by apartheid in managerial skills to fill managerial positions in the health sector. It is therefore is necessary to introduce as a matter of urgency new health management programmes, which will promote efficient and effectiveness management at all levels of health care service delivery. Current health managers need to be reoriented from the predominantly bureaucratic, rule-based approach towards a participative approach. The development of managerial capacity in areas such as participative and change management, leadership development, strategic planning, programme management and evaluation, and policy development and implementation is of crucial importance.

The study concludes with a series of specific recommendations with regard to affirmative action, managerial and institutional capacity, human resource planning, and training needs for various sectors.

OPSOMMING

Een van die hoofdoelstellings van die nuwe Suid-Afrikaanse regering wat in 1994 aan bewind gekom het, was om die leefomstandighede van al die land se inwoners te verbeter. *Tot watter mate het die regering geslaag in hierdie doelwit?* Dit is die basiese navorsingsvraag onderliggend aan hierdie studie. Ten einde die ondersoek binne hanteerbare grense te hou, is op slegs een aspek van dienslewering gekonsenteer , naamlik die lewering van gesondheidsdienste. Hierdie terrein is verder vernou tot die Wes-Kaap en meer spesifiek tot die rol van openbare hospitale. The Wes-Kaap was interessant om dat hoewel die regering op nasionale vlak deur die ANC beheer is, die Wes-Kaap basies deur die NNP in die periode van ondersoek geregeer is. Die provinsie was verplig om nasionale beleidsriglyne te volg, maar op provinsiale vlak het dit 'n sekere speelruimte geniet om eie beleid te formuleer en te implemanteer.

Die studie bestaan uit twee dele. Die eerste het te doen met beleids*formulering,* die tweede met beleids*implementering.* Wat beleidsformulering betref, is 'n studie gemaak van die basisdokumente wat die kernwaardes, nasionale prioriteite en hoof doelstellings van die regering bevat. Dit het ingesluit die Vryheidmanifes, die Konstitusie en die Heropbou- en Ontwikkelingsprogram. Daar is bevind dat hierdie waardes en prioriteite in die algemeen suksesvol vertaal is in beleidsopsies op beide die nasionale en provinsiale vlak, veral in die dokumente wat gerig was op die transformasie van die nasionale gesondheidsektor.

Die tweede deel van die studie het die implementering van die breë beleidsriglyne in die area van openbare gesondheid in gelekteerde publike hospitale in die Wes-Kaap ondersoek. Die hoof-ondersoekmetode was gestruktureerde onderhoude met verteenwoordigende werknemers van alle vlakke. Die bevindinge was gevolglik meer van 'n kwalitatiewe as kwantitatiewe aard. Die fokusareas waarop geskonsentreer is, was personeelbestuur, menslike hulpbronbeplanning, arbeidsverhoudinge en die ontwikkeling van menslike potensiaal.

Die hoofbevindinge was dat die formulering van beleid beide van baise waardes na gesondheidsbeleid en van die nasionale na provinsiale vlak in die algemeen suksesvol was. Aan die ander kant het ernstige gebreke aan die lig gekom sover dit die implementering van beleid op verskillende vlakke betref. Die resultaat was 'n gemengde en dikwels kontrasterende prentjie. Hoewel sommige hospitale goeie

vordering gemaak het in sekere opsigte, laat die lewering van gehalte-diens aan alle pasiënte nog veel te wense oor. Die verbintenis to gelykheid in gesondheidsdienste veronderstel 'n verbintenis tot die regstelling van geslags-, klas- en rasse-ongelykhede in die ontwikkeling van menslike hulpbronne in die gesondheidsektor. Dienslewering gebaseer op sorg en empatie is van deurslaggewende belang in hierdie opsig. Daar is 'n groot behoefte aan behoorlike beplanning vir die verbetering van bestuur- en ander vaardighede van agtergestelde groepe. Die implementering van behoorlike bestuursopleidingsprogramme is van die uiterste belang, wat kan bydra tot effektiewe en goeie dienslewering. Die huidige oorwegend burokratiese en reëlsgebonde bestuurstyl behoort in 'n deelnemende benadering omgeskakel te word. Die ontwikkeling van bestuurskapasiteit in gebiede soos deelnemende veranderingsbestuur, leierskapsontwikkeling, strategiese beplanning, programbestuur en –evaluering en beleidsformulering is van die grootse belang.

Die ondersoek sluit af met 'n reeks konkrete aanbevelings met betrekking tot regstellende aksie, verbetering van bestuurskapasiteit, menslike hulpbronontwikkeling en die opleidingsbehoeftes van die verskillende afdelings.

DEDICATION

To my dear and beloved parents, Pendu and Nomakhwezi Mnyembane,

who have been sources of great support and encouragement during my studies.

I cherish you, great companions and friends, for your understanding and care.

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I would like to thank Professor Johann Kinghorn, Dr. Hans Müller and my study leader Professor Bernard Lategan, all from the Department of Information Science. I am greatly indebted to you for your wholehearted support in many ways: By providing a very pleasant working and study environment, positive encouragement and financial support. Dr. Müller was always willing to make time available to talk things through and to give critical feedback on my work. Thanks also goes to Professor Johann Mouton of the Centre for Interdisciplinary Studies, whose understanding of social research methods has influenced my own thinking profoundly. I would like to recognize the efforts of my study leader in particular, whom had the most input in my studies. Because you could see in me beyond what I could, I was able to believe that I could do more. This helped me to stay focused, to work harder and whenever you were not happy with my work I knew what you were asking for. My deepest gratitude to you, scholar and wise guide. I hope that this study represents, somehow, that what you have always seen in me. My gratefulness also goes to Mrs Maria Mouton, assistant to my study leader. It was an honour and privilege to get to know you both on an academic on a personal level. You supported me like a 'second mom' during my time at Stellenbosch.

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The management of the nine hospitals, which formed the focus of the study, deserve special mention (Conradie, G.F. Jooste, Groote Schuur, Karl Bremer, Stellenbosch, Valkenberg, Lentegeur, Gugulethu and Khayelitsha Hospitals.) You not only allowed me to do my research in your institutions, but also provided invaluable support and assistance in the gathering of data and the completion of the study. I trust the results will be of some value for your challenging and important task.

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ABBREVIATIONS

The following abbreviations will be used in the study:

AA	Affirmative Action
AAH	Associated Academic Hospitals
APH	Associated Psychiatric Hospitals
ANC	African National Congress
ADN	Assistant Director Nurse
CEC	Co-ordination Education Committee
CAA	Cape Administrative Academy
CDE	Centre for Development Enterprise
CHC	Community Health Committee
CHR	Centre for Human Resource
CPN	Chief Professional Nurse
DC	Disciplinary Committee
DENOSA	Democratic Nursing Organisation of South Africa
DoH	Department of Health
DONHPD	Department of National Health and Population Development
DHA	District Health Authority
DHS	District Health Services
DHRD	Directorate Human Resource Development
DP	Democratic Party
DPSA	Department of Public Service and Administration

EBS	Employee Benefit Scheme
EEA	Employment Equity Act
FEDUSA	Federation of Unions of South Africa
GCIS	Government Communication Information Service
GNU	Government of National Unity
HOSPERSA	Health & Other Service Personnel Trade Union of South Africa
HWU	Health Workers Union
HMT	Health Management Team
HRD	Human Resource Development
HRDDDH	Human Resource Development Directorate of the Department of Health
HST	Health System Trust
ICU	Intensive Care Unit
IDHWG	Interim District Health Working Group
IMLC	Inter Management Labour Caucus
LRA	Labour Relation Act
MEC	Member of Executive Council (of the Provincial Government)
MINMEC	Ministerial Forum (of national Ministers and Provincial MECs)
NACTU	National Council of Trade Unions
NAPCH	National Assembly Portfolio Committee on Health
NAPSWU	National and Allied Public Servants Workers Union
NC	Nurse Club
NDH	National Department of Health

NHB	National Health Bill
NHLRC	National Health Legislative Review Committee
NNP	New National Party
NEHAWU	National Education Health and Allied Workers' Union
NGO	Non-Government Organisation
NHA	National Health Authority
NHS	National Health System
PAWC	Provincial Administration of the Western Cape
PAWUSA	Public and Allied Workers Union of South Africa
PHA	Public Health Act
PHA	Provincial Health Authority
PHC	Public Health Care
PHP	Provincial Health Plan
PHS	Public Health Service
PHILA	Public Health Intervention through Legislative Advocacy
PHRDITT	Provincial Human Resource Development Implementation Task Team
PSLDP	Presidential Strategic Leadership Development Programme
PMG	Parliamentary Monitoring Group
PSA	Public Service Act
PRC	Public Review Commission
PSC	Public Service Commission
PSCBC	Public Sector Co-ordinating Bargaining Council

PSR	Public Service Regulation
PSLDP	Presidential Strategic Leadership Development Programme
PBC	Provincial Bargaining Council
R&D	Research and Development
RDP	Reconstruction and Development Programme
SA	South Africa
SADNU	South African Democratic Nursing Union
SALGA	South African Local Government Association
SAMDI	South African Management Development Institute
SAQA	South African Qualification Authority
SLO	Staff Liaison Officer
SDA	Skills Development Act
TAC	Transformation Action Committee
TNA	Training Needs Assessment
VSP	Voluntary Severance Package
WC	Western Cape
WCHD	Western Cape Health Department
WPTHSS	White Paper for Transformation of the Health System in South Africa

CHAPTER 1

Introduction

1. Nature of the study

To what extent did the new South African government who came into power in 1994 fulfil its promise to improve the daily living conditions of its citizens?

This is the basic research question, which informs the present study.

In the months leading up to the 1994 election the ANC made the slogan "A better life for all" one of the cornerstones of its campaign. It summed up both the conviction that the preceding system of racial discrimination is to blame for the inequalities of South African society and the expectation that a change of government and of government policy will substantially improve the living conditions of all its citizens.

Our topic is eminently suitable for investigation from the perspective of a Value Analysis and Policy Formulation Programme. The ANC's approach to policy is explicitly value-driven. As part of a long historical tradition, going back even earlier than the Freedom Charter, the alternative that the Congress Movement promoted for South Africa was based on the basic values of non-racialism, non-sexism and non-discrimination (in their negative formulation) and of freedom, equality and respect for human dignity (in their positive formulation). These values have been translated into a wide variety of policy documents on national level (e.g. the RDP), departmental level (e.g. the White Paper on Higher Education), provincial level (e.g. the policy documents of the various provinces) and even continental level (e.g. the newly released NEPAD documentation.) The enactment of these policy positions in an equally diverse and large body of legislation and regulations represents the transition from policy formulation to policy implementation.

The relationship between policy formulation and policy implementation is a crucial aspect when assessing the success or failure of the government's performance. This

study therefore has two distinct foci: The *formulation* of policy (which includes the *translation* of policy in various contexts) and the *implementation* of policy. As will be explained later, chapter 2 and 3 broadly represents this distinction.

To change the structure and the fibre of a society which has been moulded over a period of more than three centuries by history, tradition, ideology and values in a very specific way, is a very ambitious undertaking indeed. Not only is the underlying value system to be replaced, but also its translation in every possible form, which affects every possible aspect of South African society, must be changed. Given the pervasiveness of the system it is seeking to replace the magnitude of the task the government has set itself is staggering.

It might therefore be asked whether four years (1996 to 2000, when this study was first started) is a realistic time span to evaluate results and whether substantial improvement of living conditions can realistically be expected. Although this is a valid concern, the reality of the present electoral system is that elections are held every four years and that the government in power is evaluated over this period whether it is reasonable or not. Furthermore, it was the ANC itself who set targets for implementation and the present dissatisfaction with government even within ANC ranks is directly linked to the (perceived) lack of service delivery.

Within the confines of a master's thesis it is impossible to investigate the problem in all its facets. It was imperative to restrict the study to a very specific aspect of policy formulation and implementation. For reasons that will become evident later, the health sector was chosen as field of investigation and even more specifically, service delivery in public hospitals in the Western Cape.

Such a narrowed-down focus provides us with a scope that is wide enough to study the translation of policy from national to provincial and to local level, but also specific enough to assess the state of service delivery on the ground.

The choice for the Western Cape was one of convenience and accessibility. But it is also attractive as field of investigation because of the ironic political and policy implications. It is one of the few provinces where the ANC did not succeed in gaining an outright majority in the 1996 elections. Here we had a government who during 1996-2000 consisted mainly of NNP and DP elements. While on the national level the NNP

was included in government of national unity and collaborated with the ANC, this coalition did not exist on provincial level. In fact, the Western Cape became the alternative showcase for the NNP. While it controlled no other province, the Western Cape was seen (and used) as an opportunity to demonstrate to the ANC and the rest of the country how a government should be run and how the (perceived) mistakes the ANC were to be avoided by alternative and better policies and governance.

From a policy point of view, this created a very interesting situation. While the NNP on a national level was part of the government and committed to implementing national policies (including the new National Health System), on provincial level it had some scope for own policies, especially in the hospital system, which falls under the provincial government. At the same time, many of the employees in the management of these hospitals were supporters of the NNP or DP (or at least sympathetic towards their policies.) However, this also depended on where a specific hospital is situated and on the composition of its staff. Hospitals on the Cape Flats or in black townships represented alternative and even opposing views. Care was therefore taken to include a variety of hospitals in the study and to ensure that there was the widest representation of views that was practically possible to achieve.

The choice of sector and of level provided the study with a unique (if restricted) insight into the process of policy formulation and implementation in action. It reflects the problems in translating lofty ideals into working procedures on the ground and in moving from national to local level. It also reflects the ambiguities, tensions and contradictions when policy becomes part of the political struggle between parties and sympathisers and when it becomes serviceable for other (political) purposes. Time and again the views of respondents demonstrate this basic division and emphasise the need to return to the values informing and driving the process.

From the preceding it is clear that this is a *qualitative* study. The intention is not so much to measure the extent to which policy has been implemented successfully, but to determine its nature and implications. The research interest is twofold: What has happened? How do role-players experience what has happened? The focus will therefore be both on content and on process (cf. Babbie & Mouton 2001: 490) and will follow established methods of qualitative research with some adaptations.

2. Methodology

2.1 Research design

Although the study could rely on well-developed approaches to qualitative studies, it also required a lot of ingenuity and imagination (which, according to Babbie & Mouton 2001: are essential elements of good social research.) The analysis of documentary data, direct and indirect observation and systematic interviewing (cf. Mouton 1996: 175) were some of the techniques employed.

The decision to focus the study on the health sector was based on two considerations. Firstly, there is a well-developed set of policy documents for this sector from national level downwards to local level. Secondly, it is a sector, which affects the quality of life of citizens from all levels of society and where the experience of service delivery is not only very visible, but also very existential for all role-players in the sector.

Access to data required the most ingenuity. This does not refer to policy documents, which were readily available, but especially obtaining permission to conduct interviews in hospitals. The health sector is professionally very much a closed shop. Furthermore, the delivery of health services became a controversial issue in the government's program with strong political overtones. This was especially the case in the Western Cape where the provincial government was led by the 'opposition,' as explained above. Added to this, the demands of the transformation program, the reduction of budgets and the consequent strain on existing employees did not contribute to a climate where inquisitiveness from outside was welcomed. The researcher was fortunate in having worked in this environment and having access to some individuals on management level, who were willing to open some doors. Nonetheless, it required individual formal requests to each of the hospital superintendents concerned plus several follow-up visits to obtain the required permission to work in the specific hospitals. An added requirement was to meet the strict ethical protocols, as will be explained below.

Given these restrictions, it was soon clear that structured interviews would be the most appropriate way to gather data. A draft questionnaire was devised, tested and finalised after several trial runs (cf. addendum A). Although the questions in each case were the same, there was also sufficient opportunity for respondents to elaborate on points and to express their own opinions on matters.

The researcher himself conducted all the interviews. This had both advantages and disadvantages. Having the opportunity to observe the non-verbal communication of respondents ensured consistency and continuity. Having Xhosa as mother tongue did help to create a rapport with some respondents and encourage frank answers (cf. Russel & Mugyenyi 1997.) People with Afrikaans as mother tongue were willing to conduct the interviews in English and facilitated the process. The disadvantage was that there were no other interviewers with whom to compare notes and to serve as a sounding board.

The interview process was very demanding and exceeded the expected time schedule by far. Often respondents did not turn up because of work demands or unexpected emergencies in attending to patients and constant rescheduling became the rule of the day. Although this extended the study far beyond its planned parameters, it also had the advantage of giving the researcher the opportunity to review notes, refocus, and rephrase questions and to explore new leads (cf. Babbie & Mouton 2001: 290.)

2.2 Sources

The study relies on two main sources. Firstly, documentary evidence concerning the national government's objectives, the values underpinning its approach and explicit policy statements regarding the health sector. This was supplemented and contrasted with documents containing the position of the Western Cape government on these matters. The primary documents were readily available, but very little detailed analysis of these positions. Press clippings and various reports, especially from non-governmental sources also provided valuable

material. Secondly, the structured interviews described in the previous section were the main source for the second part of the study.

2.3 Limitations

To be operationally viable, given the fact of a single interviewer, the categories of respondents had to be limited, without sacrificing representativity and validity. It was accordingly decided to focus on the employees of public hospitals in the Western Cape, as they are most directly involved in the process of policy implementation and in rendering health services to the general public. Because private hospitals do not fall directly under government control and not subject to the same policy guidelines as public hospitals, they were not included in the study.

The following categories of employees were interviewed at each hospital:

2.3.1 Non-managerial (nurses, cleaners and trade union officials)

2.3.2 Middle management (supervisors and human resource officials)

2.3.3 Senior management (heads of departments and superintendents)

The respondents were chosen randomly from a list of employees at each hospital. Transfers in the course of the study and availability at specific times necessitated changes in the list of original respondents.

To keep the study within manageable proportions and to ensure maximum representativity, the following nine hospitals in the Western Cape region were included in the survey:

Metropole region: Conradie, G F Jooste and Karl Bremer

West Coast/Winelands region: Stellenbosch community hospital

Academic hospitals: Groote Schuur

Psychiatric hospitals: Valkenburg and Lentegeur

Community hospitals: Gugulethu and Khayelistha

2.4 Focal areas

Within the broader spectrum of policy issues, certain focal areas were chosen for special attention. This was done in the realisation that not all actions/interventions can be observed at the same time and that not all evoke the same level of response (cf. Babbie & Mouton 2001: 202.)

The choice of these areas was informed directly by the policy documents on national and provincial level, which dealt with the transformation health services. We shall discuss these documents in more detail in chapter 2. Suffice to state at this point that these are all issues, which receive special attention in the policy documents. If our purpose is to determine whether the national and provincial governments were successful in improving health services and in transforming the sector, then we have to take the policy objectives as stated by the various government instances themselves as contained in their official documents as our point of departure. Consequently, the following focal areas were selected:

2.4.1   Personnel management issues

- Affirmative action and employment equity

- Other transformation initiatives

- Remuneration policies and incentive schemes

2.4.2   Human resource planning

- Staff composition and staff shortages

- Redeployment of personnel

- Decentralised hospital management systems

2.4.3   Labour relation issues

- Conditions of employment

- Labour Relations Act requirements

- Disciplinary and grievance procedures

2.4.4 Human resource development issues

- Health service management training

- Assessment of training needs

- Career planning

The rationale for this selection was that these issues would yield the most relevant information regarding conditions in the workplace, interaction between employees, worker morale, productivity and efficiency, work loads, grievance and misconduct handling and levels of employee satisfaction.

2.5 Indicators

Basic indicators were chosen to obtain information regarding the level of service provision and the level of implementation with regard to both the national and provincial policy frameworks for the health sector, in particular with regard to human resource development policies. An important factor influencing the choice of indicators was whether reliable data could be obtained. The following indicators were selected:

- Transformation initiatives

- Affirmative action (composition of staff)

- Human resource shortages and disparities (employment conditions)

- Decentralisation of the hospital management system

2.6 Ethical issues

In order tot get access to the various hospitals and their employees, formal applications had to be submitted in each case. The fact that the researcher

worked in this sector on a temporary basis before the study was undertaken facilitated the process in some instances.

Apart from obtaining access, the study had to be cleared by the respective hospital ethical committees. For this purpose the aim, procedures and especially the questionnaire had to be submitted for scrutiny. Clearance was obtained in all cases, with some minor changes recommended with regard to some questions in the questionnaire. (See addendum 1 for the final form of the latter.)

2.7 Data collection

Having obtained the necessary permission to interview employees and the go-ahead as far as ethical aspects were concerned, the greatest challenge the researcher faced was the very logistics of collecting the necessary data. The researcher had to rely entirely on the goodwill of senior management and other individual at the various hospitals for the statistics of staff in the first place, to select a representative group of employees and especially to arrange the necessary appointments for interviews. This proved to be the most difficult part. The researcher was dependent on the voluntary co-operation of respondents and interviews mostly took place during their off-duty times. However, because of the demands of caring for patients and the unpredictable nature of medical (and emergency) services, but especially because of the understaffed situation of most hospitals, respondents often were not able to keep appointments for interviews.

Appointments had to be constantly re-arranged and often the person originally selected was no longer available because they were transferred or left the profession. Often senior management also changed, including the person who helped arranging appointments. This meant returning to the same institution several times before a specific person could be interviewed. In some cases in the townships it was possible to interview respondents at their homes after work. The originally planned time schedule for the study was consequently exceeded by far and in the end it took at least twice as long as anticipated. In general, the respondents were co-operative and forthcoming and the fact that the

respondent was able to speak several African languages was a considerable advantage.

3. Anticipated results

In view of its scope and limitations explained in the previous sections, the undertaking was in fact more of a pilot study than a comprehensive survey of the state of health services in the Western Cape. The latter would require much more than what could be reasonably handled within the limits and nature of a master's thesis. The study does not claim to be representative of the all the hospitals of the Western Cape. Nor does it cover all aspects of the health service in the province. But given these restrictions, it was nonetheless broad and representative enough for the researcher to expect to gain an understanding of the overall situation at the moment, of the main problems facing the sector and the province and the general trends that are emerging. It is anticipated that the author will be in a position to provide at least some answers to the main research question and to make some considered recommendations based on the information collected and on the analysis and interpretation of this information. These findings and recommendations will be presented in the final section of the study.

4. The structure of the study

The first chapter sets out the nature and aim of the study, the methodology that was followed, the design and implementation, the selected focal areas and indicators, ethical aspects and the anticipated contribution of the study.

The second chapter provides a critical analysis of the process of policy formulation in the health sector from national to provincial and local level and discusses some of the problematic issues in this regard.

The third chapter contains the results of the structured interviews of respondents and a summary and discussion of the general trends and recurring problems.

The final chapter presents the findings of the study and some recommendations for improving the situation in the health sector.

CHAPTER 2

From principles to policy: The process of health policy formulation

1. Introduction

How did the policy that was being implemented in the Western Cape hospitals came into being? What was its basis and on what principle did it rest? In any policy process, its genesis forms an inherent past and is just as important as its eventual implementation. As Peters argues: "Polices are not just appraised by their impact and effectiveness, they are also evaluated by the way in which they originated and were carried out, ascertaining whether they are concluded in a manner that allows some openness, as well as a degree of legitimacy". (Peters pg.78: 1998)

The process of policy formulation is therefore important just as its content, for at least two reasons: A badly conceptualised and formulated policy has little chance for the legitimacy of the policy and its changes by the various stakeholders involve, its is essential that the process is seen and experienced as inclusive and participatory.

At first glance, the Western Cape has a well-defined health policy. But in this chapter we want to take a critical look at its genesis. As we indicated in the introduction, the Western Cape makes a very interesting case. On the National level, the New National Party was part of the Government of National Unity, with De klerk as one of the vice-president and a number of cabinet posts. On this level the NNP serving to support the basic aims of the ANC dominated government. It subscribed to the underlying principles of the Reconstruction and Development Programme (RDP), which as we shall see, really formed the basis of the national health policy.

But on provincial level, the NNP formed part of the government with the Democratic Party (DP) as its partner while the ANC was an opposition. The Western Cape was actually the only province that was not fully or partly in ANC's hands. It was very important for the DP and its partner the NNP to show that this combination was better for the country than an ANC dominated government. The Western Cape thus became the showpiece for the DP and NNP to demonstrate how well they could govern in contrast to the ANC.

One could therefore expect that there will be differences and even conflict between health policies on national level and that of provincial level in this case the Western Cape. What was the case? One analysis will hopefully provide us with an answer. But it will also help us understand how the actual process of policy formulation works.

We begin the chapter with a brief overview of history of policy formulation in the health sector. This is followed by a discussion of constitutional context with reference to health rights and service delivery. The main part consist of an analysis of the main policy documents on national and provincial level, namely the RDP, the White Paper for the Transformation of Health System in South Africa (WPTHSSA) and the Provincial Health Plan (PHP) of the Western Cape.

2. The history of health policies in South Africa

The history of the hospital management system in the Western Cape must be seen in the context of the main health policies of the country. We shall restrict ourselves to the period 1948 to 1994. In putting our discussions into context throughout the study a deliberate attempt will be made where we critically examine as to whether to what extent had the overall governmental policy formulation process had been adhered to i.e. firstly try to establish whether the current WPTHSSA contains the basic fundamentals of general governmental RDP policies aimed at addressing the concerns of improving the health status of the country. Secondly, we shall ask whether the current Provincial Health Plan (PHP) of the Western Cape government covers all the basic elements of improving the health sector as prescribed by the WPTHSSA. Subsequent to that a critical assessment will be made and to ascertain how well the PHP was communicated and implemented down to institutional or hospital level and to what extent was it received by the various hospital managers.

One of the reasons, which prompted me to critically examine the policy formulation process of health policies, is precisely because I wanted to analyse the relations between the national, provincial and local spheres of government. Some fundamental questions arising within the new constitutional context are: how are the national, provincial and local spheres of government connected to each other? Where do the powers and functions of each component begin and end? What falls within the

jurisdiction of each sphere? These issues are of major importance to provincial health policy makers and legislators, who have to innovate in this unique context.

2.1 Historical overview of public hospital management system in the Western Cape

In reviewing the evolution of the health policies in South Africa before 1994, it is possible to trace several clear and persistent trends. According to the *South African Health Review 1995* issued by Health System Trust (HST), there are about six distinct socio-political phases that can be identified in discussing the evolution of health policy in the Western Cape and in South Africa. These are: phase 1: prior to 1919, phase 2: 1919 to 1940, phase 3: 1940 to 1950, phase 4: 1950 to 1990, phase 5: 1990 to 1994, phase 6: post 1994. For the purpose of this study we will concentrate on the last three phases, i.e. the phase from 1950 to 1990, from 1990 to 1994 and lastly the phase after 1994 to the present.

There is a widespread perception that the policies of the apartheid government contributed significantly to the legacy of inequity in the South African health sector. This is manifested not only by maldistribution of certain categories of health care personnel between the public and private sector, but also by an inequitable distribution of public sector resources along geographic, racial, gender lines, between level of service and within provinces.

PHASE 1: 1950 to 1990

The first phase commenced with the victory of the National Party in the elections of 1948. This period was characterised by legislated racial discrimination and segregation, which affected not only the way in which health services were organised, but also the health of people themselves. Health policy development mirrored the ideology and social engineering of the white minority government. The systematic racial fragmentation of South African society and its health care system during the era of Grand Apartheid gave birth to the "Native Health and Medical Service".

In this period health policy and planning was highly autocratic and fragmented, based primarily on political rather than health criteria. For all practical purposes it was an exclusively "white" enterprise. The Tomlinson report of 1954, which entrenched a

separate "Bantu Health Service" and the choice of repression rather than tentative reform. This heralded a period when little new thinking or action was taken to improve the health services available to the majority of the population. Grand apartheid in the form of "independent" and "self-governing" homelands for Africans was systematically erected. (HST 1995:20)

The creation of the Tricameral Government 1983 and the subsequent establishment of three "own affairs" departments of Health Services and Welfare, (for whites, coloureds, and Indians) aggravated fragmentation. The "political development" of African people was intended to continue in the African homelands, although a provision was made for African local authorities. The newly created Department of National Health and Population Development (NDHPD) (formerly the Department of Health and Welfare) was responsible for overall national policy formulation and central control of health services, while provisions were made for the delegation of executive functions to provincial and local authorities on an agency basis.

What is striking about the early history of hospital institutions in South Africa is the uncoordinated and unsystematic manner in which the establishment, management and control of these services evolved. Yet, the development of the larger health services system was clearly steered in the direction of fragmentation. Despite the volatile situation in South African health care, most changes were mainly cosmetic and indicative of a drift in the same direction. The result was the sedimentation of several problematic structural features, rigid and resistant to reform. Amid sporadic restructuring and isolated attempts at real reform, changes were never fundamental. Crucial deficiencies in health policy thus remained substantial, steering health care in specific avenues with distortive effects on both organisation and financing system, and with discriminatory effects on both the provision and the distribution of health services.

Especially after 1950 these developments lead to polarisation, which gradually built up to a sharp divide, even to confrontational politics in health policy matters. On one hand, for many years the Nationalist government, along with its powerful allies in the private sector and in state bureaucracies, pursued the explicit policies of apartheid and privatisation in health care, based primarily on the principles of racial segregation, liberalism, and health care as a privilege (HST 1995:33). In direct opposition to this dispensation, however, a multifaceted progressive or patriotic health front evolved since the 1940's which, positioned itself ever more strongly against the prevailing

policies and structures in the health sphere. This opposition agitated for a unitary, democratic, non-racial and non-sexist health system, preferably in the form of a national health service, undeniably leaning on the socialist principles of collectivism, statism and equalitarianism.

It strongly advocated a primary health care approach and regard health care as a basic human right, not as a privilege. In the Western Cape health sector racial segregation, accompanied by the fragmentation of services and staff into separate facilities, homelands and "own affairs" divisions divided human resources and led to differential and exclusive treatment in training and development. The Public Health Act (PHA) of 1948 and later legislation which organised services and therefore the deployment of health employees under local authorities, fragmented public health even further.

The resultant urban/rural divide aggravated the disparities in the distribution of personnel in health, catering well for urbanites but under-resourcing non-urban areas. Males (especially white males) occupied most management positions, and more males were selected for training in the high status health profession than females, resulting in neglect of women (especially black women). As in all other sectors management, the bureaucracy and organisational culture were not conducive to sound labour relations. Efforts were made over the years to reform the services, but the socio-political order prevented this. Despite resistance by the government of the day, the late 1980s and early 1990s saw the systematic dismantling of apartheid in hospital institutions. Since 1994 there has been a commitment to fundamental reform of the health system, including the human resource elements.

PHASE II: 1990 to 1994

The second period heralded the first serious attempts to effect a significant break with the past. These were initiated under increasing pressure from a progressive health sector demanding fundamental reform of the health sector and beyond. This phase was marked by efforts to bring about de-fragmentation and de-racialisation of government structures within the health sector. Nevertheless, the steps towards reform were taken within the framework of a still racially segmented and overtly undemocratic societal

context, which meant that reforms were cosmetic rather than fundamental. (Health Strategy Project: 4)

The events following the 2nd February 1990 signalled the starting point of fundamental socio-political reform in South Africa and paved the way for long-awaited democracy. The numerous laws that upheld apartheid and undemocratic institutions were scrapped, and negotiations for a new political and constitutional dispensation commenced. Progressive health organisations played a major role in these developments, particularly in challenging existing health policy, championing the values of equity in health, combating the impact of apartheid on health services, and demonstrating the viability of community-based approaches to health delivery.

PHASE III: 1994 to present

Recently South African health policy entered a purposively new and different historical phase, which commenced on 27 April 1994, the date of the country's first democratic elections. The first ever democratic government came into power, an ANC led Government of National Unity (GNU) was inaugurated, a new Department of Health was instituted, and the minister concerned, tasked with bringing about a unitary and equitable health service for all South Africans. These elections not only brought the apartheid regime to an end, but also created the opportunity for a process of fundamental transformation to take place.

During the transitional period, which preceded the 1994 elections many debates took place on how change could be implemented under the new dispensation. The ANC's policy framework for socio-economic development was spelt out in the RDP. Within the health sector, general consensus emerged that a Primary Health Care (PHC) approach should be adopted.

The major locus of implementation of the new, unified, national health system would be the District Health Authority (DHA). The DHA would provide access to essential health care to all South Africans. In 1996, a new Constitution was adopted, this provided a master plan to guide the transformation process. The nature of transformation in South Africa is such that it focuses primarily on the needs of present and future generations. Thus, experience must be gleaned from the past, and learning from difficulties and mistakes needs to take place. In addition, society and its

institutions need continuity in order to function until such time as change takes place. (PHILA: 22)

At the same time all public institutions including the various components of the national and provincial health system, were undertaking the massive task of redressing past inequities and laying the foundations for the emergent society. This involved three key activities, which will be discussed in this document: (1) the drafting of policies to guide the transformation process; (2) changing the legislative framework in consistency with new policies; (3) implementing change. Policy legislation and implementation are intrinsically linked. In view of the urgency and the magnitude of the task of transformation, and the inherent challenges of each of the process, however, gaps sometimes occurred between policy, legislation, and implementation.

The state has undergone a fundamental re-organisation under the new dispensation. The geographic and geo-political divisions of the past have been replaced by a single state constituted by national, provincial and local spheres of government. The Constitution provides guidelines concerning the powers and responsibilities of each of these spheres. National and provincial executives, legislative and administrative authorities, as well as local government and civil society, all have a fundamental role to play at various stages of the process.

3. The Constitutional context

Before examining specific policy documents, it is important to place these within a constitutional context. The Constitutions of both the country and the province provide the fundamental basis and acts as the final arbitrator for any policy matter. But they are also important for our interest in how the translation process from principle to policy proceeds. We shall highlight those provisions in the constitution of South Africa and the Western Province, which have specific relevance for health matters.

3.1 The Constitution of the Republic of South Africa (Act 108 of 1996)

In addition, it has now been in effect for more than four years, in comparison with many other legislative documents relevant to the health sector, which are still in draft form. Parts of the Constitution relevant to provincial health legislation had been

selected. These include sections from the Bill of Rights; sections and schedules outlining relations between national, provincial and local spheres of government; and sections dealing with the public service and finance.

Section 2: The Constitution is the supreme law of the Republic of South Africa; law or conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled.

The Bill of Rights

The Bill of Rights *"enshrines the right of all the people in our country"* ...(section 7). It *"applies to all law, and binds the legislature,...and all organs of the state"* (section 8)

Section 12: Freedom and security of the person

- *Everyone has the right to bodily and psychological integrity, including the right to make decisions concerning reproduction, the right to security in and control over their body and the right not to be subjected to medical or scientific experiments without their informed consent.*

Section 24: Environment

- *Everyone has the right to an environment that is not harmful to his or her health or well-being.*

Section 27: Health care, food, water, and social security

Everyone has the right to have access to-

- *health care services, including reproductive health care*

- *sufficient food and water, and*

- *social security*

- *The state must take all reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of these rights.*

- *No one may be refused emergency medical treatment.*

The state's responsibility is qualified by three provisos: "the right to access", as opposed to the right itself; "within its available resources", and "progressive realisation.

The Bill of rights further contains under section 36 a Limitation of Rights clause. These are important to take into consideration when defining core minimum standards, which will form the basis for national and provincial departments of health to monitor and evaluate performance.

Chapter 3: Co-operative Government

The principle of co-operative government gives equal status to each sphere of government 40. (1)..All spheres of government and all organs of the state within each sphere must-

(e)...respect the constitutional status, institutions, powers and functions of government in their spheres.

(f) not assume any power or function except those conferred on them in terms of the Constitution.

(g) exercise their powers and perform their functions in a manner that does not encroach on the geographical, functional and institutional integrity of government in other sphere; and

(h) co-operate with one another in mutual trust and good faith...

Public Administration

Transformation cannot take place unless it embraces the people who work within South Africa's public institutions, including health services. While the principle applying to public administration applies to all spheres of government, yet the local government employees are not part of the public service.

Section 195: Basic values and principles governing public administration

Public administration must be governed by democratic values and principles enshrined in the Constitution, including the following principle.

(a) Public administration must be broadly representative of the South African population people, with employment and personnel management practices

based on ability, objectivity, fairness, and the need to redress the imbalances of the past to achieve broad representation.

Section 197: Public service

(1) There is a public service which must function and be restructured, in terms of national legislation and which loyally executes the lawful policies of the government of the day.

(2) Provincial government is responsible for the recruitment, appointment, promotion, transfer and dismissal of members of the public service in their administration within a framework of uniform norms and standards applying to the public service.

3.2 The Constitution of the Western Cape

Chapter 3: Provincial Parliament

Section 9: Legislative authority

(a) the provincial parliament may pass legislation for the Western Cape in terms of the national Constitution and accordance with this Constitution. (b) assign to a Municipal Council any of the legislative powers referred to it.

Chapter 5: Local government

Section 52: Local government in the Western Cape

The Western Cape government by legislative and other measures must support and strengthen the capacity of municipalities to manage their own affairs, to exercise powers and perform their functions

Chapter 10: Directive Principles of Provincial Policy

Section 81: The Western Cape government must adopt and implement policies aimed at achieving:

(h) realising the right to access to-...

(ii) health care services

What is important in both constitutions is how prominent the issue of health is. It is explicitly contained in the Bill of rights and expressed in the form of a basic right. This places an explicit obligation on national and provincial governments to provide access to health care services, including reproductive health care. The Constitutive (i.e. the way constitutions are formed) is not clear how these rights are to be implemented, but what is indisputable is that the provision of health care services is not a voluntary matter, but an obligation.

3.3 Analysis of Policy Documents concerned with Health Sector

We now proceed to examine the three primary policy documents which provides the framework for providing health services in the Western Cape

3.3.1 The Reconstruction and Development Programme

The RDP was an integrated, coherent socio-economic policy framework. It had seek to mobilise all citizens and the country's resources towards the final eradication of apartheid and the building of a democratic, non-racial and non-sexist society. It was drawn up by the ANC-led alliance in consultation with other key mass organisation. A wide range of Non Government Organisation (NGO) and research organisations assisted in the process. The process of consultation continued and joint formulation continued as the RDP developed into an effective programme of the government. RDP acknowledge that the history of South Africa was a bitter one dominated by apartheid and repressive labour policies. Segregation in health, education, transports and employment left deep scars in equality and economic inefficiency. The result was that in every sphere of society, South Africa was and is still confronted by serious problem.

The RDP is based on six basic principles: Firstly, the process needs to be an integrated sustainable one. Secondly, it should be people driven process i.e. people themselves determining its course of action and its pace. Thirdly, it should promote peace and security for all people and expand national peace initiatives. Fourthly, it should link reconstruction and development. Fifthly, it should encourage and foster nation building, as that is the basis on which to ensure that our country takes up an

effective role within the world community. Lastly, RDP should promote the democratisation of the state.

3.3.1.1 Meeting healthcare needs of the country within the context of the RDP

The RDP recognises that mental, physical and social health of South Africans have been severely damaged by apartheid policies and their consequences. The health care and social services that have been developed were grossly inefficient and inadequate. Health services were fragmented, inefficient and ineffective, and resources were grossly mismanaged and poorly distributed. Within the context of health the RDP dictates that its fundamental objective is to raise the standard of living through improved wages and income-earning opportunities, all of which will have a positive impact on health. The following were some of the RDP objectives within the context of improving the National Health System of South Africa.

Firstly, there is a need to draw all the different role players and services into the National Health System (NHS). This must include both public and private providers of goods, services and must be organised at national, provincial, district and community level. Communities must be encouraged to participate actively in the planning, managing, delivery, monitoring and evaluation of health services in their areas.

Secondly, reconstruction in the health sector must involve the complete transformation of the entire delivery system. All relevant legislation, organisation and institution must be reviewed in order to redress the harmful effects of apartheid. Introduce management practices that promote efficient and compassionate delivery of services. Involve and encourage all the stakeholders to participate in planning, managing, delivery, monitoring and evaluation of the health in their environment.

Thirdly, there must be a single National Health Authority (NHA), which must develop national policies, standards, norms and targets, allocate budget, and coordinate recruitment, training, distribution and conditions of service of health workers. Each province must have Provincial Health Authority (PHA), which must be responsible for providing support to all the District Health Authority in its programme. This must include providing secondary and tertiary referral hospitals, running training facilities and programmes, evaluating and planning services, and any support the district may

request. The main aim is to encourage high-quality, efficient services through decentralised management and local accountability.

All the statutory bodies must be rationalised and restructured to reflect the rich diversity of the South African people, they should be better able to promote and protect standards of training and of health care, and to protect the rights and interests of patients.

Fourthly, there must be a complete transformation of health worker training. This must involve improving human resource planning and management systems; reviewing all training programmes, reviewing selection procedures, and developing new (and often short) training programmes to redirect existing personnel. Redistribution of personnel must be achieved through more appropriate training, through incentives to work in under serviced areas. There is a particular need to train existing and new staff in the PHC approach, in management health, in health promotion and advocacy. Strenuous effort must be made to attract health workers in private practices back into the public sector, at least on seasonal basis, and to encourage active cooperation between the sectors with the common goal of improving the health of the nation. The primary aim is to encourage high-quality, efficient services through decentralised management and local accountability.

In summing up the RDP as a policy framework for developing our society, within the perspective of improving HRD issues around health related matters. The RDP calls for the need to address the need to address the development of human capabilities, abilities, knowledge and know-how to meet the people's ever-growing needs for goods and services, to improve their standard of living and quality of life. It is a process in which the citizens of South Africa acquire and develop the knowledge and skill necessary for occupational tasks and for other social, cultural, intellectual, and political roles that are part and parcel of a vibrant democratic society.

Lastly, RDP puts more emphasis on developing the status of women in our society, especially given the fact that women had been frequently denied access to education and training opportunities solely because of their gender. The kind of education and training that women received was to fulfil traditional roles, which perpetuated their oppression. Thus there is a critical need for education and training programmes to give special attention must be given to the special interest of women. Campaigns and

information should also open up a wide range of learning opportunities and choices for women, which in turn should lead to a wider range of income-generating forms of employment. However, special steps must be taken to give full recognition and value to the work and skills that are traditionally associated with women. The RDP document concludes by pointing out that, "the future is in our own hands and we must carry forward the work needed to finally liberate ourselves from the evils of the past".

These basic guidelines of the RDP have been accompanied by a plethora of policy documents, legislative interventions and reforms from the National Department of Health (NDH), most of which have impacted significantly on provincial and local government. Some of the most important developments and reform initiatives in the health sector include the WPTHSSA and PHP in the context of the Western Cape

3.3.2 White Paper for the Transformation of Health System in South Africa (1997)

The second most important policy document besides the RDP to take into account is the White paper for the Transformation of the Health System. In 1994, the Minister of Health appointed a series of ministerial task teams and committees to assist the DoH in reviewing the various components of the existing health system and in making recommendations for its transformation. The National Health Legislative Review Committee was one of these committees. This committee concluded that health legislation could not be drafted until a broad policy framework had been agreed upon. This policy framework gradually emerged from various task teams, building upon the considerable groundwork carried out in a broad consultative manner before the elections. The DoH consolidated all these initiatives into the White Paper published in April 1997. Lobby groups and this policy process influenced the National Assembly Portfolio Committee on Health (NAPCH) significantly. NAPCH successfully monitored the development of policy and enabled the public to comment on a number of controversial issues.

The White Paper represents the policy objectives and principles upon which a unified National Health System (NHS) will be based in South Africa. In addition, the document presents various implementation strategies to meet these objectives. Within its 255 pages, there are 21 separate chapters on different aspects of NHS. Many of the policies outlined in the documented are already being implemented. The extent to which this is

happening, and time frames for achievement of the various objectives it outlines, are unclear. The final chapter does, however, provide some concrete, time bound, indicators against which transformation can be measured. The following are most relevant issues for our study are:

The aims of the restructuring of the health system are the following:

- to unify the fragmented health services at all levels into a comprehensive and integrated (NHS).

- to reduce disparities and inequalities in health services delivery and increase access to improved integrated services, based on PHC principles.

- to give priority to maternal, children's and women's health, and

- to mobilise all partners, including the private sector, NGOs and communities in support of an integrated NHS.

Additional goals and objectives include:

- developing human resource available to the health sector and promotion activities.

- fostering community participation across the health sector, and

- improving health sector planning and monitoring of health status and services.

The White Paper also draws attention to specific issues, which include:

3.3.2.1 Reorganisation of the Health Sector

The reorganisation of health services requires that distinct responsibilities and functions be assigned to the national department, the province and the district/municipalities. It constitutes a major shift away from the centre to the periphery.

The functions of the National Department of Health are:

- to provide leadership in the formulation of policy and legislation

- to provide leadership in quality assurance, including the formulation of norms and standards

- to build capacity of provincial health departments and municipalities

- to ensure equitable allocation and appropriate use of resources by the provinces and the municipalities.

Provincial health departments will promote and monitor the health of the people in the province, and develop and support a caring and effective provincial health system through the establishments of the district health system (DHS). During the period of transition required to establish the DHS, provincial authorities will perform functions that will be devolved to district at a later stage.

3.3.2.2 Developing Human Resources for Health

The Department of Health views human resource development is a critical factor in the implementation of health and social development. It advocates that, a policy should provide guidelines for the recruitment, selection and placement of health personnel, based on national needs and affirmative action. Design education programmes aimed at developing competent personnel; promote the optimal use of globally competent, caring and critically minded personnel functioning within a multidisciplinary team; and promote a new culture of change management in the health sector, based on participatory leadership.

The development of human resource included the following elements:

3.3.2.2.1 Planning human resource

Principles

A national framework for the training and development of health personnel will be established.

Implementation strategy

(i)   A national audit of the numbers and distribution of trained health personnel will be undertaken.

(ii)   An audit of training institutions and their capacities will be undertaken, and the relevance of existing curricula assessed.

The skills, experience and expertise of all health personnel should be used optimally to ensure maximum coverage and cost- effectiveness.

Implementation strategy

(i)   Upgrading the skills of mid-level health workers

Consideration should be given to supporting existing categories of mid-level workers through distance learning in order to upgrade their skills. Those with two years of training, be they monovalent or polyvalent in their range of clinical skills, should be provided with a career path with appropriate exit points. Staffing in the peripheral areas should be aimed at nurturing skilled generalists; separate categories of mid-level workers should be avoided.

Health personnel should be distributed throughout the country in an equitable manner.

Implementation strategy

(i)   National planning system

A new, uniform system for the distribution and financing of personnel at all levels of health care will be developed at the national level. Norms and standards will be developed for the selection and appointment of health professionals, thereby determining a profile of human resources in relation to the skills and competencies required, and to conduct quality assurance and personnel performance appraisal.

(ii) Addressing the maldistribution of personnel

The maldistribution of human resource should be addressed primarily through an incentive-driven process. Incentives should be developed the magnitude of which should be based on the level of in-hospitality of the working environment. All categories of professionals should benefit from such incentives.

3.3.2.2.2 Education and training

<u>Principles</u>

Education and training programmes should be aimed at recruiting and developing personnel who are competent to respond appropriately to the health needs of the people they serve.

Education and training programmes should comprise relevant, reality-based curricula which are aimed at attaining competence within the psychomotor and affective domains of education objectives. Education and training should provide comprehensive,

integrated, community problem-based health care delivery education for competent practice within a multidisciplinary team ideology; and should be co-ordinated, reviewed and rationalised to meet the health needs of the country.

Implementation strategies

(i) Training appropriate to the level of care

The ability of health professionals to deliver approved health service packages at various levels of health care should be developed.

(ii)   Co-ordination of training

The large number of health personnel education programmes offered by a variety of institutions should be co-ordinated and, if necessary, rationalised. The Human Resource Development Directorate of the Department of Health (HRDDDH)should establish a Co-ordinating Education Committee (CEC), which should include representatives of universities, technikons, nursing colleges, the Departments of Education and Health, health service providers, health science students, non-governmental organisations and the public, to facilitate an interdisciplinary approach.

   The function of the CEC for health care training and education programmes will include the selection of training of all professionals, curriculum review, community-based education, integration of educational experiences for different professionals, continuing education, re-certification and accreditation. The activities performed at this level should include the planning, implementation, monitoring, evaluation, review and co-ordination of all health personnel education programmes.

(iii) Career path development and continuing education

The development of career paths and continuing education for all health professionals should be promoted. The system of visiting consultants should be structured in such a way that specialist categories function as educators at the primary health care level

Particular emphasis should be placed on training personnel for the provision of effective primary health care.

Implementation strategies

(i)   PHC-orientated curricula

Health sciences curricula should be restructured to reflect community needs more accurately, and teaching should place greater emphasis on community and outcome-based programmes. The fundamentals of a community needs-based health sciences curriculum are primary health care, social sciences, health promotion, ethics, basic management, community participation, conflict resolution and communication, basic counselling, information use, and first aid (emergency care).

(ii)   Primary health care orientation of existing personnel

An understanding of and emphasis on primary health care should be instilled in all existing health personnel through appropriate reorientation programmes with ongoing evaluation and monitoring components.

New policies and strategies for human resource development should address priority education and training needs.

Implementation strategy

The subsidy system for educational institutions should reflect priority education and training needs. This system should be reviewed by the Departments of Health and Education, and make provision for a more equitable allocation of subsidies, especially for historically Black tertiary institutions.

3.3.2.2.3 Creating caring ethos

The experience of people using the health system should be one of caring and compassion

Implementation strategies

(i)   Rights of health care personnel

The rights of health care workers should be defined and respected, so that an ethos of caring is nurtured, and not undermined or exploited. The security and safety of staff should also be ensured.

(iii) Campaign of caring

An active campaign to engender a culture of caring throughout the health services should be launched by senior officials at all levels, including the Ministry. The following are among the activities, which should be undertaken:

Health care providers should be rewarded for compassionate and caring service.

Ethics courses on health care, properly supervised, should feature prominently in training programmes.

Peer pressure could be used as a means of ensuring compassionate and caring attitudes among health personnel.

3.3.2.2.4 Changing the nature of management

Principles

Management authority should be decentralised to all levels of the institution to allow for a greater degree of autonomy

Implementation strategies

(i)   Decentralised management

Capacity will be built to ensure effective management at the provincial, district and local levels. Such decentralisation will be aimed at promoting innovation and efficiency where a Health Management Team (HMT) constitutes the structural unit. Such a team should consist of a health service manager, a chief nurse, medical practitioners and other appropriate staff co-opted as the needs of the community served are determined. However, monitoring and assessment of upholding of norms, standards and guidelines will be conducted at the national level.

Health service managers should be supported in acquiring the skills required to manage a decentralised health service

Implementation strategy

(i)   A health management training committee-comprising representatives of selected educational and training institutions, the health services student organisations and consultants should be established.

(ii)   This committee, with a view to optimising should compile an inventory of all health services management training and, where necessary, rationalising such training.

(iii)   Formal and in-service courses in health systems management emphasising democratic management principles should be developed.

(iii)   A particular effort should be made to recruit management trainees reflecting the demographic structure of the population.

A participative, democratic management style and management by objectives should be engendered

Implementation strategies

(i)   National Human Resource Development Consultative Forum

The Consultative Forum will consist of all stakeholders in the health sector. The purpose of the forum will be to share information, discuss matters of mutual concern, such as personnel and education needs, resource distribution and referral systems, and ensure that policy-makers are aware of the needs of and challenges facing health professionals

(ii)   Training in participative management and conflict resolution

Senior health care personnel should receive training in participative management, negotiation, labour relations, conflict resolution and management by objectives.

Effective evaluation techniques and procedures should be introduced to assess management efficiency at all levels of health service

Implementation strategy

Existing tools for personnel evaluation should be reviewed by a multi-professional committee consisting, amongst others, of representatives of the Public Service Commission, the departments of health at the national, provincial and district levels, employees, the communities and labour relations experts.

3.3.2.2.5 Building capacity

Principles

The clinical skills of health workers should be upgraded

Implementation strategy

The clinical skills of health professionals should be developed in accordance with approved health care packages in existence at the various levels of service delivery.

Particular attention should be given to the training of PHC nurses, advanced midwives, community psychiatric nurses, paediatric nurses, chronic disease nurse-clinicians, psychologists, nutritionists and health managers. In view of the reliance on nurses and PHC nurses in both primary care and referral teams, an investigative committee, representative of all the stakeholders, should be appointed to -

(a)   Examine the existing one year training programme for nursing auxiliaries with a view to creating a separate, non-professional category of nursing which would later progress along a career path to the professional nursing programme.

The skills of all managers at all levels should be developed, if substantive health reform is to be sustained

Implementation strategy

The development of management skill development in the following areas should be accelerated:

(a)   management by objectives

(b)   participative and change management

(c)   Leadership development and community participation

(d)   financial and fiscal management

(f)   strategic and operational planning

(g)   programme management and evaluation

(h)   policy development and implementation

(i)   policy analysis, monitoring and evaluation

Institutional capacity to support human resource planning and management should be developed

Implementation strategy

Structures and systems should be developed to support the effective and efficient delivery of health services:

(i) A human resource development unit should be established within the HRD Directorate at the national level.

(ii) A nationally uniform system of planning the personnel establishment at service delivery points should be established.

(iii) A national information management system should be established.

(iv) Job descriptions of health professionals at all level of service delivery should be so specified that duplication and/or fragmentation are avoided.

(vi) Human resource development units and programmes should be rationalised to promote cost-effectiveness and efficiency in the development of human resource capacity.

(vii) New and vacant posts should be filled in all the health services. This must be done through the reallocation of budgets and personnel from under-utilised to under-served areas and health services.

(viii) Additional posts should be created at the point of delivery at all levels of health of care in critical instances.

(ix) A policy to enable greater mobility of personnel between positions in the institution should be encouraged.

Research capacity focussing on essential health research strategy is implemented so to support health sector development

3.3.2.2.6 Affirmative action

Principles

Affirmative action policies should be aimed at transforming the public health services into a non-racial, non-sexist organisation.

Implementation strategy

A strategic change management programme should be developed at the national level to facilitate a process of institutional change at all levels, thereby ensuring a spirit of openness and involving all stakeholders prior to the implementation of policy. This will ensure –

(i)   the integration of the health services;

(ii)   the development of skills to promote effectiveness and efficiency, while increasing

representative ness at the administrative, managerial, supervisory, professional and technical levels; and

(iii)   that imbalances of the past in the composition of the labour force with regard to race and gender are addressed.

The personnel profile of the health system should reflect broadly the composition of the relevant Labour market at all organisational levels.

Implementation strategy

(i)   Affirmative action in appointments

- A realistic affirmative action policy, linked directly to recruitment, job description and career advancement, performance appraisal, training and study programmes and promotion should be developed.

- Sound human resource systems should be established to ensure an adequate supply of suitably qualified health personnel, while also improving the representative ness of the public health service.

- The present criteria governing appointment to management positions and the determination of remuneration packages should be reviewed, in order to advance disadvantaged persons with potential

- A special effort should be made to train Black health service managers.

- Mechanisms should be established to review the representation of women in the higher echelons of management at ail levels of health care.

- Gender sensitivity should be applied in recruitment and promotion practices, conditions of service and retirement practices, e.g. housing subsidies for married women and equalising pension schemes and ages of retirement.

- A standing committee should be established to monitor the process of affirmative action.

- To set benchmarks that will serve to guide and monitor adherence to the time frames set for the implementation.

(ii)   Affirmative action in education and training, and in health research

- Racial, gender and geographic inclusivity should be ensured in all health personnel education and training programmes.

- A representative staff structure should be promoted at academic health complexes.

- The admission of students to training and educational institutions should reflect national demography.

- Student selection should be co-ordinated at the national level in order to implement and monitor affirmative action policies.

- The process of capacity building will require strict monitoring.

The role of hospitals

Problems of inequity, efficiency and poor quality services have to be addressed to bring the public hospitals in line with the transformation process currently taking place in the NHS. In 1996-7 budgets, the expenditure on hospitals estimated to account for 77% of total public sector health expenditure. Thus their role should be redefined to bring it in line with the PHC approach. Savings should be made through the rationalisation of hospital services, through the decentralisation of hospital management to promote efficiency and cost-effectiveness, and through the introduction of a user fee system. Hospital boards must be established to increase accountability o communities

3.3.3 The National Health Bill (draft nine)

This Bill was produced long before the White Paper, and by November 1996 it was already in circulation. Its aim was to provide for the establishment of a NHS. The future National Health Act will replace the Health Act, of 1997, and will allow for the amendment of other laws, which are no longer necessary.

Chapter 1 (Fundamental Provisions) outlines the responsibilities of the NPDoH and of all government's bodies public health establishments and care providers. It also

allocates the functions of national and provincial departments, which are listed under schedules 1 and 2, respectively. It stipulates that every Provincial Health Department (PHD) must attempt to reach agreements with all municipalities in the province on the rendering of municipal health services.

Chapter 2 concerns the rights and duties of health care service users and health care providers. The rights of users include the right to information on services, to emergency treatment, to respect, to participation in decision, the requirement for consent, right concerning treatment for educational, experimental a or research purposes, provision relating to patient's records, and complaints. Complaints procedure could include the creation of the office of a provincial ombudsman by the MEC with the concurrence on the NHA (section 24(2)). The obligations users, and the right and obligations of health care providers, are also stipulated

Chapter 6 deals with HRD, it provides for the training of redistribution of health care providers, and for their training, including norms and standards for training. The national or provincial department may design and implement programmes to ensure the acceptable and equitable distribution of health care providers.

According to the report issued by the Ethic SA, the national DoH emphasised government's commitment to improve the quality of care provided in the health sector as a key challenge during the next four years. Above that, the department highlighted the following as critical: (1) the role of health-service users in ensuring that their needs are met, and (2) the quality of care being acceptable standard. The DoH asserted that health-care providers also have an important role to play in improving quality of care in the public health sector.

3.3.4 Provincial Health Policy: The Provincial Health Plan

How were these principles and policy guidelines on national level translated on provincial level? This is very interesting transition. Provinces (including the Western Cape) were of course bound to the Constitution and were also expected to follow national policy. But provinces also had a certain freedom to shape their own provinces. How did the western Cape, given its unique portion, used this opportunity? We shall try to answer this question by analysing the main element of the Provincial Health Plan. The following is a summary extracted from the PHP documents:

Vision, Mission Statement and Principles of the Provincial Health Plan

Vision

To promote and maintain the optimal health of all people in the WC province through the integration of health within the broad context of social reconstruction and development, and by ensuring the provision of a balanced health system and all related services. To develop an integrated, co-operative and health sensitive framework for the planning and implementation of the province's health status.

Mission Statement

The integration of health and development will be characterised by:

- a comprehensive PHC approach, with strong emphasis on environmental health and inter-sectoral collaboration;

- its congruence with the priorities and policies of the RDP at both national and provincial levels:

- its sensitivity to local needs and circumstances;

- its provision for human resource advancement and development while being responsive to the need for historical redress;

- the assurance of democratic and accountable participation at all levels of the system through its organisation and structure.

The health system and services will be provided or co-ordinated in a manner which ensures that they:

- are caring, high quality services at all levels, responsive to the needs, rights and dignity of patients, staff, clients, the community and other provinces;

- are responsive to the specific needs generated by age, gender, sexual orientation, class, religion, occupation and disability;

- are equitable, affordable, accessible, effective, efficient and appropriate;

- recognise the importance of evaluation, education, training and research by promoting them at all levels in response to provincial and national needs;

- are delivered within a unitary system, incorporating active support of decentralised district health structures with devolved responsibility and authority;

- are managed in a participative manner such that there is effective input by labour and the community into the process;

- recognise the specific needs and rights of those persons rendering services;

- recognise the specific need to rectify the deprived state of the rural areas in regard to health services.

Philosophy of the Department

The PHP advocates that work of the DoH will be guided by the PHC approach with its essential elements of equity, comprehensiveness, community participation and empowerment, affordability and sustainability. The DoH will aspire to be driven by the need to promote health rather than simply dealing with disease, and the future structure of the Department will reflect this commitment.

The document provides an enabling framework for the restructuring and improvement of provincial health services. It states vision, and principles, which guide health care delivery in the province. Health is integrated within the broad context of reconstruction and development. A comprehensive PHC approach is adopted characterised by equity, comprehensiveness, community participation through community and local government structures and the RDP process.

Among major challenge which the document highlights that faces the Western Cape Health Department (WCHD) is to expand district health services while rationalising other services, in particular academic hospitals, within the context of a receding budget.

Driving Imperatives

Facilities and services throughout the province should be managed so as to provide a coherent health service to meet the needs of the people and this principle will be placed

above the demands of individuals or institutions. The Department must manage its resources so as to provide an optimal service strictly within the confines of the budget. The establishment of the new health system is taking place in two phases. Firstly, the people of the province (and not just for hospital services). Secondly, the DHS is being established within each region. The driving imperatives identified include:

Management

Institutional management needs to be strong and to be supported by the department and its senior management. It is recognised that it is at institutional level that most of the health plan will be implemented. Management at all levels must be participatory in nature. As far as is possible within existing regulations, autonomy relating to both financial and personnel matters will be devolved to the lowest level possible. Means must be found via legislation and other routes to enable management to enjoy this autonomy. The status of the public health and health system outputs must be monitored using the techniques of modern public health and epidemiology. The management structure of the Department will reflect this approach.

The District Health System

The health system is to be based on a tiered system of relatively autonomously managed functional geographic areas, each being monitored, supported and co-ordinated by its higher level. The province will be divided into 4 health regions, each of which will in turn be divided into health districts, each of which in turn is divided into community areas.

Functions of the Provincial and Regional Offices

Decision-making responsibility in respect of services, personnel and finance will, as far as possible would be delegated from the provincial to the regional level (and to the institutions within each level). It is clear that Department will function at optimum efficiency and with appropriate accountability of its officials if the necessary delegation of authority is given to these officials. Where personnel and financial regulations of the provincial administration are unnecessarily restrictive in this regard, appropriate

representations will be made to have these amended. The delegation of authority will receive urgent attention in order to enable the regional offices of the Department to function effectively as soon as they are established.

The Provincial Office

The responsibilities of the provincial office will include:

- the overall co-ordination of the Department;

- the establishment and support of efficient Regional offices of the Department,

- an-going policy development and formulation of the necessary Provincial health legislation,

- liaison with the other PHD and with the National Department; liaison with the training institutions

- development of norms, guidelines and protocols in respect of health services and priority health programmes,

- the development of a standardised health and management information system throughout the province,

- the development and implementation of effective evaluation mechanisms; and

- overseeing and monitoring the rationalisation and relocation of resources and services in accordance with the PHP.

In the area of an on-going policy development, the provincial office will be responsible for the formulation, in consultation with the other PHD and the National Department, of various policy options for the establishment of DHS.

The Regional Offices

The primary function of the regional offices will be the development of the DHS within each of the regions. Each regional office will have a Deputy Directorate for DHS, which will be responsible for co-ordinating the development of the district system

within that region in close co-operation with the Interim District Health Working Groups (IDHWG), which have already been established in the majority of districts.

The regional offices will be responsible for the co-ordination of all district and regional health services in the region. They will be responsible for ensuring the upgrading of regional hospital services in their areas, in accordance with the PHP, and for ensuring that appropriate district support services are implemented. The provincial and regional department will ensure that appropriate training is provided for personnel, and will continuously monitor and evaluate the services within their areas. The integration of current vertical programmes into the comprehensive services will take place in a planned and measured fashion in order to ensure that services are not disrupted during this process.

District level service

Community areas will be sub-units of the health district. The district health management team will be responsible for planning, managing, provide appropriate personnel management and HRD for district health personnel, co-ordinating and supporting all non-specialist health services within the district, including those of the community health centres and of the district hospital in the district.

Training requirements within District

In the process of upgrading clinical skills, the integration of currently vertically organised health programmes into comprehensive community health services requires that refresher courses and skills-upgrading be provided for current provincial and local authority personnel working at the community and district levels. Some of this training will be provided by the appropriate rotation of personnel. Areas, which have so far been identified, are:

* mental health, reproductive health (including STD/HIV), trauma and emergency services, clinical forensic services and environmental health

<u>Powers and Functions of Community Health Committees (CHC)</u>

The following powers and functions of CHC in respect of their community areas are as follows:

Personnel

- To make recommendations with regard to the appointment of personnel within the community area, in accordance with the personnel codes of the employing authority;

- To make recommendations with regard to disciplinary measures in respect of personnel within the community area, in accordance with the personnel codes of the employing authority;

- To make recommendations with regard to the evaluation of personnel within the community area, in accordance with the personnel codes of the employing authority.

Planning

- To set health and health care goals and objectives for the area within national, provincial and district guidelines;

- To review regular reports from area management personnel with respect to health monitoring, health services provided and finances;

- To periodically evaluate the services provided and determine any corrective actions which may be required;

- To participate in the planning of new services and facilities in the area in accordance with needs assessments and provincial and district guidelines.

<u>Community Participation</u>

Structures will be implemented at community, district, regional and provincial levels, which ensure that services are accountable to local communities and that communities have meaningful input into management.

Human Resources Development

The changes required in establishing the new provincial health system have important implications for employees both professional and non-professional. Any changes that are made will be fully discussed with professional organisations, labour unions and employee associations. It must be stressed that the changes outlined in this plan provide the broad policy framework within which modifications will continuously be made through an on-going process of consultation. It also needs to be stressed that this is a medium-term plan and, as far as is possible, reduction in employees will take place through the abolition of vacant posts, attrition, voluntary retirement and transfers. Only as a last resort will retrenchment be considered.

The PHP states that employees of all categories in the health service have made important contributions to the building up of our health services and the care of patients in the province. This needs to be given greater recognition, and greater attention needs to be paid to improving conditions of work in our health service. The Primary Health Plan recognises human resource management requires attention, and a Human Resource Development Directorate is established within the Department. Priorities include:

- carrying out a detailed audit of personnel across the services, determining personnel requirements at different levels of service, and developing appropriate training programmes, career paths and personnel evaluations systems.

- redistributing and re-orientating health personnel towards the district health system: this entails offering of incentives to attract employees to under-served areas; and the standardisation of salaries and conditions of services.

- improving the management of personnel; the Health Department favours greater autonomy from public service regulation and codes; it need to improve its labour relation capacity and to implement and affirmative action policy

Training

The PHP dictates that, there is an abundant supply of training institutions in the WC and these institutions need to be fully utilised in realising the training required for its employees. The three universities, two technikons and four nursing colleges with respect to the training of all categories of health professionals must develop a rational

plan. The Department will also develop its capability (utilising appropriate training capacity of the Provincial Administration and relevant training institutions) to ensure the appropriate training and development of non-professional Departmental personnel.

Training for all levels of management in the health service is an urgent need and the Department must ensure that a detailed programme to train managers is commenced as soon as possible.

Personnel Management

The current systems of personnel management will be reviewed in conjunction with the Provincial Service Commission (PSC). There is a widely accepted view that the DoH and the institutions within it should have greater autonomy from the public service regulations and codes. Steps have been taken, in creating the new organogram of the Department, to strengthen its labour relation's capability at all levels. There is a great need to make the health services more representative of the people of the province. An effective affirmative action policy must be implemented to correct the racial and gender imbalances in the system.

The rigid personnel administration system of the public service needs to give way to a more autonomous system so that districts and other institutions, particularly hospitals, must be able to make decisions about employment and working conditions of personnel. At the same time, districts and institutions need to adopt a more participative style of management that is in keeping with the latest thinking in the draft Labour Relations Act that has been negotiated at the NEDLAC.

The policies articulated in this document are bold but reasonable; they have been planned carefully and with widest consultation as possible. The fullest success of implementation of policies depends on a number of fundamental changes that need to be made to the public service in South Africa as a whole and to our approach to the management of health services generally.

3.3.5 Review of other legislation applicable to the Province of the Western Cape pertaining to the Health sector

This section contains relevant summaries and analysis of (1) the existing legislative framework in the province; (2) the constitutional context; (3) the changing national and provincial policy legislative framework.

The WC is one of the wealthier provinces. In many some respect, better equipped than other provinces to adapt to socio-economical changes. The province has retained the infrastructure and resources of the Cape metropole. There were no former homeland territories, which had to be integrated within its boundaries. WC's comparative advantage is being taken into account in calculating its share of national revenue.

At the same time, the province is faced with massive needs for redress, in particular between urban, peri-urban and rural areas, and between various sections of the population. Another characteristic of the WC is that it is one of the provinces where the ANC does not have a majority in the provincial legislature after the 1999 national elections. This resulted in ideological differences between the national and provincial spheres, and in political strategies of opposition in the province.

In terms of the new dispensation, the province of the WC comes much smaller area than the former province of the Cape of Good Hope. The political, social and economic dimensions are undergoing radical transformation. Relationships with the national and municipal spheres are now conducted according to the principle of co-operative government.

The next section provides a summary of all relevant legislation that is directly and indirectly concerned with health, either in the form of provincial ordinances or as assigned legislation.

3.3.5.1 Provincial Ordinances

According to Programme Primary Health Care Report (PHILA), the statute books of the Province of the Western Cape have not been cleared under the new Constitution. The only important change to the ordinances under the new dispensation consists of the delegation of powers for the former Administrator of the Province of the Cape of Good Hope to the Premier. Ordinances dating back to the beginning of the century, and spanning the historic years of the apartheid regime, are still in force at the present time. Many of the officials they refer to, do not exist in the new dispensation: for example, the Administrator and the Provincial Secretary. Their validity is subject to the

Constitution, which is the supreme law of the RSA. Much of the content of the ordinances is unconstitutional. Ordinances are steeped in the ideology of racial discrimination, also much of the terminology and content of the ordinances is gender biased and sexist.

Ordinances concerning provincial and local government employees

These ordinances deal with general terms of employment, provincial and local government and medical aid schemes. Their current status is unclear, but in general terms, some of their sections are overtly racist and genders biased, and as such are highly unconstitutional and problematic. In addition, several cross references to ordinances, which are no longer on the statute books, still needs to be amended.

The Local Authorities Pensioner's Ordinances, no. 9 of 1967 uses race and marital status as criteria for the amount of benefit to be received by beneficiaries.

The Provincial Service Ordinance, no. 9 of 1982 is, in general terms outside the ethos of public service policy. Employment policy discriminates against people with disabilities (section 9(1).

The Provincial Official's Pension Ordinance no. 17 of 1967 discriminates along racial lines between members defined as contributors and any person in receipt of an annuity or a temporary annuity from the fund. It discriminates along gender lines in terms of benefits (section 22: benefits payable from the Fund to female contributors discharged or residing in contemplation of marriage)

3.3.5.2 Assigned Legislation

The provincial statute books contain several national Acts of Parliament, large portions of which have been assigned to the provinces. Most were first drafted within the constitutional context of the apartheid regime, the incoherence of which was further complicated from 1983 by the introduction of the Tricameral system. They were amended by proclamation in 1994, providing a facelift, which only partially adapts them to the new dispensation.

3.3.5.3 The Health Act no. 63 of 1977

Before SA's first democratic elections, health services were fragmented along racial, geographic and geopolitical lines. The 1977 Health Act was designed to co-ordinated the many fragments of the apartheid health system. However, this excluded the 'Bantustans', each of which had its own Department of Health.

Under the 1977 Health Act, the NDH was given responsibility for the overall co-ordination of health services. Provincial administrations were primarily given responsibility for curative services. The task of the local authorities related mainly to the prevention of disease. From 1983, health matters classified as 'own affairs' included hospitals, clinics, school medical services, and medical services for the indigent, health and nutritional guidance. Section 20 of the Act still forms the legal basis on which local authorities are allocated responsibilities for health care. The Act provides an unsatisfactory legislative framework for comprehensive primary health care to be delivered by municipalities.

Although amended in 1994 in line with the interim Constitution, the Act still reflects the fragmentation of health services under the previous dispensation the lack of integration of preventive and curative health care services, and the vertical approach to health programming. It does not embrace the PHC approach, which underpins current health policy. It vests powers and functions within the provincial administration and local authorities as they existed under the apartheid regime. Moreover, it does not make provisions for community involvement in health.

The introduction of the Tricameral Constitution 1983 led to the creation of three additional 'own affairs' Minister of Health, one for 'Asians' one for 'coloureds' and one for 'whites'. Thus, by 1994 SA had fourteen ministries of health. The ten 'Bantustan' ministries, the three 'own affairs' ministries and the 'general affairs' ministry of health, human resources for health care in SA, as in other countries, were developed in an ad hoc and fragmented manner. The ideology of apartheid not only compounded the inherent inequality in the provision of health care along race, gender and class lines, but also entrenched the development of human resources along these lines. This has resulted in an inequitable of human resource in SA.

3.3.5.4 Evaluation of the Process of Policy Formulation

When analysing these key policy documents, one can not but be impressed by the thoroughness with which the issue of health is dealt with and with the comprehensiveness of the policy proposals. It is clear that the government was determined to carry out its mandate to transform every aspect of South African society. There is an awareness of the immense scope of this task and also a clear understanding that the transformation could not chance or that the government could not rely on the goodwill of its citizens to implement the programme on its own accord. Rather, one senses the realisation from the side of the government that the transformation will be resisted from many quarters, especially from the formerly advantaged sector of the society. There is a sense of urgency not to the transition to chance and to err on the safe side. One therefore cannot escape the impression of a certain measure of "over-prescribing" and of going into too much operational detail.

When comparing policies on the national and provincial level, the remarkable conclusion is that there are no substantial differences between the two levels. This was one of the aspects where we expected there could be some conflict. If there any tensions between the WC and central government, this is not apparent on the level of policy formulation like in many other fields. The new government who came into power in 1994 has been exemplary in its formulation of policies for the transformation of South African society. The policies for the new health sector are comprehensive, consistent and based on sound principles. The country has not a only model constitution, but also an excellent policy framework. The crucial question now becomes: How are these policies implemented? What is the quality of service delivery and what is the impact on the providers and recipients of these services?

The focus of the next chapter, as it is clear that policy implementation is very much of the mind of the authors of these policy documents. This is especially true of HRD and this is the main reason why this aspect was chosen as one of the focal areas to assess the quality of policy implementation. It must be also said that the policy makers took special steps to ensure the involvement of every role players in both the

formulation and implementation of the proposed policies. To illustrate this, we focus again on the issue of HRD.

As indicated earlier in the chapter, RDP identified the development of HRD as one of its five keys programmes, and outlined basic principles, as cornerstones to improve health service provision within the framework of human resource development strategy.

According to the 1998 HST annual report, in 1994 the newly democratic department of health established a non-racial, no-sexist single NHA, within it set up HRD unit responsible to develop policies and guidelines for HRD for the PHC approach. In line with its vision and mission the DoH established a Committee for Human Resource (CHR) in health to develop recommendations for HRD in the health sector in response to country's needs. In order to develop these recommendations a Ministerial Committee for HR in Health was constituted in August 1994 with the brief of making recommendations, by January 1995 for the development of a draft policy on human resource development for health care for South Africa.

In developing its own policy aimed at adequately addressing and improving the status of HRD in health service provision, the WCHD undertook a broad and extensive consultation process on the PHP, where detailed comments and suggestions were received. There came, amongst others, from all departments within Provincial Government a number of metropolitan local councils and municipalities, and a number of academics and consultants. In order to achieve a wide spectrum of opinion as possible, the DoH facilitated a public consultation process on the PHP with organs of civil society including the private sector. A series of workshops and forums were held with labour federations (COSATU, NACTU, FEDUSA), NGO's and CBO's.

The comments, suggestions and discussion points that emerged from these various workshops were compiled by the DoH to form a very comprehensive document. In the preparation of PHP, the Provincial Government made extensive use of the various comments and suggestions made by a wide range of stakeholders. The main purpose of the PHP was to outline a common vision and strategic framework to guide the DoH in the province, in ways which will enable the WC to successfully to promote and maintain the optimal health of all people in the province, through the integration of health within the broad context of social reconstruction and development, and by ensuring the provision of a balanced health system and all related services.

From the above, it is clear that a serious attempt was made by the WCHD to actively engage itself and key stakeholders in the formulation process. A wider consultation process was carried out with reference to policies aimed at addressing HRD issues within the context of its sector by drawing together all relevant stakeholders from the different sectors.

In line with the new transformation policies of the National Government, the provincial and local government structures were obliged to change and rationalise in ways, which make them more responsive, representative and capable of combining greater cost-effectiveness with new service delivery responsibilities and requirements. As the DPSA's 1997 Provincial Review report and the 1998 report of the Presidential Review Commission demonstrate, such reform processes have been less than a complete success. This applies especially to areas such as co-ordination and co-operation within and between the different spheres of human resource capacity building and the representation of previously disadvantaged groups within the higher managerial echelons. Nevertheless, the transformation has been marked by a number of possible achievements. Examples include the establishment by the WC government, of a PHP designed to build human resource capacity of the provincial hospital administration, and to develop and fast-track promising administrators from previously disadvantaged groups (black people, women and people with disabilities).

A decision to implement a Training Needs Assessment (TNA) was initially taken at Provincial HRD Implementation Task team (PHRDITT). This team included HRD delegates from all regions, Associated Academic Hospitals (AAH) and Associated Psychiatric Hospital (APH). The implementation plan adopted by the PHRDITT in 2000 envisaged the process taking place within all regions of the Department.

According to PHP, the main aim of the TNA was two-fold: Firstly to identify specific key performance areas per occupational category and secondly to assess training needs associated with each of these key performance areas. The CORE manual was used as a guideline throughout the process. The approach of the process was to analyse, in focus groups made up of current incumbents within specific occupational groups, the competencies required for each job and an assessment of the gap between the current and essential/desirable competencies of the particular occupational category. The regional HRD co-ordinators communicated the aim and overall benefit of the

project to all personnel within the regions including the AAH and APH. The communication process included consultations with unions at the local IMLC level.

It is clear that a determined effort was made on provincial level to prepare the ground for the implementation of the new policies

According to the report of the Centre for Development and Enterprise (CDE) on Policy-Making in a New Democracy published in 1999, argues in the first five years of ANC rule the government has managed the complex politics of a diverse and divided society with great skill. "They have opened up new opportunities for many South Africans both black and white. Their second and increased election mandate in 1999 was a confirmation of competent domination of South African politics and the faith of voters in their ability to lead the country and build a better future for all citizens. No one could expect a perfect record and mistakes have been made. Nonetheless, the first five years of majority rule have been impressive and better than very many expected". Certainly, apartheid policies had been harmful and morally wrong, the new government's policies had therefore to right these wrongs, and new policies had to be devised. Given the fact that the nature of policy is necessarily evaluative, yet the role of students, academics and independent institutions is to raise the difficult questions and to look at a bigger picture.

The CDE report further argues that, in the enormous effort that has gone into reviewing old policies and formulating new ones since 1994, various methods had been used across departments. Many of new policy players did not have the skills or experience needed to analyse or make policy. The gaps between multiple policy reform initiatives introduced since 1994 and implementation of these policies seems to be due to policy management capacity shortcomings in government. The White Papers and other policy documents and attempts to actually implement these policies exhibit some extremely worrying characteristics. These include:

- o *4.1 Confusion of policy advocacy with policy analysis*, with the result that many in government believed their own propaganda and never undertook the detailed systematic analysis essential for good policy-making.

- o *4.2 A lack of appreciation for the system of government* that had been developed over decades. There was a tendency to destroy everything that came from the past, whether it was good or bad

- o *4.3 A tendency to govern by legislation rather than sound administration.* The ANC in government has been characterised by an increasing volume of legislation—well over 300 pieces of legislation, many of which have yet to be implemented.

- o *4.4 Within the context of policy formulation, there is assumption in government that good intentions will automatically result in good policies*, yet in practice that is not the case. White Papers have reflected a lack of any real analysis. Typically, they indicate what needs to be done, but there is no thought about how to do it. The gap between policy and reality has been filled by legislation, often with unintended and contrary outcomes.

Given the complexity of our society and its problems, it is important to acknowledge that the current government has not performed badly, and that there are several examples of good judgement and achievements.

Against this background, the next chapter will present and analyse the evidence from respondents on various aspects of concrete service delivery in Western Cape.

CHAPTER 3:

Documenting findings and analysis of the report

The viewpoints of different respondents across all level of employment categories has been recorded and reported in the below section, against that background, what now follows in this section is the analysis of such responses in light of our basic research question which was to evaluate the communication and implementation of human resource development policies at hospital level i.e. to what extent these policies have been implemented and to what extent they have been effective. In view of the nature or the method of collecting our data and the constraints experienced with regard to the interviewed hospitals as explained in chapter 1, the most suitable method in analysing our data will be that of the 'logic model' as defined by M.Q. Patton (1998). This approach follows the following steps: Firstly, the classification of interview data under different headings or topics. Secondly, a brief summary of the key issues under each topic and thirdly, the presentation of verbatim quotes to draw attention to a specific argument or point, and finally an overall analysis of the presented data.

As outlined in chapter 1, given the variation in individuals, who were the primary focuses of our study, we collected responses from three categories of hospital employees i.e. (1) the senior managers (head of various department including superintendent), (2) middle managers (particularly from the HR department) and, (3) non-managerial employees (mainly nurses, cleaners and trade union representatives). Following our chosen method, we shall begin by presenting the primary interview data under these three categories, therefore providing an overall analysis, where all three levels of analysis are integrated in a broader perspective of the experience of hospital employees in transforming public hospitals in the Western Cape.

1. Responses from middle managerial employees *(cleaners, nurses and unions)*

From the interviews, the overwhelming impression was that four main factors hampered effective reform in the Western Cape. These were issues related to: transformation, affirmative action (composition of the staff), industrial relations and human resource development (health service management training and personnel evaluation).

1.1 Transformation: The impact on human resources

The policy of transformation led to a number of unsuspected consequences. It bred a climate of inflated expectations, caused job insecurity and exacerbated stress level; it dampened initiative and confused legitimacy and authority. From the hospitals interviewed, internal organisation factors, top-down management practices, grievances not taken care of speedily and efficiently, failures in the communication system, the dragging of feet with affirmative action, etc, all perpetuated discontent among non-managerial hospital employees. As the process of transformation is meant to accelerate the process of restructuring, many non-managerial employees complained about the continuous disruptive effects of restructuring on motivation, morale, personal relationships and staff turnover, resulting in the overburdening of remaining employees. Interviewees expressed concerns about the ways transformation was applied, which had as a result that unrealistic levels of service delivery were expected of over-extended employees.

There was also the criticism that the WCHD has engaged in the development of "a silo...of White Papers" that had no bearing whatsoever to the day-to-day working conditions of employees at hospital level. Some felt that the transformation process was designed to serve the interest of a specific racial group over another, regardless of what the cost might be.

1.2. Affirmative action and employment equity: Redressing racial and gender issues

Central to the issues of affirmative action was the ability of interviewed hospital's HR departments. To address the issue of employment equity and to accelerate the

transformation process. The overall impression (with one exception) was that these were very few promotional opportunities (especially for non-managerial employees) if they existed at all. Several non-managerial employees indicated that they had been doing the very same of jobs for more than ten or even twenty years in some cases.

Female nursing assistant at hospital A for more than 15 years: "I had been a nursing assistant as long as I can remember in this hospital, and that is because I am not in the good books of the Senior Matron in charge. She picks whom she like and hope to gain something in return. It is disturbing to note that at this hospital, despite of the changes taking place in our country, there is still a lot of apartheid thinking by the senior management. First preference is still given to those who have lighter pigmentation, when it comes to promotional opportunities, and not based up on the level of qualifications and ability for one to do the job".

However, opinions were divided with regard to the existence and changes brought about by the affirmative action policies as a prerequisite for employment in their respective hospitals. Some respondents indicated that there were no such policies in existence, and if they did exist, they were not implemented. On the other hand some respondents pointed out that, such policies were in place within the context of their respective hospitals and that they were effectively implemented.

Female nurse at Hospital C for more than 10 years (Auxiliary Service Section): "There are no changes that had been realised by the implementation of affirmative action policy. Instead, there is conflict and demoralisation among our hospital employees, especially when it comes to employment opportunities in this hospital. That negatively impacts on the performance and service delivery on the part of our staff, because prospective nurses are not chosen on merit".

Male cleaner at hospital G for more than 7 years: " There are no changes has been realised by the implementation of such a policy. Despite the new laws governing or dealing with employment equity in the workplace, preference is still given to the coloured community as opposed to the blacks for employment opportunities. What matters is not what input or level of expertise one can offer to this hospital more than the pigmentation of your skin and whom do you know, apartheid tendencies are still rife in this hospital, when someone has to be employed or so-called 'promoted' from gardening to be a cleaner".

Trade union representative at hospital D for more than 15 years: "From the paper point of view yes, we do have such a policy but from a practical level it does not exist. We've got a constituted body to oversee the implementation of affirmative action. This body is ineffective in that, firstly there is no consensus and sense of professionalism within and among those who are tasked to oversee the process. In most instances there is a lack of professionalism and by in large the integrity and professional ethic being compromised. Thus we view the process itself as useless. It has no power nor authority to enforce its recommendation. All the powers are vested within the hospital superintendent, who has the final say in every matter concerning this hospital".

Female nurse at Hospital C for more than 10 years (Auxiliary Service Section): "There are no changes that have been realised by the implementation of affirmative action policy. Instead, there is conflict and demoralisation among our hospital employees, especially when it comes to employment opportunities in this hospital. Yet, that negatively impacts on the performance and service delivery on the part of our staff because prospective nurses are not chosen on merit or ability to do the job".

Some nurses who indicated that within the confines of their hospital, affirmative action policy was a used as prerequisite for employment of employees, argued that the process itself had somewhat improved the inter-personal relations among nurses. Furthermore, it enhanced teamwork, good working relationships among nurses and contributed to the general well being of the hospital.

Trade union representative at hospital B for more than 9 years: "Such a policy does in fact exist and it is a prerequisite for employment in our hospitals. There has been tremendous improvement in terms employee interaction and what is expected of them, for they know that because, they are employed or promoted on a quota basis they are expected to put the very same weight in executing their responsibilities in the hospital".

Female nurse at Hospital G for more than 15 years (Auxiliary Service Section): "The application of affirmation action policy as a prerequisite for employment of employees in our hospital has enabled better working relations among our employees, reason being the fact that nurses are not employed through a Boetie-Boetie system but rather on the level of their integrity, sense of professionalism, and their love for the nursing profession. As a result such a process had created a better understanding not only among nurses, but also most importantly between nurses and patients. Because in the

past we struggled to understand some of our patients who could not understand neither English or Afrikaans language. Now we do have Xhosa, Tswana and Sotho speaking nurses who are of vital importance for nursing and translation purposes to doctors who do not understand some African languages".

Male cleaner at hospital E for more than 17 years: "There has been tremendous improvement in terms general staff in executing their daily responsibilities and some understanding. For they know that a person is not simply employed on the basis of his/her skin colour but most importantly up on the level of his or her effectiveness and efficiency".

(a) Racial representativity

Among the interviewed non-managerial employees, opinions were divided regarding the extent of racial representativity both at senior and middle management level of hospitals, where the majority of respondents indicated that the top echelons in hospital management were almost 'all-white'. At the senior level white staff accounted for more than any race even if coloured and black employees combined. Africans in general were considerably under-represented in the management corps in comparison with the overall racial composition of the hospital's management staff. However, there was also some discontent with progress in racial representation in the various interviewed hospitals.

Another interesting aspect, central to the whole issue of racial representativity was that, two of the hospitals that were investigated, respondents indicated that there was a clear domination of black employees at all levels of their hospitals, with fewer or no whites at all in some cases. The racial component of their hospital from top to lower level of position was wholly African. When asked on why was the 'status quo' was the way it was, they alluded to the fact that other races (particularly skilful white employees) were neither willing or interested to offer their services in these under-developed areas, and the DoH in the Western Cape has done very little if anything at all, in terms of re-dressing or rectifying the situation, by encouraging white skilful employees to relocate their services in these areas.

Female nurse at hospital G for more than 23 years: "The senior management of this hospital is lily white, but one hardly find a single white person in junior position or

frontline management, even our coloureds whom are occupying senior positions, they are simply there for window dressing purposes. The poor blacks do not have a single face in the senior management".

Interestingly enough, at the middle management level, respondents pointed out that the racial representativity was characterised by non-whites with a clear domination of coloured population. Very few blacks if they were employed at this level. Usually one will find the large contingency of black people in the lower ranks of the hospital, particularly in the catering and gardening service department, and another large pool of coloured in the cleaning services.

(b) Gender representativity

From the responses of non-managerial employees regarding gender representation it is clear at all levels there were more females compared to their male counterparts. One of the basic reasons for this state of affairs is the fact that, throughout the history nursing profession and broader hospital working environment was perceived to be a female occupation. However, there was a considerable increase of male nurses and of male counterparts occupying various positions on middle and senior management level.

Explanations given for failing productivity were in abundance. Foremost was the effect of taxing and protracted transformation. The most recurring reasons given were: no improvement staffing situations, backlog in promotions, staff turnover and staff shortages. But more mundane explanations also prevail. Male nurse at hospital A for more than 10 years: "In certain areas we don not have sufficient resources, people got frustrated because of little things that are not in place, this little gadget is broken, this is finished...next time you put patients off"

(c) Incentive system to improve staff performance

With an exception of one respondent, it was clear that non-managerial employees had no knowledge of any incentive mechanisms applicable within their respective hospitals. Where they did exist, they were not implemented correctly. In the opinion of respondents there was lot of favouritism and total neglect in some cases on the basis of race or colour. Some respondents pointed out that, their incentive schemes were corrupt

and very skewed. Who you know was more important than the ability or the potential one has to do his/her job satisfactorily. In some bizarre occurrences in order to be considered for promotion you had to bake cakes over the weekends, at times buy lunch for your supervisors, agree or conform with everything your superior tells you without being critical to what one is told.

Others argued that apartheid thinking was still prevalent and rife in their respective hospitals, made some suggestions to remedy the situation. Shop steward at hospital F for more than 10 years: "There is a need for apartheid thinking to be uprooted from the mindset of many supervisors and senior staff members in conjunction with the white dominated management". Female DENOSA representative at hospital A for 9 years: "Nurses work under very difficult conditions, especially in township areas where there are not much facilities. The lack of financial incentive and improvements of hospitals has prompted many nurses to leave. Nurses had raised their problems at hospital and governments forums but, despite endless promises, the situation was unchanged". A NEHAWU representative further argued that nurses were exposed to verbal and physical abuse from the community because of problems created by the health department.

Female cleaner at hospital for more than 15 years "A policy regarding incentive mechanisms exists only on paper and not in practices in our environment. A person is informed about it only when being appointed and thereafter nothing is done to further the objectives of the policy. Our promotion is very skewed towards who you are and not what can you do. As a result we often call it 'Boeti-Boetie' process".

Nurses in particular were very critical to the normal nurses rank promotion process and the current Public Service notch increase system that is in place and called for the review of the entire process to promote fairness. They argue that it created a lot of negativity and conflict among nurses and led to bad performance in their working environment.

By the rules governing the nursing fraternity, rank promotion is a necessary process irrespective of working conditions. When one completes his/her three-year term as Professional Nurse (PN), such a person needs to be promoted to Senior Professional Nurses (SPN), and after completing SPN she/he becomes a Chief Professional Nurse (CPN). As rank promotion needs to take place by rules regulating the nursing

profession, the interviewed nurses experienced this as a central issue. In reality rank promotion do not take place at all, or it is not applied orderly and fairly. Some nurses pointed out that they had more than five years in their respective positions as PNs, and they are told year-in and year-out that they are going to be considered for promotion, yet nothing is done about it.

Most nurses indicated that there is a need for the process of rank promotion to be reviewed because, "the problem with rank promotion is that, regardless of one's ability to do the job (effective or ineffective), when the time comes for PN to be given the rank, he/she must be given because the period is due as stated by rules. This means that, one is forced to promote people even if they are not effective. Secondly, the process itself creates many CPNs (for that is the final or last rank promotion a nurse is given).

To be considered for the position of Assistant Director Nurse (ADN), one must apply, and the whole recruitment procedure takes place i.e. from short listing; interview and possibly being hired. The reality is that there are very few ADNs per institution one or three depending on the size of the hospital. Lately as a result of that, we had witnessed massive relocation or flight of competent; experienced and qualified CPNs to countries like England, Australia, New Zeeland, Saudi Arabia etc for greener pastures, and if nothing is done to remedy the situation, we are still going to loose lots of qualified nurse.

Paradoxically the system of notch increases which was meant to encourage and reward outstanding nurses, has had the opposite effect by creating and increasing the bitter divisions and conflict among nurses. Part of the problem was the numerical percentages attached to each notch.

Male nurse at Hospital I for more than 25 years: "Such a system rewards people not on the basis of their ability of how effective they to do their respective tasks but on how good writers/orators they are. The Peer Review Committee depends hugely on information presented to them in written form in order to make recommendation for notch increase. The problem is that some people are doers as opposed to good writers, whilst to be a good writer does not mean that one can do the actual job. In most cases these orators oversell themselves, which is very unfair to hard workers".

Female nurse at Hospital C for more than 10 years: "The quota system attached to the process also makes it very unpopular with those it is meant to serve. Because at the

end of the day, not every good nurse is rewarded or honoured accordingly. For example, only 5% got selected as recipients of notch increase system out the entire hospital's nursing profession. This system needs to be revisited or scrapped totally. Above that, the question of neutrality is sometimes compromised, for one is evaluated by her supervisor, yet that puts one at a disadvantage if you are not on good terms with your supervisor".

Female nurse at Hospital H for more than 20 years: "The notch increase system had become very unpopular to us as workers. It is something of a joke. We do not have faith in it and in those who sit in such committees, for they consider their friends and families for increments. Few if any still submit their incidents for notch increase consideration. The process is a flawed and leads to hostility and conflict among workers. That on its own impacts negatively not only to the morale of employees but also most importantly on the overall efficiency of workers with reference to executing their responsibilities and delivering service. At the end of the day patients suffer and service delivery is compromised due to low morale amongst staff, created by this ridiculous system we are forced to accept and work with it".

One of the respondents, who alluded to the fact that within the confines of her working environment their incentive system has a component of affirmative action policy, indicated that the effective implementation of such a measure had positively improved her specific working environment and the general well being of her institution. The work relations among employees had improved positively; as a result everyone is committed and dedicated in his/her responsibilities, executing them with passion. Everyone pulls his/her weight for they knows that one is not judged and promoted on the basis of colour or gender, but judged on the level of output i.e. expertise, effectiveness and overall efficiency in carrying out their respected responsibilities.

Female registered nurse at hospital E for more than 15 years: "Every nurse in this hospital put above the required effort in whatever he/she is doing, for they know they would recognised and rewarded according to the result they produce with respect to their responsibilities. In fact, the current notch increase system based on written incidents in principle is a good initiative to motivate us as employees. The only

challenge to the process itself is to find strategies or measures through which there could be minimal loopholes and make sure that people do not misuse the process for their personal gains"

The data from the interviewed non-managerial employees regarding the existence of programmes aimed at attracting qualified, experienced and competent employees indicated that, with the exception of one respondent, the overwhelming majority was not aware of any such programmes.

Male CPN at hospital A for more than 20 years: "We do not have programmes aimed at attracting and retaining us as employees here. In fact what interest me to come here was just simply the love of the nursing profession, the desire to make a difference in my job and to support my family. Other than that, for more than twenty working years in this hospital as CPN there is absolutely nothing to retain me. As a matter of fact I can leave this hospital at any given moment if there was a position with better incentives".

Female cleaner at hospital A for more than 10 years: " To my knowledge the hospital and the broader sector of health, provide no incentive programmes whatsoever aimed at attracting and retaining us as qualified and competent employees. Among reasons, which keep me going is the love of my job, the housing subsidy I received last year as a government employee, and to feed my kids. Otherwise nothing compels me to stay here".

The one exception was an employee who said (Male CPN at hospital G for more than eight years): "Examples of such programmes are: programmes for 'continuous learning', including offering bursaries to interested nurses to further their study in the nursing profession. There are lot of recreational facilities ranging form all kinds of sports up to partaking in choral music competitions. Such activities are not only restricted to hospital corridors, they move beyond to the general public, where nurses not only compete against each other on hospital level, but also take part in provincial and national activities e.g. in provincial and national choral music competitions. Such programmes had been very effective in boosting the morale and enthusiasm of nurses, showing them that there is life after nursing and there are lot of opportunities available for by interested and determined individuals".

1.3. Labour relation issues

According to respondents in all of the hospitals interviewed there were mechanisms or formal and informal management-staff communication policies envisaged in their hospital's protocols on how all the structures within the hospital should constructively interact in the best interest of the hospital itself. Each hospital had its own model of engaging management and staff, of which the most prevalent structures were: Inter Management Labour Caucus (IMLC), Nurses Clubs (NC) and Transformation Action Committees (TAC). The extent to which all these structures and initiatives were effective varies from hospital to hospital.

One's immediate impression having analysed the responses from non-managerial employees is that, despite the existence of such initiatives and existence of such structures at institutional level, there is still a lot of work to be done. The extent to which they are effective leaves too much to be desired. With the exception of two respondents, the overwhelming majority of non-managerial employees indicated that, in principle such structures and initiatives at shop-floor level were very crucial and relevant, but at times lack power or authority to implement these properly, due to the fact that much power was vested within the hands of a hospital superintendent. These following were some of the responses:

Trade union representative at hospital A with more than 13 years: "In my experience and capacity as a shop steward, the IMLC in fact should be called M.C. i.e. Management Council, for it is the management ideas and view points which prevail at the end of the day. They have no regard for the opinions of the employees how to better the working relations both at top and bottom level of our hospital. I believe that the management of this hospital suffer from the syndrome of 'I know everything, for I am entrusted to do so'. This kind of thinking really hampers any chances of us engaging constructively with the management. As a result the management tends to dominate the show and impose their will and decisions on us as employees".

Female nurse at hospital D for more than 10 years: "Senior management in this hospital does not involve employees at lower levels of hospital management in the decision making process. They are operating us like robots with the remote control, for they are not visible to the people on the ground. Most issues are forced up on us, leading to a negative attitude towards management. There are no channels available for

us as employees to follow. When we are dissatisfied with the decisions management is taking. In fact, the IMLC is just an extended management platform, because the only people who have a final say in the deliberations are the management. It is simply a window dressing to the public and not far from being a circus machinery which has no power to effect changes to the working conditions of ordinary employees. When issues affect them as management they are very quick to address it, but they drag their feet when it affect employees. The management will simply frustrate the entire process or merely ignore it".

But there are also different experiences. Female union representative at hospital A for more than 7 years: "The management no longer unilaterally implement decisions and resolutions as it wishes. It knows that it has a duty to inform employees, and employees on the other hand has also an obligation to notify the management of any issues it has with regard to the effectiveness and efficiency of running this hospital. Ever since our hospital embraced and successfully practices the system of IMLC, there has been a productive and good working relations between management and our respective staff".

Regarding the existence and effectiveness of unions at their respective hospital. Sometimes four to five unions are active in one and the same hospital. The following were some of the unions operating in the hospitals that were investigated: NEHAWU, HWU, HOSPERSA, PAWUSA, DENOSA, PSA, NAPSU, SADNU. Opinions were divided with regard to union's effectiveness in various hospitals. Among the reasons put forward for the ineffectiveness of unions, resulting them in being viewed simply as 'toothless-structures' which had no capacity to influence overall decision making process at hospital-management level, was the following: They are so concerned about membership numbers and the amount of revenue/funds they generate in the process, that they give very little attention to bread and butter issues affecting employees at shop-floor level. Some respondents pointed out that beside the fact that there was no cooperation between various unions at institutional level. There were also no reciprocal relations between union representatives and those whom they represent. In most cases, union representatives themselves were expected to have expert knowledge on every matter (which in actual fact was not the case). Most interviewed union representatives indicated that their members expected them to provide solutions for any matter or challenge they were faced with. At times members indulge in unnecessary wrongful

activities and then expect the union to cover for them or to represent them when management takes actions against them.

There were also examples where there were close and reciprocal relations between union and its members, between unions and between unions and management, thus contributing to the better management of the hospital. Female cleaner at hospital E for more than 10 years: "So much as we differ on membership and allegiance, once we view an issue that is likely to affect the well-being of us as employees and on working conditions, we stand up with one voice and conviction. Then there is unity among employees, in pursuing our justifiable needs. This approach is also translated in our dealings with the greater management of the hospital, in ensuring its overall effective performance. It is because management and employees of this hospital had come to a realisation that, in order for our hospital to have any meaningful contribution or have positive effect to the service which we provide to our patients, we need each other to join hands and forces in realising that objective".

(a). Disciplinary procedures

Regarding issues of employee misconduct i.e. the existence, composition and effectiveness of disciplinary structures as mechanisms to deal with wrongdoings by employees. There were some interesting materials. The majority of respondents indicated that such structures were still in the initial stages in their respective hospitals.

They therefore found it difficult to comment on the functioning of such structures. Of those who indicated that such structures were operative in their working environment, there were different opinions with regard to their effectiveness. Some pointed out that they were efficient while others argued that regardless of their relevance, they were very ineffective in addressing employee misconduct. Interestingly enough, the striking finding from the majority of those who indicated the prevalent of disciplinary structure in their hospital was that none of them have received a copy outlining the disciplinary code of conduct, as required in terms of the LRA. The latter stipulates that the standards of conduct should be clear and made available to employees in a manner that is easily understood.

Among reasons put forward by non-managerial employees why disciplinary structures are ineffective and not enjoying much support from employees side was the

following: In some instances the required procedures were not followed with regard to the composition and specific rules relating to DC. Structures were not representative in their formation i.e. consisting only of senior management of the hospital, reflecting management's perspective on how to enforce the rules with no regard whatsoever on employees views in the process. Union official at hospital H for more than 15 years: "The process itself is enforced upon us as employees, without our consultation and involvement in its deliberations".

Another finding central to the functioning of DC was that there was limited or no training provided to the DC members. In some cases DC members were selected to served on committees solely on the basis of their working experience in the respective hospital. As a result, at times members tended to focus on the integrity and personality of the wrongdoing employee, rather than on the case at hand and the factual circumstances, which led to the offence. Interviewed respondents indicated that there was no consistency in dealing with cases. The outcome of the process was influenced by whom the offender knows in such committees rather what he/she has committed or alleged to have committed. The length of the DC processes was another reason that was mentioned to have led to the inefficiency of disciplinary committees. All the above-mentioned reasons severely affected the interaction of employees in the workplace, worker morale, productivity and efficiency of staff, their motivation and relationships in the workplace.

Trade union representative at hospital B with more than 10 years: "We do have that kind of a structure here, but it is so inefficient because we as employees strongly feel that such a process is a tool of management. We were never consulted nor informed about its formation and it's functioning. There is inconsistency in dealing with cases from person to person. In most cases the process itself drag on for too long and the employee accused of misconduct continues to work despite the disciplinary hearing pending. As a result that kills team spirit among employees in that there is a lack of a harmonious relationship amongst us as employees. Offenders do commit other offences or similar ones in future, knowing very well that they are not going to be severely dealt with by the committee".

Of the respondents who argued that the DC structure was effective pointed out that in an attempt to promote a sense of professionalism and fairness, in all DC cases the presiding officer is drawn from another public hospital for that specific case. The

assumption is of course that he/she would be neutral and objective in dealing with the case in hand. Irrespective of the gravity of the specific case, the DC always followed the proper procedure, for example to give an offender a verbal warning coupled by written one where necessary. If the culprit fails to comply, he/she must face disciplinary committee. Depending on the outcome of the DC a misconduct employee might be acquitted, fired, suspended with or without pay for a certain period, relocated or the worse case face dismissal. Dismissal in the last resort, after all other available avenues in terms of the law had been exhausted. Such a process would be completed within six months. In these circumstances the DC was very effective and acted as deterrent mechanism for perpetrators or potential perpetrators. According to interviewees, since the implementation of DC as prescribed by law, misconduct by employees decreased dramatically. Lawlessness was no longer the order of the day and there was a high level or a sense of efficiency and effectiveness epitomised by professionalism conduct.

(b) Grievances of employees in the workplace

The majority of interviewed non-managerial employees indicated that in one way or another there were measures in place through which employees could address their grievances. However, opinions were divided with regard to the procedure being followed in addressing these grievances and with regard to their effectiveness. With the exception of two hospitals, respondents indicated that no matter how important or how many grievances one writes as a group or individual, at the end of the day nothing gets done or no action is taken to rectify the situation. This resulted in employees not reporting grievances for they know nothing will be done and they simply keep quite in most cases.

Of the respondents who argued that the grievance procedure was functioning effectively, pointed out that not all grievances were registered. Most of them were resolved by timely intervention before being formally registered. Very few cases are reported to the CCMA and hardly anybody proceeds to the Labour Court.

1.4. HRD issues (health service management, training and personnel evaluation)

Opinions were divided with regard to issues pertaining to the offering of training and development programmes aimed at equipping employees with necessary skills and to

develop career paths. Some pointed out that in their hospitals, although they were encouraged to put down their names to be considered for training no training was offered in the end. The reason management gave us was the lack of funds or the lack of time to embark in such kind of activities. Others respondents indicated they did attend training programmes offered internally by the hospital (induction programmes) and externally offered by PAWC or CAA. However, the respondents were critical of some of the key aspects relating to these programmes. Some of the criticisms were that: despite of the training being offered and a certificate issued at the end of the term/training workshop, there is no compensation or some form of recognition. At the end of the day, one has a piece of paper called a certificates with which has no bearing whatsoever in the way one do his/her job.

Even when employees attend programmes, in most cases there is simply no time to pass on knowledge one gained to those who did not have an opportunity to attend training. Consequently, the skills and expertise one acquires from these training programmes become self-centred, empowering individuals themselves and do not benefit his/her co-employees. In some cases supervisors determined who should attend which training programme without regard to the interest of the person concerned. The medium of instruction at these training programmes was a matter of great concern and need immediate attention from the authorities if such programmes are to make any meaningful contribution. Instructors were alleged to have taught their programmes only in Afrikaans with no regard to those who do not understand the language.

This had serious consequences in so far as, two of the nine hospital investigated decided not to attend these programmes. Female nurse at hospital E for more than 9 years: "Those PAWC instructors have no respect for us...I do not bother attending such programmes anymore, because I do not understand Afrikaans language. We have courteously and repeatedly requested various instructors to provide such programmes in English, yet they blatantly refused to do so, on the grounds that the majority of racial population in the Western Cape talks the Afrikaans language, therefore we must be able to express ourselves in the language of the province".

With the exception of respondents from two hospitals, respondents said that there were no mechanism or measures in place to deal with employee evaluation or assessing employee's overall performance in terms of the hospital goals and vision. Female nurse at hospital A for more than 8 years: "There are no such measure here in this hospital. If

they do exist it must be on paper or in the thinking of the management, whom are supposed to oversee the implementation and performance of skill auditing or performance appraisal".

Of the respondents who asserted that in their hospitals an evaluation or performance appraisal was indeed conducted, some indicated that they were not effective in that they did not get feedback about the process itself. Consequently, they do not take such measures seriously any more because they do not have any bearing on the manner in which they execute their work/responsibilities.

Female nurse at hospital C for more than 7 years: "We do have such a programme in operation in which we participate every three months. The biggest problem with our job evaluation programme is that nothing gets done after the entire process. There is no improvement in our working conditions, despite the fact that some of us would raise crucial issues during the evaluation process, which need attention. As a result, we have lost our interest in participating in such time-consuming and useless exercises. The worst part is that questionnaires in most cases are irrelevant and not specific to one's job description. We just fill questionnaires for the sake of filling them".

The majority of non-managerial employees pointed out that there were no programmes in place to ensure that they perform their services or execute their responsibilities as expected, except the inefficient evaluation programme. Trade union representative at hospital E for more than 10 years: "It does not matter here whether you do your job or not accordingly or as expected. No one cares here, as long you will get your salary at the end of the month that is fine. Although I must admit that it will be an ideal if we were to have such system in place, not only it will benefit us as individuals but also contribute to the overall efficiency of the hospital"..

Female nurse at hospital H for more than 20 years: "We do not have measures aimed at ensuring effective delivery of staff here, despite the fact that the morale among our staff is very low. There is lot of negativity here. Apart from organisational factors, individual bread and butter issues such as personal conditions of service, lack of progression and promotion have an adverse effect on work morale in our hospital environment".

All non-managerial employees were strongly opposed to any attempt by the government to engage in more privatisation of services public hospitals. Citing that

such a process will in fact lead into massive job losses and to increased poverty, suffering and eventually to crime. Another interesting concern was that privatisation by nature does not necessary translate into better service.

Trade union representative at hospital G with more than ten years: "Management of this hospital in pursuing the principles of capitalism and greediness. They embarked up on the process of privatising services such as the kitchen and security section. Since the inception of such a process the level of service is very poor and worse than before. The kitchen and security employees are sometimes drunk or very late for work. There is nothing, hospital officials or even supervisors can do to reprimand them, for they are not accountable to anyone except to their private company, which employed them. At the end of the day these private companies receive exorbitant fees for the pathetic service they provide to public hospitals. Consequently, patients suffer and our security is put at risk".

Opinions were divided regarding the extent of seriousness of the management in speeding up the transformation in their respective hospitals. There were strong indications that senior management was not fully committed to the transformation process in the health sector. They were accused of dragging and that the process very slow and at times frustrating, Trade union representative at hospital D for more than 10 years: "Management in this hospital do as they pleased, with no regard whatsoever to us as employees. When issues affect them they jump into it head on, but drag their feet if it concerns employees. They always bargain in dealing with issues i.e. what is there for them if they give in on certain matter. I doubt very much if the management are interested in any way to carry out the transformation gospel as contained in the White Paper for the Transformation in the Department of Health. Anyway, even our hospital superintendent is not a South African citizen. For that reason alone how one can expect him to have our country's interest at heart or a will to transform this hospital so to make a positive contribution to the immediate community and broader society? Senior management always passes the buck to the provincial department who really should take responsibility for the implementation of transformative policies in the workplace."

Of the respondents who argued that their management was somewhat serious in speeding up the transformation process. Because of the seriousness of management to speed up the process, not only did their hospital management's system improve, but also their entire hospital image and reputation as well. Trade union representative at

hospital A for more than 15 years: "Our management is indeed serious in speeding the unfolding transformational process here and as a result of that we are beginning to reap the fruits of our commitment in transformation.

The image of our hospital has somewhat improved positively and dramatically due to some changes effected by the management in conjunction with us as union representatives and other stakeholders. We had seriously engage ourselves in the process of really marketing this hospital to the business sector and surrounding communities and they are beginning to play a pivotal part with reference to the effective functioning of this hospitals. The surrounding community members including NGO's and CBO's are taking care that their hospital is not being threatened by criminals or vandalised in any manner. On the other hand the surrounding business entities be it small or big, are assisting in fundraising activities that are hosted by the hospital thus helping us to render our services properly".

The overwhelming majority of non-managerial employees choose not to comment on the nature of the professional and personal relationship with their superintendents, because (as was pointed out earlier) they had minimal or very limited contact (formally or informally) with their hospital Superintendent. Of those that did commented, indicated that they had a good and effective relationship with their Superintendents, for they view them as a friendly yet professional in dealing with all the staff. Male cleaner at hospital C for more than 10 years: "As a person, he has a genuine respect and understanding for the individual at all levels, always eager and willing to listen and help where necessary, referring you to someone else if he can not do so".

Male trade union representative at hospital A for more than 20 years: "The Superintendent as an individual is very genuine and has a genuine respect and understanding not only for the staff but for patients as well. Eager to learn, listen and provide assistance where needed. We relate to him not only as our man in charge but as a friend. One reason that made him popular not only among management but also to employees on the ground level to the fact that he was a trade unionist. Losing him to another hospital would be tragic and detrimental to the service and type of reciprocal management we've managed to built over the past years, which were very demanding and challenging indeed". (After two-weeks visited hospital A, the Superintendent in question left hospital A and took up a senior post at another hospital).

On the question of the quality of management by the hospitals, opinions were divided. Most non-managerial employees believed that under the challenging and demanding working conditions their hospitals were not well managed in one way or another. Few respondents believed that their respective hospitals were well managed. The implementation of Voluntary Severance Packages (VSPs) during mid-90s its unforeseen effects by the government, was seen by many as one of major causes why some hospitals were not well managed. The experienced and skilful employees left the health sector and less-skilled or 'dead-wood' as they are often referred to, stayed behind. They assumed very senior positions merely because of their long period of service and not because of their effectiveness and efficiency in doing their work.

Trade union representative at hospital D for more than 20 years: "One reason why our hospital is not being well managed is that, after the implementation of VSPs a few years ago, there was a massive outflow of experienced and qualified nurses. They were not replaced even up to now. Most of the old and inefficient employees left behind. Currently we are under staffed, we need more nurses and doctors in order for us to cope with our work".

Female nurse at hospital G for more than 10 years: "Senior management together with their respective supervisors should come down at our level and not manage this hospital like a satellite. They need to walk the talk and stop their wishful thinking on how this hospital will be in future. They need to realise that there is a critical need to make this hospital and the larger provincial hospitals the best in the country and in to the SADC community".

On the other hand there were respondents who were more positive and who argued, that their hospital was to a great extent well managed by their senior officials. They pointed out that their management does look after their interests as employees, opening the lines of communications. The effect of VSPs was not as severe as in other hospitals. Male cleaner at hospital F (Psychiatric Ward) for more than 13 years: "To a great deal, the management of this hospital does look after the interest and needs of both the patients as well as of its employees. This hospital has been able to retain most of its experienced and competent employees, regardless of the challenges pose by Voluntary Severance Packages. In addition, for the past seven years this hospital have lost just few

jobs and employed more staff. On a different note, we treat each other with respect and dignity in this hospital. No one's viewpoint or suggestions are looked down. The good cooperation that coexists between the management and our respective unions is something that make this hospital a well managed one".

Despite the general opinion among the non-managerial employees that the level of service delivery has not improved since 1994, there was a sense of optimistic. They experienced a steadily decline of the health system, as one respondent sum it up by saying: Female nurse at hospital A for more than 30 years: "Our level of service delivery is not better but going down. Everyday the management tells us about the diminishing resources. It becomes a struggle to get things done here. Consequently, nurses become despondent, and every department seems to be in conflict with one another. Furthermore, the negative impact of Voluntary Severance Packages as ordered by our government in the mid 90's is still felt by many departments, although there is no massive exodus of nurses.

One no longer feels proud and content coming to the hospital to make a contribution. We come just in order to survive financially, work-work-work and then leave at the time of the end of shift. In addition there is a lack of supervision especially because of the uncertainty caused by the fragmentation and privatisation of various supporting services in the hospital. Among staff, there is no longer tender caring in dealing with patients, there is a lot of negligence in executing responsibilities, with no empathy in the service we are providing to the public. No one is prepared to go an extra mile and make an extra effort in whatever one is assigned to do".

Female cleaner at hospital D for more than 15 years: "Our public hospital health system is going down the drain at an alarming pace. Apart from organisational and administrative point of view, individual 'bread and butter' issues such as personal conditions of service, lack of progression and promotion have all an adverse effect on worker morale, which resulted in the appalling state of our public hospital system. However, despite these challenging times, I do believe that with the necessary resources and positive mindset from top management down to the ordinary employee on shop floor level, the situation will definitely improve. This is simply a phase we need to join our forces, try at all times to do what is just and necessary".

The following were some of the recommendations and suggestions put forward by non-managerial employees:

- "Government must not only commit itself through a 'silo' of White Papers, but should learn to walk the talk".

- "Government must provide public hospitals with necessary funds to execute their responsibility to the electorate and the greater community of South Africa".

- "Government must abolish any privatisation talks within the corridors of public health sector in the province and throughout the country".

- "Either the government must start to walk the talk by effectively implementing its long over-due Primary Health Care system or must not cut funds at tertiary and secondary hospital institutional level as it doing now".

- "Management must accept us as union representatives as equal partners in the process of negotiations and management of the hospital".

- "Management should commit itself to stop racial discrimination and encourage racial tolerance among staff at all levels of the hospital".

- "Management should stop being dishonest and be open so that we can work together in good faith".

- "The position of the Superintendent should rotate every two years to ensure continuity of the management system in the event that the Superintendent decides to leave".

- "There is a need for a hands on approach and enthusiasm on senior management level, for that will somewhat boost the staff morale".

- "Management should communicate with the employees timeously and effectively".

- "Employ people on merit, those who know their jobs, have a love and the will to serve patients wholeheartedly".

- "Hospital management must provide counselling programmes to the staff where needed".

- "The Superintendent must employ more staff to cope with the ever-increasing workload".

- "We as employees should become more tolerant and humane towards the patients".

- "People should learn to work in teams, performing their daily duties as allocated by the supervisors".

- "People need to be recognised not only as objects but most importantly as human beings, and given credit where it is due".

- "Provide relevant training to the general staff in the language that is most likely to be understood by everyone and not by a certain section of the community".

- "We as nurses need to bring out the love and compassion we have for caring for our patients, for there is nobody will do that except we ourselves"

- "Built or create resting and recreational facilities".

- "Employ more staff, for we are understaffed".

2. Responses from middle managerial employees *(supervisors and HR)*

2.1 Transformation: The impact on human resources

From the interviewed sample of middle managerial employees, opinions were divided regarding the changes brought about by the affirmative action with specific reference to recruitment, racial and gender imbalances. The opinion of the majority was that despite of the challenges they are facing in implementing affirmative action policy as prescribed by the LRA, Employment Equity Act and other related policies, there was a sense of optimism. Many commented that since the adoption of these policies, working conditions have improved for the general staff.

HRD representative at hospital A for more than 15 years: "In the past our hospital was characterised by lawlessness and a high level of favouritism when it comes to employment opportunities for recruiting and promoting staff general. People were judged solely on the basis of their sex and race. The implementation of affirmative action as a means to redress the historical imbalances brought about by the apartheid policies has positive results. There is a high level of dedication and commitment on the part of the staff and an improvement of overall effectiveness. Lines of communication improved not only between our patients and us as employees, but also between us. We have Xhosa, Tswana and Sotho speaking employees in our hospitals for patients who do not understand English or Afrikaans languages. While not underestimating the work lies ahead of us and things still to be done. I am confident that the appalling conditions experienced in our public hospitals throughout the province and the greater South Africa will improve. It just a matter of time, finding the right people to carry out the process fairly and consolidating on the gains we have made".

On the other hand, some were very much concerned with the pace and the manner with which such laws are implemented in their respective hospitals They were questioning the senior management's or hospital superintendent's commitment to the process of restructuring their hospitals. They were unimpressed with the whole process of affirmative action, arguing that it was a form of discrimination in reverse.

HRD representative at hospital C for more than 11 years: "Under apartheid it was lawful to discriminate against the non-white people in preserving white hegemony.

Currently under the pretence of redressing racial imbalances by applying affirmative action policies, non-whites are favoured over white people regardless of their competence and expertise in doing their jobs. That is one of the reasons of massive exodus of skilled white people either to private hospitals or to other parts of the world".

Some respondents argued that policies aimed at redressing racial and gender imbalances both at senior and middle management level, existed merely on paper and simply a lip service from the senior management.

HR representative at hospital A for more than 12 years: "The management of this hospital is lily-white...one hardly finds a single white employee in the non-managerial or junior level of this hospital. The coloured employees who are occupying these senior positions, are simply part of a window dressing process for they have no power to influence the decision making process regarding restructuring in this hospital, yet black people are nowhere to be found within the corridors of the senior management of this hospital. They are largely to be found in the very low ranks of our hospital, most notably at the kitchen".

2.2. Affirmative action and employment equity: Redressing racial and gender issues

Judging from the responses from managerial employees regarding the application and efficiency of programmes aimed at attracting and retaining qualified and competent staff was that, with the exception of two out of nine hospitals interviewed, there were no such programmes in place. In fact, the idea was welcomed, if such mechanisms could be devised as part of a process overseen by the provincial health department in consultation hospital management. The level of frustration was very high. Most indicated that there are absolutely no monetary or non-monetary incentives to retain them. They were merely working to earn their salaries at the end of the month to pay their bills and support their families. Others went on to say that they were just waiting for better opportunities to be available within or outside the country, before they leave their jobs. Lack of funds and resources were the major reasons why nothing was done.

HRD representative at hospital C for more than 15 years: "There is nothing exceptional to retain you here, I am here simply to support my family and payout my bills, otherwise I am looking for greener pastures within or outside the country".

Of the respondents who indicated that such programmes were in existence in their respective hospitals, pointed out that they were effective to some extent in retaining their staff and boosting morale. There were many recreational programmes such as sports of different kinds i.e. soccer; tennis; netball tournaments etc that were conducted, bursaries offered for one to continue with his or her studies, part-taking in choral music competition. One particular hospital even had recreational indoor games, where interested employees could go to and entertain themselves during lunchtimes or after work. As one HRD representative at hospital G for more than 10 years puts it, "these programmes have been very effective for our overall staff in boosting the deteriorating morale and enthusiasm, showing them that there is life after work and lots of opportunities for dedicated and determined individuals to succeed".

2.3 Labour Relations

Labour Relations issues are very much part of human resource management. Since 1994 there has been a great emphasis on these issues in the public health sector. The Act had introduced a new deal in the LR domain, with implication for the freedom of association. The right for trade unions to exist and to be recognised was entrenched. According to the interviewed managerial employees, there were mechanisms for formal and informal management-staff communication policies envisaged in all their hospital's protocols. These were aimed at restructuring the system so as to interact constructively for the best interest of the hospital. Each hospital had its own model of engaging management and staff, of which the most prevalent structures were: Inter management Labour Caucus (IMLC), Nurses Clubs (NC) and Transformation Action Committees (TAC). Other hospitals had daily morning meetings and monthly hospital forums Nonetheless, the extent to which all these structures and initiatives were effectives vary from hospital to hospital according to the experience of respondents.

With the exception respondents of two hospitals, the managerial employees of the other seven indicated that such measures were effective in fostering consensual working relations and cooperation between the senior management and overall hospital employees. Furthermore, these interventions had brought about harmony and good relations, increasing the effectiveness of the hospital. Senior management no longer unilaterally and forcefully implement decisions and resolutions without informing

stakeholders and consulting with them to hear their viewpoint on the subject matter or issue at hand.

HR representative at hospital A for more than 10 years: "Ever since our hospital embraced and successfully implement the IMLC system there has been tremendous improvement in working relations between management and hospital employees in general".

In the experience of some respondents, measures and interventions like IMLC, TAC often were like a 'claw-less bear' i.e. with no influence and authority. This is often caused by distrust and a desire to compromise between employee's representative on one hand and senior management on the other hand. At times senior management push their own agenda, ignoring the interest of others and without consulting employee's representatives or to deliberate on the matter to encourage responsive management. Thus at times, unions, despite of their inclusion in structures like IMLC's feel powerless, because they do not have a meaningful input to the decision making process.

HR representative at hospital A for more than fifteen years: "The senior management makes our task very difficult if not impossible. Often they do not involve people at lower level of hospital management in decision-making process. They are operating us like robot with the remote control; for they are not visible to the people on the ground, and most issues are forced up on employees as a result there is high-level of negative attitude towards management. There are no clear channels available for employees to follow when the are dissatisfied with decisions management is taking. At the end of the day we as human resource officials (middle-management employees) have to face the wrath of various unions representatives trying to explain to them why various things had been done in certain way".

The majority of middle managers felt that shop stewards needs to be equipped and aquatinted with necessary skills to deal with issues, for they are "very far, far, far from understanding the rules of the game", and are almost elected on grounds of their radical inclinations, rather than their merits and skills in negotiations. These were among of the responses:

HR representative at hospital A for more than 20 years: "Unions here are so divided and largely worried in increasing their membership at the expense of another union. They negate the fundamental principle of their existence i.e. to represent their

membership on institutional and working related matters/issue, despite of their numbers or how big their membership is. The fact that unions are so divided among themselves gives the management an edge to play off one union against the other during negotiations process".

Human resource representative at hospital A for more than 25 years: "Unions in this hospital never agree on anything. As structures representing workers interests they always fight one another. The stronger union becomes dominant and vies for the attention and recognition it receives from the senior management. They should undergo rigorous training to increase their ability to negotiate and comprehend issues. They just argue and criticise everything without understanding or analysing issues thoroughly. Thus they are not efficient in the process".

Regarding the willingness of senior management to take suggestions from middle-managers seriously, the overwhelming response was that senior management infrequently consult them as middle managers. There feeling was expanded that at times they are left in the cod and wonderland. They as middle managers are supposed to form the link between employees and senior managers, but often senior management do not include them in their deliberations for it 'knows how to manage' and ignore their input. On the other hand non-managerial employees do not trust them (the middle managers) because they are perceived to side with senior management. These are some of the challenges middle managers had to deal with.

On the question of the quality of management of the hospitals, most middle managers interviewed believed that their respective hospitals were relatively managed, despite day to day challenges that they were confronted with.

(a). Disciplinary procedures

Regarding issues of employee misconduct i.e. the existence, composition and effectiveness of disciplinary structures as mechanisms to deal with wrongdoings by employees, the majority of middle-managerial employees indicated that despite of such structures being in the infant stage, these were nevertheless signs of positive improvement.

According to the interviewed middle managers, in order to promote a sense of professional ethos, impartiality and fairness in the process, the presiding officer in all cases is drawn from another public hospital. Irrespective of the gravity of the case in

hand, the DC always followed the proper procedure i.e. to give an offender a verbal warning coupled by written one where necessary. If he/she fails to comply the culprit would face a disciplinary committee. Depending on the outcome of the DC a misconduct employee might get acquitted, fined, suspended with or without pay for a certain period, relocated or at the worse face expulsion from the roll of employment. Expulsion is considered as a last resort, after all other necessary measures no success. Depending up on the gravity of the case in hand it would not last more than six months. They believe that under these circumstances the DC process was very effective in that such practices acted as a deterrent for perpetrators or the potential perpetrators. Misconduct by employees decreased dramatically. Law-less was no longer the order of the day and there was a sense of efficiency and effectiveness epitomised by professional approach to one's work.

Despite of the effectiveness of the DC process as outlined above, there were some challenges that had to be overcome. Sometimes employees do not report certain misconduct by co-employees and some DC members fear to sit in such committees because of being threatened by those offenders who appear in DC structures.

Female HR representative at hospital C for more than 20 years: "The system itself is good, but the problem is that if for whatever justifiable reasons an employee has been found guilty or the ruling has been against the offender in most instances we as people who sit in such committees become the victims of the process because we receive endless threats from those employees whom are found guilty. The result is often that representatives keep quite in such deliberations or even request to be exempted from the process. What make things worse is that of late employees are reluctant to witness against an employee who is alleged of having committed a misconduct".

(b) Grievances of employees in the workplace

The interviewed middle-managerial employees pointed out that in their hospitals channels were in place through which employees could address their grievances, as prescribed by the PSA and the LRA. In the event where an employee feels aggrieved by certain matter or individual, he/she can put such a complaint in writing and address it to the person who is most relevant to attend to such an issue amicabiy. Not all grievances are registered. Most of them are resolved timely and by effective intervention before they are registered. Very few cases if any were reported to the CCMA and hardly

anyone proceeds to the Labour Court. Most of the reported grievances had to do with unwarranted treatment from co-employees or supervisor.

Female HR representative at hospital A for more than 15 years: "Any aggrieved employee can either consult his/her union representative, talk to the supervisor, zone manager or consult with us as human resource department in their personal capacity. So far there has been no employee grievances that were not adequately and amicably resolved or moved to the next level, for example to the CCMA or Labour Court. Through the existing structures we have been able to sort out minor issues quickly which would have been very time consuming in the IMLC meetings".

Female HR representative at hospital C for more than 20 years: "Sometimes supervisors must learn to treat their subordinates with humility and respect. They should regard their position not as a matter of status, but as a responsibility that must be exercised equitably and fairly. It is of no value for the DoH to come up with master plans or grand policies aimed at improving working conditions if those whom are tasked with the responsibility to implement and manage the process are not professional in their conduct, but rather abusing the responsibility and power that is invested in them".

2.4. HRD issues (health service management, training and personnel evaluation)

With the exception from two from the other seven hospitals middle managerial employees pointed out that there were continuous training programmes provided by the PAWC, to assist employees to execute their responsibility efficiently and develop career paths at the same time. Such training programmes were provided either quarterly or monthly pending on the need. Their duration varied considerably from one day workshops to a week of training. Most of the respondents indicated that they had attended a training programme within two-month period from the interview stage. They believe that such training programmes were crucial and that is vital for every employee to attend. It equips employees not only with work-related expertise but also with life-long skills, which can be used outside the work place. Some respondents pointed out that there was a need to move away from a text book approach in offering these training programme and integrate them within the context of our societal experiences and integrate them within Ubuntu philosophy.

Some of the respondents alluded to the fact that although there was a need for such programmes, in most cases those whom were tasked to provide them rendered them unworkable and irrelevant. These respondents cited PAWC trainings as case in point where instructors would teach only in Afrikaans regardless whether the rest of the class is able to comprehend Afrikaans or not. They admitted that at times they were caught in two minds whether to motivate and encourage an employee to attend such programmes or simply ignore the whole process.

Male HR representative at hospital C for more than 15 years: "As an HR representative how do you begin to motivate and encourage employees that they should attend these programmes, whilst those whom are tasked to instruct them are not willing to accommodate learners. Our employees always complain about the language issue, Afrikaans is the medium of instruction in these workshops. As a result few if any employees are willing to sign up for such programmes. We have tried endlessly to communicate with programme organisers but it fell on deaf ears. They always promise to rectify the matter in the next workshop, but they do the very same thing over and over again".

Regarding the availability and effectiveness of job evaluation programmes, opinions were divided. Some respondents indicated that in their hospitals such measures were in operation, while others pointed out that they were not.

Male HR representative at hospital B for more than 10 years: "For years I had been working in this hospital. We do not have job evaluation programme in place. It could have been ideal if it did exist. One would be able to assign people according to their skills, expertise and ability to do the job, as opposed assigning people with huge responsibilities that they can not carry out. Evaluation will reveal them according to their strength and weaknesses".

Male HR representative at hospital D for 24 years: "Here in this hospital we do have continuous job evaluation programme which is carried every third month within a year to us the general staff. The process itself is very effective, because it helped employees to have a better understanding about the service they are providing to the public and to carry out their responsibilities efficiently. At the end of every evaluation process that has been carried out, we give them feedback about the process and within that light the

we are knowledgeable about staffs level of work they do, where do the hospital need to invest more skills, resources and human capital".

In the hospitals where evaluation programmes existed there were still some challenges. Respondents said that nothing gets done after the completion of the process, regardless of their input and recommendations.

Female HR representative at hospital C for more than 20 years "We do have such a programme in operation in which we participate every three months. The biggest problem with our job-evaluation programme is that nothing gets done after the process. There is no improvement in working conditions, despite the fact that some of us would raise crucial issues that need attention. This has discouraged the staff to participate in such time-consuming and useless exercises, which had no effect at the end of the day. The worst part is that questionnaires in most cases are not returned and answered properly. Employees just fill questionnaires for the sake of filling them".

An overwhelming concern of HR officials was that with a few exceptions, there were no measures in place aimed at ensuring effective performance on the part of staff. They consider job evaluation programmes to be a very important mechanism, because at the end of evaluation process one is given feedback about his/her overall performance. A person would reflect back and improve where needed.

There was a strong response from managerial employees that, in an attempt to improve the level of service delivery within public health sector in the Western Cape and speed up the processes, the provincial government should privatise some of the support services within public hospital i.e. catering, laundry or security personnel.

Female HR representative at hospital A for more than 25 years: "I do support the notion of privatisation for it will lead to speedy and better service for the patients at the end of the day. Getting a privatise company to execute some of the supporting services will somewhat reduce the workload of the overburdened and overstretched employees. Not only as the management you will have a choice to sign a contract but most importantly it will save the hospital a considerable amount of money. Such a process will give time to the management and hospital staff to focus on the real hospital business i.e. caring for patients. If a company does not deliver according to expectations and contractual agreements, one has a choice either to enforce such

agreement or terminate the contract without any fuss as per agreement, without having to endlessly negotiate with trade unions on such matters"

Female HR representative at hospital B for more than 15 years: "I completely support the notion of privatisation of supporting services such as catering, security and laundry section within our hospital. I believe that it will prevent the hospital from loosing huge sums of money, because certain individuals are taking unnecessary leave and are committed to their responsibilities. If we were to privatise security personnel for instance, and the person on duty does not pitch up, we are not going to loose any money because the contracted company will promptly bring in a replacement for the day without any costs incurred. They have a pool of workers to choose from unlike us, for we are not employment agencies".

Female HR representative at hospital C for more than 15 years: "Privatising services such as laundry, security and catering will save hospital thousands of rands that it had lost as a result of theft by our staff in these three supporting services. In the past employees in these supporting services acted like a syndicate in that security staff at the gate did not properly check the cars of certain employees when leaving the hospital. Through our search we discovered that certain employees were stealing the groceries, linen and medicines that was reserved for the patients. It was very pathetic and very bad indeed. So if we got an outside company it will be better because they do not know each other. The security firms constantly change their security personnel at various depots, making it difficult for the syndicate of employees to operate".

Most of the managerial employees were very optimistic about the prospect for improvement of the public health system in the Western Cape, despite of the current challenges that faces the broader health sector faces. Their specific hospitals, like any other sector in our country, coming to terms with the whole issue of social and economical transformation that is unfolding.

Female HR representative at hospital A for more than 20 years: "This is a very painful and challenging period in our history as a country. All sectors of our society are trying to make ends meet. We need to be firm and strong in our conviction and not falter, try at all times to learn to walk the talk and not come up with grand policies that will not have any bearing in alleviating our social and economic life in practice".

Female human resource official at hospital B for 22 years: "Give it some time and South African health service will be a force to be reckoned with no only in SADC community or continentally, but in the global arena and a model to many countries that want to improve their health sector".

Below were some of the mentioned suggestions put forward by the interviewed managerial employees:

- There is a need for hands-on management and enthusiasm on senior level, for it boost the morale of employees.

- Employ more staff and communicate with the all role-players timeously and effectively.

- Provide relevant training to the general staff in the language that is most likely to be understood by everyone, not by a certain section of the community or racial group.

- Increase the budget of health service in the province, in order that public hospitals may function effective.

- People should be employed on merit, employ those who knows their jobs, have a love for nursing and a will to serve patients wholeheartedly.

- Bring in new senior hospital staff and transfer the old staff to other hospitals or sectors.

- The government must start to walk the talk by effectively implement its long over-due Primary Health Care system and not cut the budget of hospitals.

- Encourage and implement privatisation.

- Provide resting and recreational facilities at hospitals to relieve work-related tension and stress.

- Provide counselling programmes to the staff where needed.

- Stop retrenching or cutting back on staff under the disguise for budgetary constraints. Employ people not because they are women and black, but because they are competent and they can effectively do the job.

3. Responses from senior management employees *(HOD and Superintendent)*

3.1 Transformation: The impact on human resources

Transformation processes often bred a climate of inflated expectations, job insecurity and exacerbated stress levels. Nevertheless are meant to accelerate the process of restructuring. Many senior managers complained about the continuous disruptive effects of restructuring on motivation, morale, work relationships and staff turnover, resulting in overburdening of the remaining staff. Some of them expressed concerns about the transformation. Because the delivery of proper services was difficult to achieve with staff that are over-extended.

3.2. Affirmative action and employment equity: Redressing racial and gender issues

Central to the issue of affirmative action is the ability of the human resource departments of hospitals to address employment equity and to accelerate the pace of the transformation process. Most of the senior hospital staff interviewed indicated that they had more than ten years of working experience in their respective positions. Most of them moved through a number of ranks, from lower to higher positions. From their own experience, they could attest that there were clear and effective promotional opportunities existing in their hospitals.

Many of the hospital superintendents interviewed reported that they find it difficult to manage their time. They had to handle a double responsibility as medical doctor on one hand and as hospital managers/superintendents on the other hand. They suggested that it would be ideal to have two superintendents to deal with medical matters and another one concentrate on management issues. They welcomed some of the DoH strategies to ease the burden of the hospital superintendent by creating Chief Executive Officers (CEO). Nonetheless, they remained sceptical of the process itself, which might lead them to the loss of their job or to demotion from their present position as hospital superintendent. Some of them suggested that the powers of hospital's HR Director be strengthened in dealing with personnel management issues, for example relinquishing some of managerial responsibilities entrusted to hospital superintendent. This will free

the hospital superintendent to help in setting the hospital's protocols to set management goals. They believed that such a strategy would positively contribute to improve the core business of hospitals i.e. to heal patients.

Male Hospital Superintendent at hospital A for more than 15 years:" In this hospital I spent approximately 20 hours a week attending to administrative matters and 36 hours practising my profession as a doctor. As a matter of fact I do not have a correct balance in the time I spent at my joint responsibilities. It is really frustrating and time consuming to be a fulltime office-bearer who deals basically with management issues, yet at the same time one is expected to be a full-time doctor attending to patients, regardless one is busy with administrative responsibilities or not. Given the size and magnitude of this hospital, I think there is a need for someone who is responsible on a full-time basis to deal with personnel management issues. I can just assist by setting protocols and management goals. I believe that will contribute to the overall efficiency and effectiveness of this hospital".

At the same time there were some hospital superintendents who did not experience any difficulties in managing their time. These were superintendents in psychiatric hospitals.

Male Hospital Superintendent at hospital D for more than 20 years: "I am not under pressure in any way in terms of executing my responsibilities as the superintendent in this hospital. This is because I concentrate solely on administrative matters and do not interfere with medical matters. I believe, one does not need to be a medical doctor in order to assume the responsibility of hospital superintendent. You do not manage patients, but people to ensure the overall efficiency of the institution. For instance I have an MBA and I never attended any medical related course. But here am I, tasked to be in charge of this hospital".

Male Hospital Superintendent at hospital E for more than 27 years: "I do not have any problems in executing my joint responsibilities and managing my time in this hospital. But what I would like to advise is that, in effecting change and contributing meaningfully to the unfolding transformation in our public health system, there is a critical need for hospital superintendents to go through a intensive course on management. This will enable them to better manage their respective hospitals better, to handle labour related matters".

Some respondents indicated that it was uncertain whether the policy of affirmative action did bring about any significant in their respective hospitals. The process was a still in its infancy stage and the effect on affirming the previously disadvantage employees was still not clear. Nevertheless, the overwhelming majority of respondents indicated that the policy was applied in their respective institutions and used as criterion in recruiting new staff. Some indicated that even though there were no formalized processes in their hospitals, they follow the guidelines of the provincial DoH. In accelerating the transformation process as prescribed by the Provincial Health Plan and the broader national policies, some had set up BTC's i.e. Branch Transformation Co-ordinators. According to them, there have been significant and positive outcomes as a result of applying such a policy even though they had to deal with challenges from employee's representatives and members of the general employees, who resisted change.

Female HRD Director at hospital A for more than 20 years: "The process itself had somewhat boost the moral of the workers, no one feels alienated and the overall performance and co-ordination of the hospital have quite improved. All employees know that each an everyone of them is selected not on the basis of his/her lighter pigmentation but rather on the level or ability to do the job efficiently and effectively".

Male Hospital Superintendent at hospital F for more than 15 years: "Tentatively speaking, one can argue that in this hospital the application of affirmative action had brought about some positive changes and the recognition of previously disadvantaged members of our community. In the history of this hospital there has never been a hospital superintendent who was a black person. But to today here am I, a disable black person (blind), as a hospital superintendent, in a previously white male dominated senior management institution".

Male Director of Administration at hospital C for more than 10 years: "Affirmative action had supported some changes which we as hospital had already put in place some years ago, in an attempt of changing the complexion of our staff so to resemble the racial demography of our immediate and larger community. As a result staff communication with patients and across all levels of hospital management had improved considerably. Although I do believe that we still can improve by consolidating the gains we have made thus far".

(a) Gender and racial representativity

Regarding the racial and gender composition of senior hospital management, senior management pointed out that there was a clear dominance of females but the racial balance was beginning to reflect the overall racial demography of the hospital. Previously, there was large population of white males in senior management posts of the hospital, with fewer coloureds and Indians, but a growing number blacks. Only at two out of the hospitals interviewed, there was a clear majority of female employees and only blacks at all levels of the hospital. respondents at the these hospitals indicated that non-African employees were not interested to serve in African communities under the pretext that it was not secure and dangerous.

Hospital Superintendent at hospital D for more than 20 years "We had made a major strides in addressing the issue of race and gender at senior management level. Yet there is still clear majority of white employees as opposed to our blacks counterparts. But that needs to be understood within the context of the environment of where our hospital is situated, taking into consideration the racial demography that surrounds this hospital. Also, there is a lack of qualified and experienced people of the colour. Despite of these challenges there is a commitment and a willingness to change the gender and the racial complexity of this hospital, especially at senior management level".

Concerning the question as to whether as senior management of the hospital were under pressured in any way to meet certain provincial quotas for the composition of their employees, response was as follows: The majority of the respondents indicated that they were indeed under pressure, while a few maintained that they were not pressurised any sense of the word. As there was a need to address the deficit of blacks (particularly black women) that are qualified to meet the criteria. They argue that the challenge was to find the right person who meets the required prerequisites both academically and with a right pigmentation (specifically black women). They further pointed out that there was tension between them as hospital superintendents and the provincial DoH at times more especially when it comes to meeting racial quotas. According to some of respondents the regional DoH need to be sensitive about the process and not enforce the implementation of such quotas without superintendent being involved in the process or taking into account the social and racial demography of the particular hospital. These

respondents strongly believed that the powers to balance gender and racial distribution at hospital level should be vested at institutional level in the hands of the hospital board and not on provincial level. They argue that at the end of the day it is institutions themselves who had to provide health service and not the regional DoH offices.

Male Hospital superintendent at hospital H for more than 20 years: "Despite the fact that we had rigorously and constructively engaged ourselves to meet provincial quotas, we are pressurised to meet these numerical goals as prescribed by health policies. We need more qualified African nurses to fill the vacant positions, we are really battling but we are optimistic that the process will prove worthwhile at the end of the day. So as much as we support in principle such a move without reservation, we should have been consulted before the finalisation of specific numerical goals, but we were not. These numerical goals are difficult to attain, because the racial demography of our respective environment becomes an issue. One finds a very limited number of qualified and experienced individuals from people of colour. The moment you are not able to attain such numerical goals, you are regarded as a rebel or not committed to the provincial policies aimed at accelerating the transformation in our country. In any event the process itself is still in infancy stage and there is of course resistance to change, particularly from those who enjoyed unlimited privileges from the past government".

Male Hospital superintendent at hospital D for more than 25 years: "There are very few qualified professional black nurses and doctors in the province interested to work in public hospitals. This makes it difficult to meet provincial targets as set out in the PHP. My point of view is that to rectify the situation, the targets should not be based on abstract numbers, but rather on the number of unemployed people within a given environment. The current system of quotas allows one an opportunity to pick and choose between employment opportunities, whilst for others it is a matter of survival to get employment, especially the impoverished population of black communities. In my opinion, the whole strategy to meet certain population quotas is a flawed and subject to criticism. Critics argue that it is a legalised form of apartheid, because (in their opinion) the architect of apartheid had valid reason for the system, thereby excluding the majority of the population on the basis of one's pigmentation".

On the other hand some respondents who indicated that in their respective hospitals they were not under pressure to meet provincial gender and racial quotas. These were some of the reasons given:

Female Director of Administration at hospital C for more than 10 years: "I believe that we are not pressured in any manner. The reason is that both management and employees were committed to it and cooperated to make this possible. This has been the corner stone of our success".

Female Director of Administration at hospital E for more than 15 years: "We do not feel pressured in any way to meet provincial quotas in terms of racial representative ness of our hospital. The reason is that very few non-African applicants are willing and interested to come and work at our institution and in our township area. We have advertised in many ways, at times offering better incentives and perks, with the intention to encourage prospective candidates to work with us, yet that was all in vain".

Despite the process itself being in the infancy stage and facing considerable resistance, there was a general acceptance by senior managers that an affirmative action policy as a prerequisite to create promotion opportunities for their employees is vital. They pointed out that they do have a policy as prescribed by the PHP and that it is being implemented. The implementation of the policy did lead to some improvement on staff morale and performance.

Female Director of Administration at hospital A for more than 13 years "We do not have a policy cast in stones, but we do work according to provincial recommendations. It really brought about positive changes, for it had boosted our staff morale and improved the overall performance of the hospital and promoted good working relations among our employees in general. Employees on senior level have become slowly and surely more representative. Although I must admit that the process itself has been faced with continuous resistance from other employee members, who view it as simply an apartheid in reverse".

Incentive system to improve staff performance

Opinions were divided on the existence and effectiveness of programmes aimed at attracting qualified and competent staffs. Some respondents indicated that there were such programmes and that these were implemented. As a means to improve career opportunities, some hospitals advertise only internally for all of their non-promotional positions. At other hospitals, the kind of management training offered was very broad. It also prepared employees to an extent that it offers others for career opportunities

outside the hospital or health fraternity, making it possible for them to posts even in business.

Male Director of Administration at hospital B for more than 20 years: "We do have more than just programmes simply aimed at retaining qualified and experienced employees. The structure of our organisation is so flat and decentralised that it accommodates and enable everyone be on senior or junior level to have a say in running the hospital. We've got excellent induction programmes coupled with a focussed mentorship and needs assessment training. Our human resource department has an Employee Assistant Coordinator, who is solely responsible for the well being of our general staff, be it a personal or work-related matters. We do have a nurses club, which is responsible for nurse related activities and outdoors functions. Above that, all our non-promotional staffs are advertised only internally e.g. potters, clerks, cleaners etc. So in a nutshell we provide opportunities for career growth for our staff even at non-personnel level. The quality of patients and staff care at this institution is a matter of priority to the senior management and is of a high standard as well. The entire process is effective, yet there is still room for improvement".

Some hospital superintendents held an opposing view, saying that at their hospitals they do not have such measures and they are really battling as a result of that.

Male Hospital Superintendent at hospital D for more than 12 years: "At our institution we do not have programmes in place aimed at attracting qualified, experienced and competent staff. There is a lot of uncertainty about the future of this hospital, and there is a possibility of it being indefinitely closed because of the lack of funds. Really, as senior manager in this hospital one hugely depends up on the goodwill of his/her employee members, whether they will come to work the next and if so, how long do they intend to stay with us. There is virtually nothing we do offer to retain our already employed employees or what we can offer prospective individuals whom are interested to come and work here. Recently we had been hit hard by the current government's senseless policy of voluntary severance packages. We are still loosing qualified nurses to either the private sector or to the international community in countries such as Saudi Arabia, Britain, Australia, and New Zealand etc. The situation is exacerbated by the fact that our new LRA does not provide mechanism for incentives to employees regardless of the extra effort they put into their tireless activities".

3.3 Labour Relations

Most hospitals had some kind of arrangement to engage different stakeholders in management issues. Some senior managers mentioned that they follow an open-door policy as a guiding principle for their engagement and communicating with employees. Others have an employee code of conduct, made available to employees on the date of appointment. In their experience, such measures in one way or another contributed to harmonious on the general and are especially valuable in cases where misunderstandings or differences arise.

Male Director of Administration at hospital A for more than 15 years "We do have an open door policy as a means of communicating with our staff in this hospital, but it is not necessarily cast in stone. In our daily dealings we implement it and has proved to be beneficial, for it paved the way for both management and unions to engage one another. It also played a crucial role in minimising tension and conflict between management and staff and contributed to the effective functioning of the system. As a result both management and general employees are at all times informed of what is taking place. No group feels being left out in the cold".

According to the hospital managers, such measures were integral to the efficient functioning of their respective hospitals. Through these different inter-actions and bilateral negotiations between the two structures, they had been able to minimise the level of conflict arising from the different interests and promoted some sense degree of consensus. The process itself was not as easy as it may sound and there remained many challenges still to be overcome. Many employees were not exposed to such kind of institutional arrangements, where management and workers engage with one another on management issues. furthermore these were mechanisms such as Institutional Management Labour Caucus (IMLC), Monthly HOD meetings, Monthly Nursing meetings, Service area meetings, Monthly Forum meetings, Intra and Inter-departmental meetings, Operation Management team, Skills developmental meetings, Ward and departmental suggestion boxes.

Male Director of Administration at hospital A for more than 20 years: "In our institution the IMLC deals with broader institutional issues facing the hospital e.g. disputes and, notice of strikes. It is representative of the key structures of the hospital.

The operation management team is participatory in approach where it deals with new instructions, complaints and resolutions. In the spirit of encouraging good and fair working relations with our staff, we created a new post called 'Staff Liaisons Officer" (SLO). This is a very strategic and a key position in terms of neutralising any tensions that may arise between management and staff but also deals with any administrative developments within the hospital. At times the SLO represents employees in the management meetings, in the event where employees feel their union not adequately and fairly represents them. Such mechanisms have played a crucial role in minimising tensions and conflict between management and staff and brought about cordial working relations. Everyone feels part of this hospital. In fact we have become like a family, because this is where we spend most of our time rather than at our homes. Employees are encouraged to come personally to the management if they feel aggrieved or misrepresented in any form. This is so because we believe in the open-door policy. I doubt very much if we could have been where we are today in this hospital, because our hospital was really badly managed and lot of corruption involved. But today I can stand proud in front of million people in associating myself with this hospital without any fear or reservation".

With regard to the effectiveness of unions, some respondents indicated that they were effective while others thought them to be not very influential. the following unions were represented: HWU, NEHAWU, HOSPERSA, PAWUSA, DENOSA, PSA, NAPSU.

Male Hospital superintendent at hospital G for more than 20 years: "There are about four different unions operating in this hospital, representing different employees according to their preferences. In fact we as management encourage employees to belong to a union. In the event that an employee does not belong to a union, a portion of his/her salary is deducted and deposited in the Employee Benefit Scheme (EBS). Unions are not very effective, but they are very cooperative with respect to issues that need to be addressed. When we do not agree on certain issues, thus we do our to resolve the issue amicably. We are critically and constructively engaging one another at any given point in time in our meetings. I can assure you of one thing, and that we trust each other and cooperate well. In fact one will be quite surprised to note that most of the input in terms of managing the hospital comes directly from union structures themselves. These intervention have boosted morale and improved overall

performance. Of course there is a room for improvement, but both the management and union structures of this institution have the same pride and loyalty to this hospital"

It was nevertheless interesting to note, inconsistencies in the response from other senior hospital managers. On one hand they were positive about the contribution made by both parties at IMLC meetings i.e. themselves as managers and trade unions. Regarding the general effective functioning of the hospital, they argued that, "unions were not cooperative and lack a will to constructively engage the management on issues affecting them as employee representatives".

Male Director of Administration at hospital C for 30 years: "The nature of trade unions is such that they always have their own agenda in any negotiative process, and they always feel that they are not consulted properly. I know that, there will always be differences and that there will always be tension in the relation between us and unions in the running of the hospital. There is nothing bad or wrong about that. But since trade unions became active, most supervisors do not know whether are they still supervisors or whether it's the shop-steward that is in charge. It makes some of the seniors afraid to pull-in the reins, and causes a lot of uncertainty about the different roles. At times I have the feeling that they just oppose for the sake of opposing in order for them to be seen doing something and not to be seen by their membership as simply agreeing with management's proposals".

With regard to measures to deal with misconduct all the interviewed respondents maintained that such measures were in place at their hospitals. According to them such structures were inclusive in that they consisted of both management and employees representatives. Each one's viewpoint was heard and respected. Some of respondents reported that there was no support from the regional DoH, other than being instructed to set up structures without being provided with training of any a kind They had to battle in organising training themselves. Nevertheless, all of them were very positive and optimistic about the establishment of such structures, in improving the management of their respective hospitals. In a bid to ensure the effectiveness of the process and to, encourage fairness and neutrality in the proceedings, the presiding officer is always drawn from another hospital for a specific case. Furthermore, such an individual must be well trained in dealing with disciplinary issues. The most prevalent reported cases of employee misconduct were: Absenteeism, abuse of state property, misappropriation of

funds, excessive use of intoxicants, negligence in performance of duties and acceptance of bribes.

Male Director of Administration at hospital B for more than 20 years: "We've got a very good disciplinary system here ever since we embraced this new system which is corrective in nature i.e. aimed at not coming down heavily on the offender but intended at preventing similar offences. Because of the counselling programme that we do have in place to support our staff to behave in a professional manner, we seldom have to deal with misconduct employees. We never expelled anyone yet as a disciplinary measure. In its operation and in an attempt to encourage fairness and neutrality, the presiding officer is selected from outside the hospital. We look for someone who is a well trained and knowledgeable about the law. From our experience the entire disciplinary process does not take the three months as envisaged by the law. We are fast, effective and professional in our dealings. Since the inception of the current disciplinary system, the misconduct rate had dropped dramatically. One can thus safely said that it had acted indeed as a deterrent to those who may wish to engage in misconduct".

With regard to how respondents experience their relationship with employees at personal and occupational level, all the respondents indicated that they had a pleasant and excellent working relationships with employees of their hospital.

Male Hospital superintendent at hospital A for 27 years: "I believe my relationship with my staff members can be best described as neutral. This is because everyone knows me at this hospital since I was a an ordinary doctor and they dealt with me at that level. Lately it has been somewhat challenging for me. Many people still expect me to be that 'family man' and not to establish my authority as hospital superintendent. As hospital head I have a responsibility and role to play in the process, much different from being an ordinary doctor. As a result, some people are saying that I am not approachable and they are scared of me. And yet as head I have never closed my door for communication on any matter, whether it is not work-related or not".

Regarding the question of how do they view the current LRA as a help or hindrance in the relationship between management and employees, the overwhelming majority of respondents pointed out that it is a tool for improvement. Nevertheless, concerns were raised regarding to its implementation, specifically as far as the power of the superintendent to hire and expel employees are concerned. One of the interesting

responses was that as much as the current LRA sets out gender and racial quotas to be met, it does not set up mechanisms to ensure that also financial equity across gender and racial lines is also realised as part of transformation.

Male Hospital superintendent at hospital F for more than 17 years: "In my own experience as hospital superintendent, I find this new LRA both a tool for improvement and a hindrance. From a transformational point of view to restructure the health sector it is very relevant and crucial, and makes a positive and meaningful contribution. However, it is a hindrance in the sense that the whole process cf discipline errant employees is a very lengthy and painful exercise. It also affects employee morale negatively. This hampers the ability of employees to provide an efficient service to patients, who suffer at the end of the day. As much as we need a general or national policy dealing with disciplinary measures, each hospital should develop their unique disciplinary code of conduct based on the hospital's size and management style".

Female hospital superintendent at hospital C for more than 29 years: "We welcome this new LRA as one of the best and finest laws ever devised in the history of South Africa, especially taking into consideration the volatile social and political environment we experienced under apartheid government prior to 1994. So as much it attempts at improving the labour relation conditions of our workforce, it also constrains us as managers in efficiently running our hospitals. With remuneration levels and agreements on promotion (such as rank and leg promotions not linked to the financial position of hospitals, and retrenchment and redeployment not an option), hospital superintendents have little power to control personnel expenditure. A key prerequisite for making the system efficient is to provide superintendents with appropriate personnel management tools, including an affordable retrenchment tool. Although retrenchment should not be the main mechanism for managing personnel, redundancy and rationalisation, the moratorium on retrenchments in the public sector as well as the absence of an affordable retrenchment tool makes it extremely difficult for hospitals to effect redeployment and manage down employment costs.

In our efforts to manage our hospitals and adjust to changing priorities in the health sector, we as hospital superintendents are extremely constrained by the current collective bargaining structures. Many crucial decisions are effectively determined at the central bargaining chamber, which receives very limited input from hospital level.

As a result settlements reached at bargaining level in most cases do not take into account the institutional realities faced by specific hospitals".

Female Director of Administration at hospital A for more than 18 years: "The current LRA is the best thing that could have happened to the history of industrial relations in South Africa, especially when one takes into account the volatile situation that we came from, where employees had virtually no rights. Even if there were any, they simply existed on paper and not in practice. This law must be seen within the context of nation –building and reviving our economy, for it spells out the rights and limits of both the employees and the employers in black and white. If one party feels aggrieved in one way or another, such party has the option to take the matter either to the CCMA or the Labour Court. This law puts into effect reciprocal relationships for management and employee. Neither side can unilaterally take its own decision without informing the other, for they have a duty to notify one another. For example, unions can no longer engage in strikes without notifying the management, neither can management lay off employees without informing employee structures".

Female Director of Administration at hospital A for more than 22 years: "So much as our LRA looks rosy on paper, the critical challenge that it faces is the ability to translate that into practice, for the will always be human factor involved (duck and dive) when executing some key aspect of the law. Most notably, we need to create culture of excellence and the acknowledgement of differences i.e. politically and socially, because at times when one questions the integrity of the law, some view that as being against the principles that underline the current labour relations act. Nevertheless, this new LRA is an achievement and something we can be proud about. If implemented correctly that will bring us close to perfection I have every reason to be optimistic about the future of our industrial relations, which are improving at a rapid rate".

Regarding the grievance procedure being followed and the extent of its effectiveness in dealing with employee grievances. Mangers follow the standardised grievance procedure as prescribed by the Public Service Act and within the confines of LRA, by Circular H84/2000. On average, they handle less than ten grievances per month. The most recurring grievances were: Unfair treatment by supervisors or co-workers, drinking at work, absenteeism and late arrival at work.

Male Hospital superintendent at hospital E for more than 29 years: "The approach followed in addressing employees concerns is that of employees approaching their union first. If that is not satisfactory for whatever reason such an employee can approach his/her supervisor or unit manager. If that is also unsuccessful he/she can directly consult with the Employee Assistant Officer (whose responsibility is to mediate between management and staff on one hand, also among employees themselves where necessary). In our working experience, this three-pronged approach has been very effective because we had been able to ease out tensions or minimise problems that arise from the process

Male Director of Administration at hospital B for more than 9 years: "The procedure followed in addressing employee concerns at our institution, is to take the matter firstly to their ward mangers, alternatively to their unit supervisors or union representatives. If that also fails to produce results, they can directly go to the management. Furthermore, employees have unions to represent them. We have a sister's meeting every Thursday morning for nurses to voice their concerns and grievances. From our experience we can proudly argue that it has been effective. We believe that the more people voice their concerns or grievances, the more management becomes aware of their circumstances and the quicker action is taken to address the issue at hand. Thus the whole system of service provision becomes effective and efficient. In the survey we conducted about our grievance procedure i.e. how efficient and fair it is, the response was overwhelming positive in that employees informed us that they believe their voices were heard and the management attended effectively to their grievances".

3.4. HRD issues (health service management, training and personnel evaluation)

All the interviewed senior hospital managers indicated that personnel training were provided to enable hospital employees to do their work effectively and develop career paths in the process. This training is offered either by PAWC or hospitals themselves. They pointed out that such training was provided throughout the year. The duration could be as long as two-weeks pending the content of the training offered at the time. Most of them alluded to the fact that they had attended training within a month or so before the interview. Yet there were two respondents who indicated that they last attended PAWC training about a year ago, citing the language barrier as a problem.

According to them, the courses were offered in Afrikaans and not in English. They accordingly decided not to attend them anymore. They also said that they raised language difficulties with instructors, but it was all in vain. In some cases the question of the availability of time and resources was also crucial.

Female Director of Administration at hospital A for more than 15 years: "Yes we do have in-service training for all our employment categories. we participate in PAWC training programmes. At the same time we encourage our staff to realise the strategic value of attending these training programmes in order to develop career paths, even if this is outside the fraternity of health service. Our hospital board funds our training. The duration of such programmes vary considerably i.e. ranging from one day activity up to two weeks pending up on the need. The last time I participated in such a programme was last month. It was about financial auditing and developing marketing skills. The biggest problem is that there is no time or opportunity to report-back and pass on the knowledge and skills, one that has learnt in attending these training programmes".

Male Director of Administration at hospital B for more than 26 years: "We do have an ongoing training programme that we offer here internally and externally i.e. by PAWC and CAA. The duration of such training programmes vary considerably. Some would last for a day whilst others will take up to a week or so. The last time I attended a training programme was about three weeks ago. This was a course on computer skills, financial and stress management. I found the courses to be very relevant and informative, for they helped me to have a better understanding of my responsibilities and to be effective in my work".

Female hospital superintendent at hospital C for more than 12 years: "As of last year I took a resolution that I will never attend PAWC training programmes again. Since the public health service was integrated into one structure, we as black people who, no fault of our own are unable to understand Afrikaans language are forced to follow the course in Afrikaans because 'most of the people in the province and attend these programmes are Afrikaans speaking'. The management of this hospital had various discussions, wrote back and forth to the provincial department of health informing them of our dilemma with the language barrier in these PAWC training programmes. They always promise us that they will look into the matter and address it, but for more than three years they did not do anything about it. We feel powerless and not motivated to

encourage our junior staff to attend such programmes for I do not attend them as a senior official of the hospital. If you are unsuccessful as a leader to effect change, how can you motivate your subordinates to embrace that change and believe in it?. It will be appreciated if someone would attend to this issue as a matter of urgency because I believe that one of the reasons why 'our' township hospital are not able to compete equally with those of people with lighter pigmentation, is precisely because of the lack of appropriate and adequate training".

Opinions were divided with regard to the existence and efficiency of formal personnel evaluation programmes. Lack of funds the main reason why some hospitals were unable to implement these. Some of them indicated that they have repeatedly written to the provincial DoH and various business within the province, requesting funds to implement such programmes, but that was all in vain. Even those hospital managers who indicated that they do have such programmes in place in their hospitals, are still faced with challenges in the process.

Only at one out of nine hospitals maintained that continuous evaluation was carried out to measure the level of development of employees and ascertain the hospital's overall performance.

Male Director of Administration at hospital B for more than twenty years: "We do have such a programme at our institution, but it is effectively implemented at senior level where zone-managers are expected to submit a quarterly performance review. The challenge we are faced with in embarking at a broader and effective evaluation programme, which will include all the levels of employment at our hospital, is the lack of funds to execute such a massive project. Even the one we tried to execute last year, proved to be a failure because we had no experienced people to implement the process properly. Though we had the collected data, we could not do anything with it for there were no people with the necessary skills to analyse it. In fact the process itself was not professionally executed and administered. As a result tensions and bitterness arose at the end of the process. We are under-resourced and have to squeeze our tight budget for some other priorities. But if given enough resources, I believe that we can pull it through. I do believe that we have a considerable number of people who are either incorrectly placed in their positions or who under-sold themselves at the time of their appointment. If we were to have an evaluation process we can begin to identify such gaps and provide better health service to all our patients".

A female Director of Administration at hospital H for more than 10 years indicated that, in her hospital, a continuous evaluation process was carried out. She pointed out: "In an attempt to boost the morale of our staff and to ensure that they are performing up to optimal standard as expected, we had created what is known as the 'employee of the month award'. Without the knowledge and involvement of the management, employees themselves choose the employee of the month on a regular basis. We have received positive feedback from the employees for they view the whole process as empowering for them as employees. They see it as an intervention to motivate and complement employees by their peers themselves".

Opinions were divided on the issue whether government should encourage more privatisation of some services within public hospitals. The large majority was in favour of attempts to privatise some hospital services, while a few were totally opposed to such attempts. Some of the typical responses were as follows:

Female Director of Administration at hospital I for more than 15 years: "There is just no way we could begin to entertain the concept of privatisation of some services within our public hospital. Such a move will not only lead to higher levels of unemployment, but also have a direct effect on the crime level that is rife in our country. Whenever we decide on policies, which are meant to serve our people, we should always be govern by the principle of social development and not by monetary greediness. If we were to allow privatisation to become the rule, we will be negating our responsibility as government and poor communities will suffer severely. To my understanding there is no difference whatsoever between all the sectors within a hospital environment, a cleaner is as important as a doctor. The difference is just the job title and responsibilities, but all units should in an integrated and dependable manner.

The success or failure of one unit depends hugely up on the efficiency of the others. No doctor can perform well without the assistance from nurses, and no nurse can perform well within a filthy environment. There is a need for hospitals to be kept hygienic by cleaners. In order for patient to recover fully from their illness, they need good food, which is served by our kitchen staff. So if you choose to separate that linkage under the pretext of saving money or for whatever reason, you are bound to have crisis. This was the case in many hospitals decided to privatise some of their support services".

Hospital Superintendent at hospital H for more than twenty-five years: "If we are serious about improving the level of service delivery in our public hospitals, it is crucial for government to encourage more privatisation of some of the services in public hospitals. Not only should the hospital be given an opportunity to privatise services such as catering, security and laundry. These are non-medical services and not part of the core of the hospital, which is healing patients. With regard to over-expenditure, it is important to state that some of the over-expenditure could be attributed to poor management. This is particularly evident when one considers the present centralised provisioning procedures and accounting system. For example, existing contractual agreements force hospital departments to use particular suppliers, even if the same goods or service could be obtained more cost-effectively elsewhere. So we as hospital superintendents must be given a right to chose which supplier to use, even if this is a private company, so long as it is going to be cost-effective and result in efficient service provision".

Male Director of Administration at hospital B for more than twenty years: "I fully support the notion of government engaging in more privatisation of support services, like security, kitchen, laundry and cleaning. This is not only more cost-effective, but it will eliminate the high level of theft of hospital property by badly behaving employees. One can easily replace a badly behaving employee without having to go through all unnecessary channels, which at times are simply time consuming. If one is caught stealing hospital property or involved in some unethical behaviour, all you have to do is simply to contact the contracted company and they will deal with such a person the way they see fit and find a replacement without any hassles. That could also address the problem of high level of absenteeism and abusive sick leave, especially in the hospital support service sector".

Male Director of Administration at hospital C for more than 20 years: "The whole concept of privatising some of hospital supporting services is very attractive, because government is cutting our budget up to a point where our hands are tied. It leaves us in the cold to face the wrath of our hospital trade unions when we try to privatise some support services within our hospital. Then unions will then accuse us of being against the policies of government that are aimed at alleviating the escalating level of unemployment and addressing the problem of poverty. Nevertheless, so as much I support the notion of privatisation I believe there should be a proper consultative and

negotiated process first, to enable stakeholders and affected parties to voice their views. In this way I trust that labour unrest or disruption in the service delivery can be avoided, for everyone would have consented to the process. I believe that such a move will not only be cost-effective, but would also improve service delivery considerably".

The overwhelming impression from the response of senior hospital managers is that the general level of service delivery since 1994 has declined considerably. According to them this trend will continue unless the provincial in conjunction with national department of health does something speedily to rectify the situation. On the other hand, some of the respondents were enthusiastic about future prospects and about what has been achieved since the current government took reigns in 1994.

Male Director of Administration at hospital H for more than 20 years: "The level of health service since 1994 has considerably improved compared to the situation we had few years ago. Hospital wise, steadily but surely the conditions are improving. We have increased our 154 beds by 30 pushing it to 184. Attempts are made to change the stereotypes of how the public perceives this hospital (for they regard it as a mortuary than as a hospital). The management structure and the approach to management received considerable attention as a consequence, the relationship between the general employees and us has improved. This led to an increase in general efficiency in the hospital. What we need to do is to get rid of 'dead-wood' people who frustrate and stifle the process of transformation in our public hospitals".

Hospital Superintendent at hospital G for more than 15 years: "In my opinion coupled with my professional experience as hospital superintendent in this hospital since 1994, the level of service delivery had gone down considerably and still continuing to do so, unless something is done quickly. We have a very sick society compared to six years ago. The Department of Health has adopted the primary health care approach because it believe that is the most effective and cost effective means of improving the population's health.

Its implementation necessitated a shift of resources from tertiary hospitals to primary and secondary health services. Yet up to now that did not happen and no shift of resources took place. This placed tremendous pressure on hospitals to perform effectively. What makes matters worse is that, the introduction of free PHC to people also increased the pressure on hospitals. The number of visits to the hospital grew at an

alarming fast pace. It was very difficult for the staff to deal effectively with such a large number of patients. Despite the fact that number of nurses showing symptoms of burnt-out under these challenging conditions, they are expected to provide a higher quality of service with fewer resources. At the same-time, the level of skills needed to perform effectively in their different fields continues to get higher and changes rapidly. There is a perception that delivery is being squeezed out of employees that are over-stretched".

Female Director of Administration at hospital B for more than twenty years: "Not that I prefer the previous system to our current one but the level of service delivery is really going down the drain unless something is done rapidly to address the problem. We are becoming like a banana republic in our sector. National government is cutting our budget at an alarming rate especially in this Western Cape province under the pretence of financing primary health care. But the latter has not got off the ground for the last three years as was proposed in the White Paper. That on its own puts us in a predicament, because we must really struggle to get our act in order to provide a better service to our patients".

Female Director of Administration at hospital A for more than fifteen years: "Our level of health service delivery is going down and that is because not only we had to deal with diminishing budget, which make it impossible for us to service our patients properly, but we also suffer the consequences of an unimaginable and disastrous government policy of voluntary severance packages which it encouraged for the last two years. We lost al our experienced, competent and qualified doctors and/or nurses to the private sector and international community. I do believe that every one has a right to health, but people must learn to pay for services. Because ever since our government took over in 1994 it preached free health, yet there was no contingency plan put in place to implement this policy effectively. For example, no resources were provided and number of doctors/nurses per patients at our hospital was never increased. In many cases, one person is doing five or more people's work with no remuneration or any form of incentive. That on its own had compromised our ability to deliver better services to our patients. Our under-staffed nurses and doctors cannot cope with the very sick society that we are faced with currently. Patients suffer for they are not getting the proper attention they deserve as human beings".

Female Director of Administration at hospital C for more than 10 years: "In simple language and without making excuses, the simple fact is that, our level of service is

going down. There are many reasons that one can give for this, but I do believe that the culture and structure at our hospital are changing at rapid rate. There is not sufficient time to deal with the massive issue of this transformation, for we are dealing with human beings who have grown accustomed to a certain manner in dealing with issues and who are not robots that you can turn on and off as you wish".

Male Director of Administration at hospital G for more than 15 years:" It is a disturbing fact that the productivity of our health service is going down at the very time, it is supposed to be in an excellent state. Explanations for failing productivity can be given in abundance. Foremost is the effect of the taxing and protracted transformation. To be more concrete: No improvement of the employee situation, the backlog in promotions, the moving around of people, staff turnover and staff shortage. In certain areas we do not have sufficient resources. People get frustrated because of little things that are not in place...this little device is broken, this is thing unfinished...next time you push patients off".

When respondents were asked to make suggestions to improve the situation, the following emerged:

- Hospitals should be provided with appropriate personnel management tools, including an affordable hiring and retrenchment tool procedure.

- Hospital managers should be provided with incentive to manage down their personnel expenditure and ensure an appropriate balance between personnel and non-personnel spending.

- Hospitals should be allowed to retain the revenue or funds that they had generated from serving patients.

- Allow institutions to retain a certain percentage of fee income. This will serve as an incentive to improve collection and might enhance efficiency of management. It will contribute to improved accountability at institutional level. For such a system to be effective a clear policy directives should exist and a fair distributive policy should be adopted.

- Mandating procedures for collective bargaining for health should be reviewed to ensure appropriate representation for hospital institutions

- There must be an adequate budget to cover all the needs for training and retraining of our employees.

- There is a need to create a participative management at all levels, supported by a set of basic values and people committed to serve their patients.

- The current appalling incentive system must be reviewed as a matter of urgency in order to have highly motivated personnel with greater productivity and efficiency.

- Government must employ more nurses to enable employees to give adequate attention to the patients, thus reviving the spirit of maximum patient.

- We need more qualified staff (specialised nurses at Intensive Care Unit, state of the art equipment to resuscitate patients)

- Give hospital management boards more powers and responsibilities for example, hiring and firing employee more than simply rubber-stamping decisions already made by the provincial DoH. Give us also powers to decide the nature and structure of a decentralised management system at each hospital to have.

- Public hospitals differ greatly in size, number and kind of patients therefore need differentiated systems. Improved working conditions and offer better salaries, thus give credit where it is due.

- The provincial DoH should start to walk the talk and not make promises that it cannot keep.

- All stakeholders should be involved in the process to play their part effectively and efficiently.

- We need to establish proper and quality auditing committees at hospital level and promote business co-operation with outside companies.

- Government to assist us in breaking down the stigma that is attached to psychiatric hospital in the province.

- Embark on team-building exercises with other departments.

- Respect the professional status of nurses and look down on them.

- Develop a competent nursing management structure in order to ensure that our interventions to save people are effective.

- Develop better conditions of service, including salaries structures and institute performance management

A final comment:

Male Director of Administration at hospital G for more than twenty years: "We need skills development first. We also need more financial resources, more equipment, more. Bear in mind that our hospital is indeed the crucial link with the under hospitals of our immediate communities such as Gugulethu, Langa, Nyanga, Manenberg, Heideveld, Netreg, Bonteheuwel, Lentegeur, Mitchells Plain, Kapteinsklip, and three hospitals in Khayelitsha. That means more than 1 million patients have to be served by one hospital with only 184 beds Trauma Hospital. How does the Western Cape provincial Health Department expect us to cope at the end of the day, for the situation is indeed pathetic (to use a polite word to describe it). Having to deal with more than nine resuscitations, MVA per day is just not possible. This is just the tip of the iceberg compared with what we had to endure every day in our operation. The provincial government needs to put the horses before and not the other way around. Most importantly, it must translate what sands in policy documents into practice".

CHAPTER 4:

Findings and Recommendations

1. Findings

The main finding of the study can be summarised as follows:

1.1 Policy Formulation

1.1.1 National Policy

The period under review (1996-2001) is characterised by vigorous and extensive policy formulation. Government has not underestimated the magnitude of the task to transform South African society from an apartheid state to a democratic dispensation. The Process of policy formulation went through various stages. The most important policy document in this period, the RDP, was informed by various other earlier documents statements and declaration of principles. The process was thus not done on the spur of the moment, but was rather the culmination of a long where the alternative to the apartheid state was conceptualised, formulated and debated. There is a clear line of consistency running through these various stages and the basic principles remain the same. Where the RDP was basically a declaration of intent the Constitution with its Bill of Rights provided the legal basis and framework for all subsequent policy formulation.

The way, in which national policy statements or documents were translated in specific areas like the health sector, shows the same consistency. The National Health Plan does not deviate from national documents, but rather concretise and reinforce these principles as they apply to the health sector. The same goes for supporting legislation in other field like the Labour Act and its policies that also apply to labour relations in hospitals.

The process of policy formulation during this period must therefore be regarded in general as a successful understanding. The government should be commended for the consistent and thorough way in which they undertook this mammoth task and for the way in which specialised policy formulation remained same to the principles and intentions of the basic documents.

1.1.2 Provincial Policy

The provincial health policy of the Western Cape followed the framework and main points of departure of the national health policy. We found that contrary to what might have been expected that these were no serious discrepancies between the health policy of the national government and that of the province. In fact, as an example provincial health plan must – also be considered as a very successful policy framework.

1.2 Policy implementation

In contrast to the above positive finding as far as policy formulation is concerned on national and provincial level, the same cannot be said about the actual implementation of these policies. Our study, which has been confined to certain aspects of health policy and their implementation in selected hospitals in the Western Cape, has revealed a number of serious shortcomings. As a general statement it can be said that the implementation of health policy in the province present a mixed and often contradictory picture. These are examples of very effective and successful implementation, but there are also examples where there is either resistance to the new policies or where these implementation has brought about little or no improvement of the situation on the ground.

On almost every aspect investigated by the study, respondents held different views. There were not only differences between hospitals, but also between different levels of employees and even between employees of same category. This differentiation is indicative of a situation in flux, which is causing a large measure of uncertainty. Tensions and opposing views are only to be expected in such a situation. But we find that the differences are also indicative of the fact that the process of policy implementation was not well-prepared or executed in many instances and that a lot of hard work still remain to be done. Often difficulties were caused by factors outside the control of hospitals and their management, who then cannot be blamed for not being able to implement policy successfully. We also found instances where transformation was achieved in an exemplary manner and where the atmosphere and work environment have improved considerably.

Because of the varied picture of policy implementation, we present our findings with regard to the chosen focal areas in more detail in the following section.

1.2.1 Findings with regard to specific issues

1.2.1.1 Transformation: The impact on Human Resource

Transformation – pace, confusion, neglect

Transformation accelerated the process of restructuring. Many hospitals HR spokespeople complained about the continuous disruptive effects of restructuring on motivation, morale, and relationships and employee turnover, resulting in overburdening of remaining employees. There is perception that " delivery" is being squeezed out of employees who are over-stretched. There is also a criticism that the Provincial Department of Health has engaged in the development of "a silo...of white papers" resulting in haphazard transformation. Some feel that the transformation is not co-ordinated and it's not very focused. In short, employees are showing signs and symptoms of "burn-out".

1.2.1.2 Affirmative Action: Redressing racial and gender disparities

(a) Racial representativity

The top echelons in hospital management are still almost "all-white". At the senior level white accounted for 65% of management staff. Africans in general are considerably under-represented in the management corps in comparison with the overall racial composition of the hospital's management staff. However, there was also some discontent with then lack of progress in racial representation in the various hospitals.

(b) Gender representation

Gender representation at all levels of the hospitals is still unbalanced: 70% women and 30% men. One of the basic reasons for the disparity if the fact that historically the nursing profession and the broader hospital-working environment were perceived to be

a female responsibility. However, there is a considerable increase of male nurses and of males occupying various positions within the hospital management system.

1.2.1.3 Human resource shortages and disparities

The development of adequate human resource is an integral component required for the effective and efficient delivery of health services. However, there is marked maldistribution, which accentuates the shortage of certain types of skilled health personnel in many areas. Human resource inequity, shortage and disparities occur in terms of geographical spread, community location and socio-economic position.

On the other hand, the Health Department in the Province has committed itself to radical decentralisation and "taking the services to the people". It has established interventions to redistribute professionals, throughout the different previously disadvantaged communities, by means of Health Plan.

Apart from the above-mentioned current challenges facing human resources, there are also softer side to HR. After all; HR management is about human beings. Questions pertaining to aspects such as interaction in the workplace, worker morale, productivity and efficiency of staff, work satisfaction and dissatisfaction, coping with the work, overload, grievances and misconduct, etc. are all important, for such dimensions directly affect the interest of health workers, their motivation and relationships in the workplace.

Worker morale among public health staff

Worker morale among employees is a sensitive barometer of the "climate" prevailing in the workplace. In particular it is indicative of levels of satisfaction and discontent with working conditions. HR officials (at hospital level) are generally concerned about the current state of worker morale. Morale is almost unanimously depicted, as down, as low or even very low. "There is a lot of negativity". Low morale is ascribed to many and diverse causes both within and external to the health sector. The transformation and restructuring that has been going on for the past five to six years is seen as one of the main causes.

Transformation bred a climate of inflated expectations, job insecurity and exacerbated stress levels. It dampened initiative and confused legitimacy and authority. Internal organisation factors, top-down management practices, grievance not taken care of speedily and efficiently, failures in communication systems, dragging feet with affirmative action, etc. all perpetuate discontent among staff, perhaps more so in the more infrastructure-deprived areas.

Furthermore, financial-driven objectives (instead of services-driven objectives), absence of strategic plans to follow, and the loss of skills due to the outflow of especially white males, put tremendous pressure on remaining staff, and result in abnormal stress levels. Similarly, the high incidence of corruption, theft and fraud bred perceptions of the system as being 'out of control' and 'chaotic' and led to a 'lack of pride in a public servant".

There was a perception that the role of unions is sometimes one of collectively fuelling discontent and demoralising staff, with rippling effects to all employee levels. "With the advent of trade unions, most supervisors at times do not know whether are they still supervisors or whether it is the shop-steward who is in charge. It makes some of the seniors afraid to hold the reins, and one is not sure at time whether 'I'm doing the right thing' or who should be doing it".

One respondent indicated that, "apart from these macro and micro organisational factors, individual 'bread and butter' issues such as personal conditions of service, lack of progression and promotion have an equally adverse outcome on worker morale".

Creative developments that undoubtedly do affect staff morale positively and constructively have been highlighted, inter alia: The provision of air-conditioning furniture and transport for staff. Other morale boosters comprise stimulation via training courses, regular staff indabas, sporadic team-building exercises, merit awards, second and third notches, stand-by and overtime-allowances and better salaries. On a different level, the current skills audits, increasing devolution of decision-making powers to health institutions themselves, transformation units, the introduction of "employee assistance programme" to promote coping with stress in the workplace, may all eventually uplift staff morale.

Most notably, those measures in place are unfortunately often of such a general or isolated nature that they cannot make any significant difference, especially not in view of the very large numbers of people employed in public health services. Moreover, where constructive initiatives are taken, these are too often dampened or nullified by financial constraints.

1.2.1.4 Productivity of public health employees

It is not easy to measure productivity and performance accurately. Nonetheless, HR officials ventured general observation on productivity of public health employees. There was a concern about the current state of productivity. For many it is perceivably "on the decline", for others it is "picking up"-but, for now, "in general, productivity is a problem ...it is at a low ebb".

Numerous explanations are given for failing productivity. Foremost is the effect of the taxing and protracted transformation. Others are: The deterioration of certain services, no improvement staffing situations, backlog in promotions, the moving around of people, employee turnover and staff shortages. But more mundane explanations also prevail: "In certain areas we don't have sufficient resources – people got frustrated because of little things that are not in pace...this little gadget is broken, this is finished...next time you push patients off".

But, at the same time an "unhealthy demand attitude for more, irrespective of good quality prevails too often among staff, sometimes resulting in unjustified feelings of relative deprivation affecting productivity adversely. There appears to be a bit of dragging feet here".

1.2.1.5 Structuring Labour Relations in the public health services

(a) Unrest, grievances, misconduct

Labour relations issues are very much part of human resource management. Since 1994 there has been a great emphasis in the public health. The Act had introduced a new deal in the LR domain, for instance within the context of freedom of association, a right to existence and recognition of trade unions and dealing with disciplinary measures. According to the LRA (1995) every employee has the right, to participate in forming a

trade union or federation of trade unions; and to join a trade union, subject to its constitution. Every member of a trade union has the right, subject to the constitution of that trade union to participate in its lawful activities.

Among the main achievements in the health sector are recognition and participatory agreements between management unions, as well as mechanisms for collective bargaining. LR in the health sector is presently on a healthy footing, generally described as good to even excellent. Provincial Bargaining Councils/Chambers function at provincial level. Inter Management Labour Councils (IMLC) function at hospital level.

Managers and labour leaders meet frequently in "IMLC's and "hospital sub committees". At institutional level there are several significant initiatives with so-called multi laterals (fora for management and all unions) and bi-laterals (fora for management and one particular union) particularly in those areas characterised by strong unionisation of the workforce. All hospitals have LR components to deal with labour relations, grievances and disciplinary issues. The LR components, however, vary in size and capacity, independence as well as in their operational effectiveness and efficiency.

On the other hand some hospital Superintendents felt that the management of the hospital system was characterised by extreme over-centralisation, with hospital managers having almost no authority to manage their own institutions. This has led to severe underdevelopment of management systems, structures, and capacity at hospital level, and to a distorted management culture.

The net effect of all these problems is demoralisation of hospital managers, and serious under-management of hospitals, most of which are simply administered by provincial head offices, rather than actively managed. Poor remuneration and lack of career paths aggravate these problems for managers, preventing the public hospitals from attracting and retaining good managers.

(b) Strikes, unrest and disruptions

In terms of the LRA the parties at the Public Sector Co-ordinating Bargain Council (PSCB) have agreed that the public sector health service is an "essential service". Public health sector workers therefore may not legally strike. At present labour unrest,

disputes and conflict in the public health sector are efficiently structured, firmly controlled and fairly ordered. There has been no legal (protected) strike, while only scattered cases of illegal (unprotected) strikes occurred among public health personnel. This resulted in decrease in the incidence of strikes, unrest and person-days lost in recent years.

According to most of the respondents the LRA played a major role in ordering the LR scene most notably at their hospital level. It contributed to "interaction between structures" and "bridged the gap of miss-trust". The entire atmosphere has fundamentally changed from erstwhile militancy to one of "regulated interaction". It is not that dissatisfaction or discontent does not exist in various hospitals. It does and it will always be there. There are still sporadic threats of strikes and disruption, but in most cases these are resolved timeously. Management and union leaders are nowadays fairly well equipped to deal with the prevailing challenges. Yet managers felt that shop stewards needs to be equipped and aquatinted with necessary skills to deal with issues, for they are "very far, far, far from understanding the rules of the game", and are almost elected on grounds of their radical inclinations, rather than their merits and skills in negotiations.

(c) *Grievance in the workplace-procedure, profiles and constraints*

According to the Public Service Act (1994), for the purpose of asserting his/her right to have his or her complaint concerning an official act, an employee may lodge that grievance with the relevant executing authority under the prescribed circumstances, on the prescribed conditions and in the prescribed manner. The grievance is not resolved to the satisfaction of such an employee, that executing authority shall submit the grievance to the Commission in the prescribed manner and within the prescribed period. After the Commission has investigated and consider any such grievance, the commission may recommend that the relevant executing authority acts in terms of a particular provision, having regard to the circumstances of the case, the commission considers it appropriate to make such a recommendation.

The Public Service Act and the Public Regulations and the Public Service Regulations provide a framework for the hospitals to deal with grievances. The nature and extent of

grievances, hospital abilities to implement current procedures and their degree of efficiency and effectiveness in acting on grievance differ significantly. Not all grievances were registered. The majority is in fact resolved by timely and effective intervention before being registered. Very few cases proceed to the Centre for Conflict Mediation and Arbitration, and even fewer proceed to the Labour Court.

(d) Profile of misconduct among public health staff

According to the LRA (1995) the key principle in the code of good practice is that employers and employees should treat one another with mutual respect. A premium is placed on both employment justice and the efficient operation of business. While employees should be protected from arbitrary action, employers are entitled to satisfactory conduct and work performance from their employees. All employers should adopt disciplinary rules that establish the standard of conduct required of their employees. The form and content of disciplinary rules will obviously vary according to the size and nature of the employer's business. In general, a larger institution will require a more formal approach to discipline. The act advocates that management's rules must create certainty and consistency in the application of discipline.

This requires that the standards of conduct are clear and made available to employees in a manner that is easily understood. Employers/management should keep records for each employee specifying the nature of any disciplinary transgressions, the actions taken by the employer and the reasons for the actions. Some rules or standards may be so well established and known that it is not necessary to communicate them. Generally, it is not appropriate to dismiss an employee for a first offence, except if the misconduct is serious and of such gravity that it makes a continued employment relationship intolerable. Examples of serious misconduct, subject to the rule that each case should be judged on its merits, are gross dishonesty or wilful damage to the property of the employer, wilful endangering of the safety of others, physical assault on the employer, a fellow employee, client or customer and gross insubordination. When deciding whether or not to impose the penalty of dismissal, the employer should in addition to the gravity of the misconduct consider factors such as the employee's circumstances (including length of service, previous disciplinary record and personal circumstances), the nature of the job and the circumstances of the infringement itself. Whatever the

merits of the case for dismissal might be a dismissal will not be fair if it does not meet these requirements.

In the ten hospitals investigated, from the total number of reported misconduct cases occurred in the last three years. The following causes of misconduct: absenteeism (35), abuse of state property (10), theft (20 excessive use of intoxicants (25), fraud/misappropriation/embezzlement of funds (10), negligence in performance of duties (5), acceptance of bribes (5).

CHAPTER 5:

Recommendations to the study

It is neither usual nor expected to close a dissertation with recommendations. In this case, there are two compelling reasons to do so. Firstly, the focus of the study was to asses both policy formulation and policy implementation in the health sector. The latter is not a theoretical issue, but something with great practical implications if the improvement of health services is to be taken seriously. For this reason alone, it is important to include recommendations.

Secondly, the expectations of the persons who were interviewed, was that the results of the study would be shared with them, including any suggestions to improve the quality of health services. I feel that it is therefore appropriate to share these suggestions in the form of recommendations and in a spirit of solidarity with our great responsibility to care for the well being of our people

The recommendations are not addressed to specific hospital or employee,, but were kept on purpose on a more general level. The format is also not prescriptive, as this study was not commissioned in any way by the relevant authorities. Rather, in the spirit described in the previous paragraph, they are offered as aspects that need serious attention. In my experience, the institutions and individuals involved are quite able to draw their own conclusions and I am confident that they will apply these recommendations where appropriate.

As the another purpose of this Chapter was to propose recommendations for an improved institutional framework for provincial development, capable of promoting more effective coordination and partnership, as well as speedier decision-making and implementation, in the work the various role-players involved. I believe that, the Department of health, both nationally and provincially requires input from and support of a host of stakeholders. In order to maximise the involvement of relevant stakeholders effective strategies for communication must be established, and where they already exist, strengthened. Strategies to improve communication could include regular national and province-wide meetings, the participation of stakeholders in committees and task teams, inviting stakeholder comment on draft policy documents, and involving

communities in decisions about service provision at facility, district and provincial levels. The use of electronic communication tools to inform stakeholders, like the Internet and non-electronic forms of communication like newsletters should be used to strengthen communication.

The effective realisation of the vision, strategic imperatives and initiatives set out in WPTHSSA, NHB, PHP and other policy documents aimed at improving the plight of health in the Western Cape, will require full co-operation and collaboration of the wide variety of stakeholders involved in the provincial developments, as well as effective coordination and integration of their activities. Although efforts have been made to improve efficiency, coordination and communication in the work of such stakeholders, the evidence presented so far in this document suggest that there is clearly scope for significant improvement.

In the context of suggesting in improving health service delivery the is recommended

1. Affirmative action

A commitment to equity in the health services of the country implies a commitment to correcting the historical gender, class and racial imbalances in the development of human recourses for health care. Of necessity, a compassionate and caring health service will address the issue of corrective action. There is a real need to provide proper planning of those most disadvantaged by apartheid in managerial skills to fill managerial positions in the health sector.

2 Management capacity with special focus on senior and middle-level

Numerous conducted investigations of our hospital sector reveal significant levels of inefficiencies. It argued, the fundamental contributor to this is the archaic management, systems and culture. This often causes management paralysis. A compounding, related, element is the pervasive lack of appropriate management competencies and capacity among management teams. A change in health care policy and services requires capacity building in management from national to local level. The most significant obstacle to the implementation of primary health care has been the lack of managerial expertise. Therefore it is necessary to introduce new health management programmes,

which will promote efficient and effectiveness management at all levels of health care service delivery.

Current health managers need to be reoriented from the predominantly bureaucratic, rule-based approach towards a participative approach. The development of managerial capacity in areas such as participative and change management, leadership development, strategic planning, programme management and evaluation, and policy development and implementation, is crucial.

Above that, hospital heads must be given managerial authority to manage, and sufficient administrative support capacity to ensure that the most cost-effective management system is introduced and conditions created for clinicians to do their work efficiently and effectively. As a matter of urgency, there must the creation of the right combination of incentives to drive the entire towards greater efficiency. Having said that, performance agreements, performance-linked bonuses and retention of portions of revenue generated to improve service delivery are among the instruments, which must be in place.

The strategy to revitalise public hospitals is partly dependent on hospitals ability to increase their revenue generation, within their context. However, incentives such as revenue retention are required to encourage greater revenue retention. As various pilots are being used to explore this issue (where one of our interviewed hospital functions as a closed account). It was given initial funding, and then kept all income it generated

3 Institutional capacity

The capacity to plan, manage and monitor human resource development properly is lacking on all levels of the health system. The successful and optimal deployment of human resources is contingent upon developing this capacity on institutional level throughout the health care system. In order for hospital managers to have the tools to manage personnel and improve productivity there is a need to streamline disciplinary procedures, improve supportive supervision, and introduce professional management practices. However, it must be noted that labour organisation are also equally important in the process. The required change in work practices will not be possible without the support and co-operation of labour organisation. In fact, labour organisations are integral in the process of restructuring.

4. Research capacity

The development of human resource for health care depends upon good research, which is at the moment inadequate on all levels in the hospital health care system. In order to address this deficiency, inter-sectoral research units at all levels, which will prioritise action-orientated research, should be established.

5. Planning human resources

The most important input into the health sector is the health provider. This implies that we must strengthen our skills and systems in human resource management to gain optimal efficiency. It is also important that health providers render health care of high quality.

While numerous progresses has been made with regard to the planning, training and deployment of human resource much work remains to be done. It is vital that a human resource plan for the health sector be developed as a matter of urgency. It is equally important that such a plan includes plans for entry-level providers of each occupational class, and plans for continuing professional education. Among activities that must be completed to contribute to the plan include:

- An audit of the current human resource in public hospitals for each occupational class to determine areas of over and underproduction and the distribution of health providers across the province (even in township hospitals).

- The determination of the gap between current levels of human resources, current training programmes and the need.

As it was discovered in the findings that the skill levels within and between hospitals vary greatly and as skills are developed, the deployment of personnel to areas of greater need must be considered. This 'internal consultancy' system will result in the sharing of scarce resource within our public health system and may ensure the retention of staff accompanied by appropriate incentives.

To facilitate effective planning, a database of all the posts in the public (health) sector should be created as a matter of urgency. An important human resource management tool is a functional human resource information system. Such a system

should enable management to have on line information on all personnel from the time of their recruitment to the point at which they leave the Department. Besides being useful for increasing the efficiency of human resource use such information is also useful for strategic planning purposes. The historical imbalances along class, geographical, gender; racial and sectoral lines should be addressed. Imaginative strategies are needed to ensure the implementation of the plan and it must be done with the commitment of all those concerned with the provision of an equitable, appropriate, responsive health care system for the people of the province and throughout South Africa.

6. Identifying priority education and training needs

The production of human resource for health care in South Africa occurs at education and training institutions renowned for their high academic standards. However, although the quality of health science education and training is excellence, their relevance and appropriateness requires serious examination. One way in which the health science training programmes can be harnessed to produce the human resource appropriate to the needs of the nation is through the establishment of co-ordinating committees. The responsibilities carried out at this level should be planning, implementation, monitoring, evaluation, reviewing and co-ordination of all health personnel education programmes offered, both structured and non-structured. Throughout the country health workers face difficult challenges created by worsening socio economic conditions and the impact of emerging diseases.

We have duty to look after the health of our people and sometimes the decisions that we take determine whether a person lives or not. We are tasked with taking care of those who have no power to take care of themselves. These duties require a lot of courage. They required spiritual strength and willingness to serve people with dedication. We must be driven by a desire to see our hard work translating into health lives.

Health workers are expected to provide more high quality health services with few resources, while the skills needed to perform effectively in their different fields continued to grow and change rapidly. "The best can only be achieved if the environment is conducive to change and reinforce new form of behaviour" We have

passed through what could have been the worst period of transforming our health system and are now among those at the forefront of change not just in our province but the whole country.

7. Availability of appropriate staff

A key shift in health policy has been the shift towards PHC services. This and other shifts have implications for staffing. PHC requires different types skills and people compared to those necessary for highly specialised tertiary care. More flexibility in remuneration and staffing policies may also be required to address issues of staffing. Particular incentives are necessary to attract qualified staff to certain hospitals and services, and to retain dedicated and appropriate personnel.

It makes no sense to talk of South Africa having 'Rolls Royce' policies or the 'best labour system' in the world without proper implementation. If we do not have the resources or capacity to implement such sophisticated policies they will fail.

The approach suggested here does not require that the government abandon its reform and construction commitments. However, certain adjustments in the approach is urgently needed to ensure policies that are based on an assessment of required inputs within a given period, likely and possible consequences, realistic mechanisms for implementation, resources for sustainability, the ability and motivation of personnel, and the impact on other policies. Government must prioritise strategic management, consolidation, and sustainable policy interventions. This strategic approach to govern will require a reassessment of the government's vision on how to change South Africa.

The disjuncture between idealistic call for total transformation and the complicated realities of institutional change in South African state has brought into sharp focus one of the key realities of effective reform in such a complex system. In some respect South Africa resembles what has been termed a 'suspended state' - a state in which formal authority has either not been entrenched or has only been partially established. One sees this most clearly in respect of the behaviour of many civil servants.

In this context, the notion of privatisation is open to serious criticism. It has not produced the benefits it is supposed to deliver. In fact, it has led to loss of jobs. Joblessness leads to poverty and the cause of crime in most instances is poverty. Privatisation itself does not necessarily mean or translate into better service delivery.

For instance, currently supporting services such as security, laundry are commissioned to an outside company, yet the services are still poor, at times much worse than before privatisation process. Patients are eating stale food that was prepared three days ago by the kitchen staff, given less food because of food shortages, because inter alia kitchen staff steal cooked and uncooked food and take it to their homes. Security personnel often arrives late at work and sleep at night when their inspectors are not available. There are often cases of drunkenness especially on weekends.

The worse part is that, many of these security guards are not professionally trained to deal with patients, especially mentally disturbed patients. Some respondents claimed that they attack patients and rape female patients at times, for they know hardly anyone will believe stories coming from a mentally handicapped person. It was further said that personnel in the laundry section are often late, drunk and hardly ever wash the patients bedding and clothes properly. The main point was that, not only hospital service was not up to professional standards but it was also impossible to discipline these workers for they are not accountable to hospital supervisors or management.

8. HRD Training

One of the most important challenges that confront our public health sector is the creation and provision of a caring and humane service delivery, in line with national government plan of Batho Pele i.e. "People First", under the auspice of the Department of Public Service and Administration. Fundamental change and development start with people. People are both the source and the ultimate purpose of development. They are the major source of a country's and an organisation competitive advantage.

Human resource training and development in the health sector must focus not only on organisational transformation, but must equally focus on authentic personal transformation. Human resource development practitioners in the health sector and in broader public sector must dedicate themselves to the creation of a development programme that will help people to reinvent themselves. It is difficult, if not impossible, to transform a nation and an organisation with growth less individuals. Employing more employees and giving more required resources to public hospitals will not adequately address challenges that the health sector is facing. As development is

about our "being" rather than our "having", to do more and get more in life, we need to become more and grow.

This is the essence of the African philosophy of Ubuntu. Literally translated, Ubuntu means "I am because we are – I can only be a person through others". To be, and not to have, is the starting point of organisational and national development. How we feel about ourselves and how we feel about others, is the essence of our being. This is the heart and soul of the African philosophy of Ubuntu. The essence of improving our public health sector and meeting overall national government objectives is to create a cultural awakening and a cultural revolution, which will enable us to look at our collective continued existence issues with new perspectives.

The goal is to develop an attractive and inspiring development with sound values, and proper political governance and performance standards. Human Resource Development is about finding innovative ways of executing our responsibilities by harnessing cultural strength and inspiration to meet the challenges that lies ahead. HRD programmes have to be inspired not merely about so called "classical" or widely accepted HRD principles according to certain textbooks, but be rather inspired by our cultural strengths. These strengths lies in people care and the collective brotherhood of humanity with its sense of a shared destiny to improve people's lives. Thus there is a critical need for our HRD programmes to embrace the ancient wisdom of Ubuntu.

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