Sustainability and financial implications of the Labour Relations Amendment Act No.6 of 2014 for Western Cape health services outsourcing

by

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Declaration

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Abstract

The Labour Relations Amendment Act No. 6 of 2014 was gazetted during August 2014, and came into effect on 1 January 2015. This amendment act and specifically sections 198A and 198B changes the manner in which employers outsource certain employment functions by means of contract employment. Section 198A specifically changes the definition of temporary employment services and section 198B changes some aspects of fixed-term contracts.

When the Act came into effect, employers were given three (3) months to ensure that they become compliant with this new stipulation. The Western Cape Department of Health (WCDoH) currently delivers certain health services through Non-profit Organisations (NPOs). The WCDoH sees this practice as a cost-effective method to reach more clients and areas where traditional formal health services are not available. The WCDoH thus relies on NPO contracts and outsourcing to deliver health services on its behalf.

The WCDoH formalises relationships with NPOs through a Service Level Agreement which obligates NPOs to employ suitably qualified staff on an annual contractual basis to deliver these health services. The WCDoH in turn transfers funds to the NPOs for the payment of staff as well as for NPO administration activities. The WCDoH provides strict guidelines as well as standard operating procedures for how, where, when and what services have to be rendered and how payment has to be made for these services.

The challenge is that the amended stipulations of the Labour Relations Amendment Act place a damper on the current manner of NPO outsourcing models. The Act stipulates that any employee of outsourced contracts that is in the employ of a contractor for more than three months; and who is not substituting a permanent employee; and / or where the service is not temporary and the contract employee earns less than a certain threshold, is regarded as an employee of the employer, outsourcing the service. The Act further stipulates that these contract employees must receive the same benefits regarding pension, medical aid, housing allowances and service bonuses, as well as leave benefits, as in the case of permanent employees of the employer.

The WCDoH regards the current way of NPO outsourcing as cost effective, the reason being that the funding norms to NPOs do not include benefits and the majority of NPO employees receive a stipend, allowing NPOs to employ much more staff with the funding received from the WCDoH.

The purpose of the research was to investigate sustainability and whether the Labour Relations Amendment Act of 2014 has financial implications for current NPO outsourcing models applied by the WCDoH. The current NPO outsourced model is applied uniformly in the WCDoH through all it districts and sub structures. The Northern Tygerberg Sub Structure was the area where the study took place.

Documents containing the strategic directions for both the WCDoH and the NDoH were reviewed to determine the value placed on NPO outsourcing in health services in particular and the indications are that the strategic direction of the WCDoH is to continuously improve its methods regarding wellness. This direction is evident in the strategic document called “Healthcare 2030”. The document provides detailed analysis of and methods towards how the WCDoH will strengthen partnerships with NPOs and other private providers to keep communities healthy. Further to this document, the strategic direction of the National Department of Health in terms of primary health care services for South African communities is contained in a document called “primary health care reengineering”. Findings from this document indicate that the country is also moving towards rendering services outside of traditional health facilities and is moving towards forming partnerships with NPOs to deliver care in the communities. The aforementioned documents provide a definite indication of the importance of NPO service outsourcing both in the WCDoH as well as the NDoH.

It is evident from the analysis of the WCDoH NPO outsourcing model that is applied, that NPO outsourcing is well structured in the WCDoH and documents such as the Services Package of Care for NPO funding, the Service Level Agreement and the Finance Instruction FA21 of 2015 in particular, direct the operationalisation and funding for NPO services.

The analyses of NPO performance through outsourcing of services, as well as the access to health care that the model creates through service coverage, indicate the unmissable contribution NPOs make. NPO services have been described as beneficial by managers who were interviewed and there is a definite concern amongst them that

the amendments to the stipulations of fixed-term contracts and what the Act regards as temporary employment services will have financial and service sustainability implications.

Documentary evidence and findings further show that the South African Labour Court previously ordered that another province should employ staff on a permanent basis with full benefits as a result of the way current NPO staff are contracted. The aforementioned can have further implications for the WCDoH NPO outsourcing models as this province applies a similar approach to NPO outsourcing.

To ensure that the WCDoH complies with the Labour Relations Amendment Act of 2014, in particular with the stipulations under sections 198A and 198B, recommendations in the form of different options of staffing funding models as well as organisation structures are made. These recommendations are made on the basis of the current staffing models and service coverage, funding norms, salary, and benefit packages for the public service, with due consideration of the current financial envelope and budgetary constraints.

Opsomming

Nadat dit gedurende Augustus 2014 in die Staatskoerant gepubliseer is, het die Wysigingswet op Arbeidsverhoudinge no 6 van 2014, op 1 Januarie 2015 in werking getree. Dit bevat spesifieke wysigings in artikels 198A en 198B wat implikasies het vir die huidige manier van uitkontraktering van dienste. Die gewysigde artikels stipuleer onder meer watter werknemers in werkverskaffings dienste as tydelik beskou kan word in artikel 198A en wysig ook sekere aspekte van vaste termyn kontrakte in artikel 198B.

Nadat die wet in werking getree het, is werkgewers drie maande gegee om te verseker dat hulle aan die nuwe bepalings van die wysigingswet voldoen. Die Wes-Kaapse Departement van Gesondheid (WKDvG) lewer tans sekere dienste met behulp van Nie-Winsgewende Organisasies (NWO) en beskou die gebruik van NWO's as 'n meer koste effektiewe metode van dienslewering en kan op dié manier meer klante bereik, sowel areas waar die department nie formele tradisionele gesondheidsdienste beskikbaar het nie. Die WKDvG maak dus staat op uitkontraktering van dienste aan NWO's om sy gesondheidsdiensmandaat te eerbiedig.

'n Diensvlakooreenkoms word gesluit om te verseker dat beide die WKDvG en die NWO hulle verpligtinge nakom. In die diensvlakooreenkoms word sekere verpligtinge en verwagtinge vir beide partye uiteengesit; daar word byvoorbeeld van NWO's verwag om geskikte en gekwalifiseerde personeel in diens te neem om die verwagte gesondheidsdienste te verrig. Die personeel word op 'n jaarlikse kontrakbasis aangestel. Die WKDvG moet op sy beurt die dienste befonds. Fondse wat aan die NWO's betaal word, sluit personeel en administratiewe uitgawes van die NWO's in. Verder word streng riglyne deur middel van standaard operasionele prosedures vir NWO's vasgelê en finansiële instruksies bepaal hoe, waar, wanneer en deur wie dienste verrig moet word en hoe betaling vir dienste moet geskied.

Die uitdaging wat die gewysigde bepalings van die Wysigingswet op Arbeidsverhoudinge stel, plaas 'n demper op die huidige metodes van NWO-modelle vir uitkontraktering. Die Wet bepaal onder andere dat 'n werknemer wat van uitgekontrakteerde dienste gebruik maak, nie 'n kontrak met 'n werknemer vir meer as drie maande mag sluit nie tensy die werknemer 'n permanente werknemer van die

werkgewer vervang, en bepaal dat kontrakwerkers wat minder as 'n sekere drempel verdien in die bepaling ingesluit word. Kontrak werknemers soos vooraf anngedui, kan in gevolge van die wysiging as permanente weknemers van die werkgewer gesien word en moet dieselfde diensvoordele geniet, sowel as besoldiging soos in die geval van permanente weknemers van die werkgewer.

Die huidige NWO-befondsingsmodel sluit nie voordele in nie en stel daarom die WKDvG in staat om veel meer personeel deur middel van NWOs in diens neem.

Die doel van die ondersoek was om vas te stel of die Wysigingswet op Arbeidsverhoudinge van 2014 volhoubaarheids- en finansiële implikasies sal hê vir die huidige NWO uitkontrakteringsmodelle wat deur die WKDvG toegepas word. Die huidige NWO uitkontrakteringsmodel word eenvormig in alle distrikte en sub-strukture in die WKDvG toegepas en die Noordelike/Tygerberg Sub-Struktuur was die fokus area vir hierdie ondersoek.

Om die waarde wat op NWO uitkontraktering in gesondheidsdienste geplaas word spesifiek aan te dui, is dokumente wat die strategiese rigting vir beide die WKDvG en die NDvG aandui, nagegaan en die aanduiding is dat die WKDvG besig is om sy metodes ten opsigte van gesondheids dienste voortdurend te verbeter. Hierdie rigting is duidelik in sy strategiese dokument genaamd 'Healthcare 2030'. Die dokument verskaf gedetailleerde ontleding en metodes van hoe die WKDvG vennootskappe met NWO's en ander private verskaffers sal versterk om gemeenskappe gesond te hou. In aansluiting by hierdie dokument word die strategiese rigting van die Nasionale Departement van Gesondheid aangehaal in terme van primêre gesondheidsorg dienste vir Suid-Afrikaanse gemeenskappe wat vervat is in 'n dokument genaamd “Primary Healthcare Reengineering”. In hierdie dokument dui bevindinge aan dat Suid Afrika ook op pad na die lewering van dienste buite die tradisionele gesondheidsfasiliteite, en nou meer sal fokus op die vorming van vennootskappe met NWO's om sorg in gemeenskappe te lewer. Die bogenoemde dokumente verskaf dus ‘n definitiewe aanduiding van die belangrikheid van NWO diens uitkontraktering beide in die WKDvG asook die NDvG. Dit blyk uit die analise van die WKDvG se NWO uitkontrakteringsmodel wat toegepas word dat NWO uitkontraktering goed gestruktureerd in die WKDvG is, en dokumente soos die dienspakket (*Service Package of Care*) vir NWO befondsing, die Diensvlakooreenkoms en die Finansiële

Instruksie FA21 van 2015 in die besonder, die operasionalisering en befondsing vir NWO dienste stuur.

Die ontleding van NWO prestasie deur uitkontraktering van dienste, sowel as die toegang tot gesondheidsorg wat die model deur diensdekking skep, dui op die onontbeerlike bydrae van NWO's.NWO dienste is deur bestuurders met wie onderhoude gevoer is,as voordelig beskryf en daar is definitiewe kommer by hulle dat die wysigings aan die bepalings van vaste-termyn kontrakte en wat die Wet as tydelike indiensneming beskou, finansiële implikasies en implikasies vir diensvolhoubaarheid sal hê

Dokumentêre bewyse en bevindings toon verder dat die Suid-Afrikaanse Arbeidshof voorheen beveel het dat 'n ander provinsie personeel op 'n permanente basis met volle voordele in diens moet neem vanweë die manier waarop die huidige NWO-personeel gekontrakteer word. Dit kan verdere implikasies vir die WKDvG se NWO-uitkontrakteringmodelle hê as dié provinsie 'n soortgelyke benadering tot NWO-uitkontraktering toepas.

Om te verseker dat die WKDvG aan die Wysigingswet op Arbeidsverhoudinge, 2014 en in die besonder aan die bepalings kragtens artikels 198A en 198b, voldoen, word aanbevelings in die vorm van verskillende opsies vir personeelbefondsing sowel as organisasiestrukture gemaak. Hierdie aanbevelings word op grond van die huidige personeelmodelle en diensdekking, befondsingsnorme, salaris en voordeelpakkette van die staatsdiens met inagneming van die huidige finansiële posisie en begrotingsbeperkings gedoen.

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List of Abbreviations

TES - Temporary employment services

LRA - Labour Relations Act

OHSA - Occupational Health and Safety Act

BCEA - Basic Conditions of Employment Act

CBS - Community-based services

PHC - Primary health care services

WCDoH - Western Cape Department of health

WC - Western Cape

MDHS- Metro district health services

PFMA - Public finance management Act

NPO - Non-profit organisation

NGO - Non-governmental organisation

CBO - Community-based organisation

FBO - Faith-based organisation

SLA - Service Level agreement

SOP - Standard Operating Procedure

RSA - Republic of South Africa

SA - South Africa

HCBC - Home- and community-based care

NDoH - National Department of Health

ILO - International Labour Organisation

DoL - Department of Labour

NTSS - Northern Tygerberg Substructure

CCMA - Commission for Conciliation Mediation and Arbitration

USAID - United States Agency for International Development

UNAIDS - United Nations Programme on HIV/AIDS

SSO - Social Sector Organisation

HIV - Human Immune Deficiency Virus

HST - Health Systems Trust

WHO - World Health Organisation

PN - Professional nurse

NA - Nursing Assistant

SAC - Senior Administration Clerk

SN - Staff Nurse

PM - Project Manager

ASD - Assistant Director

HP - Health Promoter

AO - Administration Officer

GDoH - Gauteng Department of Health

OSD - Occupational specific dispensation

Chapter 1: Introduction

1.1 Introduction

The Western Cape Department of Health (WCDoH) relies heavily on outsourcing certain health services. The current practice/model used is to enter into agreements with Non-Profit Organisations (NPOs), in particular to deliver community-based services. In terms of the WCDoH Finance instruction FA 21 of 2015, as amended, the WCDoH should conduct what is called an external call for proposals every three years to invite NPOs to submit business proposals to render specified services on behalf of the department. Following the submission of proposals, the WCDoH will adjudicate these proposals to identify the best and most suitable service provider. The department then enters into service level agreements (SLAs) with successful NPOs formalising the service delivery relationship for a period of three years.

To ensure a continuous and mutually amicable relationship, both the department and the NPO have to fulfil certain obligations in terms of the SLA. These obligations include that the NPO will ensure and maintain a competent workforce to deliver the agreed services. This means that the NPO must employ staff to fulfil its obligations to the department. NPOs employ specified staff such as community health workers, nurses, administrators and project managers on an annual contractual basis. The contractual arrangement with staff employed by the NPO is usually renewable depending on staff performance as well as NPO performance in terms of its contractual obligations with the WCDoH.

On the 18th of August 2014, the Department of Labour gazetted the Labour Relations Amendment Act 2014, which became effective on 1 January 2015. The stipulations in this Act dramatically changed the working relationship between (1) an employer outsourcing services (WCDoH), (2) the contractor (NPO), and (3) the employee being contracted by the contractor (staff employed by the NPO) to deliver services on behalf of an employer.

The amendment defines those who may be classified as temporary employee services (TES), and if they are not falling within the definition of TES, how they should be

treated in terms of basic conditions and benefits and, lastly, that the contractor as well as the employer who outsources services are both liable in complying with the stipulations in the Amendment Act (Republic of South Africa, 2014, S 198)

In light of the reliance of the WCDoH on NPO outsourced contract services, due to its cost effectiveness, the Labour Relations Amendment Act of 2014 and its stipulations can have a serious impact on the current outsourcing model used by the WCDoH.

1.2 Problem Statement

In terms of the Labour Relations Amendment Act of 2014, henceforth referred to as the Act, all employers were given a period of three months from the date the Act was promulgated to comply with the stipulations. All employers, employees as well as registered trade unions are required to comply with the stipulations of the Act.

In terms of the Act, several changes in the employer and contract employee relationship are outlined which have a direct effect on how outsourcing is currently being done in the WCDoH. The Act stipulates, in section 198A (1), that temporary employment services are defined and confined to three aspects which include that contracts may not exceed a period of three months, the substitution of a permanent employee who is temporarily absent and where contract work is determined as a temporary service by means of a collective agreement in a bargaining council, a sectoral determination and or a notice published by the Minister of Labour. Section 198A (2) stipulates that the provisions in Section 198A (1) are only applicable to employees earning less than the threshold as stipulated by section 6(3) of the Basic Conditions of Employment Act No. 75 of 1997. In terms of the aforementioned act, the prescribed threshold currently is R205 433.30 per annum (Republic of South Africa, 1997).

Section 198A (3) stipulates that only employees falling inside the definition of temporary employees and under the prescribed threshold of the Basic Conditions of Employment Act (BCEA) will be deemed temporary workers. All those falling outside the definition and earning above the threshold will be deemed permanent employees. In addition, the employee will be the permanent employee of the employer irrespective

of the stipulations in a service level or contractual agreement even though the employer obtains the services of employees through a contract.

Further to the above the contract employee has recourse against the employer outsourcing services and can refer any disputes arising from the aforementioned to the Commission for Conciliation Mediation and Arbitration (CCMA) and or the Labour Court. This means that, should an employee who falls outside the definition of temporary employment be fired by the contractor; the outsourcing employer can also be held liable for unfair dismissal.

Section 198B stipulates that an employer may employ an employee on a fixed term contract (for more than three months) if the employer complies with the stipulations in subsection (3) however these contract employees may not be treated less favourably as the permanent employees of the employer. This means that fixed term contract employees must have the same receive the same benefits as permanent employees.

The problem for the WCDoH is that outsourcing via NPOs is the most cost effective option available to cover current community-based services. The Act clearly wants all employers to be compliant with the stipulations of the Act, however. This makes it necessary to examine the influence the act has on NPO outsourced models, and financial and service sustainability. The importance of such an examination is further emphasised given that:

- The period stipulated by the Act for employers to comply has lapsed
- The current NPO outsourced model might not comply with the stipulations of the Act
- Several awards in favour of contract employees have been made by the Commission for Conciliation, Mediation and Arbitration.
- It may just be a matter of time for the WCDoH to be taken to the CCMA or Labour court by a contract employee.

1.3 Research question and objectives

The research question originating from this situation was:

What implications will the Labour Relations Amendment Act 2014 have on the current NPO outsourced model, and how will it affect sustainability in terms of financial cost and service delivery coverage in the WCDoH?

1.4 Objectives

The objectives set to facilitate answering this question were:

1. To contextualise outsourcing by means of a literature study.
2. To assess the current legislative environment pertaining to the rights of health care users and health care workers.
3. To describe the NPO outsourced model used in the WCDoH.
4. To examine the implications of the Labour Relations Amendment Act 2014 for current WCDoH/ NPO outsourcing models.
5. To recommend possible solutions that would ensure compliance with the Act with minimal disruption to service delivery as well as current funding.

1.5 Research design and methodology

- **Methodology**

  The proposed study is classified as an empirical study with a mixed design that included qualitative and quantitative methods. The researcher examined secondary data by analysing existing policies, databases, legislation and regulations. Babbie and Mouton (2001:374) discuss what is called unobtrusive research methods. The abovementioned research method was applied in this study as content analysis of existing data and documents was to be conducted.

  The purpose of the study was to explore and explain as the researcher explored the implications of the Labour Relations Amendment Act for NPO outsourcing models and tried to explain the financial and service delivery consequences. The unit of analysis comprised existing documents such as relevant policies, legislation, standard operating procedures, as well as finance instructions

applicable to NPO outsourcing in the WCDoH. Probabilistic sampling and theoretical selection were used to construct the sample (Mouton,2001:159).

Probability proportionate to size stratified sampling was used to interview relevant managers in the Metro District Health Services of the Northern Tygerberg Substructure (NTSS). The interview sample included one manager from each of the following categories – district manager, operational, finance, labour relations and human resources. Due to the standardisation of the application of NPO outsourced models in the WCDoH, a representative sample of managers from the NTSS provided an overview of how NPO service models are applied in the WCDoH. The limitations of this type of sampling is a lack of depth and insider perspective, as the analysis is confined to the surface level and is only based on the sample (Burger, 2015).

- **Data collection**

Data collection for the purpose of the study included analysis of existing documentation, in this case policies, standard operating procedures and legislation. Interviews with managers responsible for labour relations, people management and operations were also conducted to obtain their perspective.

- **Data analysis**

Qualitative and interpretive analytic strategies were applied to analyse data.

1.6 Brief Chapter Overview

Outline of chapters

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Chapter 5

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Chapter 6

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Chapter 7

- Conclusion
- Recommendations
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1.7 Summary

The Labour Relations Amendment Act of 2014 changed the way in which outsourcing and contracting of workers was done in South Africa. This legislation was signed into power to protect the rights of vulnerable workers, as well as to ensure that contract workers are not exploited. However, services such as public health services rely on workers to render the services to vulnerable communities. NPOs and their assistance in the WCDoH play a vital role as they ensure access to health care for vulnerable communities unable to reach traditional services. Through its objectives, this study unpacked the imperatives of the current environment in which NPO workers are functioning, the stipulations of the Amendment Act and its implications and how a fine balancing act must be adopted to ensure compliance with worker rights with minimal to no disruption in service delivery.

Chapter 2: Literature Review on Service Outsourcing

2.1 Introduction

The objective and the purpose of this chapter is to contextualise service outsourcing in public services and especially how other stakeholders such as private providers as well as non-profit organisations can contribute to the service delivery outputs of the health sector. The United States Agency for International Development (USAID) (2010) has indicated that any decision to outsource should only be made following an exhaustive evaluation of resources and intended outcomes. It recommends a phase of deliberation during which the core competency of the organisation is identified and operational bottlenecks are recognised, in order to highlight processes that have potential for outsourcing.

The public sector, however, increasingly develops partnerships with the private sector to reduce cost and to improve service delivery. Bureaucracy and "red tape" in the public sector results in slow responses to the needs of communities and the private sector is continually being approached to deliver projects on behalf of government.

In this chapter, the various aspects of outsourcing are reviewed, starting with the definition of outsourcing and what it entails; the partnerships that the public sector forms with private providers and NPOs to meet its objectives; outsourcing and public value, as well as what organised labour organisations and its opinion is on service outsourcing.

2.2 Service Outsourcing

Outsourcing is defined as the process of "turning over all or part of an organizational activity to an outside vendor" (Barthelemy, 2003:87).

The Global Alliance for Vaccines and Immunization (GAVI) study (2015) states that:

> "Many industry leaders outsource their non-core functions to partners better placed to provide those services enabling them to focus on their core competencies. For example services like information technology, logistic and transportation of its products while focusing on the core business development and design".

Government agencies could likewise consider the outsourcing of their non-core functions to enable ministries of health and their personnel from the most rural health centres up to the highest leadership roles to focus on health service delivery and health system management (their core competencies).

Contracting or outsourcing of non-core functions, such as warehousing and transportation, allows the public and private sectors to apply their core competencies, focusing on what they do best. In the South African public service, for example, non-core services such a cleaning, maintenance, transport for distribution of medicines, gardening and laundry services are being outsourced.

In recent years, however, the public health sector has started to outsource certain core services such as health care to private partners. These outsourced services include child care, which has been outsourced to private clinics and general practitioners; home-based care including institutionalised care outsourced to non- profit organisations; health promotion, prevention and screening services outsourced to NPOs, and, lastly, the distribution of chronic care medicines, which has been outsourced to private companies. The abovementioned examples of outsourcing allow the public health sector to reach and deliver health services to clients where the sector does not have an original footprint; this in essence brings services closer to where people work, live and play.

USAID (2010) suggests that the emergence of outsourcing is a potential way to maximise the resources of the public health sector as well as to improve service delivery while leveraging the expertise of private sector service providers to better meet customer needs.

Private sector companies operate autonomously allowing them to make decisions much faster and this enables them to respond to the needs of clients much easier, which is an advantage. The public health sector is also tapping in to the expertise of the private sector where they have proven, larger and established footprints (economies of scale), which enables them to be much more efficient and cost effective. USAID (2010) describes the aforementioned as an advantage of outsourcing, while a

disadvantage is that the public health sector has less direct control over the outsourced function.

The World Health Organisation (WHO) points out that public financial management and control remains the responsibility of the public sector department and outsourced arrangements therefore require ongoing monitoring and enforcement of the pre-established performance standards (WHO, 2011:10). This requires public sectors to improve monitoring and evaluation competencies. USAID (2011) suggests that "oversight is still required to ensure that the organisation is performing its role adequately, managing performance-based contracts, and fulfilling its designated function(s) within the overall system".

Despite the successes and good practices that outsourcing of services to private companies bring, there still is host of barriers and challenges that limit further progression in the South African Public Sector. The challenges include:

- Remaining concern over loss of control, in some cases political rather than operational;
- Limited capability to manage service contracts and the use of key performance indicators to improve supplier performance and drive supply chain efficiency;
- Limited opportunity to redeploy existing resources such as human and other fixed assets employed by the public sector for these now outsources services;
- South African Unions not in favour of outsourcing is a well-known fact;
- Corruption still play a big part in these outsourced contracts;
- Disposing of government owned assets can be a complex process, and any associated income is likely to be accounted for locally, rather than benefitting the operation, so there is little incentive to transfer ownership of vehicles;
- The Public Finance Management Act still requires the Accounting Officer to account on all public funds and resources this means this function cannot be outsourced;
- In house public sector monitoring systems and capacity not yet well developed;
- Bureaucracy and red tape;
- Needs a change of mind-set to think like a customer rather than an investor, to buy a service instead of assets;
- Costs of existing in-house operation are often not fully understood, with key elements such as capital equipment costs accounted for elsewhere, and resources often shared with multiple (vertical) donor programmes. (USAID, 2015:4)

In conclusion, in this section on outsourcing, USAID (2010) states that the most common fear of outsourcing for the public sector is the loss of control and for the private sector the fear of not being paid on time. Fears in both sectors are legitimate and can be alleviated. For the public sector, the fear of loss of control can be mitigated by partial or phased-in outsourcing, which has the added benefit of reducing risk. For the private sector, concern about timely and accurate payment can lead to hesitancy to make significant investments; this can only be eliminated by developing a true partnership and trust.

USAID (2010) further highlights contract management as key to successful outsourcing; the outsourcing organisation must prepare, enforce and monitor a contract which includes clauses for payment terms and performance expectations.

2.3 Public Private Partnerships (PPPs) and Outsourcing

When services are outsourced to a vendor by a government department can it be a form of a PPP? If so, why are there such a negative connotation to outsourcing and such a positive connotation to PPPs? In this section PPPs are discussed from a South African as well as global perspective.

2.3.1 PPPs conceptualised

Internationally, "….A PPP is any medium to long-term relationship between the public and private sectors, involving the sharing of risks and rewards of multisector skills, expertise and finance to deliver desired policy outcomes"(World Bank Group, n.d.).

> "PPPs are long-term partnerships to deliver assets and services underpinning public services and community outcomes. Optimal structuring links private sector profitability to sustained performance over the long term, yielding robust and attractive cash flows for investors in return for delivering better value for money for the taxpayer".(World Bank Group, n.d.)

Locally, the National Treasury (2007: 2) indicates that:

> "A PPP is defined in South African law as: A contract between a government institution and private party, where: the private party performs an institutional function and/or

uses state property in terms of output specifications substantial project risk (financial, technical, operational) is transferred to the private party, the private party benefits through: unitary payments from government budgets and/or user fees".

2.3.2 PPS from a global perspective

According to Raman (n.d:3-4), in a study report commissioned by the WHO on public private partnerships in healthcare, neither the public and or the private sector on its own can manage a health system which will be able to fulfil in the public health needs. This means that no party on its own can meet the increasing demands of health care delivery; partnerships are required to improve the health outcomes of communities. The author believes that there are many benefits in working together with the private sector. These include greater access and reach; improved equity, better efficiency, accountability, quality sharing of best practices and, lastly, the augmentation of resources such as finances, technology and staff.

The above-mentioned is exactly why many third world and developing countries opt to work with the private sector. The study indicates that more than 80% of the population in the above-mentioned countries is dependent on the public health sector and less than 20% can afford private health care. This inequity places an increased demand on public resources and the sheer volume of clients requiring health care becomes a burden on the tax payer.

Raman(n.d:3-4), mentions several models of PPPs, which include the following: Build/ Rehabilitate, Operate, Transfer; Demand/ Supply Side Financing; Joint Ventures; Mobile Health Units; Telemedicine; Franchising; Social Marketing and Public-Private Mix.

Koppenjan (2012:5), states that the approach of new public management is to form partnerships with other sectors in the society that are based on the notion that the private sector can deliver services much more efficiently and effectively than the traditional way of doing. He however, believes that we have arrived beyond the above-mentioned belief that private is better, which is an economist-inspired mantra. The private sector is profit driven and the bottom line does influence decisions about how services should be delivered. This means that New Public Management (NPM) must reconcile quality and efficiency.

In conclusion; although there are many benefits in PPPs there are also lessons to be learned as these PPPs can quickly turn sour if not enough attention is given to the environment in which PPPs have to operate. The environment will either hamper or propel PPPs, and consideration must be given to the political, bureaucratic, regulatory, civil society, as well as the clients who make use of health care services.

2.3.3 PPPs from a South African perspective

PPPs have been regulated under the Public Finance Management Act (PFMA) since 1999. The Act provides a clear and transparent framework for government and its private sector partners entering into mutually beneficial commercial transactions for the public good.

Over recent years the South African public sector has gradually increased the number of PPP transactions covering a wide range of sectors, including transport, office accommodation, healthcare, eco-tourism, social development and correctional services.

Due to the increasing number of projects, as well as the established mutual benefit, the national treasury has published a guideline for PPPs called the “Introduction to PPPs in South Africa”. This document details the criteria and outlines how PPPs should operate within the context of the PFMA. The document applies three standard international tests to determine whether a PPP is the appropriate vehicle for procuring a public asset or service. The tests includes evaluating (1) the potential risks/threats to the public sector by entering into public private partnerships (2) whether the project is affordable for the public sector and (3) whether the PPP offers value for money. (National Treasury, 2007:5).

Whether the above is applied to all projects or not, SA has seen an increase in PPPs in all sectors and more and more partnerships are formed, especially where government does not have the footprint and/or the expertise to deliver services.

According to the National Treasury, key lessons have been learned over recent years with regard to PPPs, such as how the public sector manages risks once a PPP has been established and how monitoring is done to ensure projects do not exceed their agreed duration. However, repeated interaction between the public and private sectors

can only lead to a better understanding of one another and should ultimately achieve win-win outcomes.

Such outcomes are best achieved when government institutions have a very clear idea of what type of infrastructure and services are required to meet the needs of the public in a given sector. By communicating these needs precisely to the market, private sector players can come together in consortia that offer the best mix of skills to devise creative solutions through cost-effective designs.

Although PPPs are but one avenue for procuring capital projects, the process followed is characterised by diligent planning and transparent bidding – features that should be encouraged for all procurement methods. Moreover, the pressing service delivery challenges across all spheres of government suggest that PPPs could play an even greater role in South Africa (National Treasury, 2007:2).

2.3.4 Examples of PPPs in the South African Public Health sector

A number of examples of public private partnerships are cited by national Treasury in its document called “Introducing PPPs”. In the Western Cape, two hospitals, namely the Western Cape Rehabilitation Centre and Lentegeur Hospital, for example, formed a public private partnership with a company that provides hard and soft facilities management to both hospitals.

A feature of the PPP agreement is that the provincial health department knows the financial implications of the potential vacancy rates at the facilities upfront, which is conducive to improved value for money. Another feature is that the BEE targets include sourcing a certain percentage of the labour from the local Mitchell’s Plain communities. The project became operational in March 2007.

At the Polokwane Hospital’s renal dialysis service, a private partnership was formed whereby a private party provides 100 per cent of the clinical services, which is a first for South Africa. The private party delivers all services related to renal dialysis, including the provision of specialists and pathologists. Having taken over the function from the provincial health department, the private party is phasing in the service. Before this project, patients had to go to Garankuwa for renal dialysis. Now they have

access to medical care at standards that have been benchmarked with the private sector. This PPP could be used as a model for other projects.

Lastly, at Port Alfred and Settlers Hospital in Eastern Cape, the private party in the PPPs provides infrastructure and facilities management. This arrangement also has the private sector providing some clinical services to the public sector, and public sector staff providing some clinical services in the private facilities. A number of retired medical professionals in Grahamstown, where the Settlers Hospital is located, are able to provide some specialist care at the hospital via the private party (National Treasury, 2007 29-31)

2.4 Organised labour and outsourcing

According to Deloitte, outsourcing is good for job creation in South Africa. The debate whether outsourcing results in job losses and all the negative connotations attached to outsourcing contradict the short- and long-term benefits for the country. What is needed in SA is to professionalise outsourcing as SA has the potential to become a destination for companies that want to invest in the labour market (Deloitte, 2015:5-6).

The question however remains that if PPPs is good for service delivery and outsourcing by an employer is more cost effective, why is it that organised labour unions are so dead set against it? Dylan Barry, in an article entitled “Outsourcing is fundamentally wrong” in the Daily Marverick, quotes the National Education, Health and Allied Workers Union that states that their union membership has halved as a result of outsourcing, members are systematically exploited, and workers are paid little with few benefits such as travel allowances, maternity and retirement benefits.

The above clearly indicate that there are different perspectives on outsourcing, with employers and the private sector seeing it as a good mechanism for creating jobs and boosting the economy, whilst unions and employees feel that they are being exploited.

Unions affiliated to the Congress of South African Trade Unions (COSATU) are especially opposed to outsourcing as they feel it leads to retrenchment of permanent workers. In an online press statement entitled “COSATU welcomes the decision by the University of Cape Town to begin the process of in-sourcing all outsourced services”, the Congress in particular spoke out strongly against outsourcing and stated

that workers in lower income brackets are particularly vulnerable to exploitation (COSATU, 2016).

In summary: This section has provided a view of outsourcing and private public partnerships and how it can contribute to cost effective and efficient service delivery. When PPPs are done right it can have immense benefits for the public health sector. The reliance of the public on the public health sector requires government to form partnerships with the business, NPO and other sectors to fulfil in the need of its clientele. These partnerships however is not without controversy and is heavily criticised in instances where they flout the rights of workers, Unions clearly are not happy with the concept of outsourcing and the National Health Education & Allied Workers Union (NEHAWU) and COSATU, in particular, in representing labourers such as cleaners, gardeners and cooks, have particularly strong reservations regarding outsourcing.

2.6 Non-profit organisations (NPOs) and outsourcing

This section reviews the role of NPOs in the private sector Primary Health Care (PHC) services in South Africa and in the world. To understand the context, a definition of a non-profit organisation as per the Department of Social development is as follows:

> ”An NPO is defined, in terms of section 1 of the NPO Act, as a trust, company or other association of persons established for a public purpose and of which its income and property are not distributable to its members or office bearers except as reasonable compensation for services rendered. Non-governmental organisations (NGOs) and community based organisations (CBOs) are collectively known as non-profit organisations (NPOs)”. (Department of Social Development, 2011).
>
> “NPOs can be described as organizations whose main purpose is to serve communities and the public interest at large. NPOs are self-managed, independent, non-profit distributing, self-governed organizations. It is often referred to as the third sector”.

Hall (n. d: 1) conducted a study and found that charitable organisations had always been there and were mostly driven by religious groupings such as the Catholic Church. It is only since the 1970s that these groupings have become more focused and

organised as the socioeconomic and political landscapes changed. NPOs became more involved in organising themselves around the common human rights of citizens. Today we find NPOs in different sectors of society such as health and welfare, justice, human settlements, agriculture and education, all contributing to a common cause (Harvard University, n.d:2.).

Contributions made by NPOs in the health arena expand continually. According to the Health Systems Trust, these contributions embrace health promotion and disease prevention; nutrition and food supply; environmental hygiene; water and sanitation; reproductive health; maternal, child and women's health; infectious diseases and providing and ensuring access to essential medicine; and the prevention and control of endemic diseases.

South African NPOs have generally played and is still playing a very significant role in nourishing our young democracy and addressing the needs of vulnerable communities and groups. These organisations are characterised by a wide variety of organisations of different sizes and shapes across the political, economic and social spectrum of society (Department of Social Development, 2011).

According to a study conducted by Wolvaardt *et al.* (2008) on behalf of the Health Systems Trust (HST), private and non-governmental organisations have played an increased role in the delivery of primary health care services since 1994. The role of NPOs has become increasingly important due to the large uninsured population in the country. Post 1994, South Africa has been fortunate to receive large amounts of donor funding to assist with service provision for its uninsured population. Attached to this donor funding, there are strict criteria concerning how funding should be utilised for health care service delivery.

The government at the time did not have sufficient capacity to deliver the services to the poor and simultaneously comply with the strict funding prescriptions from donors. Government then contracted NPOs to deliver services on its behalf. With the explosion of the HIV/AIDS pandemic, the health workforce was unable to cope with the additional health service burden and government increasingly made use of NPOs to deliver services. When donor funding started to dry up post 2008, government had to take over the funding of services previously funded by donors. For government to ensure continued service coverage and service efficiency in the most cost effective manner

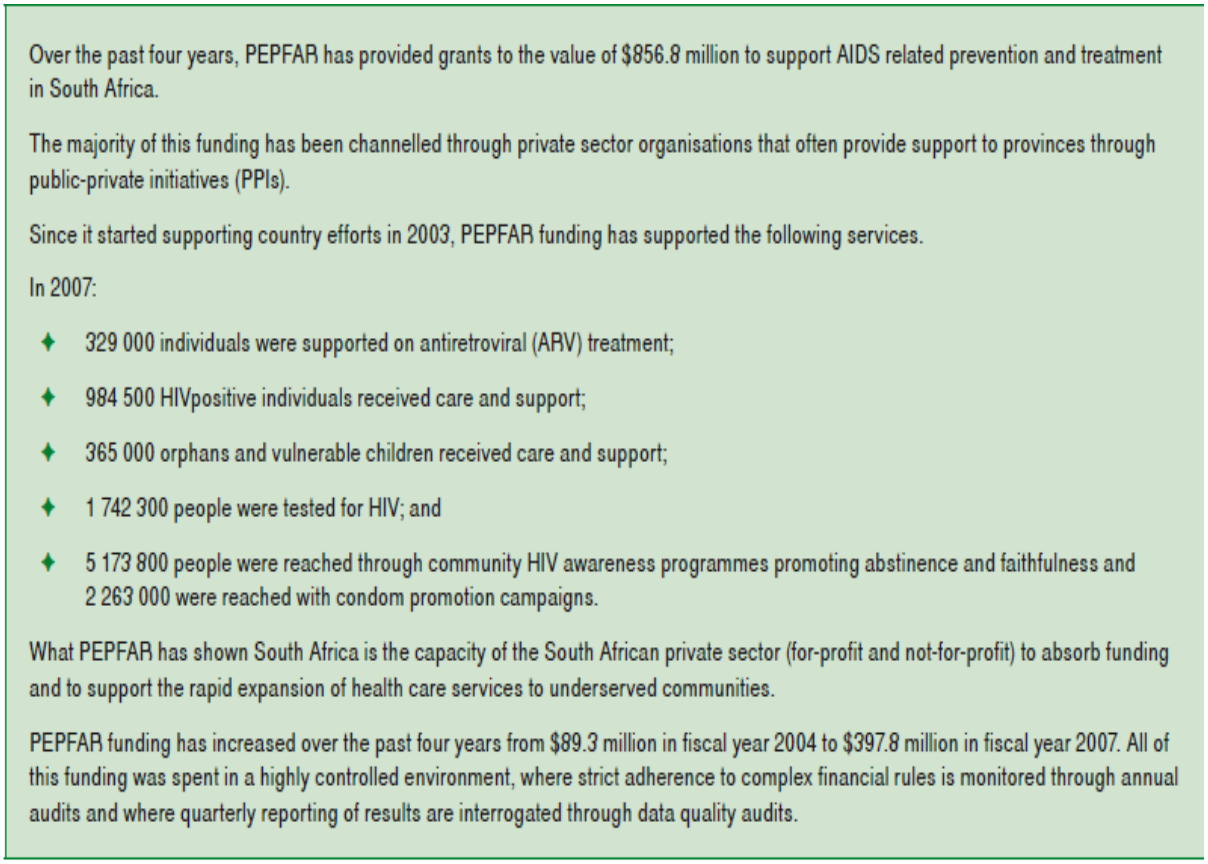
possible, it increasingly formalised partnerships with NPOs to deliver services on its behalf.

At present NPOs deliver a magnitude of services in the country and have extended the reach of the public health service into areas not reached by formal health care services (Health Systems Trust, n.d.).

The NPO sector consists of a large number of organisations providing services for a service fee or at no charge. Included are NGOs, Faith-based organisations (FBOs), CBOs and, increasingly, also other role players such as academic and research institutions. Currently, an estimated 60 000 to 80 000 not-for-profit organisations are working in South Africa (Wolvaardt *et al.*, 2008:2).

NPOs in the health sector have played a vital role in delivering essential services to the poor and marginalised for many years. These organisations play a particularly valuable role in countries where formal health services are not able to reach or cope with the health needs and demands of the population. In South Africa, for example, we have seen that NPOs played a vital role in combating the HIV/AIDS pandemic. During the late 1990s to early 2000s when South Africa seemingly lost control over the spread of HIV and more and more citizens were dying because of the disease, NPOs came to the rescue. Donor funds poured in to the country and NPOs organised themselves to assist with strategies for the prevention and treatment of HIV.

The following figure depicts a diagram taken from a case study on donor funding to South Africa by the United States President's Emergency Program for AIDS Relief (PEPFAR, 2008).



Over the past four years, PEPFAR has provided grants to the value of $856.8 million to support AIDS related prevention and treatment in South Africa.

The majority of this funding has been channelled through private sector organisations that often provide support to provinces through public-private initiatives (PPIs).

Since it started supporting country efforts in 2003, PEPFAR funding has supported the following services.

In 2007:

- 329 000 individuals were supported on antiretroviral (ARV) treatment;
- 984 500 HIVpositive individuals received care and support;
- 365 000 orphans and vulnerable children received care and support;
- 1 742 300 people were tested for HIV; and
- 5 173 800 people were reached through community HIV awareness programmes promoting abstinence and faithfulness and 2 263 000 were reached with condom promotion campaigns.

What PEPFAR has shown South Africa is the capacity of the South African private sector (for-profit and not-for-profit) to absorb funding and to support the rapid expansion of health care services to underserved communities.

PEPFAR funding has increased over the past four years from $89.3 million in fiscal year 2004 to $397.8 million in fiscal year 2007. All of this funding was spent in a highly controlled environment, where strict adherence to complex financial rules is monitored through annual audits and where quarterly reporting of results are interrogated through data quality audits.

Figure 2.1: Donor funding in South Africa (NPO)
Source: PEPFAR 2008

Outsourcing of health services is receiving increasing attention internationally in low- and middle-income countries. Outsourcing contracting takes place more frequently in these countries and the assumption is that there is wide variation in the kinds of contractual arrangements and the range of services outsourced. Donor agencies have promoted outsourcing of health services in many developing countries, during or post-conflict, because health systems were disrupted. NPO took over many of the health service as donor funds became available (Siddiqi *et al*., 2008:871).

In an online article on the WHO website entitled “Contracting for Health services” the WHO defines contracting as a practice whereby public and or private entities provide funding to an independent agent to provide services on its behalf. This implies that services usually rendered by the mother organisation is subdivided and then subcontracted or outsourced to be delivered by a contractor.

In terms of the article, the practice of contracting services was introduced in the early 1980s and had been part of international policy directions with the aim of reducing the state’s role in services. The practice of outsourcing became more and more popular

as governments' alternative ways of delivering services in a more cost-effective manner, as well as to improve efficiency in order to sustain health services.

Health sector reforms over the years have seen the state playing a continually increasing role with policy, regulatory, legislative and monitoring functions whilst the physical delivery of health services are being outsourced to private, public-private initiatives and non-profit organisations (World Health Organisation, n.d.).

In a study commissioned by the UNAID dated September 14, 2012 titled "Social services outsourcing to social organisations in the HIV Sector in Yunan Province" the organisation describes how social sector organisations (SSOs) including non-profit organisations have made a difference in the fight against HIV. The document describes the increasing role of the SSOs in an environment where donor funding decreases.

Yunnan is a province in the People's Republic of China, where the study was conducted. The study describes how China became proactive in developing and outsourcing services previously rendered by means of donor funding. When China realised that the state would not be able to absorb the services rendered by donor-funded organisations, it started utilising existing SSOs in communities to take over some of these services. China saw this as a more cost-effective manner for sustaining the service at a more affordable rate. The study also identified challenges in random using of SSOs and recommended that, for SSOs to be effective in delivering outsourced services, the SSOs has to be developed to ensure that quality services are delivered on behalf of the state (UNAID, 2012:4-5).

NPOs have assisted populations in need all over the world and have been a beacon of hope for people in war-torn countries, during natural and man-made disasters or simply in under-developed countries that are unable to meet the health and welfare needs of their populations.

The table in Figure 2.2 depicts outsourcing to NPOs all over the world. It is from an article written by Siddiqi *et al*. (2006:3) published in the Bulletin of the World Health Organization, 2006.

Country	Rationale for MOH[a] to enter into health service contracts	Interest of the NGOs[b]/ private sector in contracting
Afghanistan	• Disrupted public sector health services due to years of conflict • 80% of health facilities operated by NGOs during conflict and in the early post-conflict period	• NGOs would continue to be actively engaged in provision of care • NGOs would receive US$ 4.5 per capita as cost of Basic Package of Health Services
Bahrain	• Improved efficiency • Economies of scale in private sector • Government policy to involve private sector	• Increase scale of work • Assurance of regular source of revenue
Egypt	• Increase coverage of services • Utilize advanced technology available with private sector • Improve quality of care	• Assurance of regular source of revenue • Guaranteed registration of families (increase clientele)
Islamic Republic of Iran	• Decentralization of services • MOH policy to provide services for segment of rural and deprived population	• Access to government resources for family physicians
Jordan	• Optimize capital investments in public sector • Improve accessibility and efficiency • Decrease waiting lists at government hospitals	• Utilize spare capacity • Assurance of regular source of revenue • Increase credibility through affiliation with MOH
Lebanon	• Access more elaborate infrastructure of hospitals in the private sector • Avoid duplication of services already available in private sector	• Access to major insurers of population • Utilize capacity in private sector
Morocco	• Decentralization of services • Improve access to services • Overcome budget constraints for capital projects	• Enhanced recognition of private sector • Opportunity for partnering with public sector
Pakistan	• Improve access to services • Expand service provision for culturally sensitive issues — HIV/AIDS[c]	• Enhanced recognition of NGOs by the population • Expansion of programme activities
Syrian Arab Republic	• Public provision of services, clinical services not contracted out	• Access to government funds
Tunisia	• Reduce cost of foreign treatment by contracting with national providers	• Most contracts between Ministry of Social Affairs and Solidarity or MOH and private facilities are adherents to these agreements

Figure 2.2: NPO Service Contribution (International perspective)
Source: Saddiqi *et al*. 2006

2.7 Summary

Outsourcing in the health sector has many benefits for communities as it allows public service delivery agents to increase access to care in the case of the health sector. Public-private partnerships are another method through which the public sector can improve quality, efficiency and reach. Whilst many are of the opinion that NPOs in South Africa and in other developing countries have the capacity to do more in terms of assisting health departments with services, many obstacles still face this partnership. If it were not for international donor agencies such as PEPFAR, the NPO sector would have not been as developed as it is currently.

Internal environmental issues such as political, legislation and labour are major obstacles to outsourcing health services. Whilst NPOs have proven that they, within a

short time frame, can organise themselves to reduce HIV transmission, increase awareness and come to the aid of millions of poor people around the world by delivering services where governments have failed, their contribution and ability remain hampered.

It is naïve for government to think that it can be the sole provider of health services given socioeconomic circumstances; however it might also be naïve for NPOs to think that they will be able to deliver services forever with donor funds. This means that governments must create the environment for a relationship with NPOs that is mutually beneficial and, most important, benefit the poor and marginalised.

One of the only ways government can do this is through legislation that will enable partnerships with stakeholders such as NPOs. Legislation should however take into account the full service delivery spectrum and should be holistic enough so that when services are outsourced, the rights of employees, in terms of legislation protecting workers, are not violated. The next chapter reviews imperatives of the legislative environment for health service delivery as well as workers' rights and what the impact is on the NPO outsourcing environment.

Lastly, organised labour organisations are important stakeholders and their opinions should not be disregarded. As guardians of labour rights for workers, these stakeholders can make or break partnerships, no matter how good the intention is.

Chapter 3: Legislative Imperatives

3.1 Introduction

The current chapter presents a review of South African legislative imperatives applicable to this investigation. The review includes various pieces of legislation applicable to health care; the rights of the health care user in connection with health care service providers are reviewed first. The aforementioned is followed by a review of the labour relations environment in South Africa. Public service administration and management legislation are reviewed last.

3.2 Legislative imperatives from a health care user's perspective

This overview of the health sector from a human rights perspective specifically discusses the Bill of Rights as contained in the Constitution, the Rights of Patients as contained in the National Health Act, and the NPO Act stipulating the requirements of NPOs

3.2.1 The Constitution of the Republic of South Africa, 1996

The post-apartheid written Constitution is the supreme law of the Republic of South Africa. It contains the Bill of Rights that recognises the rights of all citizens equally. This means that the Constitution does not allow laws that are passed in SA to infringe on the rights of any citizen. Should laws that are passed infringe on the right of another, such a law is unconstitutional.

One of the statements in the preamble to the Constitution is to "Improve the quality of life of all citizens". The Bill of Rights includes the right to healthcare, food, water and social security for all. The public sector cannot meet the terms of the aforementioned right of citizens alone and require the assistance of other service providers such as NPOs in many instances to assist. .

The current legal framework for NPOs is rooted in the fundamental rights as stated in the South African Constitution ("the Constitution"). The right to freedom of religion, belief and opinion as stated in section 15 of the Constitution and the right to freedom

of association as stated in section 18 are essential for civil society formations. The existence of non-profit organisations therefore personifies these rights by enabling individuals to participate in community groups (RSA, 1996: s 15-18).

Recognizing the invaluable role of the non-profit sector in our society, the South African government, like any other modern democratic government, has created an enabling legal environment to support and encourage the formation of organisations. This legal framework is rooted in the fundamental human rights culture of the Constitution of the Republic of South Africa.

The right to freedom of religion, belief and opinion; of expression; and of association as contained in the Bill of Rights is fundamental for civil society formations. This means that everyone has the right to associate with other people and form organisations and express themselves in whatever way they choose provided that this is done in compliance with existing laws. Recent international and national studies recognised that the South African legislative framework on NPOs is the most progressive internationally and thus match the international good standards and practices for an enabling environment in civil society.

As much as NPOs assist government to meet the needs of citizens as well as to advocate for citizens' rights, when NPOs become employers of workers, they should equally respect the rights of workers in terms of labour legislation. This means that once government decides to outsource service delivery to NPOs and they become partners in service delivery, government should also ensure that NPOs comply with legislation. It therefore becomes a fine balancing act for government and NPOs to ensure services are delivered and the rights of workers are respected. Legislation in terms of worker rights is discussed later in the chapter. Access to health care is one of the rights afforded to citizens in the Bill of Rights. The next section reviews the National Health Act promulgated to give effect to the aforementioned right.

3.2.2 The National Health Act, Act No. 61 of 2003

The South African National Health Act No. 61 of 2003 provides a framework that ensures a uniform health system. This requires departments, provinces and local

governments to work together to ensure that the health needs of the citizens are met. The Act further recognises that divisions of the past that have caused socio-economic inequities that spilled over to health care service delivery that have to be addressed. The Bill of Rights in the Constitution states that all citizens have the right to health care. With this in mind, the Act has been promulgated to ensure compliance of the RSA to the Bill of Rights, which includes the following:

1. in terms of section 27(2) of the Constitution the State must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the right of the people of South Africa to have access to health care services, including reproductive health care;
2. section 27(3) of the Constitution provides that no one may be refused emergency medical treatment;
3. in terms of section 28(l)(c) of the Constitution every child has the right to basic health care services;
4. in terms of section 24(a) of the Constitution everyone has the right to an environment that is not harmful to their health or well-being;

According to the Act, the following has to be ensured to realise the rights of the citizens of the RSA:

1. unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa;
2. provide for a system of co-operative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must address questions of health policy and delivery of quality health care services;
3. establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognised standards of research and a spirit of enquiry and advocacy which encourage participation;
4. promote a spirit of co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans. (RSA, 2003: 2-3)

In terms of the aforementioned Act, the National Minister of Health must endeavour within the means at his disposal to protect and promote the health of SA citizens. The

minister delegates this to the Provincial Members of the Executive Council (MEC) for Health.

Even though health services are delivered in private and other sectors, the Act requires legislated custodians to protect the rights of citizens. This means that health authorities must ensure that health services, where delivered, promote the Rights of Patients. The diagram in Figure 3.1 depicts the rights of patients.

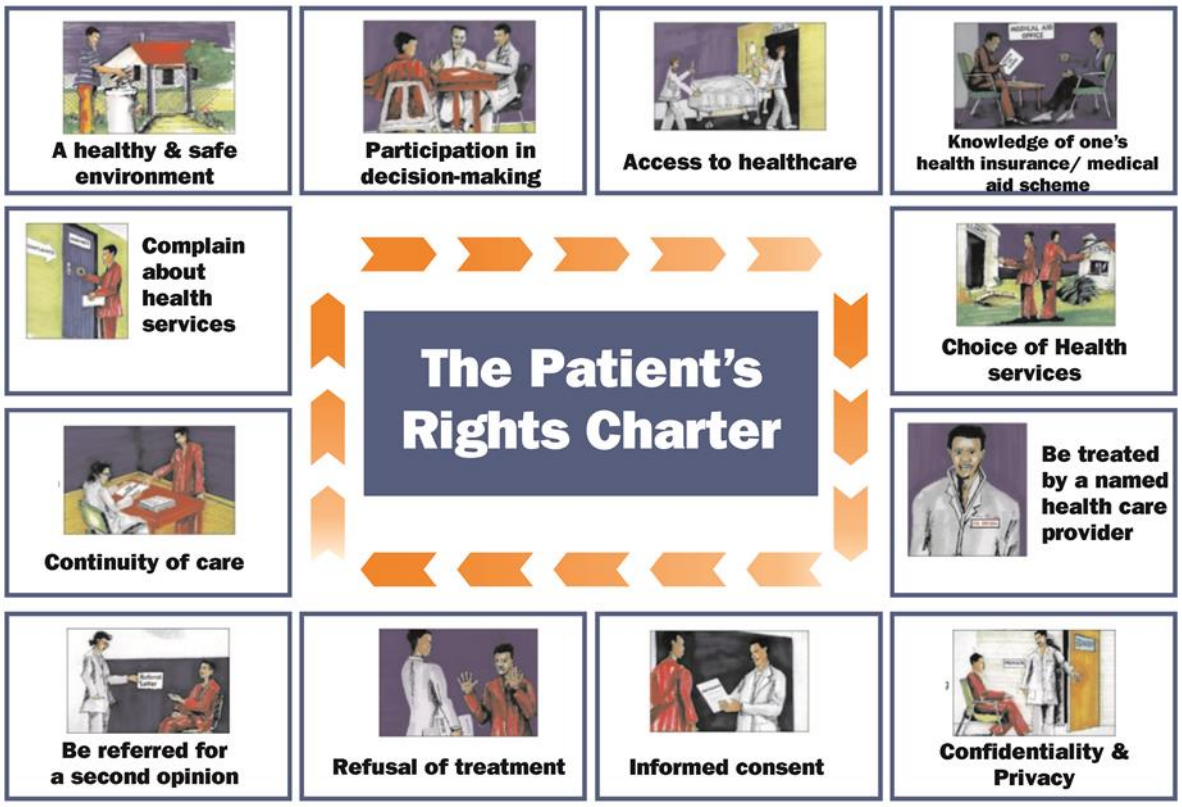


Figure 3.1: Patients' Rights Charter
Source: NHA 2003

In terms of the Act, the outsourcing of health services, whether to NPOs or other stakeholders, therefore, does not relieve legislated custodians of the responsibility to ensure compliance with the right to health care of citizens. It therefore becomes important when health services are outsourced that the contractor complies with legislation and other requirements recognised and required by legislation other than the National Health Act. In terms of the study, NPOs as a variable are investigated as outsourced health service providers, and it therefore is important to discuss the legislative imperative around NPOs.

3.2.3 The Non-profit Organisations Act, Act No. 71 of 1997

The Non-profit Organisations Act 71 of 1997 (NPO Act) is the primary legislation within the legal framework for NPOs. The main purpose of the NPO Act is to create an enabling environment in which NPOs can flourish and to establish an administrative and regulatory framework within which organisations can conduct their affairs. Specifically, the Act is aimed at encouraging NPOs to maintain adequate standards of governance, transparency and accountability and to create an environment within which the public may have access to information on registered organisations.

The Department of Social Development is responsible for the implementation of the NPO Act. A Directorate for Non-profit Organisations has been established, in terms of section 4, to administer the provisions of the Act. The core business of this Directorate is essentially to provide an efficient registration facility for organisations and to ensure accessibility to records of registered organisations. The registration standards and procedures, including the obligations of registered NPOs, are articulated within the NPO Act.

In summary, the above three pieces of legislation provide a broad overview in terms of health service delivery in the RSA. The Constitution as the supreme law recognises the rights of all citizens as contained in the Bill of Rights, which include the right to basic health care and labour rights. The National Health Act must ensure that the right to health care for all citizens is met; it contains the patients' rights charter. Lastly, the NPO Act stipulates the requirements for an NPO and in a sense also protects citizens against NPOs that do not have their best interest of citizens at heart. When the department of health outsources services to an NPO it must ensure that NPOs are registered in terms of the NPO Act before services can be outsourced. The latter will be discussed in detail under the WCDoH case study.

3.3 Legislative imperatives from a workers' rights perspective

Continuing in this section, a review of legislative imperatives with regard to employees in the RSA is presented. This includes the current South African labour relations environment, including working conditions, for which an overview is provided from a worker rights perspective. The three pieces of legislation reviewed are:

1. The Labour Relations Act, including the Amendment Act
2. The Basic Conditions of Employment Act ,including Sectoral determinations
3. The Occupational Health and Safety Act

It was important for the investigation to review the stipulations of the aforementioned Acts as this provides a basis for discussion when current policies are reviewed in terms of outsourced practices in the WCDoH. The importance of reviewing this legislation is due to the following:

1. The Labour Relations Act provides an indication of whether current NPO models of outsourcing comply with good labour relations practices.
2. The Basic Conditions of Employment Act provides an indication of benefits and other practices that employees must enjoy whilst in employment.
3. The Occupational Health and Safety Act provides explicit stipulations on the protection of employee health. It is important to review this legislation as it indicates compliance of the employer, outsourcing services.

3.3.1 The Labour Relations Act, Act No. 66 of 1995

<u>The Labour Relations Act stipulates the following:</u>

The purpose of this Act is to advance economic development, social justice, labour peace and the democratisation of the workplace by fulfilling the primary objects of this Act, which are-

- to give effect to and regulate the fundamental rights conferred by section 27 of the Constitution;
- to give effect to obligations incurred by the Republic as a member state of the International Labour Organisation;
- to provide a framework within which employees and their trade unions, employers and employers' organisations can
    - collectively bargain to determine wages, terms and conditions of employment and other matters of mutual interest; and
    - formulate industrial policy; and
    - to promote-
        - orderly collective bargaining;

- collective bargaining at sectoral level;
- employee participation in decision-making in the workplace; and
- the effective resolution of labour disputes.

- Section 27, which is in the Chapter on Fundamental Rights in the Constitution entrenches the following rights:
  - Every person shall have the right to fair labour practices.
  - Workers shall have the right to form and join trade unions, and employers shall have the right to form and join employers' organisations.
  - Workers and employers shall have the right to organise and bargain collectively.
  - Workers shall have the right to strike for the purpose of collective bargaining.
  - Employers' recourse to the lockout for the purpose of collective bargaining shall not be impaired, subject to subsection 33(I). *(*RSA, 1995:s 27)

3.3.2 The Labour Relations Amendment Act, Act No.6 of 2014

The Labour Relations Amendment Act 2014 became effective on 1 January 2015. Employers were given three months following the effected date to comply with the prescriptions of the Act. The Act has an influence on employers, employees and registered labour organisations. The following sections of the Act have a direct influence on the WCDoH-NPO outsourcing models. The following stipulations are defined in the Act:

- Temporary employment services (TES) – Section 198A(1) define TES as only
  - Services obtained through a contract less than 3 months
  - Substituting services of temporarily absent permanent staff
  - TES as determined by the bargaining council as part of a collective agreement
  - Section 198A (2) TES only apply to employers earning below the threshold as determined through Section 6(3) from time to time by the Basic Conditions of Employment Act.
  - Section 198A (3) stipulates that only employees falling under the ambit of section 198(1) and (2) are classified as TES. Employees employed outside the stipulations are deemed to be employees of the employer contracting services. This implies that should an employer contract the

employment of contract workers through a contractor and fall outside the definition of 198(1) and (2) irrespective of the agreement between the employer and the contracted the contract employee is regarded as a permanent employee.

- These results in the employer and the contractor both are being liable for the contract employee. The employees then have recourse with both the employee and the contractor and can refer both to the CCMA or Labour court. An example here is when an employee falls outside the TES stipulations and are dismissed by the contractor, both the employer and the contractor can be taken to the CCMA for unfair dismissal.
- Employees employed through a contractor by an employer falling outside the TES must have the same basic conditions of employment (pension, medical aid, allowances, bonuses, leave benefits and service bonuses) as the employee employed by the employer
- Dismissals – the definition of dismissal has changed and in terms of Section 186(1) (a) dismissal is no longer only confined to the termination of an employment contract by an employer but extend to any termination. This means where an employee is employed through a contractor and the contractor decides to terminate the employment the contract employee can refer the employer to the CCMA on the basis that the employment relationship was between the employer and the contract employee, irrespective of the agreement between the contractor and the employer.
- Failure to offer permanent employment once a fixed term contract has lapsed can be seen as unfair dismissal, where the employer cannot justify why no such permanent appointment can be made.
- Fixed term contract – Cannot exceed three months unless there is a good and justifiable reason which are the following
    - If the employee replaces a permanent employee who is temporarily absent.
    - Temporary increase in the volume of operations of an employer provided that the contract does not exceed twelve months.
    - Community service recent graduate students, students on work related training.

- Employee is employed on a project which is limited to a defined duration.
- Foreign employees whose work is limited to the conditions and duration of a working permit.
- Employee performs seasonal work such as farm workers.
- Employees employed through an official public works scheme or job creation scheme such as the Expanded Public Works Programme (EPWP).
- The position of the employee is funded by an external funder for a limited period.
- Employee has reached it normal prescribed retirement age.

- Should a fixed term contract exceed 3 months without a justifiable reason as indicated above can result in an employee automatically becoming a permanent employee
- Fixed term contract employees working for longer than three months must have the same basic conditions of employment, unless there is a defensible reason why they cannot receive the same benefits such as duration of service, rank and qualifications.
- Should a Fixed term contract exceed two years, an employee would be entitled to severance pay equal to 1 week's remuneration for every full year of service upon termination of employment.

(Republic of South Africa, 2014: s186-193)

In summary, the Labour Relations Amendment Act is one of the main variables for this study and that is why details of this Act become important to note. The Act influences the recommendation of outsourcing models and forms the basis of ensuring compliance for future outsourced models.

3.3.3 Basic Conditions of Employment Act, Act No. 75 of 1997 (BCEA)

The BCEA applies to all except members of the National Defence Force, National Intelligence Agency, South African Secret Service and unpaid volunteers working for an organisation with a charitable purpose. The basic conditions of employment as contained in the Act form part of the employment contract of employees covered by the Act. It is important to note, however, that some, but not all, basic conditions of employment may be varied by individual or collective agreements in accordance with the provisions of the Act. The aforementioned is particularly important to note for the investigation. The following is contained in the BCEA:

1. Chapter two prescribes the regulation of working hours and is applicable to all employees except senior managerial employees, employees engaged as sales staff who travel and employees who work less than 24 hours in a month. This chapter further prescribes Meal intervals: Section 14, daily rest periods; Pay for work on Sundays: Section 16; Night work: Section 17; work on public holidays: Section 18.

   Currently all NPO employees work more than 24 hours per month; the typical working day of an employee is 4½ hours per day, excepting those employees working in 24-hour residential care facilities.
2. Chapter three contains stipulations regarding leave, but does not apply to an employee who works for less than 24 hours in a month for an employer and to leave granted in excess of the leave entitlement under this chapter. Employees are entitled to 21 consecutive days' annual leave or, by agreement, one day for every 17 days worked or one hour for every 17 hours worked; Sick leave: Sections 22 – 24 - An employee is entitled to six weeks' paid sick leave in a period of 36 months; Maternity leave: Sections 25 & 2 - A pregnant employee is entitled to four consecutive months' maternity leave; Family responsibility leave: Section 27.
3. Chapter four prescribes employment and remuneration that applies to all employees except to an employee who works for an employer for less than 24 hours in a month.
4. Chapter five stipulates particulars on termination of employees and applies to all workers except those working less than 24 hours per month.

5. Chapter six prohibits children and forced labour.
6. Chapter seven stipulates variations of the BCEA as follows:
    - A collective agreement concluded by a bargaining council may replace or exclude any basic condition of employment except the following:
        - the duty to arrange working time with regard to the health and safety and family responsibility of employees (S.7,9 and 13);
        - reduce the protection afforded to employees who perform night work (s. 17(3) and (4));
        - reduce annual leave to less than two weeks (s. 20);
        - reduce entitlement to maternity leave (s. 25);
        - reduce entitlement to sick leave to the extent permitted (s. 22-24); and
        - prohibition of child and forced labour (s. 48).
    - Collective agreements and individual agreements may only replace or exclude basic conditions of employment to the extent permitted by the Act or a sectoral determination (s. 49).
    - The Minister of Labour may make a determination to vary or exclude a basic condition of employment. This can also be done on application by an employer or employer organisation (s. 50).
    - A determination may not be granted unless a trade union representing the employees has consented to the variation or has had the opportunity to make representations to the Minister. A copy of any determination must be displayed by the employer at the work place and must be made available to employees (s. 50).
7. Chapter eight, section 51 prescribes that the Minister of Labour may make sectoral determinations. This is very important for the current NPO outsourcing model applied by the WCDoH. This sectoral determination especially when it comes to community health workers has formed the legal foundation for the home based care programme since its inception. This is discussed in detail below.
8. Chapter nine stipulates monitoring, enforcement and legal proceeding and states that labour inspectors must advise employees and employers regarding their rights and obligations in terms of employment laws.

9. Chapter ten is important to note as it stipulates who will be presumed to be an employee. Section 83A states the following:

- "A person who works for, or provides services to, another person is presumed to be an employee if –
- his or her manner or hours of work are subject to control or direction;
- he or she forms part of the employer's organisation;
- he or she has worked for the other person for at least 40 hours per month over the previous three months;
- he or she is economically dependent on the other person;
- he or she is provided with his or her tools or work equipment; or
- he or she only works for, or renders service to, one person."

If one of these aforementioned factors is present, the person is presumed to be an employee until the employer proves that he or she is not.

10. Chapter eleven provides for general stipulations of what constitute offences (RSA, 1997:s 3-83)

3.3.4 Sectoral Determinations in terms of section 51 of the BCEA.

Sectoral determinations in terms of the BCEA is important to note for NPO employment as the majority of outsourced services are within the community-based environment and are regarded as part of the Expanded Public Works Programme in terms of Ministerial Determination 4, as per Regulation 342 of 2012. The determination describes the EPWP as "a programme to provide public or community assets or services through a labour intensive programme initiated by government and funded from public resources".

The following programmes are stated as constituting the EPWP:

a) "Environment and Culture Sector Programmes including: Working for Water, Working on Fire, Working for Wetlands, People and Parks, Working for Energy, Working for Woodlands, Working for the Coastline, Landcare, Working on Waste, Working for Tourism, Investing in Culture Programmes.
b) Infrastructure Sector Programmes and Projects declared part of EPWP which may include the construction, rehabilitation and maintenance of: rural and low-volume roads,

storm-water drains, water reticulation, basic sanitation, footpaths, sidewalks, bicycle paths, schools and clinics.

c) Social Sector Programmes including Early Childhood Development, Home, Community-based Care, Community Safety and other community-based programmes.
d) All projects and programmes accessing the EPWP wage incentive including those implemented by Non-Governmental organisations (NGO) and Community-based Organisations (CBO) and the Community Works Programme**.**
e) Any other programme deemed to be part of the EPWP as determined by the Department of Public Works".

(RSA,2012: 3)

Stipulations (c) and (d) are particularly important to note as the current model of NPO outsourcing is based on these stipulations. Not all NPO outsourced services access EPWP wage incentives, however, and neither do all services fall within the ambit of community-based care or programmes. This is discussed later when a review of recent Commission of Conciliation Mediation and Arbitration cases is presented.

The aforementioned determination further states that the following stipulations of the BCEA do not apply to community-based workers.

- Overtime rate
- Remuneration required for meal intervals of longer than 75 minutes
- Written particulars of employment
- Display of employee's rights
- Severance pay
- Notice of termination
- Sectoral Determinations

(RSA, 2012:4)

When compared with the stipulations of the Labour Relations Amendment Act of 2014, the above determination creates serious confusion for the WCDoH and its outsourcing model. In terms of the definition of temporary employment services (TES), the aforementioned Act is clear about who may be regarded as TES. Many NPO workers clearly fall outside this TES as they are employed on renewable twelve-month contracts and do not stand in for permanent staff in their absence and, furthermore, earn less than the stipulated threshold determined by the BCEA from time to time.

In terms of the determination, community-based programme workers fall under EPWP, which is a programme for short-term job creation and skills development. The determination further states that R347 contains the standard terms and conditions for workers employed in elementary occupations on an Expanded Public Works Programme (EPWP). It can therefore be argued that community health workers would be regarded as EPWP workers and are not covered under TES. However, the manner in which NPO staff are utilised is not what EPWP intended to do. These terms and conditions furthermore also do not apply to persons employed in the supervision and management of a public works programme.

3.3.5 The Occupational Health and Safety Act, Act No. 85 of 1993

South Africa possesses excellent legislation governing occupational health and safety and the protection of workers against diseases and injuries in the workplace. The Occupational Health and Safety Act No. 85 of 1993 are implemented within this context:

> ”To provide for the health and safety of persons at work and for the health and safety of persons in connection with the use of plant and machinery; the protection of persons other than persons at work against hazards to health and safety arising out of or in connection with the activities of persons at work; to establish an advisory council for occupational health and safety; and to provide for matters connected therewith.” (RSA, 1993:1)

The Occupational Health and Safety Act (OHSA) furthermore prescribes that employers have certain duties towards protecting workers’ against health and safety hazards in the workplace. According to the OHSA, the general duties of employers towards workers are as follows:

- It is the duty of the employer to keep the work environment safe. This includes the provision of equipment and machinery fit for purpose and safe to use. Machinery should be calibrated and serviced regularly according to manufacturing standards to ensure optimal and safe operation thereof. Workers should be trained on how to use the equipment. Employers must always strive to remove and mitigate dangers from the workplace and if this is not possible,

personal protective equipment should be provided. Workers must be trained in how to use the personal protective equipment (PPE) effectively.

- PPE should only be used when all other measures to ensure a safe working environment are exhausted. The employer must ensure that hazards are identified in each step of the workflow process and first mitigate the risk and, if not possible, supply and train the worker in the use of PPE.

To ensure compliance with these duties, the employer must:

- Identify possible hazards which may exist while work is being performed; find and ensure suitable preventative methods that are essential to protect his or her workers against the known hazards; and provide the means to implement these counteractive measures; provide the required information, instructions, training and supervision so that workers know the work processes and procedures. Workers should not be allowed to perform their duties if the required preventative actions or methods are not implemented.

- Make sure that all employees in the employer's employ abide by the prescripts of the OHSA.

- Put into effect all required methods of control that will ensure a hazard free working environment.

- Where required, employers must ensure adequate supervision of employees that do not have the proficiency or ability as yet to perform work on their own; a senior skilled employee should provide direct or indirect supervision depending on the situation.

- The supervising worker must ensure that preventative and precautionary methods are adhered to.

- Employers also have a duty to contracted employees that are not in their direct employ but either are self-employed or employed through agencies. All employers making use of contracted employees must conduct their business in such a manner as to ensure that reasonable practical steps are taken to protect the health and safety of workers that are directly exposed to hazards.

Other than the duties of the employer, the OHSA also extends rights to workers with regard to safety in the workplace. These are:

- The right to information
    - The worker must have access to –
        - the Occupational Health and Safety Act and regulations
        - health and safety rules and procedures of the workplace
        - health and safety standards which the employer must keep at the workplace.
    - The worker can also request the employer to inform him or her about –
        - health and safety hazards that can occur in the workplace
        - the precautionary and protective measures which must be taken
        - the process and procedures that must be followed if a worker is exposed to substances hazardous to health

(RSA, 1993:s8-13)

South African legislation is recognised as very progressive in that it complies with international standards. As a member of the International Labour Organisation, the onus is on SA to make sure that no employer infringes on the rights of workers. The Department of Labour and its inspectorate therefore has a duty to inspect and investigate all areas of non-compliance. The CCMA, labour courts and, on a local level, organised labour unions are institutions in place that will intervene where workers' rights are trampled on. It becomes important for the public service to recognise that the Labour Relations Amendment Act investigates areas where the service is non-compliant and to be proactive in correcting areas of non-compliance that will ultimately mitigate worker right violations that result in employees approaching institutions established to protect their rights.

3.3 Public service administration legislative imperatives in South Africa

In this section, two pieces of legislation will be reviewed, namely

1. The Public Service Act which provides specific stipulations on public service employees; their working conditions; and benefits. Since the Labour Relations Amendment Act requires that benefits enjoyed by permanent employees must be enjoyed by contract employees, it is important that an overview of this Act is provided, therefore reviewing the aforementioned legislation will provide an indication of the requirements for NPO contracts, and
2. The Public Finance Management Act that provides stipulations regarding how public funds should be managed.

3.3.1 The Public Service Act 103 of 1994

The Public Service Act applies to all officers and employees who were, are and are to be employed in the public service, whether they are working in the country or not. The Minister of the Department of Public Service and Administration is ultimately responsible for the implementation of this Act, and he or she may suggest policies and changes related to the following aspects of public service:

- functions and organisational structure;
- employment practices (including promotion, human resource management and training);
- salaries;
- information management and technology; and
- transformation and reform.

The Act establishes a set structure for public service, establishing both national and provincial administrations with particular fixed posts, ranks and salary scales. These may be changed only by the President.

Each department must have a head who is responsible for the efficient management in his or her department, as well as the effective use of resources; the protection of state property; communication between different levels of government; and giving

strategic direction to the department. The post of a department head can be occupied for five years. The position can be extended (for no less than 12 months and no more than an additional five years).

Persons appointed to the public service must be South African citizens of sound character and in a reasonable state of health. The need to redress the imbalances of the past must be taken into account when filling posts. The posts may be full- or part-time, depending on requirements and the maximum number of posts will be determined by the Cabinet in the national sphere of government.

Individuals are subject to a probationary period of no less than one year, and dismissal of a person requires one month's notice (during and after the probationary period).

Individuals in the public service may be transferred to another position when it is in the public interest, but they may not suffer a salary decrease upon transfer. Transferal does not automatically mean an immediate increase either. There are some exceptions with regard to transferals. For details, the full Act should be consulted.

Upon reaching the prescribed retirement age (i.e. 65 years), officers of the public service have the right to retire and must give written notification at least three months before the intended date of retirement. Heads of departments must give six months' notice. Certain employees may be discharged from the public service for any of the following reasons:

- continued ill-health,
- the abolition of the post,
- misconduct, and/or
- if it is in the public interest.

(RSA, 1994)

3.3.2 Public Finance Management Act, Act 1 of 1999

The purpose of the PFMA is to, in particular,

> "Regulate financial management in the national government and provincial governments; To ensure that all revenue, expenditure, assets and liabilities of those governments are managed efficiently and effectively; To provide for the responsibilities of persons entrusted with financial management in those governments; And to provide for matters connected therewith". (RSA,1999: 1)

NPO outsourcing and payment for services are regulated as transfer payments to other entities to deliver services on behalf of the public service. It is important to review the PFMA, particularly the requirements for transfer payments.

The PFMA stipulates the funding requirements of NPOs. The requirements include that the NPO/Entity must certify in writing that the entity will implement effective and transparent financial management and internal control systems as prescribed in terms of PFMA Section 38 (1) (j) and National Treasury Regulation 8.4.

Paragraph 38 (1) (j) stipulates:

> "Before transferring any funds [other than grant in terms of the annual Division of Revenue Act or to a constitution institution] to an entity within or outside government, must obtain a written assurance from the entity that the entity implements effective, efficient and transparent financial management and internal control systems, or, if such written assurance is not or cannot be given, render the transfer of the funds subject to conditions and remedial measure requiring the entity to establish and implement effective, efficient and transparent financial management and internal control systems." (RSA, 1999:s 38)

The PFMA does not allow delegation of financial responsibility to other entities. This means that the public sector officials with delegations remain responsible for public funds. In the scenario of this investigation this therefore is one of the pieces of legislation that prohibits the outsourcing of services in its entirety, including financial accountability.

3.4 Summary

The legislative environment in South Africa is well advanced with its Constitution being recognised as one of the best when it comes to protecting the rights of its citizens. As much as health care users have rights that include access to health care, the environment in which the health care providers (workers) operate must also be conducive to upholding their rights.

The purpose of labour relations legislation is to ensure worker rights are protected; the Labour Relations Amendment Act specifically protects the rights of vulnerable workers, which is important given the history and the inequities of workers in South Africa. The Public Service Act provides insight into public service administration in South Africa. The Department of Public Service and Administration as the custodian for the act must ensure compliance regarding employee remuneration packages as well employment criteria.

Lastly, sections of the PFMA are reviewed as the employment of staff has financial implications and there has to be certain rules and criteria for employing people. Because of this, it is important to review and indicate that these rules and criteria and other legislation must be taken into account when dealing with public administration and public financial management. Compliance with this mentioned legislation is of the utmost importance. Whether new organisational structures are created, or when different outsourcing models are proposed, this legislation plays a central role in decision making.

Chapter 4: Western Cape Department of Health: Case Study

4.1 Introduction

This chapter provides an overview of the Western Cape Department of Health as a service delivery entity and the WCDoH-NPO contracting/outsourcing. The context in which the department operates is discussed first and this includes the department's strategic direction, core function, service focus and service delivery platform, as well as where the WCDoH fits into the direction and focus of the broader national and international health policy framework. Secondly, an overview is provided with regards to NPO outsourcing. This includes service delivery contributions, funding norms and models, NPO governance and financial aspects, as well as service monitoring. Existing standard operating procedures and NPO service package norms with regard to service delivery are cited.

4.2 The Western Cape Department of Health in context

To provide a perspective as well as context with in which the WCDoH as a health service delivery entity functions, this section focuses on various aspects pertaining to the service delivery platform, the strategic direction, health service challenges, achievements and linkages with the rest of the health service stakeholders.

4.2.1 WCDoH as a service delivery entity

The Western Cape is one of nine provinces in South Africa and the population of the Western Cape Province, according to Statistics South Africa (Stats SA), was 6 116 324 or 11.3 per cent of the total South African population (Stats SA 2 Mid-Year Population Estimates, released July 2014). The Cape Town Metro District Municipality has the largest proportion of the population at 64.2 per cent and the smallest land surface area (2 502 km2). Hence the Metro District has a higher population density, which significantly impacts on the planning process.

Significant urban sprawl or expansion of the population away from the central urban areas that occurred as a result of apartheid has been further aggravated by the location of informal settlements at the periphery since 1994. The consequences of this

are higher cost of infrastructure, the lack of access to services, and the lack of mobility and social interaction for poor communities. The population distribution for the remainder of the Province is relatively sparse: 13.5 per cent in the Cape Winelands District, 9.9 per cent in Eden District, 6.7 per cent in the West Coast District, 4.4 per cent in the Overberg District and 1.2 per cent in the Central Karoo District (WCDoH Annual Performance 15/16, 2016)

According to the South African Index of Multiple Deprivation (SAIMD), the socioeconomic profile of the Western Cape (WC) and of 72 per cent (18/25) of the municipalities in the Western Cape indicates mixed socioeconomic deprivation ranging from the least to most deprived populations in the country. The most deprived wards within the Western Cape are within the City of Cape Town Municipality, particularly the townships on the Cape Flats alongside the N2, and in the Karoo.

Figure 4.1 taken form the Annual Performance Plan APP shows the contributors to poverty in the WC with unemployment as the highest contributor.

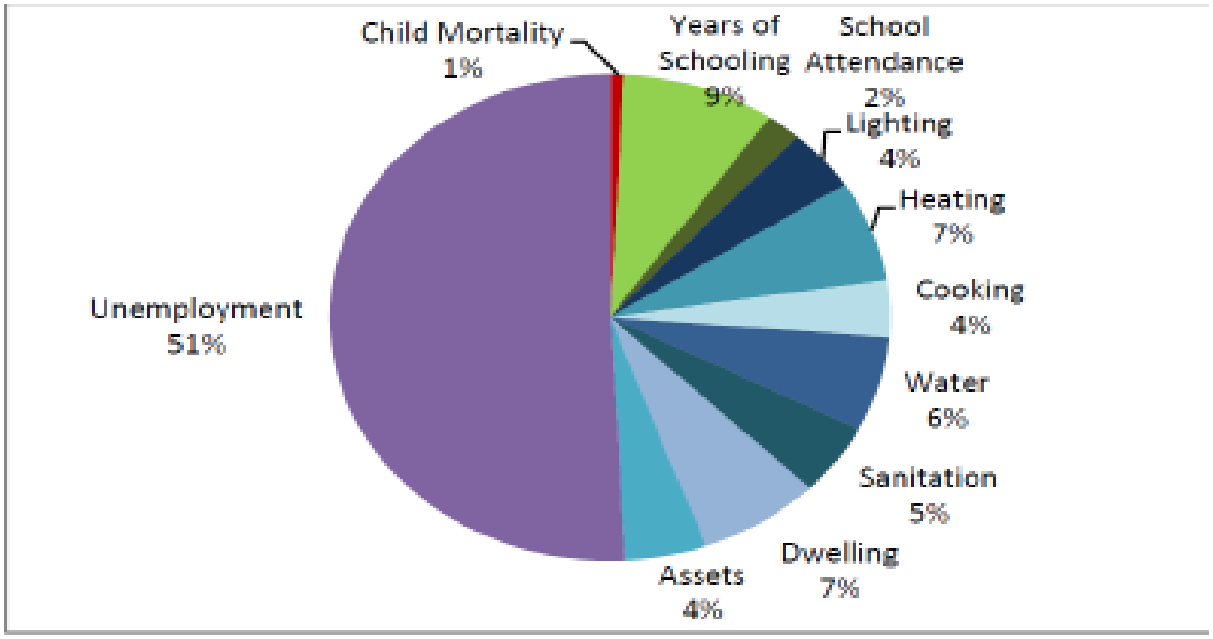


Figure 4.1: Contributors to poverty, WC
Source: WC APP 2014/15

The WCDOH Annual Performance Plan 2014/15 (2014:13) indicates that the factors and major causes of mortality affecting the WC population are unsafe sex, alcohol

abuse, smoking, diet/obesity and lack of physical activity, which accounts for over 60% of the disability adjusted life years burden in South Africa.

The lifestyle of people is not only harmful to their health but places an additional burden on health resources. After people have been exposed to these contributing factors, they normally end up as clients of the public health sector. The WCDoH has categorised the population of the Western Cape as follows:

- Insured – meaning they do not require public health services as they have a medical aid
- Uninsured – this part of the population does not have medical aid and they require public health services
- Dependant – they are able to afford private health services, but do not have medical aid and / or the medical aid has become exhausted and now depend on the public health services. The total dependent population then includes dependent and uninsured persons.

The top five leading causes of premature death in the Western Cape are depicted in the table in Figure 4.2 below is taken from the APP 2014/15.

Rank	CAPE WINELANDS	CENTRAL KAROO	CAPE TOWN	EDEN	OVERBERG	WEST COAST	WESTERN CAPE
1	HIV/AIDS (12.1%)	HIV/AIDS (14.9%)	HIV/AIDS (13.0%)	HIV/AIDS (12.3%)	HIV/AIDS (9.3%)	Tuberculosis (11.7%)	HIV/AIDS (12.4%)
2	Tuberculosis (9.8%)	Tuberculosis (11.4%)	Interpersonal violence (9.7%)	Tuberculosis (10.1%)	Tuberculosis (8.5%)	HIV/AIDS (8.7%)	Tuberculosis (8.6%)
3	Interpersonal violence (6.6%)	COPD (7.5%)	Tuberculosis (7.7%)	Ischaemic heart disease (7.0%)	Ischaemic heart disease (8.0%)	Ischaemic heart disease (8.3%)	Interpersonal violence (8.3%)
4	Cerebrovascular disease (6.0%)	Interpersonal violence (5.5%)	Ischaemic heart disease (6.7%)	Cerebrovascular disease (6.7%)	Interpersonal violence (6.5%)	Cerebrovascular disease (6.4%)	Ischaemic heart disease (6.6%)
5	COPD (5.6%)	Lower respiratory infections (5.3%)	Lower respiratory infections (4.7%)	Interpersonal violence (5.3%)	Cerebrovascular disease (6.1%)	Interpersonal violence (5.6%)	Cerebrovascular disease (5.1%)

Figure 4.2: Burden of disease based on five priority diseases
Source: APP 2014/15

With the five leading causes of premature deaths in mind, the WCDoH has prioritised health programmes as interventions to address the burden of disease that results in premature death. These are as follows:

- ***TB, HIV and AIDS*** – *The* Metro District accounted for approximately 70 per cent of the epidemic in the Western Cape, with nearly 50 per cent of the burden experienced by women between 25 and 34 years of age across the Province. The Western Cape has the third highest number of new TB infections in South Africa (746 cases per 100 000).

- ***Maternal and Child Health*** – the leading cause of death in children less than five years was neonatal, with prematurity being the leading cause. This was followed by pneumonia, diarrhoea and injuries. Other risk factors include the absence of breast feeding and increasing malnutrition.

- ***Non-Communicable Diseases*** – self-reported prevalence of hypertension and diabetes in the Western Cape was 21.2 per cent (a 95 per cent confidence interval (CI) of 17.8 - 25.0) and 6.7 per cent (95 per cent CI of 5.2 - 8.6), respectively. Similarly, data from a study on chronic disease patients presenting at primary health care (PHC) facilities within the Cape Town Metro District (Western), showed that 36 per cent of patients were hypertensive, 12 per cent were diabetic and 4 per cent were mental health patients. On average, 260 000 scripts are issued monthly and 75 per cent of these are to clients residing within the Cape Town Metro District.

- **Mental health** – Psychiatric conditions resulted in a re-admission rate to psychiatric hospitals in the WC of 7.6%.

- ***Injuries*** – One of the greatest contributors to injury-related deaths were interpersonal violence and transport injuries. The Metro and Central Karoo revealed the highest mortality rates due to interpersonal violence, at 41.6 and 41.1 deaths per 100 000, respectively. In the remaining districts, rates ranged from 27.6 to 33.5 deaths per 100 000. Transport injury mortality rates were the highest in the Cape Winelands (30 per 100 000), Central Karoo (29.4 per 100

000) and West Coast (28.5 per 100 000) while Eden had the lowest mortality rate due to transport injuries (23 per 100 000).

The above-mentioned diseases and conditions, many of which are preventable, place a great strain on WCDoH resources and require the department to be more innovative in its approach to service delivery. The public health sector cannot cope with managing the burden of disease alone and has to find ways to collaborate with the private, NPO and other sectors to address the burden of disease. The next section offers a review of the service delivery platform.

4.2.2 WCDoH Service Delivery platform

The Western Cape Department of Health is responsible for implementing, managing or overseeing health matters emanating from legislative mandates such as the Constitution, which includes the following:

> The rendering of health services is a legislative competency by virtue of Schedule 4, Part A of the Constitution of the Republic of South Africa, 1996. In addition the following obligates the Department to render certain services: • Schedule 5, Part A of the Constitution empowers the Department with exclusive legislative competence on ambulance services. • Section 27(1) (a) of the Constitution obligates the Department to provide basic health services, including reproductive health care. • Section 27(3) provides that emergency medical treatment may not be refused. • Section 28(c) prescribes that children have the right to basic health services.

The Western Cape Constitution, Act 1 of 1998 states the following:

> This Constitution applies to the Western Cape. It is subject to the national Constitution, it is the highest law in the Western Cape. Section 78(2) (a) deals with protecting and promoting the interest of children in the Western Cape, insofar as health services are concerned. Section 81 (h)(ii) places a duty on the Western Cape Government to adopt and implement policies to actively promote and maintain the welfare of its communities by ensuring proper realisation of the right of access to:
>
> (a) Health care services;
>
> (b) Basic health care services, which provide a healthy environment for all children, frail and elderly persons.
>
> (Western Cape, 1998)

Further national legislation includes mandates for direct service delivery such as the National Health Act discussed in Chapter 3, legislation from health statutory bodies such as the Health Professional Council and the Nursing Council.

The WCDoH service delivery platform consists of an array of services designed and located to focus on person-centred quality care, integrated provisioning, and continuity of care throughout the life course of a patient. The following services are delivered within a specific platform:

- **Primary Health Care Services** form a component of the health system as the most critical component, as it serves as the entry point to the care continuum, and caters for the vast majority of patient contacts. It comprises three distinct but interrelated service delivery platforms which include Primary care services (PCS) at health facilities, Home- and community-based care (HCBC), and Intermediate care. This part of the service platform is the main component investigated for this study as this is where the current NPO outsourcing model is applied by the WCDoH. This platform is unpacked in greater detail later.
- **Acute hospital services** include district, regional and tertiary hospital services. The differentiation between the hospitals is usually dependent on the specialities, number of beds and specialist categories of available staff.
- **Specialised hospitals** include mental health and psychiatric hospitals, rehabilitation centres, tuberculosis services and TB hospitals, as well as oral health centres.
- **Specialised services** include emergency medical services and forensic pathology services.

These services are supported by critical support services departments such as people management; finance and supply chain; information and communication technology; infrastructure development; and professional support services.

The priority focus areas for intervention include:

1. Reducing Infectious diseases such as HIV/TB
2. Improving healthy lifestyles

3. Preventing injuries and violence
4. Improving maternal and child health
5. Strengthening women's health
6. Improving Mental Health (WC Healthcare 2030, 2014:2)

The service platform is dependent on the following partnerships:

- The City of Cape Town Municipality, for the provision of personal primary health care and environmental health services.
- Non Profit-Organisations, for the rendering of intermediate care and home- and community-based care (HCBC).
- South African Police Services, for forensic pathology and emergency medical services.
- Department of Transport and Public Works, for the delivery of health service infrastructure such as hospitals and clinics as well as the maintenance thereof
- Department of Social Development, for assisting with social ills as well as taking care of social demands.
- Department of Education, for cooperation in delivering health services to school children.
- Higher Education Institutions, for the training of health professionals as well as research and health service improvement projects.

4.2.3 WCDoH strategic direction

The strategic direction of the WCDoH is contained in a document called Health Care 2030 and was endorsed by the provincial cabinet of the Western Cape Government in 2014. The document emphasises the health system's responsiveness to people's needs and expectations; with careful consideration given to a person-centred, integrated and continuity of care and life course approach. The document outlines the vision, values and principles for the department and provides strategic direction over the next 15 years, as follows:

Vision

”The 2030 vision for the Western Cape Department of Health is: Access to person-centred, quality care. There are multiple perspectives to this vision. These perspectives include those of patients, staff, the community, the Department, spheres of government and strategic partners. To bring the vision for 2030 to life at a physical, intellectual and emotional level, we have attempted to describe in detail what the achievement of the vision will feel like for a range of role players, from patients to other stakeholders.”

Values

”The values of the Department are caring, competence, accountability, integrity, responsiveness and respect.

The challenge of the Department is how to make these values a living reality for each staff member across the Department as we move towards our vision for 2030. The leadership will lead this process by example.

Values are important in building a cohesive organisation and must be embedded in the organisational culture of the Department.”

Principles

”The principles underlying our vision and values are as follows:

1. Striving for person-centred quality of care
2. Adopting an outcomes-based approach
3. Commitment to the primary health care (PHC) philosophy
4. Strengthening the district health system model
5. Promoting equity
6. Operating with efficiency
7. Developing strategic partnerships”

Further to this, the document has eight strategic focus areas which include – **wellness approaches**, a move from health service delivery to client-centred care, leadership and governance, **services platform**, quality of care, support services and monitoring and evaluation.

In terms of the wellness approach, the document focuses on six priority areas which are reducing infectious diseases such TB and HIV; healthy lifestyles; violence and injury prevention; maternal and child health; women’s health; and mental health. The

service platform that includes primary health care services will be employed to execute the priority focus areas.

PHC services are identified as the most critical component of the service platform as it provides access to health care to a vast majority of clients seeking health care. PHC services include community-based services (CBS) and intermediate care. To deliver CBS and intermediate care, the document proposes formalising partnerships with NPOs. CBS is geared towards health promotion, rehabilitation and palliative care that supports wellbeing and self-management as well as the maintenance of wellbeing. Intermediate care, on the other hand, focuses on regaining function following illness; end of life care; and in-facility rehabilitation.

The department, together with its partners, will proactively engage communities and families to ensure improved health outcomes. Through NPOs and other public-private partnerships the department aims to provide access to the dependent population of the Western Cape. Such partnerships will ensure efficient and cost-effective health service delivery and will allow the department to operate within its budget.

The document indicates that NPOs and community-based organisations (CBOs) have over recent years become important providers of CBS and there will be a major expansion of these services and providers as the department moves towards 2030. The document further states that good structural governance and collaborative management will be key to achieving success in this area (Western Cape Department of Health, 2014:4-6)

4.2.4 Western Cape Department of Health Policy Direction

As previously indicated, the WCDOH as a public entity must align itself to national and international policy direction and goals to ensure its population receives the required healthcare according to local and global norms. The various international and national policies and goal statements are listed below:

International

- The millennium developmental goals
- The UN Convention on the Rights of People with Disabilities, ratified 3 November 2007

National

- Medium Term Strategic Framework (MTSF) 2014 – 2019
- National Development Plan 2030
- Negotiated Service Delivery Agreement
- National Health Systems Priorities: The Ten-Point Plan
- National Health Insurance
- Primary Health Care Re-engineering
- Operation Phakisa – Ideal Clinic Initiative of South Africa
- Human Resources for Health
- National Environmental Health Policy (GN 951 in GG 37112 of 4 December 2013)
- National Health Act: Publication of Health Infrastructure Norms and Standards Guidelines (No. R116 of 17 February 2014) and GN 512 of 30 June 2014
- National Health Act: Policy on Management of Public Hospitals (12 August 2011)

The WCDoH as part of the WC province subscribes to the following provincial strategic policy directions

- Provincial Strategic Plan (PSP) 2014-2019
- Western Cape Infrastructure Delivery Management System (IDMS)

4.2.5 Basic facts of Western Cape Service Delivery Platform

A brief synopsis extrapolated from the WCDoH Annual Performance Plan 2014/15 is presented below

- 2015 population figures indicate that the WC has a total population of 6.2 million.
- of which 4.7 million are dependent on the public sector.
- 454 PHC facilities, 26 intermediate care facilities, 79 NPOs provide services to the dependent population.

- 14.1 million clients visit PHC facilities; 7000 clients' accounts for NPO intermediate care facility admissions and 8.6 million clients were visited by community-based services NPOs.
- Services were delivered by about 7 300 PHC staff members in PHC facilities and 3671 NPO staff members.
- Of the R18.8 billion total WCDoH budget, 23% was spent on PHC services = ~ R4.3 billion, and 6% on CBS services.

In summary, it is important to note the strategic direction of the WCDoH as this makes the importance of certain services and service delivery methods clear. PHC services, for example, include community-based services which are currently largely driven by NPO outsourcing. The majority of health-seeking clients are also attended to via this platform as it focuses on prevention and promotion of wellness that is easily accessible as well as affordable to the communities.

4.3 Western Cape Department of Health NPO Outsourcing

NPO outsourcing is not only a WCDoH phenomenon, the practice is adopted well within the National Health Service outsourcing context. This section begins by discussing NPO outsourcing from a national perspective and continues with various aspects of WCDoH-NPO outsourcing application.

4.3.1 NPO outsourcing from a national perspective

The NPO outsourcing model in the WC is based on the principle of proactivity as well as reactively by engaging people in terms of preventing illness and promoting health. Health services delivered by NPOs on behalf of the department include community- as well as facility-based services. The WCDoH model brings into effect the national policy direction in bringing services closer to the people through primary health care service reengineering.

In 2010, the National Department of Health visited Brazil and Cuba to examine the primary health systems that these countries are implementing. The NDoH specifically went to these countries because it was identified that health outcomes on the PHC

level was of an acceptable standard. South Africa then was and is still struggling with poor health outcomes in areas such as HIV and TB prevention, chronic disease control, and maternal and child health. Following this visit, the national minister of health instructed that primary health care services should be reengineered and a discussion document was developed.

In this document the NDoH identified key role players to assist with improving health outcomes on PHC level. Because of their strategic position in society, NPOs play an important role, especially with the supply of community health and development workers. The PHC reengineering document proposed that a total number of 41400 community health workers (CHWs) would be required as part of the ward-based outreach teams. The CHWs would have to be employed by NPOs and would form part of teams that would deliver services in what was called health wards linked to formal health facilities. The CHWs in the ward-based teams would be responsible for screening; assessment and referral; Information and education; psychosocial support; and basic home treatment, and would support community campaigns and schools services. In terms of this document, NPOs would therefore play a crucial and an increasing role in improving health outcomes on the PHC platform. (National Department of Health, 2010:2-6).

4.3.2 A description of the NPO outsourcing model in the WCDoH

The current NPO situation with regard to contracting is described in this section. The indication is that the WCDoH has given much thought to and made an effort with formalising the NPO outsourcing processes. Three documents are reviewed here, namely the NPO service package of care, the home- and community-based care framework and the standard operating procedure for NPO transfer funding. These three documents lay the foundation and prescribe how the NPO outsourced model must be implemented in the WCDoH.

4.3.3 Western Cape Service Package of Care for NPO funding

The WCDoH places high value on partnerships with NPOs. According to the Service Package of Care for NPO funding, the WC has seven service priorities for which it seeks partnerships with NPOs. These areas are home-based care; nutrition; mental health; intermediate care; high HIV-transmission areas; lay-counselling; and NPO wellness-driven centres. The WC conduct what is called an external call for proposals every three years whereby it invites NPOs to submit business proposals to deliver the aforementioned services on behalf of the department.

The WCDoH enters into service level agreements with all successful NPOs. According to the SLA, NPOs have to fulfil certain obligations to ensure continuation of funding. One of the obligations is that NPOs have to employ suitably qualified staff to render the agreed services. The obligation of the department then is to provide funding to the NPO for services delivered.

The service package of care determines the staffing norms and services standards for each project. With this service package, the WCDoH ensures that the same standard of service is rendered throughout the WC at the same cost and staffing norms. The package also determines the type of training and qualifications NPO staff should have (Western Cape Department of Health, 2016/17:4-5).

4.3.4 Monitoring of NPO outsourced services

Once an NPO is regarded as a successful bidder for services, the WCDoH enters into an agreement with the NPO. To ensure value for money, the WCDoH monitors the contribution made by the NPO by assigning targets and performance indicators to the NPO. The performance is then monitored on a monthly as well as quarterly basis to ensure services are delivered as agreed. Once satisfied with the performance, the WCDoH transfers funds as agreed to the NPO for services delivered. Table 4.1 is an extract from the MDHS Performance Template (2016) of the indicators and targets assigned to NPOs for the 2016/17 financial year.

Table 4. 1: Extract Service Delivery Indicators for NPOs 2016-2017

METRO DISTRICT HEALTH SERVICES Performance Template TARGETS AND INDICATORS 2016 – 2017	
HAST	
Sub-programme: Counsellor Programme	
Indicator	**Target**
HCT clients per lay counsellor per day	10-12
No of clients prepared for Rx per Adherence Counsellor per month	(NPO to insert counsellings/month)
No of NPO coordinator visits per facility per month (1 co-ordinator per 20 counsellors)	1 visit/facility/month
No of male condoms distributed per month	20 per client
No of clients receiving follow-up counselling per counsellor per month	20
Female Condoms	100/counsellor/month
Sub-programme: NPO DRIVEN WELLNESS CENTRES (Previous Non-medical Site Projects)	
Indicator	**Target**
New HCT clients per day per team of 3 lay counsellors [using ACTS model]	45
No of male condoms distributed per month	15 000
No of outreaches to schools, institutions, companies, etc, per month	10
No of NPO coordinator or supervisor visits per centre per month	1 visit/month
Sub-programme: High Transmission Areas - Targeted Interventions - Special Group Projects	
Indicator	**Target**
Outreaches conducted as per SLA	95%
Support Groups conducted as per SLA	95%
Male Condoms distributed per month	35000
Female condoms distributed per month	1000
Sub-programme: Drug Resistant TB Counsellor Project	
Indicator	**Target**
Number of counseling sessions per NEWLY diagnosed client in the first month of treatment	2 counseling session
Support Groups as per facilitators (2 facilitators per group)	16 (different)/month
Defaulters recalled/phoned	90%

FACILITY BASED SERVICES	
Sub-programme: Breast Feeding Peer Counsellor Rehabilitation	
Indicator	**Target**
Number of group sessions presented	Minimum 2 per day per PC
Number of mothers attending group education sessions	10-15 per session
Number of individual education sessions	4 per day per PC
Number of mothers assisted with early initiation of breastfeeding (post-natal)	2 per day per PC
Number of community-based support group meetings held	2 per month per PC
Number of mothers attending support groups	3 per support group
Number of awareness day events assisted with	1 per PC per quarter
Early initiation of breastfeeding (breastfeeding started within 1 hour of birth)	80% of all mothers
Facility's exclusive breastfeeding discharged rates	75% of all mothers

COMMUNITY BASED SERVICES	
Sub programme: Community based nutrition rehabilitation	
Target	**Indicator**
Percentage of children receiving a growth monitoring and promotion assessment	100%
Percentage of children referred with SAM for management as per WHO 10 steps	100%
Percentage of children counselled on infant and young child practices and refer if needed	100%
Number of nutrition education sessions conducted to parents of caregiver per month	2
Number of training sessions conducted for CHWs per month	1
Number of support or adherence groups established per annum	20
Percentage of new children entered onto the programme (referred)	100%
Percentage of mothers/ caregivers referred to other programmes or Departments	100%
Percentage of successful exits of children rehabilitated and discharged within six months	80%
Sub-programme: Mental Health: Day Care Centre	

Indicator	Target
Attendance of funded clients per month	80%
Comprehensive Care Plan per client	100%
Sub-programme: Mental Health: Group Home Services	
Indicator	**Target**
Residents per group home per SLA	100%
Comprehensive Care Plan per client [with 6 MONTHLY revisions]	100%
Adherence to the individual care plan	80%
Sub-programme: Mental Health: Licensed Home	
Indicator	**Target**
Residents per licensed home per SLA	100%
Comprehensive Care Plan per client [with 6 MONTHLY revisions]	100%
Adherence to the individual care plan	80%
Sub-programme: Home & Community Based Care	
Indicator	**Target**
Number of house hold assessments per CHW per month	**5-20**- or depending on base line of the previous financial year.
Number of house hold allocation per CHW per annum as part of geographical care alignment	270
Headcounts per month per Community Care Worker	80-120
Number of clients per community care worker per day • Under 5 years incl. post-natal care • Over 5 year's incl. o Pregnancy care o Adherence support /wellness promotion o Home community based intermediate care	6-10 clients
Number of community outreach and mobilization drives in partnership with PHC facilities.	one per quarter
Percentage of appointed CHW's per month	95%
Percentage of CHW supervisory visits conducted by CHW coordinators per quarter	100%
Number of support Groups as per facilitators (2 facilitators per group)	16 different groups per month
Percentage of clients defaulting from care recalled and referred back to care	95%

The WCDoH applies formal criteria in terms of the aforementioned performance indicators, this means that NPOs must achieve these indicators in terms of the SLA. The NPO will report what they have achieved in their quarterly reports on a quarterly basis. The WCDoH reviews this performance and an NPO will either be found compliant or non-compliant with the set performance criteria. Continuous non-compliance can lead to suspension of funding.

4.3.5 Contributions made by NPO services to the service platform

Table 4.2 provides an indication of the current community based services contribution. The information indicates the significant contribution NPOs makes to health care service delivery. Data from the Home- and Community-Based Framework indicate that NPOs has conducted 7 085 531 home visits in the WC.

These home visits were conducted at the homes of clients with the single purpose of increasing access to health care. Currently NPOs are the only service delivery agent in the WC that have the capacity to enter into the homes of clients. Here in the homes NPO staff ensure clients adhere to treatment, promote health and prevent diseases through health education. The data in Table 4.2 were extrapolated from the WCDoH Home- and Community-based Care Framework (2015) and are presented by district and sub district as at end March 2014.

Table 4. 2: Contribution of NPOs to the service platform

District/Substructures	Total client visits	HBC Visits as % of total visits	Prevention visits as % total visits	Adherence Visits as % of total visits	Defaulter tracing visits as % of total visits
Cape Winelands	930599	32%	49.4%	18.9%	0.3%
Central Karoo	197604	59.1%	22.1%	10.3%	8.5%
Eden	682098	51.3%	22%	25%	1.7%
Overberg	544167	43.8%	33.1%	19.8%	3.3%
West Coast	798135	40.5%	37.1%	21.4%	1%
Khayelitsha/Eastern	969647	47%	28.2%	12.9%	11.9%
Klipfontein/MPlain	1672352	25.3%	56.5%	16.2%	2%
Northern/Tygerberg	993725	40.8%	30.2%	8.2%	19.8%
Southern/Western	297204	56%	32.5%	11.5%	2%
Provincial Total	**7 085 531**	**39.1%**	**37.5%**	**16.4%**	**7%**

Based on Table 4.2 and the number of clients attended to by NPO staff, there is no doubt that the current service makes a significant contribution to the PHC service platform. This indicates that a large gap will be left in the service platform should the service be stopped.

4.3.6 Current service coverage by NPO community-based services

Table 4.3 provides an indication of the current numbers obtained from the WCDoH HCBC Framework (2015) of NPO staff that the WCDoH is able to appoint via NPOs. The current funding norms allow the WCDoH to employ much more staff than it would have been able to do with the public service remuneration norms. The NPO outsourcing model has allowed the WCDoH to appoint 3671 Community health care workers, 167 professional nurses and 79 non-professional coordinators.

These workers dramatically increase the service reach of the WCDoH and the cost benefit not only to the WCDoH but also to the clients is visible. Nurses and community health workers working for NPOs take care of clients in their homes. This allows clients to be discharged from costly hospital care much earlier. That clients are supported in their own home environment is also beneficial to them in saving travelling costs to and from traditional health care facilities.

Waiting times for healthcare at hospitals are reduced as clients are discharged into a safety net at home where professional care can be provided. PHC facilities also benefit from the NPO services as minor procedures such as wound care is also done by NPO nurses at home. Adherence to treatment, health education and support groups facilitated by NPO staff also assist with promoting wellness, benefiting both the health care user and the health care system.

Seventy-eight per cent of the WC population is uninsured and dependent on the public health system. This amounts to 4 745 103 of the total population. Only 22% of the WC population can afford membership of a medical aid which allows them to access care at private health care institutions. The burden of public health care users places significant pressure on public health resources and the WCDoH has had to find innovative, cost-effective ways of dealing with the service pressures. The NPO outsourcing model is just one of the ways in which the WCDoH attempts to address service needs of communities.

Table 4. 3:NPO service coverage

Total Populatior	Circular H15/2013
Uninsured Popu	General H 2013/14 APP, Information Management
Households	Census 2011

SUB - DISTRICTS	Total Population	Uninsured Population	% Uninsured Population	Households	% share of households	No of funded CCWs 14/15	CCW/ uninsured population per 1000	No of NPO Prof Nurses	No of Non-prof Coordinators
Breede Valley	159 840	123 077	77%	42 527	21%	65	0.53	6	2
Drakenstein	213 788	164 617	77%	59 774	30%	97	0.59	5	5
Langeberg	120 501	92 785	77%	25 125	13%	58	0.63	2	3
Stellenbosch	185 116	142 540	77%	43 420	22%	68	0.48	6	4
Witzenberg	116 789	89 927	77%	27 419	14%	41	0.46	3	2
CW DISTRICT	**796 034**	**612 946**	**77%**	**198 265**	**100%**	**329**	**0.54**	**22**	**16**
Laingsburg	6 571	5 631	86%	2 408	13%	10	1.78	2	0
Prince Albert	9 102	7 800	86%	3 578	27%	30	3.85	1	0
Beaufort West	46 487	39 839	86%	13 089	69%	37	0.93	3	0
CK DISTRICT	**62 160**	**53 270**	**86%**	**19 076**	**100%**	**77**	**1.45**	**6**	**0**
Knysna/Bitou	112 206	95 375	85%	38 538	23%	60	0.63	2	10
Hessequa	47 168	40 093	85%	15 873	10%	44	1.10	2	0
Kannaland	29 461	25 042	85%	6 212	4%	34	1.36	2	0
Oudtshoorn	94 266	80 126	85%	21 910	13%	57	0.71	3	0
Mossel Bay	107 226	91 142	85%	28 025	17%	71	0.78	4	0
George	196 507	167 031	85%	53 551	33%	112	0.67	4	0
EDEN DISTRICT	**586 834**	**498 809**	**85%**	**164 109**	**100%**	**378**	**0.76**	**17**	**1**
Cape Aghulhas	30 286	25 137	83%	10 162	13%	40	1.59	4	0
Swellendam	29 680	24 634	83%	10 139	13%	35	1.42	3	0
Theewatersklo	99 643	82 704	83%	28 884	37%	99	1.20	7	0
Overstrand	88 064	73 093	83%	28 010	36%	70	0.96	4	0
OVB DISTRICT	**247 673**	**205 568**	**83%**	**77 195**	**100%**	**244**	**1.19**	**18**	**0**
Bergrivier	49 140	40 786	83%	16 275	15%	42	1.03	4	0
Cederberg	41 895	34 773	83%	13 513	13%	65	1.87	5	0
Matzikama	62 754	52 086	83%	18 835	18%	95	1.82	6	0
Saldanha Bay	92 959	77 156	83%	28 835	27%	60	0.78	4	0
Swartland	78 205	64 910	83%	29 324	27%	56	0.86	4	0
WC DISTRICT	**324 953**	**269 711**	**83%**	**106 782**	**100%**	**318**	**1.18**	**23**	**0**
Khayelitsha	446 305	348 118	78%	**118 810**	11%	314	0.90	13	6
Eastern	464 986	362 689	78%	144 467	14%	462	1.27	13	11
Mitchells Plain	545 364	425 384	78%	133 257	12%	324	0.76	9	15
Klipfontein	477 290	372 286	78%	96 613	9%	342	0.92	8	13
Southern	593 642	463 041	78%	155 174	15%	208	0.45	8	8
Western	448 535	349 857	78%	157 981	15%	172	0.49	6	5
Tygerberg	634 055	494 563	78%	**148 485**	14%	338	0.68	16	1
Northern	370 334	288 861	78%	113 786	11%	165	0.57	8	3
CT DISTRICT	**3 980 511**	**3 104 799**	**78%**	**1 068 573**	**100%**	**2 325**	**0.75**	**81**	**62**
PROVINCE	**5 998 165**	**4 745 103**	**78%**	**1 634 000**	**100%**	**3 671**	**0.77**	**167**	**79**

4.4 NPO governance in the WCDoH

The documents below provide strategic direction for NPO service outsourcing for financial and community-based services. The Home- and community-based care framework links to Heath Care 2030 and outlines how and by whom services should be provided in communities in the WC and the Finance instruction for NPO transfer funding stipulates how funding should be transferred to NPOs in line with the PFMA.

4.4.1 Western Cape Department of Health Home Community-based care framework

According to the WCDoH, Home Community-based Framework (HCBC) over seven million clients received care in the WC province through the HCBC programme in 2014. For the province alone, NPOs employ 3671 community care workers which serve 78% of the province's population classified as uninsured. The HCBC programme is built around the WCDoH's value principles, which are to ensure affordable health care; building strategic partnerships; equality; a strengthened district health service; following the PHC philosophy; client centred quality care; and a health outcome-based approach.

The service is proactive as well as reactive in nature; proactive though prevention and promotion, early identification and empowerment, reactive by providing home-based and intermediate care. The mode of delivery is through teams consisting of community health workers, rehabilitation workers and lay-counsellors supported by health professionals such as nurses, doctors, dieticians, social workers, and pharmacists (Western Cape Department of Health, 2015: 10).

4.4.2 Western Cape Department of Health Finance instruction for NPO funding

Finance instruction FA 21 of 2015 provides stipulations on NPO transfer funding. This instruction in line with the Public Financial Management Act (PFMA) requires officials and NPOs to manage public funds in a transparent and efficient manner preventing fruitless and wasteful expenditure. The instruction stipulates the requirements in force before funding can be transferred to NPOs. The requirements include that NPOs must be registered as "not for gain" with the Department of Social Development; must have

a tax clearance certificate with the South African Revenue Services; and have the necessary capacity to sustain services.

Funds can only be transferred once NPOs comply with the criteria. A strict monitoring system ensuring that public funds are used for agreed-upon public health services is in place through the instruction (Western Cape Department of Health, 2015:2).

In summary, reviewing and providing details of the Western Cape Department of Health gives an indication of the environment in which the investigation took place. As with any public service department, the WCDoH has to abide by the rules and regulations applied to any public service entity in South Africa. The WCDoH must deliver on its constitutional and legislated mandate by providing health care to the citizens of the province. According to the APP 2015/16 the Western Cape has a 78%-dependent population. This means that only 22% of the population are able to afford medical insurance, making the rest dependent on public services. It therefore is imperative to forge strong relationships with other sectors and organisations to assist with its mandate.

The indicated priority programmes provide an overview of the daily struggles of the health system with which the WCDoH has to deal. Many of the diseases and or injuries are preventable and the necessary lifestyle adjustments can enable the population of the WC to make a huge difference in how services can be shared. This, sadly, does not happen and preventable diseases and injuries place an additional burden on already scarce resources. South Africa is currently in an economic slump and this means that even public sector budgets are reduced. Health care users, however, cannot be reduced and it is a constitutional right of the population to receive basic health services. Juggling an ever increasing demand for health services with a decreasing budget requires new and innovative ways to deliver services. The WCDoH community-based care programme is one of those innovations that target clients before they come to formal health institutions such as hospitals and PHC facilities.

The aim of the programme is to prevent and to promote wellness and that is why it is important for the WCDoH to sustain this programme. The programme can reach numerous clients at a fraction of the cost that traditionally would have been paid for by formal health services. It therefore becomes important to look at the current NPO outsource model; identify areas of non-compliance with the Labour Relations

Amendment Act; and make the required adjustments. There is definite benefit to the current model of NPO services, as can be seen by the coverage. The WCDoH must also ensure that workers are not exploited, however.

4.5 Summary

The information provided in this chapter indicates where the WCDoH is; how the WCDoH operates; what its challenges are in terms of burden of disease; who its clientele is; what its plans to address the challenges in caring for its clients are; and finally, how and with whom it will address the challenges.

The WCDoH is one of the top public health care providers in South Africa. The department always strives to provide the population with the best care possible within the allocated funding envelope of the WC and others. The strategic direction contained in the road map called Health Care 2030 (WCDoH, 2014) is linked to the National Development Plan, as well as other strategic documents and goals, both nationally and internationally.

Cost benefit and forming partnerships with private providers is valued by the WCDoH as it has found that working together with other providers enables it to reach clients much more effectively. NPOs have traditionally been the entity to go to for service delivery as they, in many instances, are part of the community and have the best interest of communities at heart. It is for this reason that the WCDoH has forged such a strong working partnership with NPOs and has cemented the relationship in its policy and strategic direction.

Chapter 5: Research Methodology

5.1 Introduction

In this chapter, the research methodology which provides details of the study's classification; the sampling methods used for the study and data collection procedures as well as how data analysis was done is explained.

5.2 Methodology

The study is classified as an empirical study with a mixed design utilising qualitative and quantitative methods. The researcher examined secondary data by analysing existing policies, data bases, legislation and regulations. Babbie and Mouton (2001:374) discuss what is called unobtrusive research methods. This research method was applied to this study as content analysis of existing data and documents was conducted.

The purpose of the study required exploration and explaining, as the researcher explored the implications of the Labour Relations Amendment Act on NPO outsourcing models and tried to explain the financial and service coverage consequences. The unit of analysis comprised existing documents such as relevant policies, legislation, standard operating procedures and finance instructions applicable to NPO outsourcing in the WCDoH. Probabilistic sampling and theoretical selection were used to construct the sample used (Mouton, 2001:159).

Probability proportionate to size stratified sampling was used to interview relevant managers within the Metro District Health Services NTSS. The interview sample included one manager from each of the following categories - district manager, operational, finance, labour relations and human resources. Due to the standardisation of the application of NPO outsourced models in the WCDoH a representative sample of managers from the NTSS could provide an overview of how NPO service models are applied in the WCDoH. The limitations of this type of sampling is a lack of depth and insider perspective, as the analysis is confined to the surface level and is only based on the sample (Burger, 2015).

5.3 Data collection

Data collection included analysis of existing documentation; in this case, policies, standard operating procedures and legislation. Interviews with managers responsible for labour relations, people management and operations were also conducted to obtain their perspectives.

The service platform of the WCDoH, as indicated earlier, is divided into various levels of care. Due to the size of the WCDoH, the management of the various levels of services is organised and concentrated within these levels. This means that responsibility and accountability has been delegated and decentralised from the Superintendent General for Health to the heads of regions, districts, substructures and central hospitals. For this study, the focus was on the Cape Metro district health services (MDHS), one of eight health districts. The MDHS is the largest district and is further divided into four substructures consisting of two sub districts each. Each substructure in the MDHS is managed by a director with delegation to manage services in its totality.

The delegation for entering into agreements with external service providers and consequent funding allocation is within the ambit of the substructure. This makes stratified sampling possible and also investigation into one of the four substructures as each substructure separately enters into agreements with NPOs to provide services on behalf of the department. For this reason, the sample comprised the Northern Tygerberg Substructure only.

Out of the seven priority health services that are outsourced, only home- and community-based care, facility-based counselling and NPO wellness centres formed part of the sample for this investigation and the focus was on the following staff categories employed by NPOs – Project managers, NPO nurse coordinators, NPO supervisors, community health workers, administrators and counsellors. The principles and criteria for NPO outsourcing are applied universally within the WCDoH so it was possible to zoom into one area and investigate whether the Labour Relations Amendment Act of 2014 had implications for financial and service coverage sustainability.

Confidentiality and privacy of collected data were maintained by ensuring that electronic data were password protected, and hard copies locked behind closed doors with access confined to the primary researcher only. The anonymity of interviewed participants was maintained by the application of study codes that protect their anonymity. Study codes are linked on a separate electronic data spreadsheet and are stored with password protection in a separate folder.

5.4 Data analysis

Qualitative and interpretive analytic strategies were applied to analyse data.

5.5 Summary

Research methodology involves a systematic theoretical analysis of the methods applied to a field of study. The methodology for this study comprised systematic collection of data from a clearly identified sample and included the analysis of collected data.

Chapter 6: Documentary Findings and Analysis

6.1 Introduction

This chapter is divided into two sections. The first section analyses current documents applicable to NPO outsourcing and the second part provides a report and analysis of interviews that were conducted with management from the sample. Existing documents with regard to NPO service application in the WCDoH and funding norms, as well as financial implications, procedures and specifications were analysed.

This chapter zooms in specifically on the current funding envelope for NPO outsourcing and the services that can be procured with this funding in terms of staff numbers that enable service coverage. It then compares the current NPO funding norms to the public service norms in terms of staff remuneration and service coverage.

This chapter also presents an analysis of the stipulations of the Labour Relations Amendment Act, 2014, as well as a labour court judgment and how it relates to the current NPO outsourcing model. The chapter concludes with an analysis and interpretation of interviews conducted with managers in the NTSS.

6.2 WCDoH NPO outsourcing – findings, analysis and interpretation

Various aspects of NPO outsourcing in the WCDoH are discussed in this section. The section begins with an outline of the NPO outsourcing model, followed by funding norms, practices and standard operating procedures and concludes with differences in remuneration between NPO staff and public service officials**.**

6.2.1 Western Cape NPO Health Outsourcing Model

As indicated in the Chapter 4, the WDoH outsources or contracts NPOs for various services. The main reason for outsourcing is to render health services in a community that cannot be reached by traditional formal health services. These services include home- and community-based care; wellness centres; counselling services; intermediate care; and mental health services. These forms of outsourcing allow the WCDoH to increase its footprint in the community for improving access to health care at a reduced cost.

The criteria for application of the WCDoH model are contained in two documents that are based on legislative imperatives and WC health policies. These documents are:

a) The Western Cape Government: Health Service Packages for NPO Funding
b) The Western Cape Government: Health Standard Operating Procedure for NPO Funding Transfer Process (FA 21 of 2015) both documents are discussed below.

a) Service Packages for NPO Funding

The Service Packages for NPO Funding are reviewed annually and contain the funding norms for NPO outsourcing. The documents include the funding requirements, the general management rules and remuneration packages and ratios. The requirements, rules and remuneration for the WCDoH are determined before the start of each financial year and, once funding packages are approved, are usually set for the entire financial year.

Deviation from the package is not encouraged as it will have additional financial implications for the substructure which were not budgeted for. Once the process of concluding NPO adjudication processes and or performance evaluations are concluded, substructures issue the NPO with a funding allocation letter detailing the funding norms and the amount for the financial year.

NPOs that accept the funding and the accompanying conditions and obligations enter into a service level agreement with the WCDoH for a financial year, which, for the public service, runs from 1 April to 31 March. The following general funding requirements are contained in the package:

- The NPOs submit business plans which detail the planned activities and budget required for projects, in line with objectives set by the WCG Health Department.
- Funding will be allocated based on health service needs and according to the adjudication process.
- Funding received from the WCG Health may not be used for any other expenditure
- Monthly statistics and quarterly reports must be submitted per funded project to the WCG Health.
- All NPOs to be registered as “Organisations not for Gain” in accordance with VAT 414; Value-Added Tax Guide for Associations not for Gain (Non Profit Institutions) and

Welfare Organisations and must have a valid Tax Clearance Certificate and Declaration of VAT Exemption.

(Service Packages of Care for NPO funding 2016/17: 2)

General management of all services include the following:

- It is compulsory that the NPO Management attend the Substructure/District NPO meetings that are held 2 – 4 times per year (as structured per substructure/district).
- Monthly data submission by latest the 7th of the following month (i.e. December data submission by the 7th of January).
- Quarterly monitoring against targets and indicators with remedial steps in place to address unsatisfactory performance.
- Monthly financial reconciliations (including bank statements and proof of expenditures) must be submitted to the Substructure/District office by latest the 7th of each month (or first working day thereafter should the 7th fall on a weekend or public holiday) as specified in the funding allocation letter, in line with the Public Finance Management Act (PFMA, 1999) as amended.
- A quarterly report on the prescribed template, linked to the Monitoring & Evaluation (M&E) Plan must also be submitted on the dates as specified in the allocation letter.
- NPO rendering the services are accountable for any staff misconduct and non-compliance to all relevant policies.

(Service Packages of Care for NPO funding 2016/17: 2)

b) Standard Operating Procedure for NPO Funding Transfer Process (FA 21 of 2015)

The standard operating procedure (SOP) for transfer funding, which is also known as the finance instruction FA21 of 2015, outlines the transfer of funding process for the WCDoH (WCDoH, 2015). This document was developed with the single objective of ensuring standard application of NPO transfer funding procedures within the WCDoH. The SOP prescribes business processes as it relates to NPOs and must be applied by all Districts, Sub-Structures and Sub districts in the WCDoH that make use of NPOs as service providers.

The SOP is based on the following legislative requirements:

- The Public Finance Management Act, No. 1 of 1999 (as amended by Act 29 of 1999);
- Treasury Regulations for departments, trading entities, constitutional institutions and public entities issued in terms of the Public Finance Management Act, 1999
- The NPO Act, 1997
- The Companies Act 61/1973, Amendment 71 of 2008 (non-profit companies); and
- The Income Tax Act, 1962.

Analysis of the Service Package of Care and the FA 21 of 2015 indicate that the criteria and prescriptions contained can be regarded as one-sided in a sense that the WCDoH prescribes many criteria that service providers must comply with in detail, while the document falls short in terms of basic conditions of service that NPOs must comply with in terms of its employees. This is understandable as legislation in terms of public finances such as the PFMA dictates that financial accountability cannot be transferred. The WCDoH must therefore make sure that funding is used for the intended purpose and that NPOs must manage public funds in a transparent and responsible manner while preventing fruitless and wasteful expenditure. Health legislation similarly requires that the rights of the health care user must be upheld at all times; this includes safe practice and care by a qualified health care provider.

The documents therefore go into much detail as to how and by whom services must be delivered, as well as the working time, but are silent regarding the basic conditions such as leave and other service benefits of workers employed by NPOs. These basic conditions of employment are left for the application of the individual NPO in its own right. This might create a challenge for the WCDoH as the employer who is outsourcing is equally liable to uphold the rights of a worker under the Labour Relations Amendment Act.

6.2.2 Funding norms and service coverage

An analysis of the funding norms contained in the Service Package of Care for NPO funding 2016/17 as indicated in Table 6.1 allows the WCDoH to cover a larger service area, as the remuneration for NPO workers is considerably less.

Table 6. 1: Extract Funding norms- Service Package of Care for NPO funding 2016/17

Project	Category	Monthly cost	Annual cost
HOME AND COMMUNITY BASED CARE including integrated models of care for the chronically ill (4½ hours/day)	NPO Project Manager if >30 CHWs	R7 180	R86160
	NPO Coordinator (Professional/Enrolled Nurse) 1:15 - 20	R7 715	R92 580
	NPO Supervisor (Non-professional)1:15 - 20 for CHW supervision and/or support group facilitation	R3 605 – R3 858	R43 260 – R46 296
	CHW Band 1	R1 745	R20 940
	CHW Band 2	R1 886	R22 632
	CHW Band 3	R2 043	R24 516
(8 hours/day)	Rehabilitation Care Worker (RCW)	R6 032	R72 384
NUTRITION PROJECTS (4½ hours/day)	NPO Coordinator (Dietitian for Nutrition Rehabilitation project only)	R5 932	R71 184
	Supervisor (Breastfeeding Peer Counsellor project only)	R3 605 – R3 858	R43 260 – R46 296
	Peer Counsellor	R1 745	R20 940
FACILITY BASED COUNSELLING including club facilitation & Drug Resistant TB (DR-TB) (8 hours/day)	NPO Project Manager if >30 Counsellors	R7 180	R86160
	Supervisor 1:15 - 20	R4 375	R52 500
	Counsellor* (average stipend for 1 – 3 & >3 years)	R3 950	R47 400
NPO Driven WELLNESS CENTRES including PEAP	Professional Nurse (PN)	R16 195	R194 340
	Relief PN for 1 month	-	R16 195
	Counsellor* (average stipend for 1 – 3 & >3 years)	R3 950	R47 400
	Rental of premises (per site)	R2 920	R35 040
	Telephone & Traveling ***(Allocation for travel under Administration Costs below is Not Applicable to project)***	R1 860	R22 320
	Allocation for PEAP at fixed rate per substructure/district		
INTERMEDIATE CARE	Separate funding norms based on per bed/day and on whether there is outreach support or not		
COMMUNITY MENTAL HEALTH	Separate funding norms based on per capita and on the various services types		
HTAs (HIGH TRANSMISSION AREAS)	As per detailed approved Business Plan Not exceeding R730 000 pa per substructure/district		

Administration Costs	Cost Per Month	Cost Per Annum
Administrator	R1 925	R23 100
2nd Administrator or top up hours for EPWP if >30 CHWs	R1 925	R23 100
In-service training related activities	R45/CHW/counsellor	R540/CHW/counsellor
UIF 1% of total stipends paid	1% of total stipends paid	1% of total stipends paid
Uniforms once off per Counsellor/CHW/PN Coordinator	-	R670
Auditing fees once off per NPO	-	R10 000
Travel per Coordinator/Supervisor: <30km radius	R1600	R19 200
Travel per Coordinator/Supervisor: >30 km radius	R2400	R28 800
Travel per HCBC RCW	R850	R10 200
Administration Fee - 10% of Total Budget	10% of total budget	10% of total budget

The working hours of staff employed by NPOs are much more flexible; funding, for example, is only for four-and-a-half hours per day. The WCDoH is able to obtain the

skills of persons such as community health workers, counsellors, project managers and administrators who are not on the public service organogram at a fraction of the cost through NPOs. This enables the WCDoH to employ far more "warm bodies" through this outsourced model than it could if it had to employ staff categories from the traditional public service organogram.

Table 6.2 illustrates the difference in cost per staff category employed on the public service organogram versus the NPO model. As explained, some of the categories are not on the public service organogram, but post categories that perform almost similar functions are used for a comparison. Note that the public service salaries indicated below is for eight hours per day and that NPO employees work four-and-a-half hours per day with half an hour provided as a rest break. For the comparison, the remuneration norm for NPO staff categories are be multiplied by two.

6.2.3 Comparison of remuneration and benefits of NPO staff and Public service officials

Table 6.2 provides a comparison of salaries and an indication of the difference in remuneration between staff employed by NPOs to deliver outsourced health services and staff employed by the WCDoH under the Public Service Act 103 of 1994, referred to as a public service officers and defined as; "'officer' means a person who has been appointed permanently, notwithstanding that such appointment may be on probation".

It should be noted that NPO staff are employed for four-and-a-half hours per day of which the half hour is set aside as break time, meaning that working hours are calculated at 20 hours per week and 80 hours per month and are remunerated as such. Public officers, on the other hand, are employed for eight hours per day, therefore 40 hours per week and 160 hours per month. For this comparison and to compare apples with apples in terms of the salary calculation, the remuneration for NPO staff is calculated for four hours will be multiplied by two. Further to this, a skills comparison between the job function of NPO staff versus public officials was done to obtain the closest match. It must be emphasised, though, that this is only a comparison of assumed skills in terms of administration, supervision and current functions within the NPO project.

It must be noted that there are many more requirements attached to the scope and function of a job for public sector officials. These are requirements related to delegation, the professional statutory body, legislation and formal qualifications according to which the job comparison is rated differently. Furthermore, it is important to note that staff categories such as community health worker, NPO supervisor and counsellor are not on the public service organogram as post classes.

The employment requirements and criteria for the NPO staff categories differ largely from the requirements for those identified in the public service. It should be noted that the duties of a CHW employed by an NPO will include some elementary home based "nursing" care as well as health promotional activities. The CHW however is not registered with the South African Nursing Council and their activities cannot be regarded as "nursing", therefore the comparison is rather made between a CHW and health promoter. Health promoters employed in the public sector are not registered with any statutory body and it is therefore more applicable to do the comparison.

The comparison thus only gives an indication of what the cost would be regarding the situation should the service be done within the public service, taking all the aforementioned into account. The salary calculation below excludes service benefits enjoyed by public officials as part of their remuneration package. The salary scales is obtained from the Service Package of Care for NPO funding for NPO staff and DPSA website for public service officers.

Table 6. 2: Salary comparison NPO staff and Public service officials

NPO Staff	Basic Salary (annual)	Closest staff category comparison of public service officer	Salary (annual)	Difference in salary NPO contract and Permanent public staff
Project Manager	R 172 320.00	Admin Officer (level 7)	R 211 194.00	R -38 874
NPO coordinator/ Professional Nurse	R 185 160.00	Professional Nurse (Grade 2)	R 259 134.00	R -73 974
NPO Supervisor	R 92 592.00	Health Promoter (level 4)	R 119 154.00	R -26 562
Community health worker	R 49 032.00	Health Promoter (level 4)	R 119 154.00	R -70 122
Counsellor	R 94 800.00	Health Promoter (level 4)	R 119 154.00	R -24 354

Administrator	R 46 200.00	Senior Admin Clerk (Level 4)	R 142 461.00	R -96 261
Total	R 640 104.00		R 970 251.00	R -330 147

Table 6. 3: Benefits currently enjoyed by permanent public service officials

Government Employees Pension Fund employer contribution	13% of the monthly pensionable salary
Medical benefits	The State pays 75% of the employee's total monthly medical contribution on any selected option based on member profile and the member contribution
Housing benefits	R 1 200
Service bonus	Service bonus equals an employee's one month salary

Salaries and benefits of public officials are centrally bargained and the Department of Public Service and Administration ensures uniform implementation of these salaries and benefits. NPO staff benefits are based on previous baselines with an inflator added each year. Some NPO staff falls within the sectoral determination 4 that prescribes minimum salaries and benefits for community health workers currently contracted by the WCDoH.

NPO funding norms only make a contribution of 1% towards the unemployment insurance fund (UIF) and do not provide for any other benefits such as medical aid, pension and other service benefits.

Benefits for public service officials are indicated in Table 6.3. For the calculation of benefits, the "in lieu of benefit" calculation used for staff in the public sector is 37%. This was used to calculate the full cost of the employee package to be used. The total cost package that includes the basic salary plus benefit package is calculated at 37% of the basic salary and is calculated in Table 6.4

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Table 6. 4: Comparison between NPO staff and Public service officials - Salary with benefits

NPO Staff	Basic Salary (annual)	UIF (1%)	Total package	Closest staff category comparison of public service officer	Salary (annual)	in lieu of benefit(37%)	Total package	Difference
Project Manager	R 172 320.00	R 1 723.20	R 174 043.20	Admin Officer (level 7)	R 211 194.00	R 78 141.78	R 289 335.78	R -115 293
NPO coordinator/ Professional Nurse	R 185 160.00	R 1 851.60	R 187 011.60	Professional Nurse (Grade 2)	R 259 134.00	R 95 879.58	R 355 013.58	R -168 002
NPO Supervisor	R 92 592.00	R 925.92	R 93 517.92	Health Promoter (level 4)	R 119 154.00	R 44 086.98	R 163 240.98	R -69 723
Community health worker	R 49 032.00	R 490.32	R 49 522.32	Health Promoter (level 4)	R 119 154.00	R 44 086.98	R 163 240.98	R -113 719
Counsellor	R 94 800.00	R 948.00	R 95 748.00	Health Promoter (level 4)	R 119 154.00	R 44 086.98	R 163 240.98	R -67 493
Administrator	R 46 200.00	R 462.00	R 46 662.00	Senior Admin Clerk (Level 5)	R 142 461.00	R 52 710.57	R 195 171.57	R -148 510
Total	R 640 104.00	R 6 401.04	R 646 505.04		R 970 251.00	R 358 992.87	R 1 329 243.87	R -682 739

The comparison in Table 6.4 provides an indication of noticeable differences in the current benefits as well as salaries of NPO staff versus public service officials. Note that the Labour Relations Amendment Act requires benefits to be the same for contract employees and permanent employees of an employer.

In summary, whilst service benefits such as leave are more or less the same for public officials in comparison with NPO staff, other benefits such as medical aid, pension and service bonuses are excluded from the funding norms provided for NPO outsourcing.

When these benefits of NPO staff and public officials are compared, the significant difference in salaries paid through contracts versus staff employed on the public service staff establishment should be noted. Further the salaries of NPO staff do not include or make provision for benefits such as medical aid, pension fund, housing allowance and other service benefits enjoyed by public service employees.

6.3 Funding allocation and processes WCDoH

To gain understanding of how finances and allocated funding are managed in the public sector, this section unpacks the budgeting process in the public sector. The aforementioned will be followed by a discussion on current NPO funding allocations versus service coverage; the stipulations of the Labour Relations Amendment Act, 2014, compared to the current NPO outsourcing model in the WCDoH; as well as a discussion and analysis of the Labour Court judgement regarding community health workers in the Gauteng province and conclude with interviews with managers on aspects of NPO outsourcing practices in the WCDoH.

6.3.1 Budgeting in the public sector

In order to make any funding recommendation in the public sector, it is important to understand the budgeting process within the sector. According to Burger (2014:87), the functions of budgets in the public sector consist of policy making, planning, organising, directing and control, which, in fact, are the functions of public management. Burger further explains that a comprehensive budget consists of a combination of operating and capital budgets; the operational budget reflects the short-term financial needs for keeping the entity going and the capital budget reflects long-term capital investment planning to ensure financial sustainability, ensuring that investment in assets are prioritised and sequenced for supporting strategic objectives.

Public sector funding and budgets are enforceable after approval by the legislature. Revenue generation for public sector funding occurs through individual taxpayers who are compelled to pay taxes and other amounts owing, and must comply with any other requirements flowing from the budget. Public sector officials and managers can only operate within the boundaries of this budgetary approval and within the stipulations of the Public Finance Management Act (Burger, 2014:91).

As with all other provincial public service departments, the WCDoH is dependent on the provincial treasury to fund its services. Funding is allocated annually on the basis of a financial year commencing on 1 April and ending on 31 March of the following year. The funding calculation is dependent on the expenditure of the preceding financial year plus an inflator, as determined by treasury.

Once the National Minister has presented the annual budget speech – normally towards the end of February – it usually takes up to two weeks for departments to be allocated their individual budgets. The sources of funding are through the appropriation of voted funds; national conditional grants; and other special grants, as determined from time to time.

The WCDoH receives its budget through vote 6 and further apportions the budget according to eight budget programmes. Programme 2 is the budget programme for district

health services, under which the substructures fall. The budget is then further divided into sub programmes and the NPO budget is included in sub programme 2.4: Community-based services: 2.6: the HIV/AIDS conditional grant; 2.7: Nutrition; and 6.5: EPWP. The budget line item Non-Profit Institution Transfers (NPI) is where sub-structures will see their allocations under the aforementioned sub programmes.

An analysis of coverage with NPI funding allocation for 2016/17 using NPO Service Package Funding Norms for the Northern Tygerberg Sub-Structure is provided below, with the aforementioned process in mind and with a specific focus on the coverage of the service. This is followed by a comparison of coverage in terms numbers of staff with the current NPI funding allocation when public service salary and benefit norms are applied.

Once again' attention is drawn to the fact that current NPO Service package funding norms are calculated at four working hours and a half-hour break which make up the total four and a half hour calculation. For the comparison the aforementioned coverage was calculated using the NPO service package norms and the Public service salary and benefit norms at for an eight-hour working day divided by two.

6.3.2 Coverage with current NPI funding using NPO Service Package Funding Norms

Table 6.5 indicates service coverage as measured by the number of staff that can be employed. The core service delivery NPO staff members who actually deliver the service to clients are the nurses, counsellors and community health workers. The support for the core staff members comes from the project manager and administrators. NPOs receive a 10% administration fee for office activities and requirements. The current deficit indicated in the funding is normally covered during the adjustment period in the mid-financial year.

Table 6. 5: Current NPO funding norms and coverage in terms of NPO staff employed vs. current budget allocation

Budget Allocation 2016/17 NTSS	HCBC	2.4	R 5 968 971.64
Service Package for NPO Funding 2016/17	AIDS:HCT	2.6	R 5 340 000.00
	NUTRITION	2.7	R 557 000.00
	EPWP	6.5	R 10 070 000.00

					TOTAL		R 21 935 971.64
							12
(A)Staff Categories	Project Manager	Number of allocated staff per unit	14	Monthly cost per unit	R 7 180.00	Annual cost per unit	R 1 206 240.00
	NPO Coordinator /PN		28		R 7 715.00		R 2 592 240.00
	NPO Supervisor		28		R 3 858.00		R 1 296 288.00
	CHW Band 1		479		R 1 745.00		R 10 030 260.00
	CHW Band 2		22		R 1 886.00		R 497 904.00
	CHW Band 3		41		R 2 043.00		R 1 005 156.00
	Counsellor (Nutrition + HCT)		93		R 3 950.00		R 4 408 200.00
	Administrator		29		R 1 925.00		R 669 900.00
							R 21 706 188.00
(B)Administrative cost	In service training allowance /CHW		542		R 45.00		R 292 680.00
	UIF 1% of total stipends paid						R 217 061.88
	Uniform allowance once off /Coordinator/CHW/RCW/Supervisor		691		R 670.00		R 462 970.00
Total budget (A+B)							**R 22 678 899.88**
(C)Administration fee 10% of total budget							**R 2 267 889.99**
Total budget (A+B+C)							**R 24 946 789.87**
				Deficit current funding			**-R 3 010 818.23***

*Note indicated deficit in current budget allocation 2016/17 for NTSS, the shortfall is absorbed in the broader MDHS budget allocation. For further calculation purposes the actual NTSS NPO budget allocation will be used.

6.3.3 Coverage with current NPI funding using Public Service Salary and Benefit Norms

In the analysis presented in Table 6.6, the staff numbers are reduced significantly to remain within the current funding norms. In this analysis there is still a slight shortfall of R 48 448.36. Note that the below calculation is based on a four hour working day instead of the eight hours in terms of public sector salary calculations and staff numbers is significantly reduced.

Table 6. 6: Staff coverage in terms of numbers with current NPO financial allocation applied to public service salary norms

Budget Allocation 2016/17 NTSS				HCBC	2.4	R 5 968 971.64
				AIDS:HCT	2.6	R 5 340 000.00
				NUTRITION	2.7	R 557 000.00
				EPWP	6.5	R 10 070 000.00
Public Service Salary and Benefit Norms (4hrs)				TOTAL		R 21 935 971.64
						12
(A)Staff Categories	Admin Officer	Number of allocated staff per unit	2	R 12 056.00	Annual cost per unit	R 289 344.00
	Professional Nurse Grade 2 (Coordinator)		5	R 14 792.00		R 887 520.00
	Health Promoter (Supervisor)		5	R 6 801.00		R 408 060.00
	Health Promoter (CHW bands 1-3)		193	R 6 801.00		R 15 751 116.00
			0			R 0.00
			0			R 0.00
	Health Promoter (Counsellor)		45	R 6 801.00		R 3 672 540.00
	Senior Admin Clerk (Administrator)		10	R 8 132.00		R 975 840.00
						R 21 984 420.00
(B)Administrative cost	In service training allowance /CHW		0	R 0.00		R 0.00
	UIF 1% of total stipends paid					R 0.00
	Uniform allowance once off /Coordinator/CHW/RCW/Supervisor		0	R 0.00		R 0.00
Total budget (A+B)						**R 21 984 420.00**
(C)Administration fee 10% of total budget						**R 0.00**
Total budget (A+B+C)						**R 21 984 420.00**
				Deficit current funding		**-R 48 448.36**

6.3.4 Service coverage with current NPO staff numbers using Public Service Salary and Benefit Norms

There is a significant shortfall in funding in the analysis presented in Table 6.7. The deficit in funding is R 41 998 240.36 when 100% of the NPO staff is absorbed in this analysis with 100% service coverage. This will require the WCDOH to source/ request additional funding from treasurer which may not be possible given the current struggling financial

environment. Attention is drawn that this calculation shortfall is only for the NTSS and will have to be duplicated for other sub-structures and districts in the WC and even nationally which might not be affordable for the public health sector. This calculation also excludes the 10% admin fee that will normally be given to NPOs to cover their administrative cost. Further CHW bands are grouped together as this doesn't apply in the public sector salary scales.

Table 6. 7: Staff coverage with current NPO staff numbers using public service salary norms

			Number of allocated staff per unit	Monthly cost per unit		Annual cost per unit	12
(A)Staff Categories	Admin Officer		14		R 12 056.00		R 2 025 408.00
	Professional Nurse Grade 2 (Coordinator)		28		R 14 792.00		R 4 970 112.00
	Health Promoter (Supervisor)		28		R 6 801.00		R 2 285 136.00
	Health Promoter (CHW bands 1-3)		542		R 6 801.00		R 44 233 704.00
			0				R 0.00
			0				R 0.00
	Health Promoter (Counsellor)		93		R 6 801.00		R 7 589 916.00
	Senior Admin Clerk (Administrator)		29		R 8 132.00		R 2 829 936.00
							R 63 934 212.00
(B)Administrative cost	In service training allowance /CHW		0		R 0.00		R 0.00
	UIF 1% of total stipends paid						R 0.00
	Uniform allowance once off /Coordinator/CHW/RCW/Supervisor		0		R 0.00		R 0.00
Total budget (A+B)							**R 63 934 212.00**
(C)Administration fee 10% of total budget							**R 0.00**
Total budget (A+B+C)							**R 63 934 212.00**
					Deficit current funding		**-R 41 998 240.36**

6.3.5 Deficit in terms of staff numbers for service coverage when the current NPI funding is applied to current public service remuneration norms compared to the NPO service package norms

The deficit in terms of service coverage when comparing the public service remuneration norms to the NPO service package is presented in Table 6.8.

Table 6. 8: Service coverage deficit in terms of staff numbers with current NPO funding when public service salary norms is applied

NPO staff per category	Total number employed with current funding (X)	Public service staff category	Total number employed with current funding (Y)	Staff coverage deficit	Service coverage
Project Manager	14	Admin officer	2	-12	14%
NPO Coordinator	28	PN	5	-23	18%
NPO supervisor	28	Health Promoter	5	-23	18%
CHW Band (1-3)	542	Health Promoter	193	-349	36%
Counsellor (Nutrition+HCT)	93	Health Promoter	45	-48	48%
Administrator	29	SAC	10	-19	34%

With current funding the NTSS is able to employ staff numbers as indicated in column (X), however should the WCDoH be required to employ NPO staff on current public service salary scales to comply with amendment act it will only be able to employ the staff numbers indicated in column (Y) with current NPO funding. Notably, the NTSS will only be able to cover 36% of service need in terms of community health worker services with the public service norms, which means that 64% of the service will not be covered. In terms of the professional nurse category, which is important for ensuring care coordination, only 18% of the service will be covered. The current PN:CHW ratio specification in the Service Package of Care is 1:20. If the same specification is applied here, 93 CHWs will be unsupervised. There will be a 52% gap in counselling services to clients requiring counselling and health education services

In terms of administration support, which is vital for the submission of performance data, overall operational and resource management, there will be a shortage of 86% in the project manager and 66% in the administrator categories.

6.4 Analysing the stipulations of the Labour Relations Amendment Act 2014 and the current situation with regard to the WCDoH NPO outsourcing model.

The Labour Relations Amendment Act Amendments stipulate substantive amendments to protect three categories of workers, which include: temporary employment service workers, fixed-term employees, and part-time employees. These amendments to the Act create a balance between the need to protect the vulnerable and the need to permit short-term flexibility. Sections 198A and 198B extend significant protection, in particular to employees earning below the BCEA threshold. The majority of these protections only apply to employees after they have been in employment for more than three months.

The aforementioned sections were analysed as these stipulations have a direct impact on NPO outsourcing in the WCDoH. This is presented in Table 6.9. Particulars with regard to the BCEA threshold are analysed afterwards.

Table 6. 9: Analysis of the current WCDoH NPO service outsourcing models compared to Labour Relations Amendment Act stipulations

Stipulation of the Labour Relations Amendment Act 2014	The current situation with regard to the WCDoH NPO outsourcing model
Section 198 A In terms of section 198A(1), "temporary services" is defined as only one of three things, these being: 1. services limited to a fixed time period of not more than three months, or 2. where the employee is substituting for a temporarily absent permanent employee of another employer, or	Contracted NPO employees fall outside the definition of the TES and annual salaries are below the prescribed BCEA threshold. **The BCEA threshold** Mildred Oliphant, the Minister of Labour, acting in accordance with S6 (3) of the Basic Conditions of Employment Act (BCEA), increased the annual earnings threshold to R205 433.30 from the

3. where a particular work category is designated as a temporary service, or the maximum temporary period is determined by way of a collective agreement in a bargaining council or by way of a sectoral determination. Section 198A(2) stipulates that the provisions of Section 198A would only apply to those employees earning less than the threshold prescribed in terms of Section 6(3) of the BCEA from time to time. Section 198A (3) records that only those employees falling under the ambit of "temporary services" as defined will be regarded as actual employees of the temporary employment service itself. Employees that fall outside the ambit of the definition are deemed to be employees of the client of the temporary employment service and not employees of the temporary employment service. i.e. If a labour broker supplies you (the client) with an employee and this employee does not fall within the above definition, this employee will be deemed to be your permanent employee, irrespective of the agreement between your company and the labour broker. Join and equal liability between the client and the labour broker – An employee has recourse to refer both you (the client) and the Labour	previous figure of R193 805.00 on 1 July 2014. Sectoral determination 4 – EPWP is currently the basis for employment of community health workers; however, a number of other categories of workers contracted through the model are not covered by the sectoral determination. Furthermore, almost 50% of all CHWs are not funded from the EPWP funding, meaning that they are also excluded from this determination. The WCDoH by implication can be seen as the employer of the NPO workers when the amendments are applied to the outsourcing model.

Broker to the CCMA or Labour Court regarding any labour disputes. I.e., should an employee be employed for a period longer than three months by a Labour Broker in your company, and the employee is subsequently dismissed, the employee would be able to institute action against both you, the client, and the labour broker. Deemed employees must have the same employment conditions as all other employees of the client – i.e. An employee employed through a labour broker or an employee on a fixed-term contract exceeding three months would have to receive the same benefits (Pension, Medical, Leave Conditions, Bonuses, and any other benefit given to employees due to their association with the company) as received by permanent employees of the client.	
Section 198 B Fixed-term contracts cannot exceed three months, unless justifiable reasons can be shown, such as: If the employee replaces a permanent employee of an employer that is temporarily absent; If there is a temporary increase in the volume of work of an employer, provided the contract is then not for a period of more than 12 (twelve) months;	Currently all contracts with NPO employees are for 12 months. None of the justifiable reasons for fixed-term contracts is applicable to the WCDoH outsourcing model. NPO staff in terms of the model does not replace any permanent worker but is contracted to increase the service delivery capacity of the WCDoH that allows for increased access to health care.

If the employee is a student or recent graduate being trained for a profession; If the employee is exclusively employed on a specific project that has a limited or defined duration; If the employee is not a citizen and the employment is linked to the period of the employee's work permit; If the employee performs "seasonal work"; If the employee is engaged in an official public works scheme or public job creation scheme; Where the position the employee occupies is funded by an external source for a limited period; If the employee has reached normal or agreed retirement age; A fixed-term contract that exceeds three months without a justifiable reason would result in that employee automatically becoming a permanent employee of the organisation. Fixed-term employees working for longer than three months must receive the same benefits as all other permanent employees – unless a justifiable reason to differentiate in terms and conditions exists, such as length of service, seniority and qualifications. Should a fixed-term contract run in excess of two years, an employee would be entitled to	If the amendments are applied to the NPO outsourcing model as a result, NPO employees might be regarded as employees of the WCDoH. The application of this will have a negative impact on funding as well as service coverage for the WCDoH.

severance pay equal to one week's remuneration for every full year of service upon termination of employment.	

6.5 Analysis of Labour Relations contract employment disputes

Notwithstanding the stipulations of the Labour Relations Amendment Act of 2014, as analysed above, a number of employment contract disputes which were brought before the CCMA and the Labour Court of South Africa to settle disputes with regard to contract employment is available on the website of the CCMA. There was one particular case most applicable to this investigation found on the website of the CCMA which cover the following

- employees who fell outside the definition of an employee, as contemplated by the LRA;
- temporary employment service, as contemplated by the Labour Relations Amendment Act who earns below the remuneration threshold of the as contemplated by the BCEA.

In this case five community health workers (applicants) contracted by the Gauteng Department of Health (GDoH) (respondent) applied to the court for a decision on whether their contracts were contracts of employment or contracts of provision of services by independent contractors.

The applicants were initially employed on a six-month contract followed by a 24-month contract with expiration date 31 March 2016. The respondent, however, on the 4th of January 2016 requested the applicants to apply for the positions they were in. The advertisement for their positions appeared in local newspapers on the 10th of January 2016. The applicants disputed this and brought an urgent application to the court on 19th February 2016. The matter was heard by the court on 11 March 2016. In their application the applicants contended that they were employees of the respondent as contemplated by the Labour Relations Act, 66 of 1995 (LRA). The respondent, on the other hand,

refuted this and argued that the applicants were independent service providers who provided services as volunteers that consequently fell outside the definition of an employee.

The LRA defines an employee as

"any person, excluding an independent contractor, who works for another person or for the State and who receives, or is entitled to receive, any remuneration; and any other person who in any manner assists in carrying on or conducting the business of an employer, and 'employed' and 'employment' have meanings corresponding to that of employee."

(Republic of South Africa, 1995, p: 3)

The respondent further indicated that, because the applicants fell outside the definition of an employee the case had to be dismissed and that it was not a matter for the Labour court as it fell outside its jurisdiction. In determining whether the applicants were indeed employees, the court applied three primary criteria which were:

1. An employer's right to supervision and control
2. Whether the employee forms an integral part of the organisation with the employer
3. The extent to which the employee is economically dependent upon the employer

The court determined that the presence of one or more of the above factors would generally be sufficient to establish whether a person is an employee or not. (Labour Court of South Africa, 2016:1-8).

As mentioned earlier, details, findings and the order by the court in this case have a direct impact on the current NPO outsourcing model applied in the WCDoH the model applied in GDoH is similar here in the WCDoH. Findings and deliberations included in the Labour Court of South Africa, Johannesburg Judgment case no: J 352/16 are analysed and compared to the WCDoH NPO outsourcing model in Table 6.10.

Table 6. 10:Labour court judgement and order on implication GDoH compared to WCDoH NPO outsourcing

Details of Judgment case no: J 352/16	Details of WCDoH NPO outsourcing model
1.The applicants were working on behalf of the respondent under a Service Level Agreement according to which they rendered care to clients of the respondent that included the following: (1) targeting individuals and households (2) submitting monthly plans and reports (3) performing duties at other places that were required by the respondent (4) reporting to the NPO to which the CHW was assigned in households.	Like with the WCDoH NPO outsourcing model, applicant CHWs in the WCDoH are appointed by NPOs to render health services to communities. Typically, the service clients requiring care would be referred to NPOs and care would be executed by NPO-employed staff. The WCDoH also has a structured process or manner in which they prescribe what and how services/ care should be rendered. The stipulations of how care should be rendered are contained in what is called a Service Package of Care for NPO funding.
2. For this service, the respondent paid them a salary and they could therefore not be described as volunteers, as the respondent portrayed them. The respondent furthermore portrayed the applicants as independent service providers who were not employees although the respondent applied control over their services, much as it would with its permanent employees, requiring the applicants to oblige, by reasonable, lawful instructions, to perform work required by the respondent.	Similar to the WCDoH outsourcing model, the Finance Instruction FA 21 of 2015, as amended, prescribes the process of how funding must be transferred to NPOs for the payment of NPO staff. The Service Package of Care and the funding norms furthermore prescribe the salary/ stipend amount for each NPO staff member employed to render care to clients on behalf of the WCDoH. NPO staff will only receive a stipend/ salary if the NPO can provide proof that the staff member has performed delegated care to clients.

3. The fact that the employer portrayed the applicants as independent contractors was refuted as their activities were directed by team leaders (nurses employed by the respondent) based at clinics and therefore were not unsupervised or independent, as the respondent alledged	As in the WCDoH outsourcing model, health professionals in the permanent employ of the WCDoH will typically refer clients to NPO staff for care. The referral is detailed and contains what, how and when care must be provided. This means that NPO staff are instructed and directed by the employees of the WCDoH about what care to provide. NPO staff is also required to provide feedback to WCDoH staff on referred client progress. In many instances, NPO staff would form part of the continuum of care and is seen as part of what is called a Multi-disciplinary team.
4. The focus of the court went beyond the dispute resolutions contained in the SLA and highlighted the actual working relationship between the applicants and the respondent. Concluding that the dispute resolution applied to the NPO and respondent and the provisions do not indicate how a dispute of this nature should be resolved.	As in the WCDoH outsourcing model, NPOs would enter into a Service Level Agreement as an organisation. The SLA would typically state the obligations of the WCDoH towards the NPO and vice versa; the SLA does not address the obligations of the WCDoH towards the NPO staff. This means that, should a dispute arise between the NPO staff and the WCDoH, the SLA cannot be used as a dispute resolution instrument.
5. The court found that even though a major goal for employing CHWs is as part of the skills development programmes (Expanded public works programme) doesn't remove CHWs from the realm of being an employee as the provision of	As in the WCDoH outsourcing model, the WCDoH model would also typically make allowances for the upskilling of NPO staff. The WCDoH would enter into agreements with external training providers and or provide in house training. This training

training is usually an indicator of employment and not of an independent contractor. The court emphasised that workers employed in terms of learnership agreements under the Skills Development Act 97 of 1998 are regarded as employees on fixed-term contracts and must receive protection under the labour law for the duration of their contracts. The respondent aiming to deny the applicants the status of employee because of training provided was therefore not justified.	normally is to ensure that NPO staff is competent and skilled to provide care to clients on behalf of the WCDoH.
6. The respondent argued that the project was dependent on annual funding that it must apply for via a conditional grant and therefore the project was funding dependant. The court found that this is not unique to this project and that the funding application could be applied to many other categories of workers in the public sector. The funding of services is therefore not a determining factor when ascertaining whether a person is an employee or not.	As in the WCDoH outsourcing model, the argument would be similar in the WCDoH as NPO funding typically is obtained through either the EPWP programme, the HIV conditional grant and/ or from the equitable share. However, as indicated by the court, this means of obtaining funding is not unique and would apply to permanent employees of the WCDoH as well.
7. The argument by the respondent that CHWs, in terms of good public policy, did not undergo vetting as with persons employed by the respondent. The court found that it was well for the respondent to implement such a process to protect the public, but this argument did not	As in the WCDoH outsourcing model, this argument would probably be similar in the WCDoH. Currently, only permanent employees of the WCDoH undergo a formal vetting process that includes police clearance and vetting of qualifications. NPO staff is not regarded as employees

detract from whether a person is regarded as an employee or not.	of the WCDoH and therefore the vetting process does not apply to them.
In conclusion, the order delivered by the court on the 18th of March 2016 declared the applicants employees of the respondent as contemplated by the Labour Relations Act, 1995. The stipulations of the Labour Relations Amendment Act in terms of the change in definition of temporary employment services links up well with the deliberations of this court case. CHWs here have been employed for more than three months on fixed term contracts however did not enjoy the same benefits or regard in terms of their status of employment as contemplated by the amendment act in Sections 198(A) and (B).	
Application of the aforementioned court deliberations and judgement has serious implications for the WCDoH NPO outsourcing model. The current services of CHWs are also obtained through NPOs through which a SLA is entered into. The obligations stipulated in the SLA is also similar in the sense that the dispute process stipulated in the SLA is mostly confined to the NPO as an organisation and does not address disputes arising between the employees and the employer. In terms of the criteria applied by the labour court that were used to ascertain whether CHWs can be regarded as employees given the circumstances and their relationship with the respondent, these criteria are also applicable in the WCDoH NPO outsourcing model. The similarities in terms of the WCDoH NPO outsourcing model is can be a cause for concern, given the reliance on this model for service delivery, and may have implications for the WCDoH in future.	

6.6 Findings from and Analysis of Stakeholder Interviews

To obtain a more in-depth view of the practical application of NPO outsourcing models a group interview was conducted with the senior and middle managers of the NTSS. The group consisted of the director and managers for primary health care, pharmacy, hospital, finance and supply chain, human resources and professional support.

6.6.1 The interview process

Following a request to the Director for the Northern Tygerberg Sub-Structure a thirty-minute slot was granted to interview managers during the monthly management meeting. The total number of managers interviewed was seven (n7). Preliminary findings from the data analysis that had been conducted by the researcher were presented and included only the following:

1. The South African Labour Court, Johannesburg Judgement and order which was specifically selected to obtain responses from managers with regard to the Labour court Judgement and order and its possible implications for the WCDoH/NTSS.
2. Sections 198A and 198B of the Labour Relations Amendment Act of 2014 were selected from the preliminary data analysis to discuss and solicit feedback as well as to obtain an understanding from managers with regard to the stipulations pertaining specifically to the change in the Act in the definition of temporary employee services as well as fixed term contracts
3. Three possible options on how to ensure compliance with the Labour Relations Amendment Act, 2014 was provided to the group to gain understanding from managers of what in their opinion is a possible solution given current realities.

Further to the above, an interview questionnaire was used by which managers were requested to answer questions individually. This consisted of four areas in which

- Area one consisted of two questions with regard to service contributions and whether NPOs add value to the current service platform. A snapshot of

contributions made in terms of service delivery by NPOs during the 2015/16 financial year was presented to managers, followed by two questions.

- Area two aimed to obtain responses with regard to the Labour Relations Amendment Act and particularly with regard to section 198A and section 198B. A snapshot of preliminary findings was presented, followed by three questions.
- Area three aimed to obtain opinions on the South African Labour Court Judgement and consisted of three questions that managers had to answer individually following a snapshot presentation of findings.
- Area four aimed to obtain opinions on affordability of recommendations, as well as the feasibility thereof. This area consisted of three questions that were posed to managers following a snapshot presentation of three recommended options.

6.6.2 Findings and Analysis

Findings and analysis of the seven (N7) managers that were interviewed is provided in four (4) areas which pertain to NPO service delivery and its value, the implications of the Act, the Labour court judgment and responses to presented options to become compliant to the Act.

Area 1: NPO service delivery and value add

(Finding) All managers interviewed responded that NPOs do add value to the PHC service platform and all of the managers felt that the WCDoH/NTSS will not be able to deliver the services without the assistance of NPOs.

(Analysis) This is a clear indication that the management of the NTSS see the NPO services as contributing to the service delivery objectives of the substructure and further indications are that, should the current services rendered by NPOs for some reason be taken away, it would result in a service gap.

Area 2: The Labour Relations Amendment Act of 2014

(Finding) Six (6) of the seven managers interviewed indicated that they were aware of the Labour Relations Amendment Act of 2014 and of the changes in stipulations with regard to fixed-term contracts and what the Act regards as temporary employment services. One (1) manager indicated non-awareness of the Act.

(Analysis) This means that the majority of managers are aware of the possible implications that section 198A and 198B can have for service delivery coverage and funding within the substructure. Furthermore, when the Act was promulgated, three (3) months was granted to ensure compliance with the amendments, but the current contracting of NPO services and staff has not changed since the Act came into effect on 1 January 2015.

(Finding) Six (6) of managers responded 'yes' to the question when they were asked whether NTSS/WCDoH should apply the amendments. One (1) manager reserved comment.

(Analysis) This is an indication that the majority of managers want to become compliant with the Act. One manager has reserved comment due to concerns about the cost implications of becoming compliant.

(Finding) Five (5) managers responded 'yes' when they were asked whether the amendments would have negative implications for the current NPO outsourcing/contract models in the NTSS/WCDoH. One manager responded 'no' to the question and one manager reserved comment.

(Analysis) The majority of managers are concerned about the implications of the amendments for the current model. The major concern related to financial implications for the NTSS/WCDoH as the current outsourcing model is cost effective. Once amendments have to be applied, the current funding allocation would have to increase drastically. One manager was not concerned and another reserved comment

Area 3: Opinions on the Judgement and Order by the South African Labour Court in which the Gauteng Department of Health was the respondent

(Finding) All managers interviewed responded 'yes' to the question of whether NTSS/WCDoH should be concerned, given the similarities of the judgement compared to current NPO outsourcing models applied here**.** All managers interviewed agreed that details described in the labour court judgement were similar to WCDH/NTSS outsourcing models. All managers agreed that, should a similar situation unfold in the WCDoH/NTSS, the judgement and ultimate court order might apply here as well.

(Analysis) Concluding from managers' responses, there is agreement that the current manner in which NPO outsourcing is done might be cost effective but infringes on the Labour rights of NPO employees. This means that in light of this court order the current status quo in the NTSS/ WCDOH cannot remain and financial and other provisions have to be made to ensure compliance with South African labour laws.

Area 4: Response to recommended possible options towards becoming compliant to the Act

(Finding) All of the managers interviewed responded 'no' to the question whether the WCDoH can afford to appoint staff on a permanent basis. All, however, answered 'yes' when asked whether the NTSS/WCDoH should start making provisions to absorb NPO staff as permanent employees, given the court order. Managers also all agreed that the WCDoH has to start making provisions to become compliant with the Labour Relations Amendment Act. Finally, managers were given three options in this area (Tables 6.11, 6.12 and 6.13) for becoming compliant with the Act.

The options were presented as compensation of employee budgets using current public service remuneration norms for options 1 and 2 and current Service Package for NPO funding norms for option 3. The justification for the calculations is as follows and used (a) working hours and (b) grading of posts to suit the current existing public service staff categories. For options 1 and 2, organisational structures must also be considered for configuration as the current NPO outsourcing configuration has no line management

function within the public service. The imperatives for organisation structure configurations are discussed under (c) Considerations for organisational configurations.

a) Working hours as proxy for salary calculation

It is within the power of the public service and the Head of the WCDoH to determine the working hours of staff as long as it does not exceed the stipulations for working hours. In this option, the aim is to ensure a smooth transition of NPO staff to public service staff by keeping the working hours at four hours plus a half-an-hour break for community-based staff and reducing the working hours of the facility-based counselling staff currently working eight hours to four hours to ensure service coverage is minimally affected.

b) Grading of post

The following were taken into account:

- Current employment qualification requirements of the public service versus the NPO service
- Statutory requirements (Health Professional Council) and legislative requirements

Project Manager. The current project manager employed by the NPO is responsible for the overall administration of the project. This includes functions like supply chain management; people management; and financial management. The prerequisites for this post varies from NPO to NPO, however; the transversal key performance areas of the incumbent of this post includes people management; financial management; and some supply chain management skills. The qualifications include the grade 12 qualification; experience as a supervisor; and, as recommendation, a management qualification.

Within the public sector, the post of an **Administrative Officer** is similar to the above-mentioned post. The post requirements are that the incumbent must be able to supervise a team; possess skills in people management and supply chain management; have budgeting skills, and labour relations and conflict management skills. The qualifications include the grade 12 qualification and experience as a supervisor. The grading of the post of NPO project manager is therefore recommended at administration officer (public service) level 7.

NPO Coordinator- The employment criteria for a NPO coordinator currently is registration as a Professional Nurse with the South African Nursing Council. The translation of this post to the public service will be to a Professional Nurse General registered with the South African Nursing Council. The criteria for this post are similar for NPOs and public service to allow easy transition. The grading of this post varies in terms of years of experience in the public service. As a proxy and median, **Professional Nurse (General Grade 3)** is used in the recommendation.

Community health worker and facility-based counsellor prerequisites for employment in NPOs generally are home-based care training by a recognised training service provider. The qualification is registered with the South African Qualifications Authority. Similarly lay-counsellors I must have undergone recognised lay -counselling training and must at least have a grade 12 qualification.

In the public service, the post of **health promoter level 4** can be utilised for this translation and can be separated for community-based and facility-based service. The prerequisites are experience in health education, promotion and a grade 12 qualification.

The employment criteria for **NPO supervisor** is similar to the above and is therefore recommended to be translated to **health promoter**. The supervisor will have more experience than the counsellor and CHW. This can be accommodated with pay notches in the public service.

Administrator- The criteria for this post in NPOs are the grade 12 (matric) qualification and computer literacy. In the public service, the job of **senior administrative clerk** is the closest match with similar employment criteria in NPOs which require the grade 12 qualification; computer literacy; and administration experience.

c) Considerations regarding organisational configurations

In addition to the above grading, organisational structures may also have to be configured, depending on the option. The community-based service platform staff has always been appointed by NPOs, as mentioned previously. To accommodate the possible

absorption and translation of NPO staff into the permanent organogram requires a new organisational structure.

According to Robbins and Barnwell (2006:7), an organisational structure defines how tasks, areas of responsibilities and authority are allocated and how this, in turn, dictates the reporting lines as well as formal coordination mechanisms, interactions and patterns that are followed. The overall dimensions, features and areas of responsibility are elements of a typical organisational structure. The dimension of an organisational structure includes complexity, formalisation, centralisation and coordination (Robbins & Barnwell, 2006:105). Complexity typically speaks of the degree of differentiation that exists within an organisation and comprises horizontal, vertical and spatial differentiation. Complexity is a typical feature of public health sector structures which should always be taken into account when proposing organisational structure.

It is important to note what it is that influences an organisation to make changes in organisational structure. Robbins and Barnwell (2006:257) indicated contingencies which include five main imperatives that have a direct influence on the structure of an organisation. These are strategy, environment, organisation size, technology, and power control. One imperative stands out when analysing the degree of influence and this is that the legal/ legislative environment has changed and therefore requires organisational structure to change. The environment typically refers to all the elements outside the organisation that have a direct or indirect influence on the organisation. NPO Service level agreements currently are centralised and managed within the substructure. Depending on the option, for example options 1 and 2, the organisational structure have to be amended to accommodate the management of additional staff members, which will lead to additional costs which are not included in the option 1 and 2 calculations.

Option 3 will not require amendments to the organisational structure, as staff will remain with the NPO as it currently is. The WCDoH will then only manage the contract and not the staff. Tables 6.11, 6.12 and 6.13 depict options presented to managers during the interviews to solicit responses from them. The purpose of doing this was to obtain an indication of what managers would have attempted to do if given the option of becoming compliant with the stipulations of the Labour Relations Amendment Act of 2014.

Table 6. 11: Calculation - DPSA (Public service) salary norms for 100% of NPO staff absorption into public service employ

Option 1							
DPSA salary level including 37% in lieu of benefits @ 4 hrs per day							
100% of current NPO staff absorbed, graded and remunerated on public service salary scales							
						12	Comments
(A)Staff Categories	Project Manager / Admin. Officer	Number of allocated staff per unit	14	Monthly cost per unit	R 12 056.00	Annual cost per unit	R 2 025 408.00	New Job grading to be done: Post translation - **Admin Officer (Level 7)**
	NPO Coordinator /Professional Nurse General		28		R 14 792.00		R 4 970 112.00	Professional Nurse General **(Grade 2-3) OSD**
	NPO Supervisor /**Health Promoter**		0		R 6 801.00		R 0.00	New Job grading to be done: Post translation - **Health Promoter (level 4)**
	CHW - **Health Promoter** (Community-based Services)		570		R 6 801.00		R 46 518 840.00	New Job grading to be done: Post translation - **Health Promoter (level 4)**
	Counsellor (Nutrition+HCT)/**Health Promoter** (Facility-based services)		93		R 6 801.00		R 7 589 916.00	New Job grading to be done: Post translation - **Health Promoter (level 4)**
	Administrator /Senior Admin Clerk		29		R 8 132.00		R 2 829 936.00	New Job grading to be done: Post translation - **Senior Admin Clerk (Level 5)**
							R 63 934 212.00	
(B) Benefits	Medical Aid/Pension/Housing Allowance/Service bonus		0		R 0.00		R 0.00	Benefits calculated @ 37% of total basic salary included in calculation above
	Leave Benefits						R 0.00	
	Uniform allowance (For Nurses and HPs only)		0		R 0.00		R 0.00	
Total budget (A+B)							**R 63 934 212.00**	
Total budget (A+B+C)							**R 63 934 212.00**	
				Current NPO budget			**R 21 935 971.64**	
				Deficit			**-R 41 998 240.36**	

Table 6. 12: Calculation Public service salary norms for 50% of NPO staff absorption into public service employ

Option 2							
DPSA salary level including 37% in lieu of benefits @ 4 hrs per day							
50% of current NPO staff absorbed, graded and remunerated on public service salary scales							
						12	Comments
(A)Staff Categories	Project Manager / Admin Officer	Number of allocated staff per unit	7	Monthly cost per unit	R 12 056.00	Annual cost per unit	R 1 012 704.00	New Job grading to be done: Post translation – **Admin. Officer (Level 7)**
	NPO Coordinator /Professional Nurse General		14		R 14 792.00		R 2 485 056.00	Professional Nurse General **(Grade 2-3) OSD**
	NPO Supervisor /**Health Promoter**		0		R 6 801.00		R 0.00	New Job grading to be done: Post translation - **Health Promoter (Level 4)**
	CHW- **Health Promoter** (Community-based Services)		285		R 6 801.00		R 23 259 420.00	New Job grading to be done: Post translation - **Health Promoter (Level 4)**
	Counsellor (Nutrition+HCT)/**Health Promoter** (Facility-based services)		47		R 6 801.00		R 3 835 764.00	New Job grading to be done: Post translation - **Health Promoter (Level 4)**
	Administrator /Senior Admin Clerk		15		R 8 132.00		R 1 463 760.00	New Job grading to be done: Post translation - **Senior Admin Clerk (Level 5)**
							R 32 056 704.00	
(B) Benefits	Medical Aid/Pension/Housing Allowance/Service bonus		0		R 0.00		R 0.00	Benefits calculated @ 37% of total
	Leave Benefits						R 0.00	

	Uniform allowance (For Nurses and HPs only)		0		R 0.00	R 0.00	basic salary included in calculation above
Total budget (A+B)						R 32 056 704.00	
Total budget (A+B+C)						R 32 056 704.00	
				Current NPO budget		R 21 935 971.64	
				Deficit		-R 10 120 732.36	

Table 6. 13 Calculation- Total remuneration package using current NPO funding norms including public service in lieu of benefit norm

Option 3									
Current NPO salary including 37 % in lieu of benefits @ 4hrs per day									
100% of NPO staff retained and remunerated at current NPO service package funding norms plus employee benefits									
									12
(A)Staff Categories	Project Manager	Number of allocated staff per unit	14	Monthly cost per unit	R 7 180.00	Add 37% in lieu of benefits	R 2 656.60	Total salary package including 37% in lieu of benefits	R 9 836.60	Annual cost per unit	R 1 652 548.80
	NPO Coordinator		28		R 7 715.00		R 2 854.55		R 10 569.55		R 3 551 368.80
	NPO Supervisor		28		R 3 858.00		R 1 427.46		R 5 285.46		R 1 775 914.56
	CHW Band 1		479		R 1 745.00		R 645.65		R 2 390.65		R 13 741 456.20
	CHW Band 2		22		R 1 886.00		R 697.82		R 2 583.82		R 682 128.48
	CHW Band 3		41		R 2 043.00		R 755.91		R 2 798.91		R 1 377 063.72
	Counsellor (Nutrition+ HCT)		93		R 3 950.00		R 1 461.50		R 5 411.50		R 6 039 234.00
	Administrator		29		R 1 925.00		R 712.25		R 2 637.25		R 917 763.00
											R 29 737 477.56
(B)Administra-tive cost	In-service training allowance /CHW		691		R 45.00						R 373 140.00
	UIF 1% of total stipends paid										R 297 374.78
	Uniform allowance once off /Coordinator/CHW/RCW/Supervisor		691		R 670.00						R 462 970.00
	Audit fees (annual)		1		R 0.00						R 10 000.00
	Travel per coordinator/supervisor <30km		56		R 1 600.00						R 1 075 200.00
	Travel per coordinator/supervisor >30km		0		R 2 400.00						R 0.00
Total budget (A+B)											**R 31 956 162.34**

(C)Administration fee 10% of total budget		R 3 195 616.23
Total budget (A+B+C)		R 35 151 778.57

Current NPO budget	**R 21 935 971.64**
Deficit	**-R 13 215 806.93**

(Findings) Four (4) managers chose option 1; one (1) manager chose option 2 and two (2) managers chose option 3.

- Managers were asked why they chose a specific option. Managers who chose Option 1, in this case the majority of managers interviewed, cited that by choosing this option the WCDoH would have direct control over staff. In terms of the Labour Relations Amendment Act, the WCDoH furthermore is still jointly liable for staff employed by NPOs so the department might as well employ them permanently.
- The managers who chose option 2 cited the same reasons as the managers who selected option 1 but added that option 1 is not affordable given the current financial austerity measures in the public service. These managers cited that 50% of staff would have to be employed, but did not indicate what should happen to the rest of the NPO staff.
- The managers who chose option 3 cited that this model is the most cost effective and would result in the most benefit for the WCDoH as it would not be as costly as option 1, and that the department could still ensure sufficient service coverage, unlike as in the case of option 2.

(Analysis) Concluding from this area, it is clear that managers find themselves in a catch-22 situation; on the one hand they responded that the department cannot afford to absorb NPO staff as permanent staff and on the other they want to comply with prescripts as well as retain the services of NPO staff.

Interestingly, the options of staff absorption given to managers and what influenced their selection and the qualifying reason for an option was mainly based on what the

WCDoH/NTSS would gain or how this would affect the NTSS/WCDoH and not really what NPO employees would gain in terms of improved working conditions and benefits.

The following analysis and interpretation were derived on the basis of the option that was selected:

a) The majority of managers chose **option 1.** Further to the findings and responses the following analysis was done:
   I. The service delivery coverage in terms of staff numbers is maintained at 100% of current coverage.
   II. Secondly, there will be no retrenchments and 100% of current NPO staff will be retained.
   III. The current funding allocation will have a shortfall of **-R41 998 240.36** and this will have to be sourced as additional funding.
   IV. This option presents a negative implication in terms of funding.
   V. This option furthermore does not take into account the reconfiguration requirements of organisational structures or the cost connected with appointing additional management and support teams to supervise additional staff.
   VI. Other overhead costs also are not included here, for example the use of additional government vehicles for work-related activities, water and electricity and other consumables, as well as stationery usage. These aforementioned overheads are currently borne by NPOs.
   VII. It must be noted that the benefit calculation in this option was done at 37% in lieu of benefits, which is the normal acceptable calculation. The 37% however detracts from the real cost once NPO staff is permanently appointed. The calculation does not factor in the real cost, for example of employer contributions to medical aid, pension scheme, housing allowance and service bonus. The 37% calculation was done on a 4-hour workday whereas the formula cannot be applied uniformly with all benefit allowances.
   VIII. For the 37% benefit calculation to make it more or less accurate and to make it beneficial to the employee, as well as to ensure that the employee

can afford to contribute to a medical aid, pension fund, housing allowance or service bonus, the 37% has to be calculated according to an 8-hour workday. This means that the total budget required will increase to **R 87 589 870.44** with a larger margin in deficit of current funding of **-R 65 653 898.80.**

b) Only one manager chose **option 2** for reasons stated. Further analysis applicable to this option in addition to findings reveal:

I. In this option the service delivery coverage in terms of staff numbers is decreased by 50% of current coverage. Secondly 50% of staff will have to be retrenched. The current funding allocation will have a deficit of **-R 10 120 732.36** and this will have to be sourced in addition to current funding.

II. This option presents the following negative implications in addition to what is mentioned under the option 1 analysis (from roman numbers 5 – 8).

III. As in option 1, the benefit calculation in this option would, in more real terms, present a further budget increase to **R 43 917 684.48** and a resultant deficit increase to **-R 21 981 712.84.**

IV. Option 2 will reduce the quality of care further due to reduced coverage of services.

V. Option 2 can result in increased admission of current patients to formal PHC and hospital services – therefore increasing service pressures on existing service.

VI. This option will result in labour relations challenges and disputes in terms of staff grievances, because of unfair dismissals in not renewing or entering into employee contracts with all NPO staff.

VII. Additional budget implications.

c) Two managers chose option 3 and further analysis of the findings indicate that:

I. This option is probably the best option in terms of affordability. With this option, staff remains the employees of NPOs and benefits only are added to current funding norms.

II. The option might be more cost effective in that the NPO remains the employee. This means that funding must still be transferred to NPOs using the current NPO service package funding norms, and the calculation includes a 10% administration fee.

III. Furthermore, staff in this option will remain contract staff.

IV. The WCDoH/ NTSS will still be jointly liable for NPO staff in that the NPO employee has recourse to labour disputes against the WCDoH/NTSS, as contemplated by the amendment Act.

V. The basic remuneration currently offered through the NPO funding norms is not in line with basic salary levels of the department and this might lead to disputes in future.

VI. 100% of staff will be retained.

VII. 100% of service coverage will be maintained with no disruption of services.

VIII. Basic remuneration (salary only) is not in line with public service remuneration scales, which might lead to grievances as NPO staff could argue that they perform functions similar to what is indicated under the grading of posts for those public service post categories.

IX. There still remains a budget shortfall of **R -13 215 806.93.**

X. In addition, it must be noted that the benefit calculation formula of 37% in lieu of benefits on current NPO Service Package Norms will not allow NPO staff to make contributions in real terms to join, for example, a medical aid or make meaningful contributions towards retirement, contribute effectively for residential housing purposes, or even a service bonus.

6.7 Summary

Indications in this chapter are that becoming compliant with the Labour relations Amendment Act of 2014 is not so cut and dried. The remuneration gap between public service officials and NPOs is significant and will require additional funding in whichever direction the WCDoH chooses to go. Benefit packages also add additional cost to the salary package and current funding norms do not even address the issue of benefits for NPO staff. Service coverage implications present another consideration as what the funding envelope currently allows for the appointment of adequate numbers of staff through NPOs to ensure adequate coverage for service delivery needs.

The judgement and consequent order of the South African Labour Court in Johannesburg in which the Gauteng Department of Health was the respondent places emphasis on a frightening reality. This court order saw NPO staff walking away victoriously, which clearly indicates that there is no place for treating vulnerable workers unfairly in South Africa any longer. The merits of the case are largely similar to current NPO outsourcing, which means that, should NPO staff take the WCDoH to a Labour Court, this order might be cited and the WCDoH may be found wanting.

The Labour Relations Amendment Act of 2014, sections 198A and 198B, has a specific purpose and that is to protect vulnerable workers. Staff working for NPOs under the current circumstances is vulnerable as they work under difficult circumstances. These workers does not receive any service benefits and earn much less then workers employed by the public health sector.. The Act is clear on (1) contract workers having to be treated the same as permanent workers and having to have similar benefit packages; and (2) the employer who outsources services is just as liable for NPO staff grievances as the NPO employing them.

Finally, whichever option the WCDoH selects towards becoming compliant with the Amendment Act will require additional funding.

Chapter 7: Conclusion and Recommendations

7.1 Introduction

In this chapter concluding remarks are provided and recommendations that may assist the WCDoH to come in line with the Labour Relations Amendment Act, 2014 are presented. The recommendation includes a remuneration and benefit package calculation for consideration. The aforementioned is based on remuneration and benefits offered to public service officials with the same qualifications and / or job scope or function.

The chapter includes a report on the limitations to the study which were unavoidable or not within the control of the researcher, as well as listing possibilities for future research.

7.2 Concluding remarks

Given the stipulations of the Labour Relations Amendment Act of 2014, all employers were allowed three months to become compliant with the Act. The above-mentioned Act became effective on 1 January 2015. To date, the WCDoH has continued to contract employees in the same way as done before the Act became effective. This generally, means that the WCDOH is non-compliant with legislation, which can have serious implications for this public service entity.

The contributions that NPOs and their staff have made to the current platform are undisputed and it would be disastrous for the clients not to have access to the service. Furthermore the strategic direction of the WCDoH is built around wellness and preventing disease and promoting health through its primary health care platform, which includes community-based services. The latter is the vehicle that enables the WCDoH to ensure that clients have access to care and wellness is promoted. This being said, the current NPO outsourcing models is not in line with the stipulations of the Act and has to change to ensure that the WCDoH becomes compliant.

The aforementioned will require additional funding, but it still remains beneficial to ensure access to services and thereby keeping clients healthy and preventing them from being admitted to formal health care facilities such as hospitals, which are more costly to run. The Labour Court judgement in which the GDoH was the respondent, has delivered a court order that will have a negative impact on the WCDoH if the WCDoH has to be in a similar situation. The outsourcing model of the NPO applied in the WCDoH has many aspects similar to that of the GDoH and the WCDoH can therefore not rest on its laurels waiting for NPO staff to drag it before a Labour court. It is for this reason that the following recommendations are made. The basis of these recommendations is in ensuring that the WCDoH becomes complaint with the Act

The following option is recommended and it must be noted upfront that the option will require additional funding but it is still more cost-effective compared to traditional formal health services such as hospitals. The current community-based service is a safety net for clients discharged from hospital who still require recuperation. This means that hospital beds are not blocked with clients that can be cared for in their own homes through community-based services.

7.3 Recommendations

The recommendation takes into account the stipulations of the Amendment Act and the BCEA, as well as the Labour Court Order. The aforementioned is articulated as follows in Table 7.1.

Table 7. 1: Stipulations of the LRA, BCEA and Labour Court order as basis for recommendations

Labour Relations Amendment Act, 2014	BCEA	South African Labour Court Order
Section 198B. As all employees are earning below the threshold contemplated by the BCEA and are in employment for	Current NPO employees all earn below the anticipated threshold, which means that NPO employees are covered in	Conditions of employment of employees under NPO contract in the GDoH mirror NPO contract conditions in the WCDoH

more than three months and do not replace a permanent employee or is not employed as part of a temporary project. The current employees of NPO service contracts can be regarded as employees of the WCDoH. Employees of outsourced services must receive the same benefits as employees of the employer.	terms of the LR amendment Act 2014, section 198A.	The court ordered that the NPO employees are the permanent employees of the GDoH (contractor).

Based on the above, a compromise has to be found. The recommendation therefore is that employees remain in the employment of NPOs, but the WCDoH must ensure the following:

1. Ensure that the current Service Level Agreement signed with NPOs is amended to include the obligations of the WCDoH to NPO staff as well as the obligations of the NPO towards its staff. Further ensure that dispute resolutions reflect how disputes with NPO employees will be addressed. The SLA is to include specific employment criteria as well as basic conditions of employment or make reference to the BCEA. A People Management Specialist should be consulted in this regard.
2. Ensure that NPOs are compliant with the stipulations of the Occupational Health and Safety Act No. 85 of 1993 and ensure conducive working conditions for all workers. This must be mentioned explicitly in the SLA. An occupational health and safety risk assessment should be done by a specialist in the field. The reason for this recommendation is to ensure that the WCDoH covers all its bases, as the department is jointly liable for NPO employees.

3. Ensure that remuneration is market related. A formal job evaluation of all NPO employees is recommended and a specialist in the field must be obtained to do this. The job evaluation of NPO employees must be compared with the closest job scope and category on the public service organogram and remuneration matched accordingly.
4. Ensure that NPO staff benefit packages make allowances for medical aid contributions, pension fund contributions, service bonuses, housing allowances, and leave benefits similar to benefits awarded to public service officials.
5. Annual cost of living adjustments should be the same as for public service officials.
6. Ensure that all NPO employees are subjected to a vetting process similar to that of public service officials to ensure the safety of clients. This must be made explicit in the SLA.
7. Make provision for further staff development opportunities in the form of skills and other training similar to what is offered to public service officials.
8. Ensure service standards to ensure quality of care across the NPO platform.
9. Ensure that NPO staff performance management is applied in line with the public service stipulations.
10. Ensure harmonious labour relations and labour peace by adhering to the rights of workers as contemplated in the LRA. This includes freedom to join a recognised labour union.
11. Ensure employee discipline and that progressive disciplinary action procedures applied by NPOs are in line with the public service disciplinary codes and procedures.

The above recommendations are made to ensure that the WCDoH protects itself by aligning labour processes to what it has in place for its own staff. This will avoid biased treatment that can lead to grievances because of unfair labour practice, which the WCDoH will be jointly liable to resolve. Table 7.2 below contains a budget calculation as part of a recommendation for new funding norms and ultimate grant transfer to NPOs.

Staff will remain employees of the NPO, but the grant to the NPO will make allowance for benefits and basic salary will be in line with the current public service salary norms and

grading. The recommendation calculation in Table 7.2 represents an attempt to come in line with the stipulations of sections 198A and 198B. The basis for this recommendation should be considered jointly with the listed recommendations indicated under 7.3.

7.4 Proposed Funding Norms for alignment with the Labour Relations Amendment Act of 2014

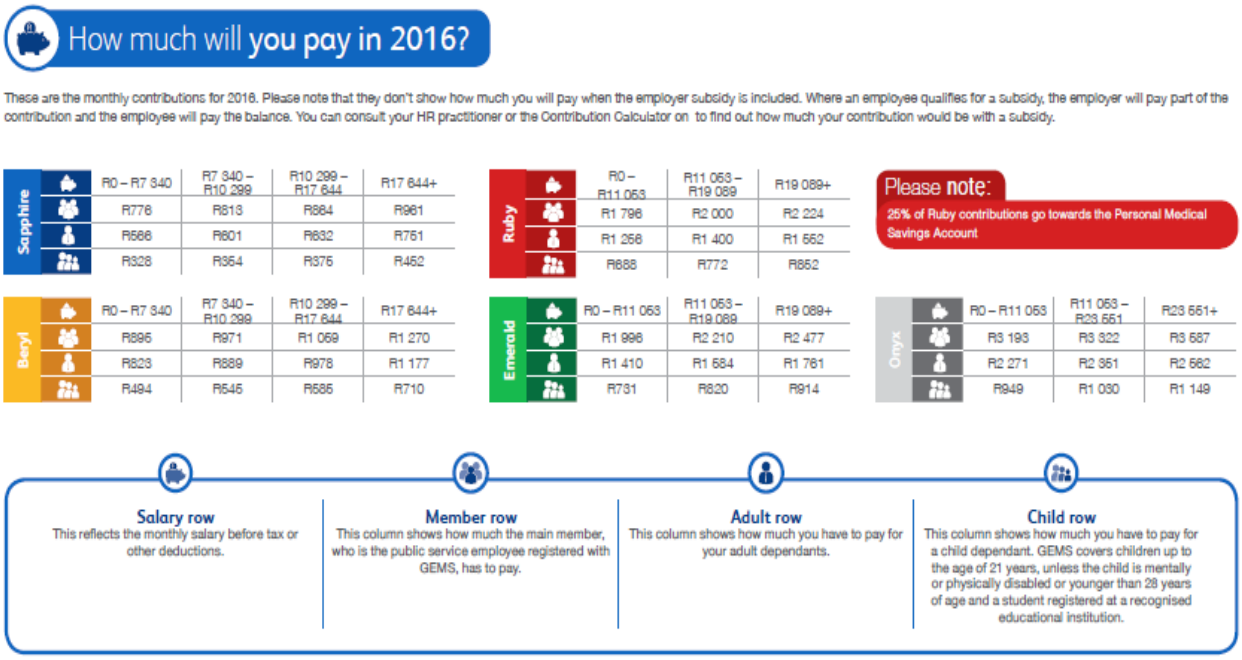
The proposed funding norms are based on the current Service Package of Care for NPO funding. In this proposal, to become aligned and compliant with the stipulation that indicates that contracted employees (NPO employees) must receive the same benefits as permanent employees of the employer. The funding norms have been taken as for the 2016/17 financial year per category and the benefits (as received by public service officials) that are indicated in **Table 7.2** have been added. The benefit structure is the current negotiated benefits package structure available on the website of the Department of Public Service and Administration (DPSA).

Table 7. 2 DPSA (Public service) Benefit structuring

Government Employees Pension Fund employer contribution	13% of the monthly pensionable salary
Medical benefits	The State pays 75% of the employee's total monthly medical contribution on any selected option based on member profile and the member contribution. For this calculation, the Sapphire option on the Government Employee Medical Scheme has been selected. This is the entry and most affordable option on the medical scheme designed for lower income earners in the public service.
Housing benefits	R 1 200
Service bonus	Service bonus equals an employee's one-month salary

All government employees must belong to the Government employee medical scheme (Gems) to receive the employer contribution. For this reason, **Figure 7.1** was used as a guideline to calculate the 75% portion of the total employee contribution to the medical aid scheme. Member contributions are calculated according to their income. The Sapphire option was used to calculate the member contribution as this option is designed for lower income earners in the public service. The medical aid contribution was calculated according to the Sapphire option @ Member+ 1 adult.

Figure 7.1: GEMS Medical aid option selection 2016



Salary bands applicable to **CHWs working four-and-a half hours/day** are awarded as follows as per the Service package:

- All new (entry level) and existing Level 1 and 2 CHWs must be paid according to band 1.
- All CHWs who successfully complete the Basic orientation to community health work programme and existing Level 3 CHWs must be paid according to band 2.
- All CHWs who successfully complete the NQF Level 4 ‘legacy’ qualification, and in future the new NQF Level 3 Community Health Worker qualification, must be paid according to band 3.

It is clear that the public health sector must comply with the Labour Relations Amendment Act, Act No.6 of 2014, however the cost implications for the public health sector and will be dire in terms of service coverage. In Section 198B makes allowances for fixed term contracts where the employer can demonstrate any justifiable reason for fixing the term of a contract. In terms of the aforementioned the WCDoH has definite justifiable reasons for fixed term contracts in terms of its current NPO outsourcing model which is cost effective and efficient. These NPO contracting process allow the WCDoH to reach communities that will not receive health care if it was not for NPOs and their services. The WCDoH should however ensure that these NPO contract workers receive the same benefits as public health officials as contemplated by the act and therefore the recommendation for new NPO funding norms.

7.5 Proposed New NPO Funding Norms

The proposed funding norms as indicated in table 7.3 are a recommendation based on the investigator findings and analysis. This funding proposal recommends a possible solution to the WCDoH to become compliant to the Act within the current financial envelope and service delivery needs.

Table 7. 3: Proposed new NPO funding norms (Recommendation)

Proposed Funding Norms for alignment with the Labour Relations Amendment Act,2014										12
Staff category	Ratio and level	Basic salary (Current Service Package For NPO Funding Norm@4 ½ hrs per day)	Medical Aid@ 75% of the total employee contribution (member + 1 adult)	Pension fund contribution @ 13% of monthly pensionable salary	Housing benefit between R900 (non-home owners) R1200 (home owners) pm - Ave R 1050	Service bonus = one month of employee salary	Total monthly salary package	Total annual salary	Total number per category currently employed	Total Cost
(A)Staff cost										
NPO Project Manager	1:30 CHWs	R 7 180.00	R 1 006.50	R 933.40	R 1 050.00	R 7 180.00	R 17 349.90	R 208 198.80	14.00	R 2 914 783.20
NPO Coordinator (Professional Nurse)	1:20CHWs	R 7 715.00	R 1 060.50	R 1 002.95	R 1 050.00	R 7 715.00	R 18 543.45	R 222 521.40	28.00	R 6 230 599.20
NPO Supervisor	1:20CHWs	R 3 858.00	R 1 006.50	R 501.54	R 1 050.00	R 3 858.00	R 10 274.04	R 123 288.48	28.00	R 3 452 077.44
Community health workers	Band 1	R 1 745.00	R 1 006.50	R 226.85	R 1 050.00	R 1 745.00	R 5 773.35	R 69 280.20	479.00	R 33 185 215.80
	Band 2	R 1 886.00	R 1 006.50	R 245.18	R 1 050.00	R 1 886.00	R 6 073.68	R 72 884.16	20.00	R 1 457 683.20
	Band 3	R 2 043.00	R 1 006.50	R 265.59	R 1 050.00	R 2 043.00	R 6 408.09	R 76 897.08	29.00	R 2 230 015.32
Peer counsellor		R 1 745.00	R 1 006.50	R 226.85	R 1 050.00	R 1 745.00	R 5 773.35	R 69 280.20	20.00	R 1 385 604.00
HIV Counsellor		R 3 950.00	R 1 006.50	R 513.50	R 1 050.00	R 3 950.00	R 10 470.00	R 125 640.00	73.00	R 9 171 720.00
Administrator		R 1 925.00	R 1 006.50	R 250.25	R 1 050.00	R 1 925.00	R 6 156.75	R 73 881.00	29.00	R 2 142 549.00
Total staff salary cost		**R 32 047.00**	**R 9 112.50**	**R 4 166.11**	**R 9 450.00**	**R 32 047.00**	**R 86 822.61**	**R 1 041 871.32**	**720.00**	**R 62 170 247.16**
(B)Administration Cost										
	Cost per month		Total number per indicated category						Number	
In-service training-related activities - CHW/Counsellor	R 45.00		621.00				R 27 945.00	R 335 340.00	R 0.00	R 335 340.00
UIF 1% of total salaries										R 621 702.47

COIDA 0.4% of total salaries									R 248 680.99
Uniform - once off per Counsellor/CHW/PN/Supervisor							R 2 352.00	677.00	R 1 592 304.00
Auditing fees once-off per NPO							R 10 000.00	16 (NPOs)	R 160 000.00
Travel per coordinator / Supervisor (work-related) average	R 2 000.00	56.00				R 112 000.00	R 1 344 000.00		R 1 344 000.00
Total admin. cost	**R 2 045.00**	**R 677.00**				**R 139 945.00**	**R 1 691 692.00**		**R 4 302 027.46**
Total cost (A+B)									**R 66 472 274.62**
Administration to NPO Fee 10% of Total cost									**R 6 647 227.46**
Total Budget									**R 73 119 502.08**

Table 7. 4: Disadvantages and Advantages of New Proposed NPO funding Norm

Disadvantages of proposed funding structure	Advantages
Current funding allocation for service **= R 21 935 971. 64** Required total funding to become compliant **= R 73 119 502.08** Deficit in current funding = **R -51 183 530.44** The NPO staff will not be directly employed by the WCDoH (could be seen as a disadvantage from a direct WCDoH control perspective)	• Compliance with the Labour Relation Amendment Act stipulations • More market-related salary norms • Living wage for NPO workers • Contributing to improvement of socioeconomic status of NPO workers • Decreasing chance of possible future litigation and legal cost due to grievances for which the department is jointly liable • Maintaining staff at current levels for service delivery • Possible improved employee satisfaction • This calculation allows for NPO workers to actually join a medical aid, retirement fund, and assists them with housing

	• The benefit calculation is done in real terms at current cost, for example for a medical aid.
	• This proposal (New NPO funding norm) is more cost effective when only staff cost is as compared with absorbing staff as permanent employees in the public service.
	  ○ The total staff cost for this proposal (100% of Staff remain as NPO employees with service benefits added) = **R 62 170 247.16**
	  ○ The total staff cost when 100% of NPO employees is absorbed as permanent public service employees **= R 63 934 212.00**
	• The new funding norms also take into account real-term uniform allowances as at current rates given to public health staff
	• Provision is also made for a workman's compensation contribution that covers for workplace injuries and diseases in the new funding norms.
	• Travel for work-related activities is also more cost effective when NPOs are the contractor as the WCDoH does not have to provide the vehicles and only reimburses for travel.

7.6 Limitations of the study and possibilities for future research

The following is a list of limitations for these investigations

- Time constraints – the investigator is a full-time employee, and even though planning was done in advance, factors beyond the investigator's control limited time allocation.
- Sample – the sample area, although it did not affect the outcome of the study, might have been too narrow, especially when it comes to the interviews with managers concentrated in the sample's geographical area.
- Funding – the study was self-funded by the investigator and this introduced its own limitations.

Future research might include research post adoption and implementation of recommendations in terms of compliance, value added to NPO workers, as well as cost and service implications. The sample might also be increased for a wider perspective on related issues such as benefits to the clients as well as the broader service delivery platform.

7.7 Summary

The specific purpose of this chapter is geared towards guiding the WCDoH towards compliance with the stipulations of the Labour Relations Amendment Act, 2014. Stipulated recommendations partly address the issues, but more in-depth specialist field work is required to ensure that the WCDoH covers all its bases. Ultimately, the contemplations and the objectives of the Act are to protect vulnerable workers. Financial implications might not always allow for this, but if we want to address the imbalances of the working class incrementally, we have to make sure that vulnerable workers are not exploited. The Act is a step in the right direction in avoiding exploitation of workers. The limitations of the study prevented exhaustion of all the avenues and possibilities and these may have to be addressed through future research and further investigation.

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