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South Africa: Case study on working time organization and its effects in the health services sector

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Sectoral
Policies
Department

South Africa: Case study on working time organization and its effects in the health services sector

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International Labour Office
Geneva

Working papers are preliminary documents circulated to stimulate discussion and obtain comments

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Preface

Working time has been a subject of central interest for the ILO since its creation in 1919. The very first standard adopted by the International Labour Conference – the Hours of Work (Industry) Convention, 1919 (No. 1) – established fundamental principles regarding the limitation of daily and weekly working hours. Since then, numerous Conventions and Recommendations have dealt with different aspects of working time, including weekly rest and annual leave with pay. In addition, sectoral standards, such as the Nursing Personnel Convention, 1977 (No.149), have addressed specific working time related issues in a number of industries, or have sought to ensure equal treatment in this area for particular categories of workers as compared to other workers.

Working time is a critical aspect of service in the health sector where work scheduling is especially complex due to the imperative need for continuous 24-hour seven-day coverage. Reconciling health workers' wellbeing, including adequate work-life balance, with organizational requirements for continuous service remains a main challenge particularly in the health services sector that involves shift work, night work and working on weekends on a regular basis.

The present working paper explores the complex issues around working time organization and their effects in the health services sector in South Africa. It is one of the products of a research initiative jointly carried out by the ILO Working Conditions and Equality Department (WORKQUALITY) and the ILO Sectoral Policies Department (SECTOR), in follow-up to the Conclusions of the Tripartite Meeting of Experts on Working Time Arrangements (2011). The research initiative aimed to develop a better understanding on how contemporary working time arrangements function in specific sectors and for different types of workers with the main objective of identifying aspects where improvements in working time arrangements and related practices can better meet both workers' needs and organizational requirements.

We hope this paper will help to stimulate discussion on working time organization and related practices in the health services sector.

Alette van Leur
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The ILO research initiative on the organization of working time and its effects in the health services sector was conceptualized and managed by Jon Messenger, Inclusive Labour Markets, Labour Relations and Working Conditions Branch (INWORK), ILO Conditions of Work and Equality Department (WORKQUALITY), and Christiane Wiskow, Public and Private Services Unit (SERVICES), ILO Sectoral Policies Department (SECTOR).

The ILO research team would like to sincerely thank the authors of this country case study for South Africa, Ms Sophia Kisting, Mr Aqiel Dalvie and Mr Peter Lewis.

We would also like to thank the national tripartite participants and the managers and workers in health care institutions who participated in the research, for their insights into the working conditions, including the working time arrangements and their effects. The completion of this research would not have been possible without the cooperation of the national authorities, and the health care institutions and professional associations that supported the qualitative assessment. Further, we are appreciative for the advice and support of our colleagues in the ILO Decent Work Team and Country Office in Pretoria.

Acknowledgements by the authors

We would like to acknowledge the immense contribution of the health workers, managers, trade unions and government representatives in different health institutions throughout South Africa, who made this report possible. They selflessly and courageously shared their work–life experiences, their working hours, their expertise and their vision for the future, despite challenging work schedules and at times intense fatigue. This was done in the fervent hope that they are making a contribution towards collective sustainable solutions. We were greatly strengthened and inspired by their dedication and commitment to the continuing quest for good service delivery and decent work. Many among them believe that we can live and realize the progressive clauses of our Constitution, that we can continue to work towards the greater protection of human rights and help ensure respect and good treatment for all patients, and that we can have greater equity and social justice while pursuing the often elusive dream of a real work–life balance in the health service sector. We owe the health workers of our country a great debt of gratitude. We firmly believe that the report can contribute towards positive interactions and collective, inclusive solutions.

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Introduction

South Africa has unified the very fragmented health service inherited from the apartheid era. In 1994, at the conclusion of the apartheid era, the country started out with a heavy burden of many preventable diseases and almost immediately had to deal also with the profound tragedy and major setbacks of the HIV/AIDS and tuberculosis epidemics. The country also has a major burden of preventable occupational diseases such as asbestos-related diseases, silicosis and noise-induced hearing loss, in addition to many preventable occupational injuries. The majority of patients with these occupationally induced health problems swell the ranks of the many sick patients dependent on the public health sector.

In spite of continuing efforts at improvement, huge expenditure and increased staff components, parts of the health service are going through a very difficult phase and are performing very poorly. On the other hand, it was uplifting during this study to see how staff members at many different health institutions are currently using a systematic policy and protocol approach in their attempts to deal with the epidemics of HIV/AIDS and tuberculosis.

South Africa is working towards a National Health Insurance (NHI) system, the details of which are still being debated, and which will have a significant transformative impact on the health sector. There is much interest and discussion on the National Health Insurance system, as it promises to help address the challenges currently faced in providing an efficient and effective health service to the people of South Africa while ensuring that health workers have decent work, a good work–life balance and high morale, and can give the very best care to their patients.

The following points influence and inform the context within which this study was undertaken:

- maintaining over the past decade a high level of spending, with respect to gross domestic product (GDP), on the health service (8.9 per cent in 2010);
 - continued growth in the nursing and doctor cadres in the health service (though not fast enough to improve the health professional :population ratios), while combating continuing critical shortages of health service providers in several areas;
 - the drain of skilled staff from rural to urban areas, and through emigration, despite government attempts to arrest it through the occupational special dispensation mechanism (a one-off rise in salaries for skilled staff), and the placing of community service doctors in underserved areas;
 - the epidemic nature of non-communicable diseases such as hypertension, heart disease, diabetes and mental ill health; the continuing challenge of preventable occupational diseases and injuries, which contribute significantly and often silently to the overall burden of disease in the public health sector; and the huge challenges presented by alcohol and illegal drug consumption, violence against women and children in particular, and accidental injury, such as road accidents and fires or flooding in informal settlements;
 - the persistent unemployment level of around or above 25 per cent (up to 40 per cent using the expanded definition), and the extreme inequality of income in the country (relative to global averages), despite attempts to mitigate with targeted programmes, mainly through social transfers;
-

- the urgent need to address the more subtle legacies of the country's divided past under apartheid, which require much greater efforts from every South African at nation building, at inclusive opportunities for development, at overcoming inequality and building a greater culture for the protection of individual human rights and respect for each and every person;
- the historic task and the opportunities to continue to strive collectively to strengthen and improve the public health sector, which provides care to the vast majority of South Africans.

Box 1 and Box 2 give excerpts from interviews with two health workers, which reflect the context within which the study is taking place and in part reflect aspects of South African history and the challenges and opportunities facing the country.

Box 1. Interview with a registered nurse

I am a migrant labourer. It is very important to me to say this. It has shaped my entire life, in a most negative way. Under apartheid I needed a permit to come into the city to work. This was very difficult to get. Once you get it, you come to the city and are subjected to the Group Areas Act. Black South Africans were pushed to the peripheral areas of the cities. This is why we now commute from the periphery to the city bowl. I live in a township about 35 kilometres away from work and have been a registered nurse for 40 years. A huge part of my limited wages and several hours of my working day are spent on transport. Our wages are too low. We lead a hand-to-mouth existence. We will be poor all our lives in spite of working very hard. We can't save money yet we work the long shifts.

There is a shortage of nurses. Many have gone overseas for better working conditions, hours, treatment, and remuneration. Our remuneration is below the breadline. In areas of specialty like oncology, theatre and intensive care units there is a crisis as we need especially skilled nurses, who are in short supply. The management may offer us overtime. That is over and beyond our 40 hours per week. Nurses work themselves to a standstill because they need more money.

We leave our homes when it's dark, and arrive back home when it's dark. We hardly see our children. Supper is so important. This is where we are taught the morals, philosophies and beliefs of our culture. Life orientation happens at that time. I see the disintegration of this. Children do as they please because we are not there. Inadequately supervised, they can start to use drugs, watch pornography or engage in other unhealthy activities. Our children may end up with no values, or otherwise have warped values. Our children are affected by this hand-to-mouth economy!

Because of my working hours I have been mugged four times in my life. Nurses are sitting ducks. We are targeted. Gangsters know the days we get paid. The uniforms put us at risk. Because we are nurses, we are told it is a noble profession. So the nurses remain silent. We belong to a culture of silence. We don't verbalize our concerns. Without unions we would still be as abused as before. We are scared of losing our jobs, to be not good nurses, to be labelled. The response of management to our complaints depends on the ability of the manager. Some managers are enlightened. Some are punitive and vengeful in their approach. Nurses feel dehumanized, demoralized and demotivated. It is because of the death of nursing. We find we are overruled.

Everybody is tired and complaining about transport. We get up at 4 a.m. to be on duty at 7 a.m., then by the end of the day we get home after 8.30 p.m. When you start work the next day you are exhausted. Can we care for patients when we have nothing left to give? Where is the work-life balance and where are our families? Collectively we should be able to address these challenges.

Box 2. Interview with a senior consultant

As health workers we experience tremendous stress not only from the hours of work but the nature and conditions of our work. Our work is to provide the best possible care for patients who often present in extremis or with severe end-stage disease. Factors precipitating workplace stress are the chronic staff shortages, lack of basic equipment, insufficient bed space, long clinic waiting times, inability to obtain relevant radiological investigations for several months and the lack of adequate theatre time to operate on cancer or other patients with chronic conditions. We have to manage limited health resources all the time and often don't have what we need to take effective care of our patients.

Doctors spend many hours every day trying to overcome these obstacles to provide proper, dignified and quality health care for patients who need our help. It is not unusual for registrars to spend 2 to 3 hours in the evening walking from ward to ward looking for beds for critically ill patients. There is this constant stress of trying to prioritize the most needy in terms of admission, surgery, radiology and even of intensive care unit space.

The medical staff is the public face of our health system. We are at the front line, having to deal with patient's frustrations and hopes without having the power to change infrastructure and budget for health that lead to chronic system failures. Most of this stress is externalized from senior management to sleep-deprived health workers caring for patients. Knowing what is needed for patients and being unable to provide the quality of care necessary has led to burnout for many doctors and specialists. Impressionable junior doctors become disillusioned.

I think for registrars (specialists in training) there is no work-life balance, that's what you do for those five years. You can't be sick, you can't have vulnerabilities. If you leave, the patients and the team suffer, so you stay. The rest of your life is put on hold for those training years. Women postpone having children until this phase is over. Registrars suffer from varying degrees of burnout. There are also three examinations to write and pass. Cumulative fatigue, competence and concentration are major concerns for sleep-deprived staff. After a 30-hour shift we (doctors) are not operating as well. You would think it would be illegal, but it's not. We do it all the time. Patients don't get as good a service as doctors are tired and it's cumulative.

The food we eat is a problem. We eat very badly. The cafeteria closes at 4 p.m. You have no time to go off site to buy an alternative option. There is no communal space to eat collectively. There are no facilities provided. This affects our health. In some hospitals sleeping facilities are unavailable and shower facilities only available in theatres.

Addressing working hours therefore is only one part of ensuring a stable and well-motivated work force. Creating an environment where patients are afforded a safe clinical space as well as humanitarian conditions such as clean bathrooms, privacy and basic dignity is key to ensuring a healthy work environment for all health workers. We should be able to address these problems.

A. Literature review

1. Overview of the South African national and provincial health systems

The health sector in South Africa consists of a mixture of public and private sector services, structured as follows (Coovadia et al., 2009):

- National Department of Health, responsible for national health policy;
- nine provincial Departments of Health, with each province responsible for developing its own provincial policy within the framework of national policy and public health service delivery;
- three tiers of hospitals – tertiary, regional and district;
- a primary health care system that is predominantly nurse driven, comprising community clinics, community health centres and district hospitals, and community-based health care services;
- the private health system, which consists mainly of general practitioners and private hospitals.

Care in the private hospitals is mainly funded through medical aid schemes. In 2008, 70 per cent of private hospitals were situated in three of South Africa's nine provinces, with 38 per cent of private hospitals located in Gauteng province (Johannesburg and Pretoria).⁴

Additionally, in 2008, the use of public and private health services by the South African population was reported as:

- 16 per cent of the population were covered by private medical schemes;
- 68 per cent of the population's health needs were solely provided by the public sector (including municipal health services in Greater Cape Town and Johannesburg, which have not to date been merged);
- 16 per cent of the population used the private sector for out-of-pocket primary care services, but were almost entirely dependent on the public sector for inpatient hospital care (Health Economics Unit, 2009).

1.1. The Western Cape provincial public health system

The Western Cape province can serve as an example of the dynamics within provincial health service management systems in the nine provinces, as it reflects

⁴ Information obtained from the Council for Medical Schemes Annual Report for 2008 and the National Treasury's Provincial Budgets and Expenditure Review: 2005/6–2011/12.

accurately the changes that are occurring in national health policy developed in the National Department of Health.

In 2002, the Western Cape Department of Health produced a strategic plan for the reshaping of public health services in the Western Cape, Healthcare 2010, which aimed to ensure equal access to quality health care for all the communities of the Western Cape.

Healthcare 2010 (as delivered according to the Comprehensive Service Plan for the Implementation of Healthcare 2010) is an indicator of change in the way health care services for the Western Cape will be delivered in the future. It was envisaged that the Comprehensive Service Plan would lead to strengthening of district health services, particularly the development of community-based services, which would result in better quality and more accessible care for most people in the communities where they live:

Healthcare 2010 was developed to improve the quality of the healthcare service and to provide a financially sustainable health service in the Western Cape. ... The purpose of the Service Plan was to provide a guideline for the implementation of Healthcare 2010 at all levels of care for the communities in the six (6) districts of the Western Cape Province (Western Cape Department of Health, 2007).

To achieve this goal, resources (human, infrastructural, financial) allocated to health care facilities had to be in line with the level and type of care they were required to provide, so that patients could be treated at the level of care that was most applicable to their needs. To ensure sustainability of service delivery, it was imperative that the budget for the Comprehensive Service Plan be carefully and expediently determined and utilized.

The Healthcare 2010 Service Delivery Plan envisaged that 90 per cent of patient contacts could take place at primary level, 8 per cent at secondary level and 2 per cent at tertiary level (Western Cape Department of Health, 2003). Therefore, for planning purposes, the total populations in each of the six districts of the Western Cape province had to be taken into consideration.

To attain the goals of Healthcare 2010, the health services needed to be reshaped as a solid base for primary health care services integrated with level 2 and level 3 services.

Primary health care is the foundation of an effective and efficient public health service as:

- it is most frequently the first point of contact between the patient and a health care service;
- it should provide a package of comprehensive and integrated primary health care services;
- efficiencies and inefficiencies at this level of care impact significantly on the entire health system (Western Cape Department of Health, 2007).

1.2. Western Cape district health services

District health services, where primary health care is operational and 90 per cent of patient health contact occurs, addresses facility-based services, namely clinics, community health centres and level 1 district hospitals; and community-based services, or “services that complement and enhance facility-based services by providing services in a community setting” (Western Cape Department of Health, 2007). The clinical nurse practitioner is central to the nurse-driven district health services.

Community-based services are supported by the National Health Act (Act No. 61 of 2003), by which “health facilities are required to establish community participation structures to facilitate community participation in the delivery of health services”. There are two main streams for the delivery of community-based services:

- services delivered by health personnel to non-health institutions, for example crèches, schools, prisons, homes for the elderly, day care centres, places of safety and workplaces;
- services delivered by non-profit organizations, for example community-based sub-acute or step-down facilities for de-hospitalized patients, respite centres, chronic or lifelong care centres, community mental health centres and home-based care services.

It was envisaged that the full package of district hospital services would be provided in the level 1 district hospitals:

- trauma and emergency units at each district hospital;
- hospital outpatient departments;
- maternity units to provide outreach and support to the memoranda of understanding within the sub-districts;
- family medicine practitioners and registrars.

The Comprehensive Service Plan further outlines and discusses the plans and resources, particularly human resources, needed for:

- reshaping of acute hospital services;
- specialized hospitals, for example the Western Cape Rehabilitation Centre and the psychiatric hospital services;
- emergency medical services;
- forensic pathology services.

1.3. Relevant demographic characteristics of South Africa and the three study provinces

The 2011 census in South Africa estimated a total population in nine provinces of 51.7 million, of whom 25.1 million were male and 26.5 million were female. Table 1 shows the breakdown by province and sex. The sex bias of the general population, with women predominating, is particularly strong in the Eastern Cape, where there are around 0.4 million more women than men, a far greater bias than in either the Western Cape or Gauteng. This relates to the traditional role of the Eastern Cape as a mainly rural labour-sending area for the migrant labour system in South Africa, particularly to mines, and especially after the mid-1970s, when the ratio of foreign to domestic labour in the gold mines, for example, switched from 2:1 to 1:2, as a result of the withdrawal of foreign labour to the mines from Malawi (1974) and Mozambique (independence 1975).

Table 1. Population by province and sex

Sex	Western Cape	Eastern Cape	Northern Cape	Free State	KwaZulu-Natal	North West	Gauteng	Mpumalanga	Limpopo	South Africa
Male	2 858 506	3 089 701	564 972	1 328 967	4 878 676	1 779 903	6 189 875	1 974 055	2 524 136	25 188 791
Female	2 964 228	3 472 353	580 889	1 416 623	5 388 625	1 730 049	6 082 388	2 065 883	2 880 732	26 581 769
Total	5 822 734	6 562 053	1 145 861	2 745 590	10 267 300	3 509 953	12 272 263	4 039 939	5 404 868	51 770 560

Note: There were 25.2 million (48.7 per cent) males counted in the 2011 census, compared to 26.6 million (51.3 per cent) females.

Source: Statistics South Africa, 2011a, p. 19, table 2.2.

Table 2 shows that while 8.6 per cent of all persons in the country had no schooling at all, the figure for the Eastern Cape was even higher at 10.5 per cent, with only around 20 per cent matriculants, compared to 28.4 per cent nationally, and 28.1 per cent and 34.2 per cent in the Western Cape and Gauteng respectively.

Table 2. Percentage distribution of persons aged 20 years and older by highest level of education completed and province

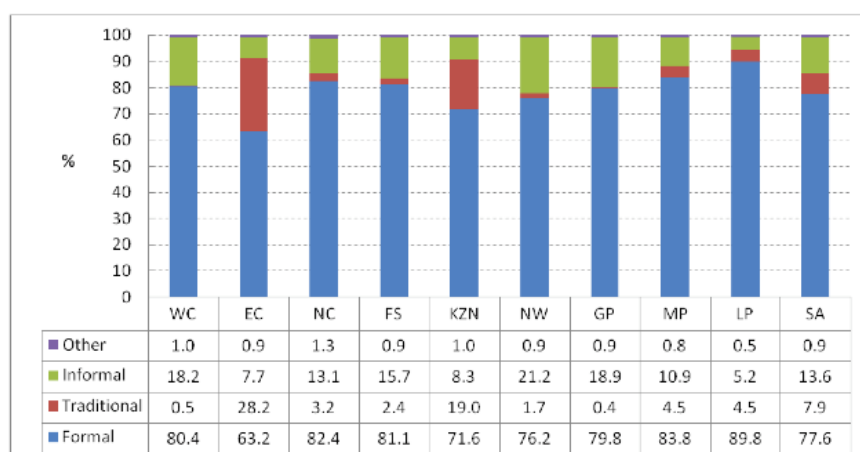
Level of education	Western Cape	Eastern Cape	Northern Cape	Free State	KwaZulu-Natal	North West	Gauteng	Mpumalanga	Limpopo	South Africa
No schooling	2.7	10.5	11.3	7.1	10.7	11.8	3.6	14.0	17.3	8.6
Some primary	10.7	18.2	17.1	16.1	13.6	16.8	7.4	11.7	11.6	12.2
Completed primary	5.6	6.2	6.3	5.3	4.2	5.3	3.4	4.2	4.3	4.6
Some secondary	38.1	36.3	34.9	34.6	31.1	33.1	32.8	31.3	34.8	33.8
Grade 12/stan. 10	28.1	19.8	22.7	26.7	30.8	25.1	34.2	28.9	22.3	28.4
Higher	14.4	8.7	7.5	9.8	9.3	7.7	18.0	9.6	9.5	12.1
Other	0.5	0.2	0.3	0.3	0.3	0.2	0.5	0.3	0.2	0.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Statistics South Africa, 2011a, p. 49, table 2.22.

With regard to the types of housing prevalent in the provinces of interest (figure 1), again, there is a large disparity between the Eastern Cape, with 63 per cent formal (brick), 28 per cent traditional (mud huts), and 7 per cent informal (self-build shacks), and the Western Cape, with 80 per cent formal and 18 per cent informal, or Gauteng, with 79.8 per cent formal and 18.9 per cent informal. These conditions determine health status to a large degree directly, and therefore the type and quantity of demand for health services.

The pattern continues, with only 78 per cent of Eastern Cape dwellers having access to piped water, compared to nearly 100 per cent of those in the much more urbanized Western Cape and Gauteng provinces (figure 2). In the Eastern Cape, nearly 13 per cent of persons had no toilet facilities at all, compared to only 3 per cent in the Western Cape and 1 per cent in Gauteng province (figure 3). Again, the dramatic differences between these provinces are a direct health issue, with powerful consequences for the burden of disease.

Figure 1. Percentage distribution of households by type of main dwelling and province

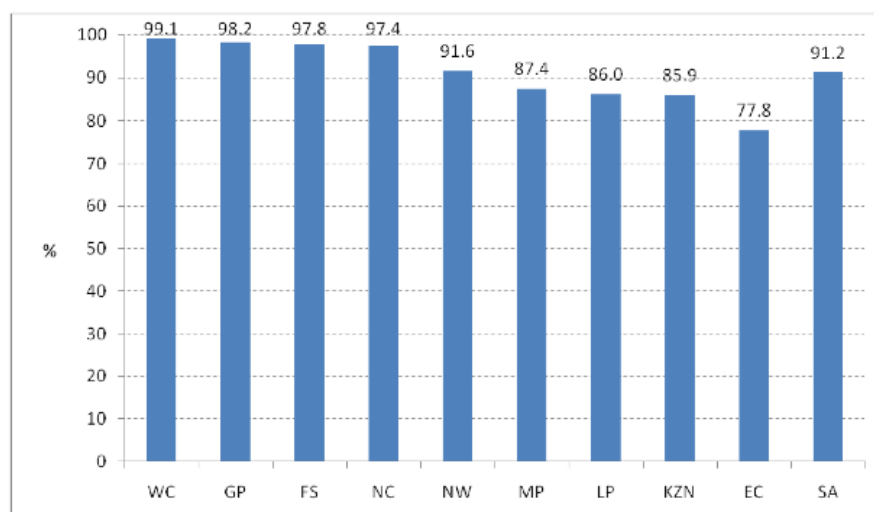


A high proportion of households in South Africa live in formal dwellings (as the main type of dwelling), with Eastern Cape having the lowest proportion living in formal dwellings.

Key: WC = Western Cape, EC = Eastern Cape, NC = Northern Cape, FS = Free State, KZN = KwaZulu-Natal, NW = North West, GP = Gauteng, MP = Mpumalanga, LP = Limpopo, SA = South Africa.

Source: Statistics South Africa, 2011a, p. 64, figure 3.1.

Figure 2. Percentage of households in each province with access to piped water

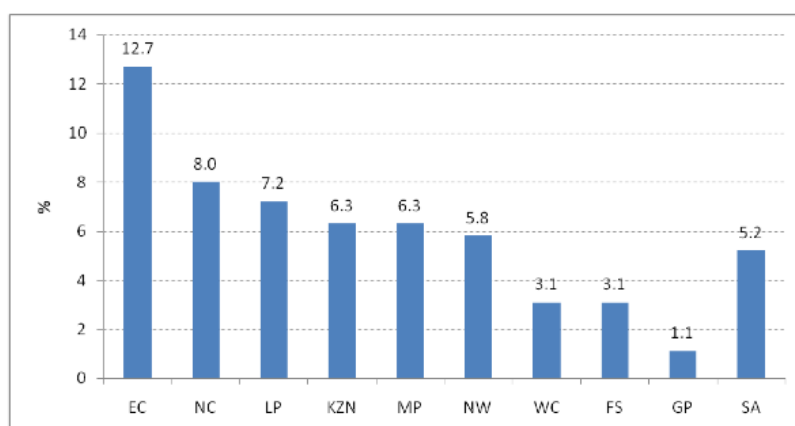


There are four provinces (WC, GP, FS, NC) where more than 95% of households have access to piped water.

Key: WC = Western Cape, EC = Eastern Cape, NC = Northern Cape, FS = Free State, KZN = KwaZulu-Natal, NW = North West, GP = Gauteng, MP = Mpumalanga, LP = Limpopo, SA = South Africa.

Source: Statistics South Africa, 2011a, p. 78, figure 3.3.

Figure 3. Percentage of population with no toilet facilities, by province



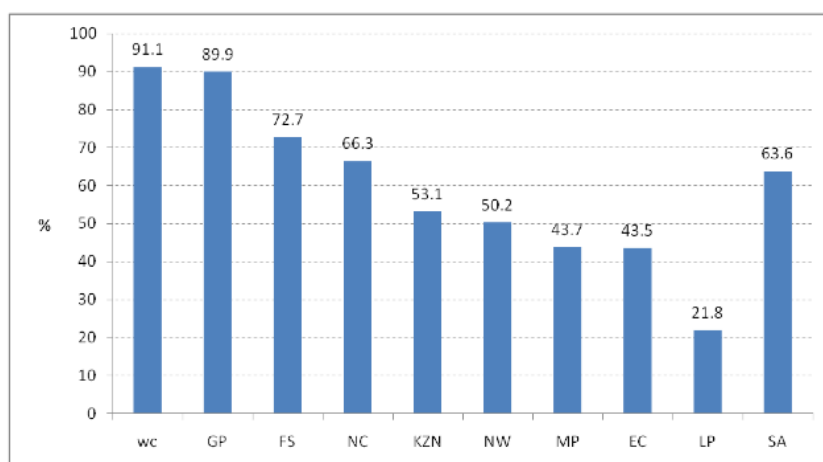
In Gauteng one in every hundred households is without any toilet facility whereas in Eastern Cape one in eight households has no toilet facility.

Key: WC = Western Cape, EC = Eastern Cape, NC = Northern Cape, FS = Free State, KZN = KwaZulu-Natal, NW = North West, GP = Gauteng, MP = Mpumalanga, LP = Limpopo, SA = South Africa.

Source: Statistics South Africa, 2011a, p. 86, figure 3.7.

For South Africa as a whole, 63 per cent of the population had their refuse collected by a local authority, compared to 91 per cent and 89 per cent respectively in the Western Cape and Gauteng provinces, but merely 21 per cent in the Eastern Cape (figure 4). These figures delineate a substantial deficit in the roll-out of municipal and provincial basic services in the rural provinces such as the Eastern Cape, with major threats to the health and welfare of the populations there. These inequalities have a great impact on the work of health service staff in the most impoverished areas of South Africa, which in turn affects their workload and working hours.

Figure 4. Percentage of households with refuse removed by local authority, by province



Limpopo province has the lowest proportion of households that has its refuse removed by a local authority, whereas Western Cape has the highest.

Key: WC = Western Cape, EC = Eastern Cape, NC = Northern Cape, FS = Free State, KZN = KwaZulu-Natal, NW = North West, GP = Gauteng, MP = Mpumalanga, LP = Limpopo, SA = South Africa.

Source: Statistics South Africa, 2011a, p. 97, figure 3.11.

Table 3 brings the extent of internal migration in South Africa sharply into focus, and shows how the rural provinces, with their “labour-sending” history, have emptied out to the great conurbations in provinces such as the Western Cape and Gauteng (both Greater Johannesburg and the mining areas further afield in the province). Fully 94 per cent of those enumerated in the Eastern Cape had been born there, indicating a one-way migration

from the province, compared to about 72 per cent of those in the Western Cape, and merely 56 per cent of those in Gauteng, the melting pot of Africa, with migration both to and from the province. Conversely, 16.2 per cent of those counted in the Western Cape were born in the Eastern Cape, a very large oscillating migration, while the largest single migration into Gauteng was from Limpopo province (10.8 per cent of whose natives were estimated to be resident in Gauteng at the time of the census).

Table 3. Migration patterns (birth to current residence) by province, South Africa, 2011

Province/ country of birth	Province where counted									
	Eastern Cape	Free State	Gauteng	KwaZulu-Natal	Limpopo	Mpumalanga	North West	Northern Cape	Western Cape	South Africa
Eastern Cape	94.0	2.5	4.5	2.9	0.4	1.6	2.7	2.0	16.2	15.8
Free State	0.4	87.3	3.2	0.4	0.3	1.2	2.9	1.9	0.8	6.5
Gauteng	1.2	2.7	56.0	1.3	2.5	4.7	4.9	1.6	2.9	15.1
KwaZulu-Natal	0.7	1.0	5.9	92.0	0.2	2.8	1.0	0.8	1.2	20.2
Limpopo	0.1	0.6	10.8	0.2	90.9	4.2	2.8	0.3	0.3	12.8
Mpumalanga	0.2	0.5	4.3	0.4	1.6	79.9	1.2	0.3	0.4	7.7
North West	0.1	1.1	3.5	0.2	0.6	0.8	78.3	3.7	0.3	5.9
Northern Cape	0.4	1.0	0.8	0.6	0.1	0.7	1.3	85.2	1.5	2.6
Western Cape	1.7	0.8	1.5	0.3	0.4	0.4	0.5	2.5	71.9	8.9
Outside S. Africa	1.2	2.5	9.5	1.7	3.	3.7	4.4	1.7	4.5	4.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Statistics South Africa, 2011a, p. 35.

1.4. Selected labour force characteristics of South Africa and the three study provinces

Table 4 shows that the rural–urban inequalities discussed above are mirrored in the labour market in the country. The official unemployment rate in the Eastern Cape was estimated to be 5 per cent higher (30.8 per cent) than that in the Western Cape and Gauteng, which were roughly equal at 24 per cent and 25 per cent respectively – close to the national average. Only one third of the total population of the Eastern Cape were involved in economic activity (employment or self-employment), compared to just over half of those in the other two provinces, which exceeded the low national average labour absorption rate of 41 per cent by almost 10 per cent. A similar pattern emerges with regard to the ratio of employment-age persons in employment to the total in that age group. Finally, the Eastern Cape unofficial unemployment rate is a very high 45.2 per cent compared to 26.7 per cent in the Western Cape and 30 per cent in Gauteng, showing an enormous indigent population in the Eastern Cape who are willing and able to work, but have given up trying to find work of any kind.

Table 4. Labour force statistics, South Africa and selected provinces

Indicator	Definition	Western Cape	Eastern Cape	Gauteng	South Africa
Unemployment rate (official)	Ratio of unemployed but active jobseekers aged 15–64 to the total number of persons in that age group	24.0	30.8	25.0	25.6
Labour absorption rate	Ratio of total number of persons involved in economic activity to the total population	51.2	31.1	52.2	41.1
Labour force participation rate	Ratio of persons aged 15–64 in economic activity to the total in that age group	67.3	44.9	69.6	55.3
Unemployment rate (expanded)	Ratio of unemployed persons including discouraged jobseekers aged 15–64 to the total number of persons in that age group	26.7	45.2	30.0	36.8

Source: Statistics South Africa, 2013, tables 2.2 and 2.3.

Table 5 switches the focus to the community and social services sector (mainly health, education and welfare), both private and publicly owned and financed; the informal or formal sector; and the gender dimension. The community and social services sector, which includes the public health sector, is the largest single sector in the country in terms of employment, being estimated at 22.23 per cent of all employed persons in South Africa (3.05 million out of a total employed workforce of 13.72 million). A large majority of these 3.05 million persons are in the public sector, by far the largest contributor to the community and social services sector. Women are highly disproportionately represented in community and social services (males 39 per cent, females 60 per cent) compared to the entire economy, itself skewed towards men in the labour force (56 per cent male, 44 per cent female). This has many implications for the question of working hours in the health sector, a major component of community and social services, because of the “double burden” of production and reproduction that employed women carry in South Africa, to a much greater extent than in Europe, for example. The female character of the community and social services sector is also shown by the fact that only 15 per cent of all males in the employed labour force were working in the sector, while almost one third of all employed women worked in the sector (30.40 per cent).

Table 5. Profile (by sex) of all employed persons (all sectors) and the (public and private) community and social services sector

Sex	All sectors (million)	Community and social services: public and private sectors (million)	Community and social services as proportion of all sectors (%)	Sex proportions in all sectors (%)	Sex proportions in community and social services sector (%)
Both	13.72	3.05	22.23	–	–
Male	7.68	1.22	15.81	56.00	39.84
Female	6.04	1.84	30.40	44.00	60.16

Source: Statistics South Africa, 2013, table 3.1.

The highly “feminized” nature of the community and social services sector (for example, in 2010, only 8 per cent of all nursing staff in South Africa were male) has implications for what hours workers in the sector actually work, as table 6 demonstrates (Department of Health, South Africa, 2011). In the economy as a whole, the ratio of women working few hours per week (less than 15 hours) to men doing so is more than 2:1, while the converse (ratio of women to men working more than 45 hours per week) is almost 1:2.

Table 6. Working hours by sex for all employed persons in South Africa

Usual working hours	Sex (millions)			Ratio female to male	Proportion by sex (%)	
	Both	Female	Male		Female	Male
Working < 15 hours per week	0.25	0.17	0.08	2.13	2.8	1.0
Working 15–29 hours per week	0.83	0.52	0.31	1.68	8.6	4.0
Working 30–39 hours per week	1.01	0.64	0.36	1.78	10.6	4.7
Working 40–45 hours per week	7.49	3.20	4.25	0.75	53.0	55.3
Working > 45 hours per week	4.12	1.45	2.67	0.54	24.0	34.8
Total	13.72	6.04	7.68	0.79	100.0	100.0

Source: Extrapolated from Statistics South Africa, 2013, table 3.7.

Generally, women work fewer average hours than men, reflecting both the traditional “double burden” issue and discrimination against women, who are much more likely to work on a part-time basis than men. Many more men work long hours than do women. There is more conformity however in the band 40–45 hours of work per week, which comprises 53 per cent of all women employed, compared to 55.3 per cent of men. This pattern, which is likely to be mirrored in such a large female-dominated sector as community and social services, would suggest that about half the women in the health sector (a highly feminized sector in terms of numbers) work similar hours – about half of them working full time, and the rest working various part-time schedules.

In terms of basic conditions of employment, the second quarter 2013 labour force survey (Statistics South Africa, 2013) shows that there are many advantages to working in the community and social services sector, compared to other (private) sectors of the economy (table 7). This is a result of the steady improvement in terms and conditions of employment in the public sector for the mass of its workers as the new labour laws have been promulgated after 1994. Coverage of paid annual leave, sick leave, maternity and paternity leave, and medical aid scheme coverage through employment, are all significantly greater in the community and social services sector than for the economy as a whole. The only exception, curiously, is the coverage by statutory unemployment pay.

Table 7. Basic conditions of employment in the community and social services (private and public) sector, compared to South Africa as a whole (2nd quarter 2013)

Main terms and conditions category	Detailed terms and conditions	Proportion of employed (%)		Ratio community and social services sector/entire economy
		Community and social services	All sectors	
Access to employment-related non-wage benefits	Paid annual leave	77.9	63.4	1.2
	Paid sick leave	79.9	68.8	1.2
	Maternity/paternity leave	71.2	52.7	1.4
	Unemployment Insurance Fund (unemployment statutory pay)	38.2	62.1	0.6
	Medical aid scheme through employment	60.3	31.5	1.9
Nature of employment contract or agreement with employer	Limited duration (temporary contract)	14.7	14.1	1.0
	Permanent	74.3	63.0	1.2
	Unspecified	10.9	23.0	0.5
How annual salary increment is negotiated	Individual and employer	6.1	10.3	0.6
	Union and employer	30.5	21.4	1.4
	Bargaining council	26.6	8.9	3.0
	Employer only	33.5	53.9	0.6
	No regular increment	3.2	5.0	0.6

Source: Extrapolated from Statistics South Africa, 2013, figures 10–12.

Around 74 per cent of community and social services workers have permanent contracts, compared to 63 per cent of all sectors in the economy, though both community and social services and all sectors have around 14 per cent on limited duration (temporary) contracts. This may be a misrepresentation, as for fully 23 per cent of all workers sampled the type of contract was not specified, while this figure was only 10.9 per cent for community and social services workers, which suggests that perhaps many in the non-specified category were in fact temporary workers. Successive labour force surveys in the 2000s have shown that almost all new jobs created in the decade, including those around the three or four boom years (in terms of GDP growth) in the mid-decade, were temporary jobs, but less so in the public service, which dominates the community and social services sector, though temporary jobs in that sector still stand at one job in seven.

Again, in terms of annual salary increments, community and social services workers have much more organized methods than the national average, because around 57 per cent of those workers have annual increments negotiated either between a trade union and the employer, or through the (public sector) bargaining councils, which constitute an enormously important and influential labour market institution in South Africa, as will be examined in the last part of this review. This contrasts strongly with the only 30 per cent average for workers in the country. The public sector is highly organized on both employer and worker sides in South Africa.

1.5. Aspects of the public health sector in South Africa

This section begins with some international comparisons between the South African public health sector and those in other countries in order to give context to the kind of model that has evolved in South Africa. The countries compared have a relatively high proportion of health expenditure to GDP, but have very different models of health delivery. Brazil, South Africa and Thailand have small numbers of doctors, both in absolute and per population terms, whereas Argentina, Chile, Colombia and Costa Rica have relatively much more doctor-centred systems. Brazil and South Africa, for example, have 17.31 and 5.43 doctors per 10,000 population respectively (South Africa the lowest of all these countries by far), and in their health systems, doctors are respectively 17% and a mere 12% of health professionals (table 8).

Table 8. International comparison of health systems: Benchmarks for staffing of health services per 10,000 population, and health outcomes (2011 data)

International benchmarks	Country						
Indicator	Brazil	Chile	Costa Rica	Colombia	Thailand	Argentina	S. Africa current
Population (millions)	193.7	16.9	4.5	45.6	67.7	40.2	49.3
GDP per capita (US\$)	4 399	6 083	5 043	3 102	2 567	9 880	3 689
% GDP health	9.05	8.18	10.47	6.42	4.31	9.53	8.51
GDP growth (annual %)	(-) 0.64	(-) 1.53	(-) 1.50	0.83	(-) 2.25	0.85	(-) 1.78
Gini index	53.9	52.06	50.31	58.49	53.57	45.77	57.77
Doctors	17.31/17%	15.71/42%	20.42/39%	19.43/58%	8.72/19%	31.96/62%	5.43/12%
Nurses	65.59/64%	10.45/28%	22.19/42%	5.83%/17	33.21/71%	4.87/10%	36.1/80%
Pharmacy	5.81/6%	3.72/10%	5.34/10%	0/0% ^a	2.92/6%	5.08/10%	2.29/5%
Oral health	13.69/13%	7.44/20%	4.85/9%	8.26/25%	1.73/4%	9.28/18%	1.2/3%
Total	102.39/100%	37.32/100%	52.8/100%	33.52/100%	46.59/100%	51.19/100%	45.02/100%
Infant mortality rate (per 1000 live births)	17.3	7.0	9.6	16.2	12.0	13.0	43.1
Maternal mortality ratio (per 100 000 live births)	75.0	18.2	26.7	75.6	12.2	40.0	165.5

Note: The source is not specific on whether these data relate to both public and private sector health services, or only public sector. The statistic on percentage of GDP spent on health might suggest that they refer only the public sector, since private sector health expenditure totals are often not readily available in developing countries.

a. Not explained, though it might reflect the note above – that all pharmacists are in the private sector, so show here as zero.

Source: Department of Health, South Africa, 2011, p. 35.

In addition, these two countries – Brazil and South Africa – have 65.69 and 36.1 nurses per 10,000 population, and nurses are 64 per cent and 80 per cent of their respective health professionals. This pattern does not seem to be particularly related to either GDP per capita ranking, or Gini coefficient (all of these countries have highly unequal income distributions, with Colombia and South Africa the most unequal of all in 2011, the year to which these data relate). The reason for these differences in health delivery models across continents is obviously complex and cannot be inferred from these bald data. The two basic health outcome measures shown in the table also do not suggest any clear pattern about

what type of model (doctor or nurse centred) has given the best results. South Africa is an absolute (negative) outlier with regard to both infant mortality rate and maternal mortality ratio, though Brazil also scores very badly comparatively on the latter measure.

Table 9 presents some results from various sources, especially the South African national health care facilities audit in 2011/12. A total of 3,880 facilities were audited at all levels of the public health service, being the total number of facilities in the sector at the time of the survey. The table also presents some data from provincial Departments of Health on district facility totals for the Eastern Cape, Western Cape and Gauteng, gleaned from annual performance plans. Regional, tertiary and national central hospitals are the great centres of employment, but are obviously a much smaller proportion of total facilities across the country, which are numerous and employ relatively few persons. The table also shows the official operating hours of these facilities, showing the great preponderance of facilities that operate over 24 hours, 7 days a week. Shift work and night work is therefore highly significant in this sector. In contrast, the 3,074 clinics operate for 8 hours per day officially, though some staff may be required to reside near the premises and be on call for emergencies. The 44 community day centres are the only other type of facility that officially operates only in 8 daytime hours per day, though again, emergency cover may be required at times.

Table 9. Type and numbers of public health facilities in South Africa, operating times, and selected numbers for facilities at district level for the three study provinces

	Facility classification (1)	No. of facilities in South Africa (1)	Operating times of facilities (2)	Eastern Cape (3)	Western Cape (4)	Gauteng (5)
District-level facilities	Clinic	3 074	8 daytime hours (some staff may be required to sleep near premises and be on call at night for emergencies)	716 (fixed) 145 (unfixed)	225 (fixed) 169 (unfixed), incl. 92 under City of Cape Town)	307
	District hospital	253	All hours	66	34	10
	Community health centre	238	All hours	42	9	34
	Satellite clinic	125	?			
	Community day centre	44	8 daytime hours per day		50	
Other facilities	Regional hospital	55	All hours			
	Tuberculosis hospital	35	All hours			
	Psychiatric hospital	23	All hours			
	Tertiary hospital	10	All hours			
	National central hospital	6	All hours			
	Specialized clinic	4	?			
	Chronic hospital	4	All hours			
	Rehabilitation hospital	3	All hours			
	Tuberculosis and psychiatric hospital	2	All hours			
	Private hospital	1	All hours			
	Orthopaedic hospital	1	All hours			
	Maternal obstetrics unit	1	All hours			
	Children's hospital	1	All hours			

Sources: Health Systems Trust, 2013; Health-e News, 2006; Eastern Cape Department of Health, 2012; Eastern Cape Department of Health annual performance plans

(http://archive-za.com/za/e/ecdoh.gov.za/2013-04-02_1794937-titles_21/Eastern_Cape_Department_of_Health_POLICIES_amp_LEGISLATION_Regulations/).

The public health sector has continued to grow in terms of employment of health professionals throughout the first decade of the 21st century (tables 10 and 11). In particular, the following is the percentage increase nationally in some key health professions in the sector between 2002 and 2010:

- medical practitioners: 60 per cent increase

- medical specialists: 26 per cent increase
- nursing assistants: 23 per cent increase
- professional nurses: 35 per cent increase
- staff nurses and pupil nurses: 50 per cent increase
- ambulance and related workers: 127 per cent increase
- emergency services personnel: 2,743 per cent increase (from low start).

Table 10. Increase in public sector health personnel 2002–2010, by job category

Occupational classification	2002	2003	2004	2005	2006	2007	2008	2009	2010
Medical practitioners	7 291	7 517	8 039	8 595	9 415	9 989	10 462	11 036	11 664
Medical specialists	3 585	3 437	3 579	3 595	4 108	4 091	4 213	4 413	4 513
Pharmacologists, pathologists and related professionals	5	4	6	10	65	49	45	47	47
Nursing assistants	28 566	29 426	30 651	31 672	33 449	34 025	34 103	34 652	35 376
Professional nurses	40 786	41 871	42 676	43 791	44 725	47 863	49 226	51 592	55 309
Staff nurses and pupil nurses	20 305	20 807	20 594	20 826	21 797	22 649	23 099	24 201	26 338
Student nurses	7 136	7 546	8 055	8 361	9 065	9 386	9 634	10 285	10 772
Dental practitioners	527	545	573	662	739	739	648	792	828
Dental specialists	30	31	37	45	41	35	47	61	134
Dental technicians	38	32	34	37	36	34	33	31	33
Dental therapists	125	124	140	150	155	157	152	173	221
Ambulance and related workers	4 686	5 397	6 071	7 517	8 796	9 705	10 984	10 244	10 560
Emergency services personnel	58	114	122	166	362	532	538	1 698	2 229
Pharmaceutical assistants	353	329	337	379	511	638	674	1 012	1 059
Pharmacists	1 234	1 203	1 381	1 574	1 678	1 742	1 790	2 344	3 285
Radiographers	1 984	1 996	2 019	1 974	2 041	2 052	2 086	2 148	2 282
Supplementary diagnostic radiographers	178	197	178	184	186	173	165	162	174
Community development workers	179	187	202	200	219	178	157	73	101
Dieticians and nutritionists	262	364	410	416	506	536	585	647	763
Environmental health practitioners	533	767	791	843	840	819	735	737	789
Health science professionals	1 354	1 434	2 045	2 326	2 636	3 256	5 963	6 060	6 330
Medical researchers and related professionals	83	97	89	70	74	70	69	73	75
Medical technicians and technologists	865	828	786	787	425	402	410	402	397
Occupational therapists	414	531	565	578	649	685	768	776	837
Optometrists and opticians	24	27	35	53	67	72	82	113	126
Oral hygienists	127	127	142	140	144	152	156	163	194
Physiotherapists	459	617	686	706	741	823	863	932	970
Psychologists and vocational counsellors	273	312	385	399	423	431	454	494	529
Speech therapy and audiology	124	209	223	255	263	283	326	347	396
Core administration			22 532	23 966	27 088	29 330	30 965	31 184	34 180
Total			153 383	160 277	171 244	180 896	189 432	196 892	210 511

Source: Department of Health, South Africa, 2011, p. 22.

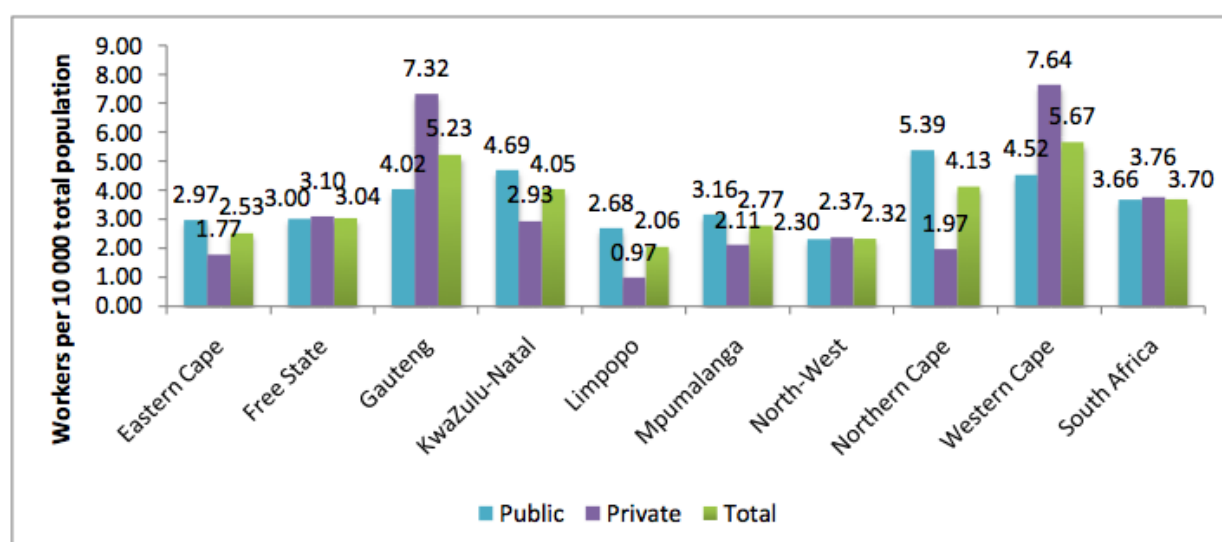
Table 11. Percentage increase in selected public sector health professionals, absolute and per population, 2002–2010

Occupational classification	Absolute numbers				Per 10 000 uninsured population			
	2002	2010	% increase	Ave. annual increase	2002	2010	% increase	Ave. annual increase
Medical practitioners	7 291	11 664	60.0%	6.1%	1.89	2.85	50.6%	5.3%
Medical specialists	3 585	4 513	25.9%	3.0%	0.93	1.10	18.5%	2.3%
Professional nurses	40 786	55 309	35.6%	3.9%	10.57	13.49	27.6%	3.1%
Dental practitioners	527	828	57.1%	6.3%	0.14	0.20	47.9%	5.5%
Pharmacists	1 234	3 285	166.2%	13.8%	0.32	0.80	150.6%	13.0%

Source: Department of Health, South Africa, 2011, p. 24.

Figure 5 shows the differences between provinces and the national average with regard to medical practitioners (doctors) in the public and private sectors respectively. First, it shows the relatively low number of doctors per population in the Eastern Cape health sector (both public and private, with public better than private) compared to both the Western Cape and Gauteng, where doctors are concentrated in the private sector, and where doctors per population are substantially higher than in the public sector. Here again, the deficit in both private and public sectors in the Eastern Cape is clear. The Western Cape coverage by doctors in both the public and private sectors is much higher, but slightly better in the Western Cape than in Gauteng.

Figure 5. Number of medical practitioners (doctors) per population in public and private sectors respectively, by province, South Africa, 2010

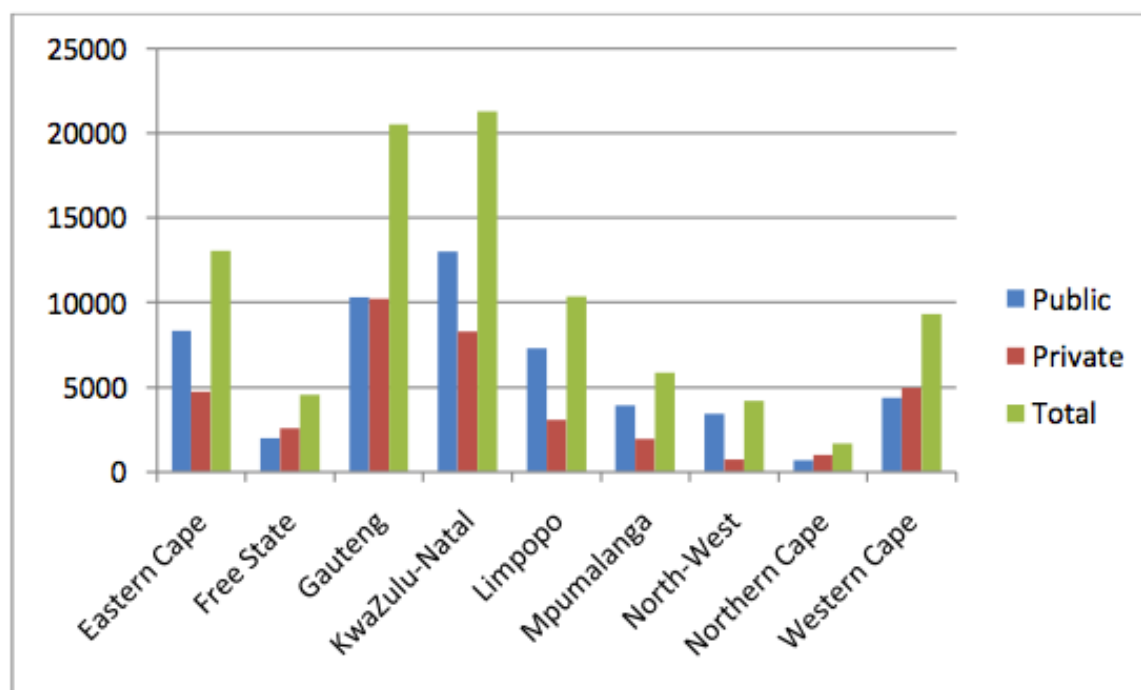


Note: A large percentage of the uninsured also visit private medical practitioners. According to Econex Health Reform Note 4, 36.7% of the total population in 2008 used private sector medical practitioners (GPs) for their primary healthcare needs

Source: Department of Health, South Africa, 2011, p. 29.

Figure 6 shows the absolute numbers of nurses per province. The Eastern Cape has a total of around 13,000, with around 8,000 in the public sector, and just less than 5,000 in the private sector. The corresponding figures for the Western Cape and Gauteng are 9,000, 4,000, and 5,000; and 20,000+, 10,000 and 10,000, respectively. For the three provinces, the total number of nurses in both sectors is therefore around 42,000. A very large proportion of them work shifts, including night work, so this is a very large shift-working, mostly female population. The implications for child care, caring roles in general, commuting and fatigue are enormous.

Figure 6. Number of professional nurses actively working in public and private health sectors, by province, 2010



Source: Department of Health, South Africa, 2011, p. 30.

Another variable that affects the workload and working hours in the health sector is the issue of staff shortages, which is an acknowledged problem in the public health sector nationally. Table 12 shows the vacancy rates reported in an influential human resource strategy and policy document for the public health sector for the years 2012–2017. The national picture shows that for the year 2010, there were 106,518 unfilled vacancies in the public health sector for health professionals. These are establishment posts according to service delivery priorities decided at the highest levels in line with budgetary constraints in the medium-term expenditure framework of the Treasury. The bulk of the unfilled vacancies are among medical practitioners, nursing assistants, professional nurses, staff nurses and pupil nurses (a total of 92,785, or 87 per cent of all unfilled vacancies; the largest single group is “professional nurses”, the backbone of the service). This large shortage puts a very considerable strain on human resources, and therefore on health care delivery in the public service, as successive annual reports in all provinces and the National Department of Health have pointed out in the past 10 years.

Table 12. Public sector vacancies in 14 clinical professions, by province, 2010

Occupational classification	South Africa		Western Cape		Eastern Cape		Gauteng	
	Public sector vacancies	Cost of filling vacancies (rand)	Public sector vacancies	Cost of filling vacancies (rand)	Public sector vacancies	Cost of filling vacancies (rand)	Public sector vacancies	Cost of filling vacancies (rand)
Medical practitioners	10 860	8 653 486 920	545	434 267 990	806	642 238 532	1 118	890 846 996
Medical specialists	3 491	3 673 355 876	397	417 737 692	418	439 834 648	533	560 841 788
Nursing assistants	20 943	2 679 426 477	1 253	160 307 567	4 585	586 600 315	582	74 460 498
Professional nurses	44 780	17 625 004 980	2 272	894 238 752	16 683	6 566 278 653	1 720	676 976 520
Staff nurses and pupil nurses	16 202	2 704 518 850	927	154 739 475	3 480	580 899 000	575	95 981 875
Dental practitioners	921	496 330 584	33	17 783 832	162	87 302 448	59	31 795 336
Dental specialists	155	163 096 580	30	31 567 080	27	28 410 372	37	38 932 732
Dental therapists	287	81 677 904	22	6 261 024	85	24 190 320	6	1 707 552
Pharmacists	3 745	1 541 127 420	229	94 237 164	373	153 495 468	263	108 228 708
Radiographers	1 621	204 758 236	96	12 126 336	293	37 010 588	145	18 315 820
Envir. health practitioners	443	126 074 256	1	284 592	24	6 830 208	31	8 822 352
Occupational therapists	1 260	358 585 920	108	30 735 936	123	35 004 816	101	28 743 792
Physiotherapists	1 074	305 651 808	83	23 621 136	102	29 028 384	86	24 474 912
Psychologists/voc. councillors	699	198 929 808	90	25 613 280	106	30 166 752	77	21 913 584
Total	10 6481	38 812 025 619	6 086	2 303 521 856	27 267	9 247 290 504	5 333	2 582 042 465

Source: Department of Health, South Africa, 2011, Annex A, pp. 6–7.

As with all other parameters, the provincial breakdown of these unfilled vacancies is hugely skewed. The Western Cape has only 6,097 such vacancies, compared to 5,340 in Gauteng, but a massive 27,267 in the Eastern Cape, where the service can only be described as running on a skeleton staff, placing great strain and overload on staff to deal with a similarly skewed burden of disease. This is a crisis of enormous proportions for the Eastern Cape health service.

The following paragraphs explore this question of vacancy rates in the three provinces in a little more detail using available data of varying vintages in an attempt to see which parts of the public health service are most affected. Table 13 (Gauteng province) shows a higher vacancy rate (35.97 per cent of approved posts unfilled) among medical officers in primary health care than in district hospitals (30 per cent). The reverse is true for professional nurses, where the corresponding vacancy rates are 16.78 per cent and 25.95 per cent respectively. This is in line with the intended nurse-based primary health care system in communities, though even there, one in six professional nursing posts are vacant. The shortage of pharmacists is very high (58 per cent vacancy rate) in district hospitals, which no doubt puts considerable stress upon nurses administering medicine regimens to clients in these facilities.

Table 13. Gauteng Department of Health vacancy rates for various categories of staff in primary health care roles and in district hospitals

	Post filled	Posts approved	Vacancy rate (%)
Primary health care facilities			
Medical officers	210	328	35.97
Professional nurses	2 756	3 312	16.78
Pharmacists	81	110	26.36
Community health workers	–	–	–
District hospitals			
Medical officers	294	426	30.98
Professional nurses	773	1 044	25.95
Pharmacists	34	82	58.53

Source: Gauteng Department of Health, n.d., p. 36.

Table 13 does not give figures for community health workers because this programme is still developing nationally (and indeed is seen as critical to the future plans for the primary health care system in the country, as outlined in the National Development Plan, which forecasts the need for 700,000 community health workers by 2030) (National Planning Commission, 2012). However, the Gauteng health performance plan document reports that health posts are to be established within each district in the province, and estimates that 13,000 community health workers will be required ultimately in the short-to-medium term. In the year 2010/11, there would be 3,000 new community health workers trained, bringing the total to 6,508. The community health workers are not permanent staff members of the department, but are retained on a very modest stipend basis for the role they play in the community. In the Western Cape, in year 2011/12 for example, these community health workers were appointed and trained by 145 community-based non-profit organizations, 92 of which deliver an integrated home-based care service. They are paid a small stipend to deliver home-based care to people with functional impairments, chronic diseases (community adherence counselling) such as HIV/AIDS and tuberculosis, and prevention of ill health and health promotion. By 2010/11, there were 2,853 of these workers in the Western Cape province. Each care worker should do between 6 and 10 home visits per day, and are supervised by professional nurses appointed by non-profit organizations. Of their clients, 36 per cent were over the age of 60 years. In addition they support particular campaigns initiated by the provincial Department of Health, such as measles, which in the year of this report occasioned 1.3 million home visits in the province. They are trained in the community-integrated Management of Childhood Illnesses programme, and 10 per cent of total visits were for children. Little is known about the actual hours they work, though being based in the communities they serve, they are likely to be on call at unsocial hours. This cadre is set to be a major focus in the National Development Plan, and in the National Department of Health until 2030. The trade union movement is cautious about it, however, because of its origin in precariously funded non-governmental organization (NGO) programmes, and its orientation towards community-based employment rather than permanent, protected employment within the collective bargaining framework of the public service.

Table 14 shows the vacancy rates (from 2008) for Gauteng province by type of health professional at whatever level in the service. Nursing staff, the backbone of the service, showed high vacancy rates at all levels in that year, with the highest nursing staff vacancy rate being professional nurses, at 34.1 per cent (more than one in every three posts vacant).

Table 14. Vacancy rates among health professionals, Gauteng Provincial Department of Health, 2008/09

Category	No. employed as at 31 Mar 2009	% of total employed	Number per 100 000 people	Vacancy rate (%)
Medical officers	1 872	4.7	22.6	3.5
Medical specialists	692	1.9	9.3	21.2
Dentists	148	0.5	2.2	0.0
Dental specialists	62	0.1	1.0	5.4
Professional nurses	9 034	18.1	87.0	34.1
Enrolled nurses	3 866	7.5	36.2	25.5
Enrolled nursing auxiliaries	5 636	11.0	52.6	24.9
Student nurses	2 589	10.6	0.3	14.1
Pharmacists	284	0.6	3.0	
Physiotherapists	185	0.4	1.8	20.8
Occupational therapists	179	0.4	1.7	28.1
Radiographers	571	1.1	5.5	29.1
Emergency medical staff	668	1.3	6.3	77.9
Nutritionists	0	0.0	0.0	0.0
Dieticians	144	0.3	1.3	34.2
Community caregivers	0	0.0	0.0	0.0
Total/average	25 930	100.0	2.64	

Note: Table does not include Metropolitan Johannesburg health services and municipal services that are also part of the public sector.

Source: Gauteng Department of Health, n.d., table Admin2, p.30.

As is by now to be expected, the figures for the Eastern Cape in table 15 are much worse, catastrophic even. Two in every three professional nursing posts are vacant, more than one in every two medical officers and enrolled nurses, and so on. These figures must lead to severe exploitation and poor morale among these key workers at the interface with the burden of disease in poor communities, who cannot expect to be treated acceptably under these conditions. The annual performance plan for 2012/13–2014/15 of the Eastern Cape Department of Health describes the challenges due to absenteeism and staff turnover. Both are high, and negatively affect service delivery. Turnover is ascribed to a “brain drain” from the province to urban centres (either to public or private health positions) in South Africa, where working conditions are better. The rural character of the Eastern Cape, lack of proper accommodation, underdevelopment of infrastructure, and lack of recreational facilities are said to drive this exodus. The National Department of Health is trying to stem this flow from rural underserved areas through such measures as a progressive bursary scheme, compulsory community service (for two years) for trained health professionals, and occupation specific dispensation (the setting of salary levels higher for scarce health professional staff). Nevertheless, young graduates prefer to leave the province when they have completed their studies. Finally, the performance plan mentions another factor: the high prevalence of diseases such as HIV/AIDS and tuberculosis among employees in the Department of Health, which exacerbates absenteeism, thereby putting further strain on the understaffed facilities in the province

(Eastern Cape Department of Health, 2012, Part A, p. 46). All of these factors affect working hours for the remaining staff, especially those that interact with the clientele, the general public.

Table 15. Eastern Cape province: Vacancy rates in the public health sector, 2011/12

Category	Number employed	% of total employed	No. per 100 000 people	No. per 100 000 uninsured people	Vacancy rate (%)
Medical officers	935	2.67	14.61	16.12	57.67
Medical specialists	251	0.88	3.92	4.33	65.62
Dentists	81	0.49	1.27	1.40	80.24
Dental specialists					
Professional nurses	7 710	28.01	120.47	132.94	66.77
Enrolled nurses	2 104	5.69	32.88	36.28	55.33
Enrolled nursing auxiliaries	5 268	11.16	82.31	90.83	43.03
Student nurses	1 702	2.57	26.59	29.35	20.13
Pharmacists	269	1.07	4.20	4.64	60.64
Emergency medical staff	1 916	9.33	29.94	33.04	75.22

Source: Eastern Cape Department of Health, 2012, Part A, p. 47.

Table 16 presents vacancy rates for the same categories of health professionals for the Western Cape province (2012), which shows much lower rates in the critical categories than does Gauteng (and Eastern Cape more so, as to be expected). The nursing categories have vacancy rates below 10 per cent, the best in the country. The reasons for this are partly historical, as public health expenditure has been skewed towards the Western Cape for a very long time, going back beyond democracy, and the major teaching hospitals have long existed in the province, with relatively very high resources allocated to them. There has been something of a historical corrective in that regard, with a leavening of expenditure distributions between the provinces since 1994, but it has clearly not deeply affected the staffing levels in the province relatively speaking. In terms of stress and strain on the system, the Western Cape manages quite well in terms of vacancy rates, Gauteng less tolerably, and the Eastern Cape disastrously.

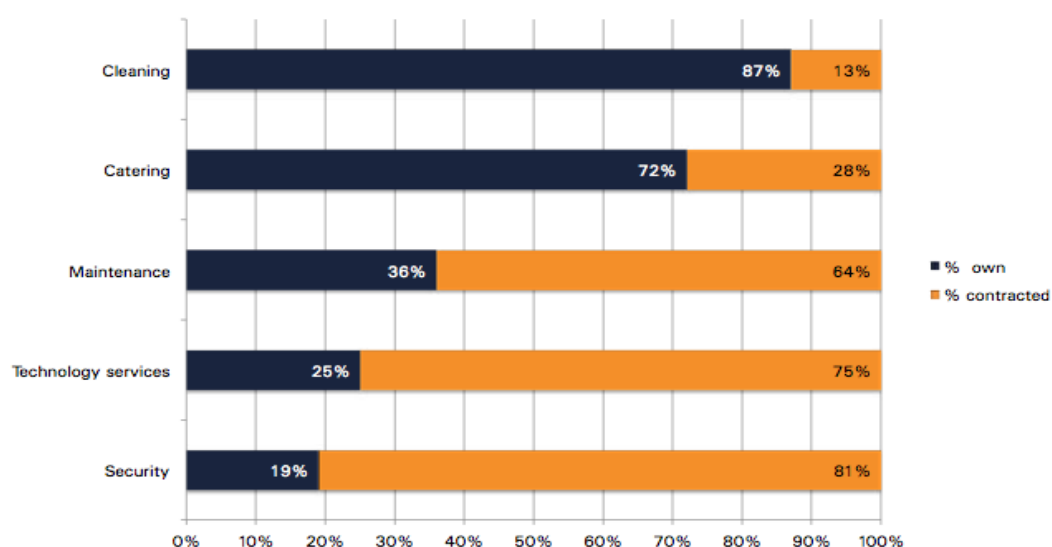
Table 16. Western Cape Department of Health, vacancy rates for various health professional positions, and other information, as of 31 March 2012

Category	Number employed	% of total employed	No. per 1000 people	No. per 1000 uninsured people	Vacancy rate (%)	% of total personnel budget	Annual cost per staff member (ZAR)
Medical officers	1 899	6.36	0.330	0.423	4.19	15.54	614 882
Medical specialists	606	2.03	0.105	0.135	1.94	8.61	1 067 560
Dentists	70	0.23	0.012	0.016	0.00	0.53	564 502
ZAR)Dental specialists	27	0.09	0.005	0.006	6.90	0.25	694 142
Professional nurses	5 720	19.17	0.994	1.274	4.56	23.89	313 753
Enrolled nurses	2 344	7.85	0.407	0.522	3.62	5.71	183 022
Enrolled nursing auxiliaries	4 141	13.88	0.719	0.922	1.96	8.35	151 425
Student nurses	–	–	–	–	–	–	–
Pharmacists	374	1.25	0.065	0.083	9.00	2.20	442 439
Physiotherapists	131	0.44	0.023	0.029	2.24	0.47	269 215
Occupational therapists	136	0.46	0.024	0.030	1.45	0.47	262 155
Clinical psychologists	76	0.25	0.013	0.017	2.56	0.43	425 560
Radiographers	429	1.44	0.075	0.096	2.28	1.77	310 681
Emergency medical staff	1 707	5.72	0.297	0.380	13.44	4.99	219 771

Source: Western Cape Department of Health 2012, p. 73.

Another factor that affects working hours and terms and conditions of employment is the question of outsourcing from the public health sector to agencies or private operators. As with virtually all economic enterprises in South Africa, ancillary (non-core) services have been outsourced to varying degrees (figure 7). For the health facilities audit of 3,880 facilities mentioned above, the main outsourced services, ranked from greatest to least, are security, technological services, maintenance, catering and cleaning. These jobs are mostly temporary, part-time and insecure jobs with labour brokers (agencies) supplying workers on demand to the public health service.

Figure 7. Subcontracting out of ancillary services in all public hospitals in South Africa, 2011



Source: Health Systems Trust, 2013, p. 20.

More information regarding subcontracting of health professional staff in the Gauteng province for the year 2010/11 is provided in table 17. For district health services, emergency medical services, provincial health services and academic health services (the large teaching hospitals), the temporary and subcontracting rate combined were 6.3 per cent, 0.4 per cent, 8.9 per cent (nearly one in ten) and 10.7 per cent (slightly more than one in ten).

Table 17. Analysis of employment types: Number of employees per programme, Gauteng Province, 2010/11

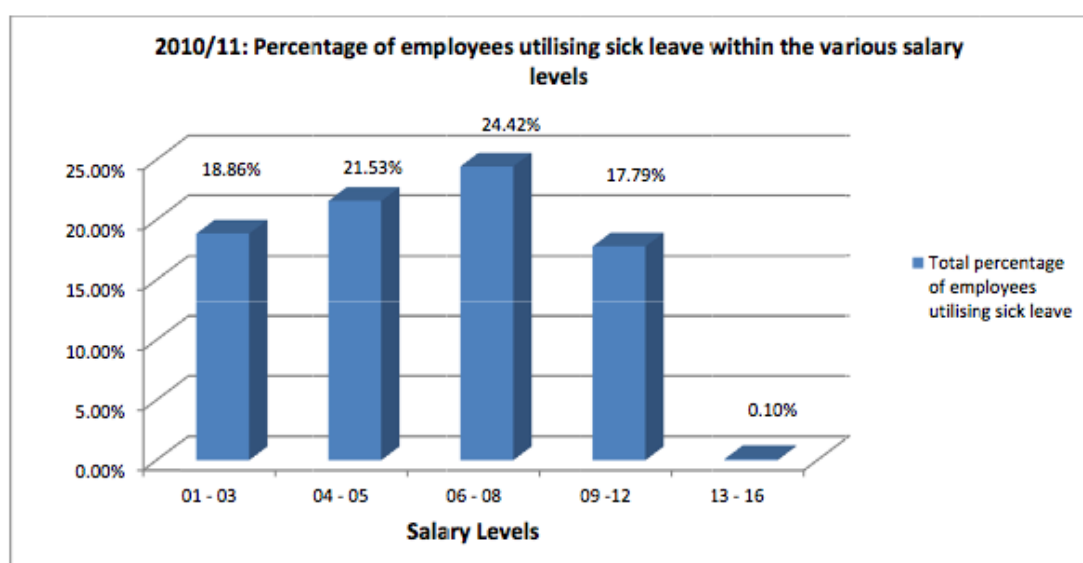
Programme	Temporary	Contract	Permanent	Internship	Total
Administration	36	61	684	428	1 209
District health services	436	376	11 888	0	12 700
Emergency medical services	0	3	688	1	692
Provincial health services	663	760	14 441	55	15 919
Academic health services	548	1 106	13 725	9	15 388
Health sciences	50	4	4 381	0	4 435
Health care support services	0	2	1 098	0	1 100
Health facility management	1	10	21	0	32
Total	1 734	2 322	46 926	493	51 475

Source: Gauteng Department of Health, n.d., p. 93.

In its 2010/11 to 2012/13 annual performance plan, Gauteng provincial Department of Health reported on its quest from 2009 to phase out the use of nursing agency staff by appointing 2,605 staff nurses and nursing assistants, 257 doctors, and 475 professional nurses. However, at the same time it reported high vacancy rates in primary health care facilities, as already seen above. These vacancy rates tend to encourage the continued use of agency staff, as well as adding to the workload (and working hours) for establishment staff.

A further highly important factor affecting workload and working hours (overtime working especially) is the question of absenteeism rates. The Western Cape provincial Department of Health performance plan 2012/13 discusses the problems of absenteeism and turnover affecting the service. The highest level of sick leave usage was among production workers and front-line supervisors, and overall sick leave usage increased by 4 per cent from the previous year. While the use of sick leave in this reporting year was not considered “abnormal”, it is acknowledged that it is affecting service delivery, and particularly occurs in the lower salary bands in the service (figure 8). Abuse of sick leave is investigated, while an employee wellness unit is designed to deal with particular problems experienced by staff. However, wellness units tend to concentrate very much on health promotion only.

Figure 8. Absenteeism rates by salary band, Western Cape provincial Department of Health



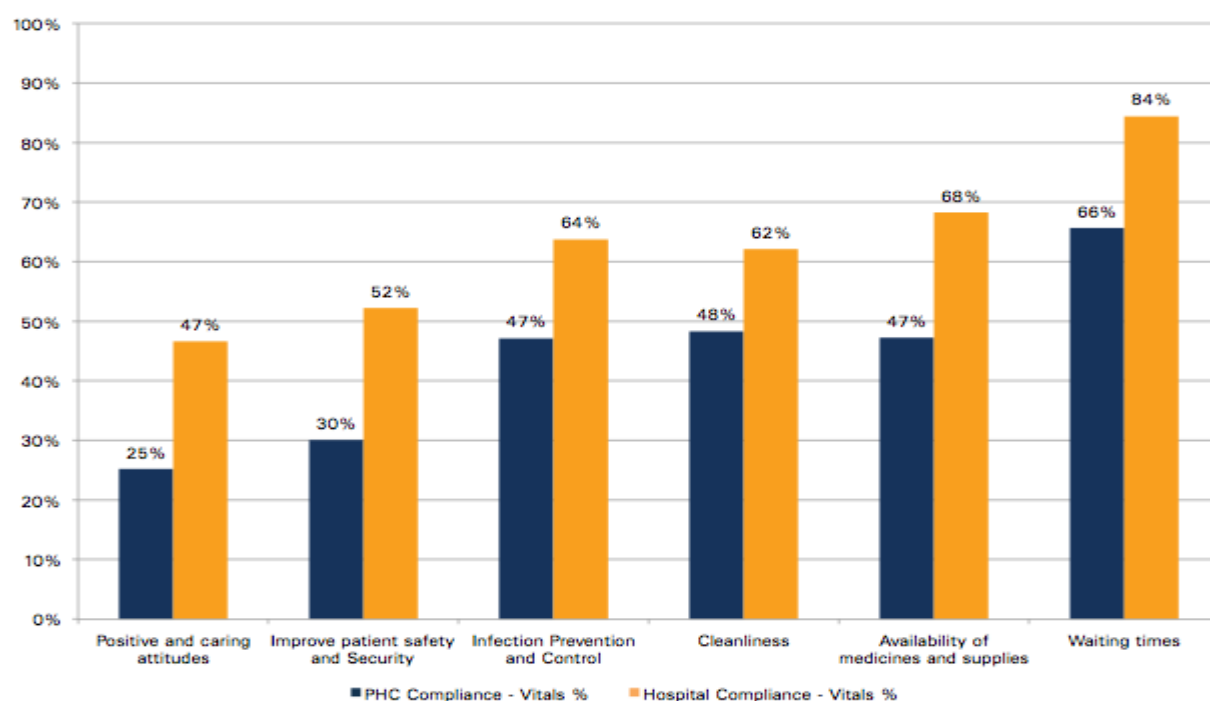
Source: Western Cape Department of Health, n.d., p. 55.

In the same province, staff turnover is similarly a major problem affecting staffing levels. The overall average staff turnover rate in this reporting year was 14.95 per cent, and this was only marginally affected by termination of fixed-term contract staff (0.84 per cent). Above-average turnover rates were exhibited by health professionals such as dietitians, physiotherapists, pharmacists and their assistants, professional nurses (especially in general services), technologists, clinical psychologists, radiographers (production), occupational therapists (production), dentists, medical officers, specialists (especially heads of departments), medical officers (production), artisans and administrative supervisors. The challenges identified with regard to turnover were the lack of recruitment and retention strategies, the lack of conducive working environments (especially ageing equipment), budget constraints, the lack of skills development of existing staff, inability to compete with the private sector, and in the global market for health professionals. All of these are being addressed gradually by the provincial Department of Health. Nevertheless, staff shortages in many departments, and the lack of requisite skills, put pressure on the workload and working hours of the staff, especially production grades (those who interface with the clientele).

The factors discussed here affecting workload, stress and working hours also affect client care in the health service. Figure 9 and table 18 look at some of the substantive findings of the recent national health facilities audit to illustrate this point.

The audit was conducted by trained inspectors looking at a raft of indicators for six priority areas of performance at health facilities, the “priority areas on vital measures”, namely: positive and caring attitudes, improve patient safety and security, infection prevention and control, cleanliness, availability of medicines and supplies, and waiting times (experienced by patients). Figure 9 shows the average scores on these core measures separately for primary health care facilities and hospitals (of all types). Scores for primary health care facilities are always worse than for hospitals. From worst scores to best, the priority areas for both are in the order listed above (positive and caring attitudes, improve patient safety and security, infection prevention and control, cleanliness, availability of medicines and supplies, and waiting times (experienced by patients). Table 18 shows that, interestingly, Gauteng scores best on all priority measures (despite its higher vacancy rates), the Western Cape somewhat behind (especially on the first three areas), and the Eastern Cape the worst, by a large margin.

Figure 9. Compliance with the six priority areas on vital measures for primary health care and hospitals, 2011



Source: Health Systems Trust, 2013, p. 16, figure 14.

Table 18. Average scores on priority audit areas of public health facilities, by province of interest

Priority audit areas	Average % scores on audit of all facilities		
	Western Cape	Gauteng	Eastern Cape
Positive and caring attitudes	37	50	22
Improve patient safety and security	39	58	34
Cleanliness	50	61	47
Infection prevention and control	50	65	53
Availability of medicines and supplies	60	68	54
(Patient) waiting times	69	79	75
Overall compliance scores	57	69	51

Source: Extrapolated from Health Systems Trust, 2013, figures 3, 4, 6, 12.

1.6. Aspects of the private health sector in South Africa

This section will focus on the private health sector, to marshal available data on its size and internal structure. For obvious reasons, this sector does not generate a large number of public data, since such data have commercial implications in a profit-seeking and intentionally financialized market. One source of data, however, is the recent investigations by the Competition Commission of the sector, which has generated two important background papers on the private health sector as a whole, and these are drawn on here.

Table 19 shows the real growth rate in expenditure on the sector by destination. Expenditure exceeded inflation in all but two categories between 2004 and 2010. The main items of expenditure by a large margin have been private hospitals, specialists and medicines, reflecting the almost exclusive focus by this sector on curative, acute care in hospitals.

Table 19. Distribution and growth of expenditure by private health schemes in South Africa, 2010, by main item of expenditure

Expenditure item	Real compound annual growth rate in expenditure (2004–2010)	Proportion of total expenditure (%)
Private hospitals	6	36.39
All specialists	8	22.85
Total medicines	4	16.57
Supplementary practitioners	9	7.92
General practitioners	7	7.30
Other benefits	10	3.04
Dentists	1	3.00
Managed care (out of hospital)	9	2.56
Provincial hospitals	–4	0.33
Ex gratia payments	0	0.04
Total benefits	6	100.00

Sources: Competition Commission of South Africa, 2012a, p. 24, table 1 (extract); Competition Commission of South Africa, 2012b.

Table 20 gives 2009 data on numbers of selected health professionals in the private and public health sectors. It shows the private sector (with a very much smaller clientele of privately insured persons in South Africa) employing more specialists than the public sector, but somewhat fewer general practitioners, and many more dentists, optometrists and pharmacists.

Table 20. Distribution of selected health professional categories between public and private sectors in South Africa (data for 2009)

Health professionals	Public	Private
Specialists	4 449	5 177
General practitioners	9 887	7 298
Dentists	471	2 524
Optometrists	633	2 249
Pharmacists	1 969	3 197

Source: Competition Commission of South Africa, 2012a, p. 40.

Again showing a skewed pattern, considering the proportion of its clientele compared to the public sector (uninsured persons), for years 1998 and 2010, the private sector had about half the number of hospitals that the public sector had, with about one fifth the number of beds (1998), rising to one third in 2010 (table 21).

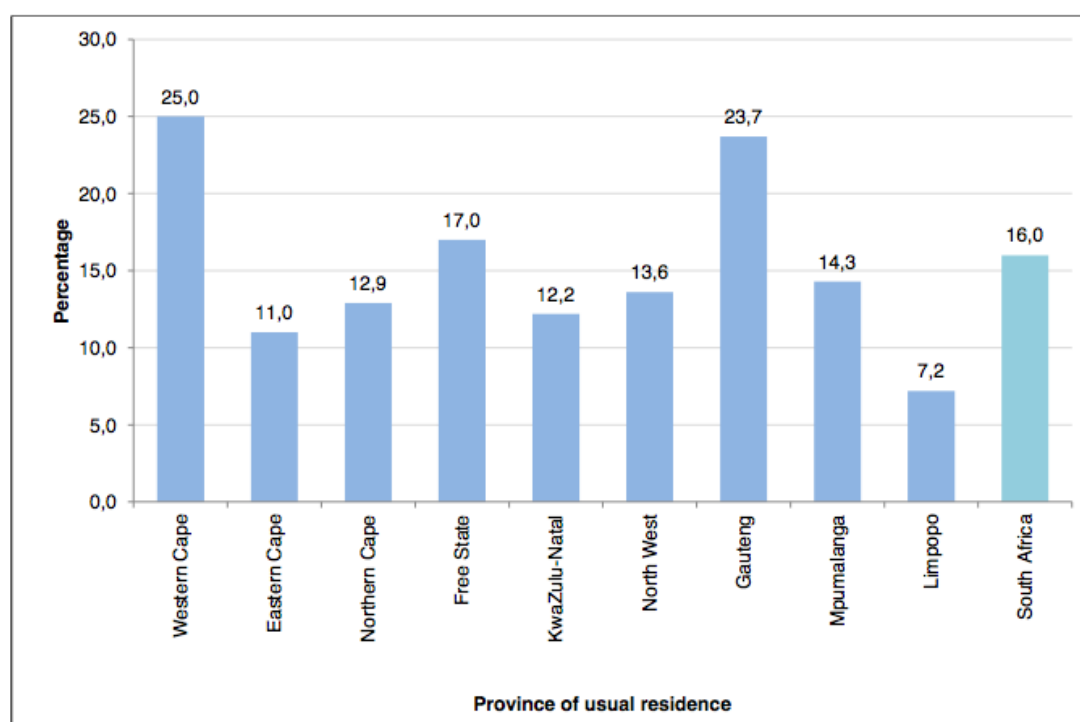
Table 21. Private and public hospitals and bed estimates, 1998 and 2010

Year	Private		Public	
	Hospitals	Beds	Hospitals	Beds
1998	162	20 908	343	107 634
2010	216	31 067	410	88 920

Source: Competition Commission of South Africa, 2012a, p. 30.

The disparity between the size of the clientele served by the private sector and the public sector is demonstrated in figure 10. The figure shows that 16 per cent of the total population of the country has private health insurance of one sort or another, and this varies between 25 per cent in the Western Cape, 23.7 per cent in Gauteng, 11 per cent in the Eastern Cape and a mere 7 per cent in Limpopo province.

Figure 10. Percentage distribution of population covered by medical aid or medical benefit scheme or other private health insurance, by province of usual residence, South Africa, 2011



Source: Statistics South Africa, 2011b, p. 23.

The National Health Insurance Plan of the South African Government is intended to equalize some of the disparities between the public and private sectors by encouraging more cooperation between the two sectors, and establishing national norms and standards with packages of basic care services commensurate to both sectors.

1.7. Wages

This section will look at wages for the backbone nursing personnel of the provincial (not municipal) public health service (wage information is not available for the private sector, but compares very favourably with the public sector). It is well known that wages in the local authority health services in greater Johannesburg and Cape Town have been greater than in the provincial health services, one important reason why the two are not merged to this day, after years of discussion about this issue. Harmonization of wages between the two segments of the public sector has proved to be a Gordian knot (and an industrial relations nightmare). Table 22 looks at the minimum and subsequent service-related notch wages⁵ for nursing staff, as settled in the long and difficult negotiations during the 2000s decade on the “occupational special dispensations” – a wage increase related to retaining more skilled staff in the service to assist with stemming the high vacancy rates already remarked upon among core health professional staff.

The table shows the wages set for full-time and three categories of part-time nursing staff at different grades. The wage levels set in the agreement have been altered here to show “take-home” monthly wages (net of non-wage benefit packages), instead of gross annual wages set in the original resolution. This alteration has been done on the basis that normally in the public service, the cost of non-wage remuneration is one third of the entire salary package. This transposition has been made to compare these nursing net wage amounts with a very low minimum wage (for the same year, 2012) set for domestic workers in rural areas in South Africa, by means of the Sectoral Determination for Domestic Workers, in terms of the Basic Conditions of Employment Act under the Department of Labour. This is a very low wage indeed, barely sufficient for subsistence, as has been demonstrated often. However, even this very low wage was extensively contested and many workers lost their jobs when it was first introduced.

The table shows that the take-home pay for a full-time professional nurse in the community-based services is only 5 times this wage, which is the among the lowest wages paid to any employee in South Africa. A part-time nurse in this position working 3/8 full-time equivalent (FTE) earns only double the domestic worker wage. Of course, as nurses move up into the higher grades, and through the annual notches, they move up to a maximum of 12.2 times the domestic worker’s wage, and 4.6 times for an FTE and a 3/8 FTE, respectively. But even these are not high take-home wages at all, more so since many of the nurses are round-the-clock shift workers. This is not to belittle the importance of the non-wage benefits of employment in these categories, but to point out the difficulty of a life as a (female) shift worker on such limited net wages, net of employment related non-wage remuneration, not of income tax.

⁵ Notch increases are annual increases for public sector staff in addition to the bargaining council wage agreements. They are effectively a sort of global length of service increase for all public sector staff (or most permanent workers). They do not apply to subcontracted or agency staff.

Table 22. Wages in the public (non-municipal for Western Cape and Gauteng) health service

Post	Salary notch (usually annual with service)	Take-home monthly pay, assuming this is 66% of total package of remuneration (normal for public service permanent positions)				Multiples of the statutory (sectoral determination) minimum monthly wage for a full-time domestic worker in a rural area (1,376.25 rand)			
		Full time	6/8	5/8	3/8	Full time	6/8	5/8	3/8
Professional nurse, community service	1	7 212.8	5 409.7	4 508.0	2 704.8	5.2	3.9	3.3	2.0
Professional nurse grade 1	2	8 791.7	6 593.7	5 494.8	3 296.9	6.4	4.8	4.0	2.4
	3	9 055.4	6 791.6	5 659.7	3 395.7	6.6	4.9	4.1	2.5
	4	9 327.1	6 995.3	5 829.5	3 497.7	6.8	5.1	4.2	2.5
	5	9 895.1	7 421.4	6 184.4	3 710.7	7.2	5.4	4.5	2.7
	6	10 191.9	7 644.0	6 370.0	3 821.9	7.4	5.6	4.6	2.8
Professional nurse grade 2	1	10 812.6	8 109.4	6 757.9	4 054.7	7.9	5.9	4.9	2.9
	2	11 137.2	8 353.0	6 960.7	4 176.5	8.1	6.1	5.1	3.0
	3	11 471.1	8 603.4	7 169.4	4 301.7	8.3	6.3	5.2	3.1
	4	11 815.5	8 861.7	7 384.7	4 430.7	8.6	6.4	5.4	3.2
	5	12 169.9	9 127.5	7 606.2	4 563.7	8.8	6.6	5.5	3.3
	6	12 535.1	9 401.4	7 834.4	4 700.7	9.1	6.8	5.7	3.4
Professional nurse grade 3 (general nursing)	1	13 238.4	9 928.9	8 274.1	4 964.4	9.6	7.2	6.0	3.6
	2	13 635.8	10 226.9	8 522.4	5 113.4	9.9	7.4	6.2	3.7
	3	14 045.1	10 533.9	8 778.2	5 267.0	10.2	7.7	6.4	3.8
	4	14 466.4	10 849.7	9 041.5	5 424.9	10.5	7.9	6.6	3.9
	5	14 900.3	11 175.3	9 312.8	5 587.6	10.8	8.1	6.8	4.1
	6	15 347.5	11 510.6	9 592.1	5 755.4	11.2	8.4	7.0	4.2
	7	15 807.7	11 855.7	9 879.9	5 928.0	11.5	8.6	7.2	4.3
	8	16 282.2	11 211.7	10 176.4	6 105.8	11.8	8.9	7.4	4.4
	9	16 770.4	12 577.8	10 481.5	6 289.0	12.2	9.1	7.6	4.6

Source: PSCBC, n.d.: Resolution of the Public Service Coordinating Bargaining Council on occupational special dispensation rates in the public health service – extract (number of resolution not known).

Low wages for public sector nurses have led to another problem affecting working hours which has been highlighted in many reports emanating from the national and provincial health administrations, as well as the discussions at the Public Sector Bargaining Council: namely “moonlighting”. Agency nurses and other agency staff working in the public sector often work for different health authorities (both public and private), clocking up very long hours to combat low wages, while shift workers on permanent public sector contracts have been known to moonlight for agencies to increase their earnings, again leading to long working hours. This aspect will be investigated in the empirical part of this study.

Finally on wages, as we have seen above there are three subcontracted worker groups who work for labour brokers in both the public and private health sectors: these are contract cleaners, private security guards and caterers (hospitality industry). A sectoral determination by the Minister of Labour in terms of the Basic Conditions of Employment Act fixes the wages for these workers. This is because there has never been sufficient collective bargaining in these sectors to fix wages for the sector, due to the failure of both workers and employers to organize themselves across the sector. The minimum wages in these sectors are as given in table 23, and again hardly exceed the low wages of rural domestic workers used as a benchmark in the above discussion.

Table 23. Legal minimum wages in sectors that employ persons in the public and private health sectors in South Africa

Sector	Contract cleaning	Private security	Hospitality
Position/minimum wage 1	General worker, urban areas 12.51 rand per hour = 2 251 rand per 180-hour month (45-hour week)	General worker, full time (48 hours per week) = 2 272 rand per month	Minimum wage FTE = 2 612 rand per month (for employers with more than 10 employees)
Position/minimum wage 2		Security officer lowest grade = 2 938 rand per 48-hour week	

Source: Department of Labour, South Africa, n.d.

2. Regulation of working hours and related issues in public and private health services in South Africa

2.1. Statutory framework for working hours and work–life balance in the health sector

This section will look at the overarching national labour legislation on these matters, and the negotiated additions due to collective bargaining, entirely at the Public Service Coordinating Bargaining Council (PSCBC) level, since these are issues regulated at national level, and affect all divisions and provinces of the public service.

For almost the entire economy, and including the public sector (except the intelligence services and the national defence forces), regulation of working hours in the Basic Conditions of Employment Act (BCEA), 1983, were revised in the form of the new BCEA No. 75 of 1997. This followed an intense tripartite debate in the National Economic Development and Labour Council (NEDLAC) and thereafter in Parliament. This debate took place in the context of the campaign at the time led by the Congress of South African Trade Unions (COSATU) for a 40-hour standard working week, and higher payment for overtime hours, intended to curb excessive working hours in the economy and the negative consequences for health and safety, work–life balance and employment. The standard working week in the old 1983 statute had been 48 hours (based on the standard pattern at the time of a 6-day working week and an 8-hour working day in non-continuous operations). Eventually, the 1997 statute reduced this to a compromise standard 45-hour week, and increased the overtime pay rate from time and one third to time and one half.

Section 7 of the BCEA outlines the basic rationale of the Act by requiring all employers to regulate working time for each employee with due regard to his or her health and safety, and family responsibilities. A further rationale to protect the health and safety of members of the public appears in the guidance on the BCEA contained in the Code of Good Practice on the Arrangement of Working Time (section 3.1), aimed especially at employers who design shift systems for continuous or semi-continuous operations. The BCEA and its associated code therefore explicitly recognize that the design of shift systems impacts upon both the health and safety of employees and the general public in cases such as health services, where, for example, staff with critical responsibilities dealing with patients who experience acute or chronic lack of concentration because of fatigue induced by poor rostering may be a threat to the public they are serving. The working hours and work–life balance aspects of the 1997 BCEA reflect the Ministry of Labour’s philosophy of “regulated flexibility” in labour market regulation, to allow for both discontinuous and continuous operations, in public and private sectors, within limits established by law.

2.1.1. Working hours and overtime

Chapter 2 of the BCEA regulates working time in detail, determining the parameters within which the health sector now operates (especially the private health sector, but also aspects of working time in the public sector). The Act stipulates “ordinary hours of work” (45 hours per week, 9 hours per day for a 5-day week, 8 hours per day for > 5 days per week), overtime maxima (only by individual or collective agreement, 10 hours with a maximum daily shift length of 12 hours) and overtime payment rates (T+1/2, or by agreement T+30 minutes off for each hour of overtime worked, or no pay but 90 minutes off in lieu of each hour of overtime worked – compensatory time off to be granted within

one month of the overtime worked, or by agreement within 12 months). A collective agreement may extend permitted overtime hours to 15 per week, though such an agreement can only apply to two months of any 12-month period.

Chapter 2 provides in addition for both the *compressed working week*, and *hours averaging schemes* in the context of the regulations mentioned above, which are of high relevance for continuous 24-hour services such as inpatient health services. For the compressed working week, an agreement in writing (which could be an individual agreement or a collective agreement) can permit or require an employee to work up to 12 hours per 24-hour period (inclusive of meal intervals allowed for in the Act), without receiving overtime pay. However, such systems are limited to a maximum 55 hours work in any week (45 ordinary and 10 overtime hours), and a maximum of 5 days (shifts) in any week (7-day period). So for example, a shift system of 5x11-hour shifts per week would be permissible, as would a system of 4x12-hour shifts plus one shift of 7 hours in any 7-day period, inclusive of statutory break and meal times.

Regarding arrangements for hours averaging, the basic limits above can be varied only by a collective bargaining agreement, which must lapse (or be reviewed by the bargaining parties and reaffirmed or altered) annually. A collective hours averaging agreement can only vary ordinary hours of work over a period less than or equal to four months, during which time the average ordinary working hours must be a maximum of 45 hours per week, with maximum average weekly overtime hours reduced from 10 to 5 hours. So, to give a simple example, a collective agreement could fix a shift system over a one-month period (four weeks) at 60/40/60/40 weekly hours (average 50 total hours per week, average 45 weekly ordinary hours and 5 weekly overtime hours). This might take the form of one week of 5x12-hour shifts (including statutory breaks), one week of 5x8-hour shifts, one week of 5x12-hour shifts, and the last week of 5x8-hour shifts. There are of course many other possible variants, with longer or shorter averaging periods, and the empirical part of this report will explore what variants are in place for different categories of staff in the public and private health sectors, and how managers and staff experience them.

2.1.2. Meal intervals and rest periods

Meal intervals and rest periods are similarly flexible within limits in terms of the BCEA. The main standard is a requirement for a 1-hour meal break after each 5 continuous (i.e. with any porosity that is less than 60 minutes) hours of work. Thus a 12-hour shift should normally contain a break for the 6th and 12th hours, with the proviso that these breaks can be overridden in cases where duties cannot be left unattended, and there is no one else to do the work required. This obviously has implications for continuous operations for inpatients in health facilities, where there is any shortage of staff. In such a case, the employee must be remunerated for the lost break time (and for any meal time in excess of 75 minutes in the case of split shifts by an employee who does not live on the employer's premises). An individual or collective written agreement can reduce the meal interval to 30 minutes, or dispense with a meal break altogether for an employee who works for less than 6 hours on any given day.

Employees are entitled to a minimum of 12 consecutive hours of rest between shifts, and a weekly rest period of at least 36 continuous hours (1.5 days), which must include a Sunday unless by agreement (individual or collective). The 12-hour rest period between shifts can only be reduced by written agreement to 10 hours for employees living on the employer's premises, or for split shift employees with lunch breaks of 3 hours or more. The weekly rest period can also be reduced to a total of 60 hours every two weeks (a loss of 12 hours) by agreement, or reduced down as far as 28 hours in any one week, if increased

by the same amount up to 44 hours in the following week (a two-week averaging of the 36-hour rest period). These parameters again give flexibility to managers designing shift options for staff in such operations as continuous health service provision.

2.1.3. Sunday work and pay premium

Continuous shift systems bring into play the questions around Sunday pay, and payment for work on public holidays. The BCEA requires employers to pay employees who perform unrostered work on a Sunday (i.e. do not normally work on a Sunday) $T \times 2$, while rostered Sunday work is to be paid at $T + 1/2$. There are provisions for deeming Saturday or Sunday night shifts as falling on a Sunday or another day for the purpose of payment. If Sunday work is not usual for an employee, it counts as overtime for the purpose of calculating his or her maximum allowable overtime hours. The Sunday premium payments detailed here can be withheld by an agreement (individual or collective) which allows the employee to take time off in lieu that is equivalent to the premium payment forgone, within one month of the Sunday worked (the default position), or within 12 months if there is an agreement in writing (individual or collective) to this effect.

2.1.4. Night work

Night work is key to the operations in both private and public health services, especially with regard to inpatient services and mobile emergency services. It is regulated in the BCEA in section 17. Night work is defined as any work that takes place between the hours of 6 p.m. and 6 a.m. It can be compensated for by means of a night work shift premium payment, or by means of a reduction in working hours for the employee (per shift, per week, per month or per year), and employers must ensure that transportation is available for night shift workers before and after their shift; most health services do not provide either hostels for staff on or near the premises, nor in-house transportation, so this clause is interpreted as requiring managers in health services to ensure that staff have public transport of one kind or another available to them, but not that the employer has to provide or pay for such services. This is a point of considerable difficulty in shift work schemes for continuous operations in all economic sectors in South Africa because of the lack of safety on public transport at night, and the poor services available at these times in many areas. This is due to the distortions in urban and transport planning brought about by the legacy of the Group Areas Act under apartheid, which have been rather slowly addressed over the past 20 years, though in more recent years steady progress has been made in the major conurbations. Combinations of private taxi “kombis”, bus services and metropolitan train services are used by commuters, which make many commutes long, fragmented, uncomfortable and unsafe due to crime, and sometimes to internecine and intermittent “wars” over routes between taxi associations, and between them and provincial bus services as they are rolled out to working-class residential areas previously underserved.

The creation of mixed-class central urban residential areas that break down the historical pattern of racially designated areas has been slow to occur, and the lack of affordable and acceptable rented housing in conurbations has added to the perpetuation of long commutes for workers in the health sector. To add to this, it is only recently that new, modern hospitals are being built in large working-class residential areas (the old “townships”) such as Khayelitsha and Mitchell’s Plain in the Greater Cape Town metropolitan area. These key infrastructural issues on the national agenda strongly influence the choice of shift systems adopted by the health sector for continuous operations, as transformation of the racial (and therefore geographical residence) characteristics of the labour force adds complexity to working time planning.

Finally, the fact that the majority of health workers are women is an added complexity due to the double burden of employment and domestic responsibilities, and added risks to safety presented by the very high rates of rape and sexual assault experienced by women (the majority of the workforce in the public and private health sectors) in South Africa, which escalate at night. All of these factors have tended to disfavour the adoption in continuous health services of 8-hour shifts (say, 6–2, 2–10 and 10–6) and to favour 12-hour shifts (6–6 and 6–6, or 7–7 and 7–7) with fewer shifts per week or month, thus saving commuting time per worker, and protecting workers to some extent from safety and security risks while commuting. Again, the empirical part of this report will show whether this is in fact the case in practice, or how this circumstantial preference might or might not be changing over time.

In addition, lack of dedicated child care facilities at work means that additional resources have to be spent on child care at home. The more often mothers are away from home the more often child care is required and the cost escalates. Also, many employers tend to prefer the 12-hour shift as it provides some continuity of care for theatre lists and other arrangements and reduces the staff budget, which would have to increase should for example 8-hour shifts be introduced. The 12-hour shift for nurses, in particular, is often presented as if there is no alternative to explore.

For night work, the BCEA requires employers who employ people on a regular basis (i.e. at least 5 times per month, or 50 times per year) between the hours of 11 p.m. and 6 a.m. to inform them of the health and safety hazards inherent in their work (especially those connected with night work itself), and of their right to undergo a confidential regular medical examination paid for by the employer, and to be transferred to suitable day work if they exhibit signs of any health condition associated with night work, should it be practicable for the employer to provide day work for the person concerned. Though the BCEA allows for the minister to regulate such medical examinations, this has to date not occurred.

However, the Code of Good Practice on the Arrangement of Working Time⁶ issued in terms of the BCEA lists the following health conditions that should be investigated:

- mild asthma
- non-insulin-dependent diabetes mellitus
- cardiac risk factors like hypertension (of epidemic proportions in South Africa), elevated cholesterol
- depression
- seizures
- frequent indigestion
- mild irritable bowel syndrome
- Crohn's disease
- peptic ulcer

⁶ GN R1440 in GG 19453 of 13 November 1998.

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- weight loss
 - poor nutritional status.

2.1.5. Leave

Leave is an important part of working time arrangement. In South Africa, the BCEA provides for four kinds of leave – sick, annual, maternity and family responsibility leaves. Medically certified sick leave (more than two consecutive days, or on two occasions in eight weeks) is designated to a 36-month cycle of leave, during which time an employee is entitled to the number of days paid sick leave that they would normally have worked, on whatever arrangement of working time they normally work, in six weeks. For example, a person working a 5-day week would therefore be entitled to 30 days paid sick leave in every three-year period of their employment by any single employer, paid at the normal daily wage. Part-time employees and employees working on compressed working weeks with longer rest periods between longer shifts may be entitled to less paid sick leave days than their colleagues who work standard working hours. By agreement (individual or collective), the wage on sick days can be reduced by up to 25 per cent per three-year cycle, if the number of sick leave days is commensurately increased. This clause might be evoked to deal with particular employees with serious conditions who might otherwise run the risk of dismissal for incapacity because their sick leave days would otherwise run out while they are recovering from illness. South Africa's high prevalence of tuberculosis and HIV/AIDS among people of working age makes these kinds of arrangements with particular employees essential. To the extent that the Compensation for Occupational Injuries and Diseases Act covers workers in the health service, sick leave for such injuries and diseases is not paid for out of the BCEA provisions, but by the system under the Compensation for Occupational Injuries and Diseases Act of employer contribution insurance for each employee, which is mandatory for all employers. Many, though not all, formal sector employers, including the public sector, top up the 75 per cent wage provided for in the Compensation for Occupational Injuries and Diseases Act for total temporary disablement due to workplace injury to a full wage for occupational injuries and disease.

Annual fully paid leave provision in the BCEA is 21 consecutive days in any annual cycle. For temporary or part-time workers, this entitlement can, by individual or collective agreement, be commuted to 1 day for every 17 days worked, or 1 hour for every 17 hours worked. Outstanding annual leave must be paid when an employee's employment is terminated.

Maternity leave is set in the BCEA at four consecutive months, which may be taken at any time from one month before the expected birth date, and must continue till at least six weeks after the birth. Payment for maternity leave is provided for in the Unemployment Insurance Act, though it is considerably less than the full wage of the woman. Larger employers, especially in the public service, generally include in the package of benefits of employment a top-up of this payment to full wage by the employer. Third trimester miscarriage and stillbirth entitle the woman to maternity leave of six weeks. Importantly from the point of view of the arrangement of working time for health service staff, an employer must consider taking a pregnant employee out of night work (or other hazardous work that poses a danger for her or her child's health and safety) for her entire pregnancy and for six months after the birth, albeit subject to the test "practicability" for the employer.

Family responsibility leave provision is 3 paid days in every annual cycle (non-accruable), but is limited to workers who have worked for the same employer for four months or above, and who work at least 4 days per week. This leave may be used for the

birth of a child, child sickness, or death of spouse or life partner, parent, adoptive parent, grandparent, child, adopted child, grandchild or sibling.

2.2. Scope of the BCEA

From the point of view of the health services, there are three possibly important categories of exclusion from or suspension of the provisions listed above (section 6 of the BCEA). The provisions for working hours (limitations, maxima, etc.) do not apply to senior managerial staff, employees working less than 24 hours per month (which could affect some agency staff for example), or employees whose total gross annual wage exceeds a specified amount (for example this was 149,736 rand or 12,478 rand per month in 2008, and is adjusted by the CPIX⁷ or similar measure at regular intervals). This would exclude senior nursing staff from the BCEA protections on working hours, though the lower levels of nursing staff would be protected. Lastly, the working hour protections do not apply to emergency work (section 6(2)), defined as work for which the employer could not have been expected to have made provision, and which cannot be performed by employees in their ordinary hours of work. This is obviously important in any public or private health service, where emergency work, or urgently necessary work, is common, and where there are staff shortages or high demands on the service, as in a country such as South Africa, where the burden of disease and serious injury is very high. The extent to which this “emergency work” clause, and its exclusion of working hour protection to workers subject to it, is a factor in the experience of workers in the public and private health services will be dealt with in the empirical part of this report.

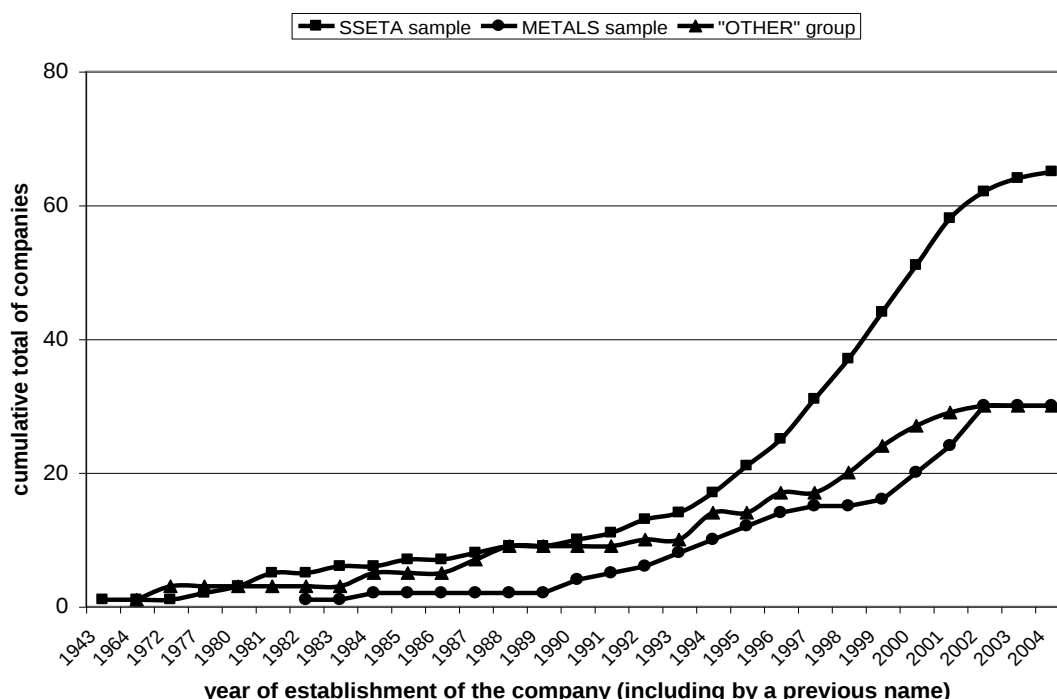
2.3. Employment agencies

The labour legislation framework in South Africa, including the BCEA, has since the 1983 Basic Conditions of Employment Act deemed employment agencies to be the employer of any workers they supply to another employer (BCEA S.82), and this has remained the statutory approach to what is called “labour broking” in South Africa. In the economic restructuring of most enterprises in South Africa after 1994, the extent of “rationalization” of enterprises, “right sizing”, business re-engineering, outsourcing, subcontracting and other forms of balkanization of the labour force was very considerable in all sectors of the economy. This has led to an ever-increasing army of employment agencies (termed “temporary employment services” in South African labour legislation) that provide workers for other employers on different types of temporary or quasi-permanent arrangements for a contract fee negotiated as a commercial contract for services rather than an employment contract. In International Labour Organization (ILO) parlance, this is termed the “triangular employment relationship”. Figure 11 shows the rapid increase in numbers of these companies in three sectoral groups in the 1990s in South Africa (the decade of the new, post-democracy laws). As in many jurisdictions around the world, in South Africa this has led to a policy confrontation and a long term campaign to ban labour brokers, including symbolic one-day rolling strikes by organized workers in unions affiliated to COSATU over recent years. The trade union movement holds to the necessity of regulating this growth in triangular employment relationships to protect its ever-increasing workforce from exploitation and prevent the creation of a dual labour market (one shrinking but regulated, one growing but unregulated), while employers insist on its role in ensuring flexibility in global markets, and in employment creation (albeit of a temporary nature) – governments are caught in the middle. In health services in South Africa, nursing agencies are among the oldest form of labour broking, dating back to well

⁷ Consumer price index excluding mortgage costs.

before the demise of apartheid, while the outsourcing of ancillary services discussed above (figure 7) is more recent.

Figure 11. Year of establishment of 60–70 labour broking companies in the services, metals, and “other” sectors, (2003/04 telephone survey data)



Source: Theron and Lewis, 2004.

After about five years of fractious debate in NEDLAC between the social partners, and the campaign led by COSATU mentioned above, the Department of Labour has now drafted one new law on employment agencies, and has made amendments to the Labour Relations Act and the BCEA to accommodate new regulation of this large segment of the labour market. These statutes have been passed by Parliament but have not yet been put in force, and remain highly contested. The main effects of this new raft of labour legislation would be as follows:⁸

- The rights of temporary employees would be tightened with a reasonable expectation that their contract will be extended, to protect them from downgrading of status if their employer extends the contract (Labour Relations Act).
- Workers will be allowed to take out proceedings against either the client or the temporary employment service, and labour inspectors will be empowered to deem either liable for any reparative order, as the case demands.
- Labour inspectors will be allowed to hold either the client or the temporary employment service responsible for any breaches of the BCEA.

⁸ Labour Relations Amendment Draft Bill, Parliamentary Monitoring Group: <https://pmg.org.za/call-for-comment/229>.

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- A temporary employment service will be required to provide a written employment contract to any worker it places with a client as soon as work commences.
 - A temporary employment service will be prohibited from employing anyone on terms or conditions of employment that are not permitted by the Labour Relations Act, any other employment law, sectoral determination under the BCEA, or a collective agreement concluded in a bargaining council applicable to a client to whom the employee renders a service (this would bring temporary outsourced workers in the public sector health service within the ambit of the terms and conditions for permanent workers).
 - All temporary employment services will be required to register under the labour administration, and non-registration will be disallowed as any defence against these provisions applying to them.
 - The time period over which a temporary employment service may place a temporary employee with a client will be limited to three months, after which the temporary employee is deemed to be an employee of the client, and will have equal status with a permanent employee (under certain conditions). If either the client or the temporary employment service terminates the contract to avoid this provision, this is deemed a dismissal and therefore subject to the requirements for fair dismissal under the Labour Relations Act, and actionable as unfair if not, through the statutory conciliation and arbitration process under the Commission for Conciliation, Mediation and Arbitration, which can impose financial penalties on the employer or temporary employment service, or order reinstatement.
 - The definition of “fixed-term contract” is tightened up to define the circumstances in which an employer (or temporary employment service) can employ an employee on a succession of such contracts, which might amount to a contravention of the provisions for the maximum three-month period for temporary contracts. Fixed-term contracts, which may sometimes be rolled over, are defined as:
 - replacements for temporarily absent permanent employees;
 - temporary increase in the volume of work (maximum 12 months);
 - training positions for students or recent graduates (this could apply to student nurses);
 - work on a specific project with a defined end point;
 - work by foreigners with a limited work permit;
 - seasonal work;
 - official public works scheme – this could apply to community-based health care workers employed by provincial Departments of Health on programmes financed by the Extended Public Works Programme of the national government;
 - work on an external grant for a limited period (such as international NGO funding) – this could apply to home-based care workers in the HIV/AIDS

programme, funded by such agencies as the Bill & Melinda Gates Foundation, but administered by provincial Departments of Health;

- work by a retired person.

Any fixed-term contract in violation of these provisions and definitions is deemed to be a permanent contract.

In addition to these provisions, the Employment Services Bill is an entirely new piece of legislation regulating temporary employment services, and the relationship between them and public sector employment agencies.⁹

This area of regulation is complex and highly contested between organized employers and workers, and it is not clear how it will affect the South African labour market in general, and the public and private health services in particular. That it will do so, particularly for agency nursing, and the subcontracted ancillary services to health facilities, is certain. This in turn will have impacts on working time arrangements, and on the general public who use the services. It will also give organized workers leverage to challenge abuses of working hour protections with regard to agency nurses, “moonlighters” and subcontracted services to the health services.

2.4. BCEA codes of practice on working time and pregnancy

Further to these statutory provisions, the BCEA *required* the Minister of Labour to consult with NEDLAC and issue Codes of Good Practice on the Arrangement of Working Time, and on the Protection of Employees during Pregnancy and after the Birth of a Child. As a result, in 1998, the Department of Labour issued both of these codes.¹⁰ Both of them are highly relevant to the question of working hours and work–life balance in the public (and for that matter, private) health services, because of their large female working population, and because of their reliance on round-the-clock shift work in many operating functions.

The codes of practice do not have the same force as statutory provisions, but nevertheless in the case of a dispute, whether legal or otherwise, the onus would be on an employer to demonstrate that terms and conditions of employment have taken the codes into account, where they are of relevance. The codes also give considerable guidance to employers, based on research, regarding practical matters around the protection of employees from health and safety hazards and risks.

The Code of Good Practice on the Arrangement of Working Time explicitly draws attention to the relationship between non-standard working time arrangements and health and safety issues, and issues of family responsibilities of workers, enjoining employers to consider both of these sets of issues when designing non-standard work schedules, especially in shift work and night work arrangements. Section 3.1 of the code draws attention to the link between working hour arrangements and the health and safety of both employees and members of the public – particularly relevant to health services – and links

⁹ Employment Services Draft Bill, Parliamentary Monitoring Group: <http://www.pmg.org.za/bill/20101217-employment-services-draft-bill-0>.

¹⁰ GN R1440 and R1441 in GG 19453 of 13 November 1998.

this to the statutory requirement that employers should conduct consultative risk assessments in the Occupational Health and Safety Act of 1993.

The Code of Good Practice on the Arrangement of Working Time puts forward good practices regarding shift work in the context of the BCEA (chapter 2) core rights on working hours (see above).

The Code of Practice on the Protection of Employees during Pregnancy and after the Birth of a Child makes two specific points regarding working time arrangements: the possible need to avoid scheduling work for pregnant workers during early mornings because of morning sickness, and the fatigue associated with pregnancy, indicating that overtime and evening work may require special attention for them.

3. National and international context of working time and work–life balance issues

3.1. Collective bargaining in the public health sector regarding working time and work–life balance issues

After the establishment of political democracy in South Africa in 1994, the public service cluster of ministries were preoccupied till the end of that decade with unification and transformation. This on the one hand meant abolition of the previous TBVC¹¹ “Bantustan” administrations, and their merging into a single, national, public service with its characteristic divisions between the various services and between the nine provinces and the national administrations, and on the other hand managing the transformation of employment in public service in the context of the “sunset” clause in the new Constitution of the country, which broadly safeguarded the jobs of incumbent (white) civil servants who had been associated with the previous regime, while implementing a positive discrimination policy designed to match the public service with the “racial” profile of the nine provinces and thus the nation as a whole (Standing, Sender and Weeks, 1996). The latter was formalized by means of the Employment Equity Act No. 55 of 1998, which established the special status of “previously disadvantaged persons” (Black – African, Coloured, and Asian – women, and disabled persons) in recruitment and retention of employees and discriminatory practices; defined sexual harassment in the workplace as a discriminatory and unfair labour practice; and required employers, including the public service, to keep and report officially to the Department of Labour statistics on the numbers of previously disadvantaged persons they employed, and to develop and report on “employment equity plans” at the enterprise or employer level that would outline what steps they were taking to align their workforces with the provincial profile of the population.

Following an ILO investigation of freedom of association in South Africa initiated by COSATU (the most representative organized labour federation in the country at the time), which pinpointed the remaining sectors of the economy still lacking freedom of association for workers, including in the public sector, the transitional national unity government began its overhaul of framework industrial relations law with the promulgation of the Education Labour Relations Act (No. 146 of 1993), the Public Service Labour Relations Act (Proclamation 105 of 1994), and the South African Police Service Labour Relations Regulations of 1995. These Acts established freedom of association for public sector workers, and provided for the establishment of several sectoral bargaining

¹¹ Transkei, Bophuthatswana, Venda and Ciskei.

councils and forums. Finally, the umbrella Labour Relations Act (No. 66 of 1995), applying to almost the entire economy, established in its Schedule 1 a single national bargaining council for most of the public service – the PSCBC. In 1998, resolutions by bargaining parties of the PSCBC took three very important steps towards formalizing a full labour relations institutional framework for the public sector:

- Establishing the powers of the PSCBC to designate sub-sectoral bargaining councils to deal with labour issues specific to them (education, health, security etc.)
- Establishing the method for election of full-time shop stewards for fast-growing registered and recognized trade unions in the public sector.
- Establishing the agency shop system for registered trade unions – all public sector workers were to pay a levy from their salary towards the maintenance of trade unions recognized for their particular occupational grade for the purposes of collective bargaining, while maintaining the freedom of individuals not to join the designated trade union should they wish. To this financial support for collective bargaining was added a levy of 1 rand for each employee per month (50 cents from the employer, 50 cents from the employee) to maintain the PSCBC as an institution, and the costs of arbitration and conciliation services it developed and maintained.

In 1999, the PSCBC resolved to establish a standard disciplinary code and procedures within the ambit of the provisions of the Labour Relations Act covering all employers and employees in the public service, set up internal and independent arbitration and conciliation mechanisms for disputes, and inaugurated the Health and Welfare Bargaining Forum at national level,¹² an informal and transitional arrangement not given any special status in the Labour Relations Act. In 2000, the PSCBC established provincial chambers with powers to deal with labour relations issues solely affecting a particular province in terms of national resolutions, reflecting the constitutional division in the public service between national and provincial competences in public administration, and to refer unresolved disputes to the national structure for resolution by collective bargaining, or for external arbitration or conciliation.

The employer and trade union parties to the PSCBC finally established the present-day collective bargaining arrangements in the health sector in 2003, when the Public Health and Welfare Sector Bargaining Council was established.¹³ Due to a name change in the Department of Welfare, this is now called the Public Health and Social Development Sector Bargaining Council. As well as dealing with matters related to all Department of Health employees and employers, it encompasses matters relating to health professionals employed in any other department of the public service. Like the other subsectors in the public services, it also has provincial chambers. The Public Health and Social Development Sector Bargaining Council deals with issues that are confined to that particular sector – all issues that affect two or more subsectors of the public service are dealt with in provincial chambers of the PSCBC (if unique to a province), or at its national structure (if affecting more than one province).

Thus in a period of 10 years after the 1994 elections, the South African public service had evolved its own comprehensive collective bargaining and dispute resolution system,

¹² PSCBC Resolution 9 of 1999.

¹³ PSCBC Resolution 9 of 2003.

sensitive to provincial and national divisions in competence, independent of the executive branch of government (though its senior administrative branch is of course represented as the employer party in formal negotiations with trade unions), and sensitive to its various branches or subsectors, allowing for parallel development at all levels within the overall frameworks negotiated at national public sector level. For a long time during the apartheid era, the basic working week was defined for much of the civil service as 40 hours per week. Continuous operations, however, were governed by the basic 48-hour week in the 1983 Basic Conditions of Employment Act, revised downwards to 45 hours in the 1997 Act. Thus the working hours of such core staff in the public health and private health services as nursing staff went through a transition to bring traditional compressed working weeks (4x12 hour shifts) into line with the new limits on working hours after 1997. This has affected many parameters of working time arrangements, including the use of agency nurses to fill in gaps.

Resolutions of the PSCBC have added to the statutory framework regarding working time and the work–life balance for employees. The trade unions represented on the Public Health and Social Development Sector Bargaining Council, and also representing the health sector at the PSCBC, are as follows:

- Democratic Nursing Organization of South Africa: 84,000 members, formed 1996;
- Health and Other Service Personnel Trade Union of South Africa: membership in both health and education sectors;
- National Education, Health and Allied Workers' Union: general public sector union with over 200,000 members in health, education, public administration, and social development sectors, formed in 1987, affiliated to COSATU, concentrates on manual or non-professional grades in the health sector, though not exclusively;
- National Union for Public Service and Allied Workers: formed in 1998, a general public sector union in several subsectors, with less than 30,000 members in the health sector;
- Public Servants Association of South Africa: an association rather than a trade union, 90 years old, with 220,000 members in all subsectors of the public service.

The adjustments to working time and work–life balance regulation by the PSCBC are shown in table 24 (several negotiations that merely adjust the method of calculation of night shift premiums and leave payments have been excluded).

Collective bargaining in the public health sector has thus secured for workers better rights regarding working time arrangements and work–life balance than pertain in the private sector (including the private health sector), which generally do not go further than the BCEA provisions. It has also resulted in a remarkably unified platform of rights and terms and conditions of employment for public sector workers with regard to working time and work–life balance, flexible enough to develop particular profiles for particular subsectors and provinces with special issues.

There are however exceptions to this unity. This review has identified the following:

- Gauteng and the Western Cape provinces have retained the division between metropolitan local authority and provincial health services, whose terms and conditions of employment differ, particularly with regard to pay rates and occupational grading. This has caused some problems in alignment of certain

professional categories, and smooth movement of staff from one to the other. This may also affect issues considered in this report (working time arrangements, work–life balance). This affects in particular emergency medical services provided by local authority ambulance services in the two metropolitan areas of Cape Town and Johannesburg.

- The terms and conditions of employment of public (and private) health service agency staff – health professionals such as nurses as well as other non-professional staff (cleaners and other ancillary staff) who are employed by third-party agencies – are often considerably less favourable than those of permanent public sector workers in terms of non-wage benefits of employment, though the PSCBC has from time to time regulated their payment rates. Their working hour arrangements and work–life balance are also normally less favourable than those of permanent health workers. Their use in the public health service is a result of the attrition or turnover rate in permanent staff, their exodus to other, developed countries for employment or to the private sector or to NGOs and the resulting unfilled position rates, and the high demand for staff in specific disciplines due to the patterns of the heavy burden of disease in South Africa.
- The public health sector makes use of persons employed in the Extended Public Works Programme of government, a job creation programme, especially with regard to home-based caregivers. Their terms and conditions of employment are laid down in a separate sectoral determination issued by the Department of Labour, with a low minimum monthly stipend (60 rand per day worked in 2012) (ILO 2012). Their importance to the health sector has however been recognized in the recent discussions around the creation of a National Health Insurance scheme, and also in the long-term National Development Plan with regard to the health sector.
- Nursing assistants (unregistered nurses, as they are not fully trained) are employed in large numbers in the public health service. Their terms and conditions of employment, and their working hour arrangements, may vary from their fully trained and registered counterparts because of their highly flexible “support” role.

The empirical part of this study will examine how the overall statutory and voluntary regulatory framework works in practice in the health service, and where the pressure points and problem areas occur with regard to both protection of workers and standards of care for the general public. That working time arrangement is of great importance, and recognized as such, is shown by the 2012 resolution of the PSCBC: “The PSCBC undertakes to conduct a review of working time arrangements in the public service with a view to determine which service delivery areas require different working time arrangements to facilitate service delivery improvement and employment creation.”

This resolution is fully in line with the BCEA Code of Good Practice on the Arrangement of Working Time, which recommends periodic reviews to ensure that changes in the workforce demography, workloads, public transport and support for working women especially are taken into account in the design of shift work systems affecting hundreds of thousands of health workers and their families and communities.

Table 24. Adjustments to statutory regulation regarding working hours and work–life balance made by the PSCBC

Year	Resolution no.	Type of provision	Working time or work–life balance provision
1999	3	Extended annual leave entitlements for continuous shift workers	For nursing personnel in institutions that provide service around the clock (continuous operations, shift work), registered nurses appointed before 1968 (i.e. with more than 30 years service) awarded 54 days; for nurses with less than 10 years service, 46 days, and with at least 10 years service, 52 days; nursing assistants with 30 years service, 40–48 days depending on length of service; student and part-time nurses, 30 days; all other employees 30–38 days, depending on length of service
1999	3	Sick leave	Up to 10 years service, 120 days on full pay, and 120 days on half pay for every three-year cycle; this is doubled for employees with more than 10 years service
1999	3	Special sick leave	For occupational disease or injury, paid the difference between workers' compensation payment and actual salary
1999	3	Maternity leave	84 days leave at full pay for each of two pregnancies, total 168 days; thereafter extended for further pregnancies under certain circumstances, or granted unpaid leave up to a further 184 days, or utilizes annual paid leave days; same conditions for adoptions of children up to 2 years of age; miscarriage, stillbirth, or termination of pregnancy – leave taken not counted in her subsequent pregnancy entitlement, and ordinary paid sick leave days used for necessary days off
1999	3	Unpaid leave	If paid leave exhausted, maximum of 184 unpaid leave days in 18 months
2012	? (not given)	Night shift allowance	Fixed fee per hour for night shift work (6 p.m. to 6 a.m. or 7 p.m. to 7 a.m.) set to rise to 4 rands per hour from 1 July 2014, and thereafter rise with the consumer price index
2012	? (not given)	Family responsibility leave	From 1 Jan 2013, increased to 5 working days per annual leave cycle, for spouse's childbirth, or sickness of child, or death of partner, or immediate family member
2012	? (not given)	Prenatal leave	Paid leave days for prenatal medical or midwife consultations set at 8 days total per pregnancy (in addition to normal maternity leave days)
2012	? (not given)	Rearrangement of working time	The PSCBC undertakes to conduct a review of working time arrangements in the public service with a view to determine which service delivery areas require different working time arrangements to facilitate service delivery improvement and employment creation.

3.2. ILO Ratifications of Conventions relevant to working time and work–life balance

South Africa has not ratified any of the Conventions relating to the matters discussed in this review. However, the statutory and non-statutory rights of workers in the health sector in South Africa outlined above broadly comply with them.

The relevant, non-ratified Conventions referred to are as follows:

- No. 1: Hours of Work (Industry) Convention, 1919
- No. 30: Hours of Work (Commerce and Offices) Convention, 1930
- No. 132: Holidays with Pay Convention (Revised), 1970
- No. 156: Workers with Family Responsibilities Convention, 1981
- No. 183: Maternity Protection Convention, 2000 (and previous versions back to 1919).

The arrangement of working time has a major impact on occupational health and safety. It is therefore important to note that South Africa in 2003 ratified the Occupational Safety and Health Convention, 1981 (No. 155), and that it is in force.

B. Research methodology

4. Methods, data analysis, ethics and limitations of study

4.1. Methods

An in-depth and extensive literature review was done, which informed the qualitative field research in both the public and the private sectors. Mapping was carried of health service centres in the different provinces. The three provinces (Gauteng, the Western Cape and the Eastern Cape) identified in the research proposal were selected for the qualitative field research. To ensure a reasonably representative national sample of health services were included in the study, it was decided that a minimum of two tertiary, two district and two primary care institutions be selected in each of the three study provinces. This involved application for clearance to conduct the study to many more institutions than planned, as several indicated that they were “overresearched” or had internal challenges that did not make it possible to conduct the study during the time available. Some institutions required additional ethics clearance, which made it difficult to conduct the study in those institutions in the time available for the study.

The tertiary hospitals are in urban areas, the district hospitals and primary care clinics could be in either urban or rural areas. In the selection of institutions it was ensured that some rural areas were included. In each one of the institutions an attempt was made to obtain interviews with health workers from different departments as well as their trade union representatives, hospital managers (including senior and line managers in human resource departments), nurses and doctors from the different medical and surgical departments, radiographers, laboratory staff, ancillary staff, physiotherapists and occupational therapists. Where these were present, attempts were made to interview nurses and doctors running the occupational health clinics of hospitals. Efforts were also made to interview health workers in different NGOs providing health services to communities, but with the exception of the community care workers it was difficult to systematically obtain interviews with groups who did not have tripartite structures.

Focus group discussions and key informant and managerial interviews were done at a number of health service centres where prior access was obtained (table 25). The guidelines for focus group discussions, for interviews with managers and for key informant interviews were adapted and then used to inform, in a semi structured manner, the questions asked. The study therefore used an exploratory, qualitative approach to obtain as far as possible in-depth information from respondents. On the whole this worked very well. In addition, the use of some open-ended questions gave the respondents the opportunity to give information in an unanticipated manner in their own words and this enriched the interviews in a most meaningful way. There was often insufficient time to fully conduct the focus group discussions and interviews, as most respondents warmed to the subject and saw possibilities for real positive engagement with the challenges. The focus group discussions also served as a forum for health workers to come together and to hear about common challenges and opportunities for collaboration in different Departments of Health. After the interviews and focus group discussions, follow-up phone calls were made or e-mails were sent to several of the respondents to clarify certain points or to seek their guidance on specific issues they raised.

Table 25. Focus group discussions and interviews conducted

Interviewees	Focus group discussions	Managerial interviews	Key informant interviews	Total number of health workers interviewed
Managers	0	12	3	
Nurses	11 (average 6 per group)	1	1	
Trade unions	8 (average 5 per group)	0	2	
Registrars	5 (average 4 per group)	0	2	
Consultants	0	10	3	
Interns/medical officers	6 (average 6 per group)	0	0	
Community care workers	4 (average 6 per group)	0	0	
Total	34 focus group discussions	23	11	214

4.2. Data analysis

All the interviews were typed up during the interview or focus group discussions by an experienced research assistant. The interviews were retyped by the research assistant within 2 days and reviewed by the principal investigator within 3 days to ensure recollection of discussions or interviews. Those interviews conducted in the vernacular languages were transcribed into English within 2 days of the interviews to help ensure recollection. Handwritten notes taken during the interviews were also included in the reviews. Key ideas generated were noted at the end of each interview. The notes for each interview were coded and grouped into thematic categories. Emerging themes were identified and their meaning interpreted.

4.3. Ethics

Informed consent was obtained from respondents and confidentiality was maintained. The study was approved by the Faculty of Health Sciences Human Research Ethics Committee of the University of Cape Town. The Health Sciences Human Research Ethics Committee reference (HREC REF) number is 436/2013.

4.4. Limitations of the study

The qualitative study limitations can be categorized into potential interviewer bias (which were reduced by using the standard guides for interviews), participant bias, selection bias and gender bias. However, it is not believed that biases were sufficient to have any impact on the study findings or the conclusions.

In addition to the limitations, several challenges were encountered during the research. These included:

- The organization of working time in health services is often not considered of critical enough importance to be given priority attention above the numerous

health concerns for which there may be study proposals with very big budgets, for example clinical studies related to chronic diseases or health problems of epidemic proportions, such as HIV/AIDS and tuberculosis.

- Access to health institutions was a monumental problem even though there was already clearance given by NEDLAC, ethics clearance, and, in some provinces, provincial government clearance. About 50 per cent of the time of the principal investigator was spent on obtaining clearance upon clearance at a myriad different levels of the health service. An important study of this nature would benefit from having at least a year to get all the administrative tasks done and to conduct the in-depth interviews at a more orderly pace. A readily available standard protocol for national and provincial health research would be of great value for future research.
- The burden of disease, especially in the public health sector, is enormous. Many critically ill people are in need of health care and the study team had to be totally conscious of this when requesting time for focus group discussions or interviews. On several occasions, interviews with doctors had to be discontinued when they were called for emergency interventions.
- The arrangement of working time is unfortunately considered by many to be a more specialized area of work, and several potential interviewees were uncertain about their own in-depth knowledge of the subject. This usually disappeared very soon into the interview or focus group discussion. Often more time was needed to record experiences respondents wished to share once they fully realized how germane to their daily working lives the arrangement of working time really is.

C. Results

5. Public and non-profit sector

In the combined results of the three provinces, there were 8 focus group discussions with trade unions, 11 with nurses and 11 with doctors. The focus group discussions with trade unions included all the different categories of workers. Participants in the focus group discussions ranged from 4 to 13 per group. It was virtually impossible to arrange focus group discussions with managers and most interviews with them ended up being individual interviews. In the district hospitals there were 2 focus group discussions with nurses and 2 with doctors. In the rural community day centres (primary care clinics) 2 focus group discussions were held with nurses, and 2 in city health clinics. Several key informant interviews were conducted with different representatives of the tripartite constituents. A total of 214 health workers were interviewed during the focus group discussions and the interview process. About 62 per cent were women and 38 per cent men.

The discussions in focus groups and in interviews took place with different staff categories, the majority of whom were nurses, and all staff, except doctors and the staff at one private hospital, were fully represented by their respective trade unions (ranging from 2 to 6 trade unions in different institutions). It was also clear that health workers with different contractual arrangements worked very different hours in the same institution. This was confirmed during the interviews.

5.1. Nursing staff

5.1.1. Working time arrangements

Registered nurses at urban tertiary hospitals work a compressed working week of 12-hour shifts (with 1-hour lunch breaks) that begin at 7 a.m. and end at 7 p.m. (day shift) or begin at 7 p.m. and end at 7 a.m. (night shift). Their shifts are rostered to include weekends, and to average out at 160 hours per month (40 hours per week). A three-shift week (33 hours) is followed by a four-shift week (44 hours) to achieve this average.

Once per month they work a short shift of 7 a.m. to 1 p.m. In some of the departments, such as obstetrics and gynaecology, night shifts are covered by including a period of at least three months of night shifts per year for each registered nurse. Because of the shortage of qualified staff in some institutions, the lunch breaks for theatre staff is reduced to 30 minutes.

Many assistant and trainee nurses in tertiary hospitals and regional hospitals work 8-hour shifts (plus 1 hour for lunch) from 7 a.m. until 4 p.m. Their basic working week is Monday to Friday, and not weekends. Their overtime hours may include stretching their shift from 4 p.m. to 7 p.m. to cover for staff shortages on the wards.

The hours of work of nurses in district hospitals are basically the same as the above in tertiary institutions. Nurses working in day clinics in the districts work from 8 a.m. to 4.30 p.m. with 30 minutes for lunch. They mostly only work Monday to Friday but there may be an arrangement with the local hospitals where they may be asked to work over weekends or some week nights. From all reports this appears to be a mutually beneficial arrangement.

Box 3 presents an interview with a registered nurse at a public regional hospital on working time.

Box 3. Interview with a registered nurse at a public regional hospital on working time

We work 7 a.m. to 4 p.m. Monday to Friday, straight shifts. There are some nurses who work 7 a.m. to 7 p.m. that is a 12-hour shift. It is different in different departments. Some work alternate weekends. Some work two 7 a.m. to 7 p.m. day shifts, then 7 p.m. to 7 a.m. for 2 days, then 4 days off. Some work 7 a.m. to 7 p.m., day shift, Monday and Tuesday. Day off Wednesday. Then 7 a.m. to 7 p.m. on Thursday. Then Friday half day, 7 a.m. to 2 p.m.

Depending on availability of staff, sometimes a person will work 7 a.m. to 7 p.m. for 3 days, then get a long weekend of 4 days off. There is a gross shortage of staff so it is very stressful. Some say it takes at least the first 2 days off after duty to feel a little better. We used to work 7 a.m. to 4 p.m., but then we started this system of 7 a.m. to 7 p.m. Before, we worked 7 a.m. to 1 p.m., then take a break till 3.45 p.m., and work from 4 p.m. to 7 p.m. That was when they had adequate staff. Sometimes, when someone is sick and phones in the person who has already worked from 7 a.m. to 7 p.m. has to stay until 7 a.m. the following morning. They would be working 24 hours and it is not uncommon.

5.1.2. Implementation of the working time arrangement

In specialty departments (oncology, theatre, intensive care unit, etc.), where there is a chronic shortage of the required skilled nursing staff, an extra overtime shift may be offered by management to 12-hour shift workers, and nurses can choose to work this extra shift or not as they determine. Many (most) nurses do work this extra shift on a routine basis to increase their wages, making a standard working week (averaged over one month) of 208 hours (52 hours per week). They cannot work more than four extra shifts per month. In some specialty areas, the nurses negotiate among themselves to increase their 30-minute lunch break to 1 hour on a reciprocal basis, covering for each other.

5.1.3. Flexibility in working hour schedules

There is little flexibility offered in the working time arrangement. However, one concession is made on a discretionary basis to allow nurses deemed to be commuting by public transport and living in insecure and dangerous areas to end their day shifts at 6 p.m. instead of 7 p.m. However, this is contentious with their colleagues who are refused this concession, who contend that it increases their own workload, and also that they too are in danger when travelling home on public transport, especially after dark. There is a perception that this concession is not made transparently, leading to allegations of favouritism.

5.1.4. Work–life and family–life balance

From the point of view of the policy of the human resources departments, the compressed working week and the option of a 12-hour overtime shift with maximum 20 hours of overtime per week is the best arrangement possible from an operational point of view for women with family responsibilities. Consultation with employees' representatives as well as the Department of Labour was included in the process of evolution of this working time arrangement.

The nurses themselves mentioned the fact that many of them are single parents, and that their schedules clash strongly with their family responsibilities, distancing them from their children, whose care is often largely handed over to other extended family members or people they have to hire. They rarely see their children on their working days in the

roster, and in particular lament the loss of family mealtime on those days. Single parents have to deliver their children to the care of others until school begins, on their way to work, in the small hours of the morning. Repeatedly health workers indicated this situation and even showed pictures of their young children (as young as 2 or 3 years) with them on public transport at hours such as 5 a.m. or 5.30 a.m. to drop them off at relatives or friends on their way to work. A trade unionist reported that one of his most difficult experiences was seeing preschool children of fellow health workers on a regular basis on trains and buses in the early hours of the morning.

Management is aware of these problems, and concedes that the working time arrangement needs to be developed further to deal with these challenges. Some managers do however consider that many of these problems are of a “social nature” and thus fall outside the scope of influence of the hospitals.

5.1.5. Staff shortages, workload, scope of tasks, stress

Nurses say the 12-hour shifts they work are made more onerous by “mission creep” in their work, such as having to take on additional administrative responsibilities when their managers are on leave, and other non-clinical tasks such as ordering and organizing medical stores. These tasks are time consuming, and take away from their already high clinical workload.

The number of patients, many of them very ill, they have to care for in a ward (often more than 30) with limited staff make their work day or night very stressful, more so since they often cannot complete their allotted tasks, and there is also a large amount of administrative work they have to comply with.

In trauma units of hospitals the pressure of taking care of patients with major injuries take their toll on staff physically and psychologically, and staff have the perception there may be greater absenteeism rates in trauma and emergency units than in some other departments. The interview with a registered nurse in box 4 is typical of the stress faced by staff.

Box 4. Interview with a registered nurse at a tertiary public hospital: Workload and stress
We are supposed to work 40 hours per week, 160 hours per month. If you come from Monday to Friday 7 a.m. to 4 p.m., that is 40 hours. With the 12-hour shifts, some weeks they work more than 40 hours, some weeks they work less than 40 hours. People often work more than 160 hours per month, they are owed a lot of overtime pay by the Department of Health. People are stressed out and burnt out. There was a time that management was asking them to work on their off-duties, because they wanted to improve much needed patient care. Sometimes there is only one sister to 30 very sick patients. Most wards have 32 beds, for most of them they will have one professional nurse and one enrolled nurse and two assistant nurses. In addition they have to go to theatre. A number of nurses applied for incapacity leave because they can't cope with the workload. It also affects behaviour and attitude. It is often the stress. If you have worked for 16 hours, you are tired and worn out, you cannot think properly.

The stress of insecurity and in some cases past trauma from robbery or rape, or both, while travelling, is uppermost in these nurses' thoughts, especially in winter when it is dark as they leave home. This is made worse by wearing uniform while commuting on public transport, which identifies them for thieves who watch them and know their paydays. This is a standard anxiety for all uniformed workers in all sectors who travel on public transport, such as security guards. Anonymity on public transport is a form of

protection. An interview with a nurse in a tertiary public hospital (box 5) highlights the dangers faced by nurses when travelling to and from work.

Box 5. Interview with a registered nurse in a tertiary public hospital: Dangers of using public transport

Because of my working hours I have been mugged four times in my life. The spirits of my ancestors protected me from worse harm. This is why I was placed in the department I am in now. We as nurses are sitting ducks. We are targeted. They know which days we get paid. The markets know which day we get paid. The uniforms put us at stake. That white dress shows we have money.

Other travelling workers travel in groups, but because of our working hours we tend to be isolated. Other negative impacts include the fact that we as nurses are not centralized in one area. It's difficult for us to get transport from one area to another. Other people can form groups and get their own transport. Some areas are so isolated that you can't get private transport, you have to use public transport only. We have to get up very early.

Because we are nurses, we are told it is a noble profession. So the nurses remain silent. They belong to a culture of silence. They don't verbalize their concerns. If there were no trade unions they would still be as abused as before. They are scared to leave their jobs, to not be good nurses, to be labelled.

The night shift, which in some institutions is for at least three months of each year, is by and large not popular with nurses. They cite the long adjustment time from day to night, causing depression and lack of sleep. Many live in areas that are noisy during the day, and do not have resources to create special day-sleep spaces in their houses to insulate them from noise, light and heat. One nurse explained how she pleaded with her neighbours who run a home business to reduce the noise of electric grinders but they indicated that their livelihoods depended on the work and she had to adjust. The three months can be done as one stretch or nurses can request to have it staggered, and this is usually accommodated. A smaller core of nurses, depending on their age and family circumstances, elect to work permanent nights (and are granted this by management) because they prefer continuous certainty and permanent adaptation. Another group of highly skilled nurses find themselves in the situation where they work in intensive care units (having critical care qualifications) and high care units and there is a national shortage of staff with these skills. Some of them therefore work for six months on night duty and for six months on day duty. The overwhelming impression gained by the interviewing teams was that the nurses in these units take great pride in what they are doing and the quality of the service they deliver. Among them were nurses who indicated that in their experience the training in some newer nurses colleges may be substandard for the task at hand. They therefore find themselves on duty with colleagues from agencies who may not have the experience and the requisite skills to cope and this places an additional load on the more experienced staff. Also, the shortages of skilled nursing staff, and at times substitution by student nurses not yet skilled enough to lighten the workload and who have to attend their training sessions in the wards, increases the fatigue associated with the 12-hour shifts.

5.1.6. Remuneration

The wages are regarded by nurses as very low,¹⁴ and a major cause of overtime working as well as moonlighting. One registered nurse said the wages of nurses keep them in perpetual poverty. Among the important reasons they give for overtime work and moonlighting is that their hours of work keep them away from their children and they have

¹⁴ Notwithstanding the implementation of the occupational special dispensation increases to retain more skilled nursing staff (see literature review).

to pay for child care services, often day and night. They also want to be able to have a better standard of living and better schools for their children.

5.1.7. Absenteeism

Human resource managers who are analysing the rates and incidence of absenteeism among nursing staff often conclude that it is a consequence of personal and home circumstances rather than the working hour arrangements, though management concedes that workload (number of patients) that nursing staff have to cope with when they are on duty may contribute to the problem. Work overload, which is a constant complaint among staff throughout the provinces, causes absenteeism due to fatigue, which further ratchets up the workload for their colleagues who cover, causing further absenteeism in a vicious circle. The pattern of the spike in workload in particular departments on the weekends (such as intensive care unit, theatre, trauma, orthopaedics) means absenteeism swells in the early part of the week (Mondays). From the point of view of nurses, their low wages also cause them to work long overtime hours, which causes fatigue, illness and absenteeism. Fatigue is a major issue for them. Low pay and long working hours are strongly correlated globally, and these nurses are no exception. Many nurses however consider the most pressing problem to be that of staff shortages combined with dated or inadequate equipment. They say posts are frozen when staff retire or leave for overseas, the private sector or for NGOs. Many of them also indicate that they often do not get their payment for overtime work in a reasonable time and sometimes never.

There is therefore not a shared conception of the root causes of absenteeism between management and nursing staff; the former do not regard the working time arrangement as a causal factor, focusing on attitude, wellness and social issues; the latter regard the working time arrangement (especially overtime hours) as a proximate cause, driven by low wages and shortages of staff.

5.1.8. Maternity leave

Maternity leave cover is either by colleagues increasing their own workload, or sometimes by hiring of agency staff. According to the registered nurses on the permanent staff, neither of these prevents an increase in workload to cover for the maternity leave taken by their colleagues. Agency staff with the level of skill required of registered nurses in specialty departments are few, and general nurses are not skilled enough to significantly reduce the workload for skilled and specialized registered nurses.

5.1.9. Transport

The nursing workforce is widely dispersed according to the legacy of grand apartheid. This is slowly beginning to change, with regional and district hospitals now constructed. For nurses commuting from far, transport to work is a major drain on their salary, and adds significantly to their total time away from home. It also adds to the significant safety and security concerns highlighted above. The fact that their areas of residence are so dispersed makes it difficult to organize collective private transport, so they have to rely on public transport.

During a key informant interview a senior trade union leader commented on a recent tragic bus accident in which three nurses died together with many fellow travellers. He indicated that the union has been advocating transport for nurses to and from work but that this has as yet not materialized. He said this tragic accident and loss of life underscored the importance of a safe and efficient public transport system and the importance of

employers and trade unions engaging and finding workable solutions to the transport challenges workers face. Box 6 gives comments by a nursing staff member on transport and safety.

Box 6. Nursing staff member on transport and safety

Transport and safety is a major problem for people travelling to work. Most of our staff make use of public transport. During the weekends and especially in winter it is dangerous because of gangsterism. Along some of the roads staff get robbed and some even end up in hospital. Around some of the hospitals the *tsotsis* (thieves) wait for the staff and almost every day someone is robbed. I stay about 45 kilometers away from work. I wake up at 5.20 a.m. and get on the bus at 6 a.m. to be here at 7 a.m. I have to walk past a dangerous field in the dark so people could rob me there. Every day I worry about this but there is no alternative.

5.1.10. Patient outcomes and satisfaction

Nurses repeatedly emphasized the negative effect that continuing staff shortages and their non-clinical duties have on patient care. This is regarded as “not fair on the patients”. They see no significant improvement unless the issue of staff shortages is addressed. As a start the many vacant posts should be filled as a matter of urgency. In box 7, a community health nurse comments on the rewarding aspects of her job and her relationships with her patients.

Box 7. What do you like about your job?

I like a job that challenges me. I like what we are doing in health. There are many positive changes taking place in health. The tragedy of the HIV and AIDS epidemic has challenged us to do things differently. In local government, you have more exposure and interaction with the community. We were trained as community health nurses, to look at the patients, in their totality. We look at the person, the human being over and above anything else. Looking at the trends, for example the youth, I wish we could change how we interact with young mothers. If we could go more on to the social media, such as Twitter. Those are the challenges that I like, it challenges you, to listen to what the young people are saying and doing and reaching them with health messages in their own language and a media they engage with. It's very interesting to hear the perspectives of community members, including perspectives of young people. In this manner we engage in very rewarding community outreach.

5.1.11. Management–worker relations, trade unions and other means of representation, and worker–worker relations

A senior public hospital manager interviewed as a key informant explained the process by which the working time arrangement evolves for nursing staff. It is usually developed at the provincial Department of Health head office as a schema, taking into account budgetary constraints, operational requirements and existing collective bargaining agreements at the PSCBC (see the literature review). It is then circulated to recognized labour union officials and representatives in the facilities concerned, for review and comment. The final decision on the arrangement of working time is an executive decision based on this consultation.

With regard to tensions in the implementation of the working time arrangement, some managers ascribe these to the relatively recent implementation of a performance management system (which applies right across the entire public sector), and the different reaction to this of an ageing workforce and management used to a system based on loyalty, compared to a new, younger cadre of nurses and managers entering the system.

For the nursing staff interviewed, the key problems in the relationship with senior management arise from the severe shortages of staff in some institutions, the centralization of decision-making, the absence of replacement of staff, lack of overtime pay, shortages of hospital beds (in part due to the ever-increasing burden of disease and injury in the different provinces) and the lack of adequate equipment. These problems have created an adverse working time arrangement out of the hours averaging and compressed working week system. For them, the tensions arising from this lack of basic resources have driven possible flexibility and ease of communication out of the system, barred support resources being allocated to shift workers, and caused high levels of overtime working, and work–life tensions of quite extreme proportions. Such flexibility as may exist is not, in their opinion, systemic or planned, but is dependent on the particular personalities of particular managers, and their approach to the tensions and stresses of the workload. In box 8, a registered nurse comments on relationships with senior management.

Box 8. Registered nurse on relationships with senior management

As nurses in trade unions we participate in meetings and forums with hospital management. We verbalize the problems. We have many problems with the provincial Department of Health mainly because of critical staff shortages and lack of overtime pay. They always say there is no money. A major problem is that everything is centralized. The hospital management is crying like us, they are hamstrung. For example, it is more than three years that they have not employed new people.

For many years, there are no replacements. People retire, people die, people leave but these vacancies are not filled. They have written to the provincial Department of Health head office. They will say they have no replacements. If someone retires, that post is not funded. It is frozen. They said that even if someone dies, they will not employ a new person. The patient numbers are increasing. We need more personnel. We identify critical posts, but even in those critical posts, they will take the numbers to the head office. The number of nurses has decreased so much that they can be regarded as critical or skeleton staff. They centralize everything, which demotivates the staff. If I am working overtime, I could be motivated if I know that I will be reimbursed.

5.1.12. Recommendations by staff for improvements

Not surprisingly because of the complexity of the issues, and because the trade unions have not yet mounted a campaign on working hour arrangements in the health service, staff were very keen to discuss many different possibilities. The most important recommendation from staff is to urgently address staff shortages, which they think will overcome most of the working hour problems. They see the two as inseparable. In each institution in every province where interviews were conducted the clarion call is for all vacancies to be filled and for staff replacements to take place based on the needs of patients and communities and not merely on the available budget. Nurses would also like to see a reduction in the dependence on agency staff, as they feel the system is unfair on the agency workers, on the permanent staff and on the patients in need of continuity of care. Nurses are keen that government should be proactive in staffing high-quality nursing colleges in the public sector that will help to restore the quality of training and boost the morale of staff. They think that a survey among nurses will indicate what type of shift structures they prefer and this, with the support of the trade unions, will help inform a more inclusive and continuing debate on the arrangement of working hours.

Members of trade unions emphasized the interconnectedness of the role of different government departments in addressing the problems nurses face. These include greater trade union engagement to help achieve a safe and people-centred public transport system. They would like the issue of their engagement in non-clinical work such as management of stores and ordering of equipment to be addressed. Box 9 highlights some recommendations for improvements raised by a nursing staff member.

Box 9. Nursing staff member recommends improvements

I think we need to work fewer hours, but we should have more highly trained professionals in both lower and higher categories of staff. There needs to be intensive training and development. The late afternoon and early evening shift is the one we need to discuss with management very seriously. This is the shift that can make a difference to our lives. This is the one we need to pay particular attention to and find answers for, so we can live our social and private lives and our kids are not on their own and unattended. So we should sort out this late afternoon and evening shift from about 4 p.m. onwards in a way that services for patients will not be compromised and we can also take care of our families. Even if it does not change for the better for us we need to address it for the next generation.

5.1.13. Summary of recommendations

The working time arrangements for nurses have been established for a considerable amount of time, through the collective bargaining process at national level in the public service. Relatively recently, the National Bargaining Council resolved to conduct a review of these arrangements (see the literature review). A working time arrangement of such importance, covering many thousands of (largely female, and significantly many single-parent) workers is bound to be influenced by wider societal and infrastructural changes occurring, such as changing public transport systems, child care arrangements, and demographic changes affecting the burden of disease, as well as internal changes in resourcing and priorities of the public health system (to name only four factors). It is therefore time to implement the Bargaining Council resolution to review the working time arrangements in place on a province-by-province basis, as the social environment in which national working time arrangements exist varies from especially rural to urbanized provinces, and with density of population.

The question of cover for absenteeism and maternity leave should be examined, and the issue of establishment staffing levels needed for this type of cover should be placed on a more scientific basis with a requisite budget.

The current situation, in which staff surveys and consultative forums attempt to address concerns (among others) of staff over their adaptation to the shift system, can only deal partially with problems in the absence of any alternatives being offered by management at a senior, human resource planning level. The issues are systemic, affect very large numbers of employees, and require long-term planning of changes and increasing sophistication of debate and agreement.

A thorough review of working time arrangements would begin with operational research and negotiation with stakeholders to devise alternative systems that would satisfy operational requirements going forward, in the light of known budgetary allocations and patient requirements and disease and injury patterns. Second, it would require scientifically designed research on the preferences of staff between the current system and the proposed alternative possibilities.

There should be a detailed investigation of the issue of the provision of transport for shift workers such as nurses. There seems to be a blanket refusal on the question of employer-provided transport, which may not be even justified on a thorough cost–benefit basis within existing budgets. A scientific examination of the issue would include geographic information system (GIS) mapping on a continuing and updated basis of residence patterns of staff, and consideration of possible (in-house or subcontracted) transport to area pickup points, for instance. This could be done on a pilot basis in consultation with the relevant trade unions to examine costs and benefits in a particular catchment area, with roll-out if judged successful and manageable within the medium-term expenditure framework and budgetary allocations to the Department of Health of

government. Such a programme, if articulated with provincial provision and future plans for improved bus services to previously underserved areas, would perhaps be more feasible financially than any attempt to return to a comprehensive nursing hostel provision. The obvious immediate benefits would be to reduce, if not entirely eliminate, the safety and security concerns of staff, while reducing their overall time spent commuting to work already long shifts.

If transport cannot be provided, nurses should have adequate changing rooms in hospitals so that they do not have to wear their uniforms while commuting.

5.2. Hospital doctors

5.2.1. Specific working time arrangements: Introduction

In the public health sector, the overwhelming majority of all doctors are employed in hospitals, from district to regional and up to tertiary teaching hospitals. In discussing the working time arrangements for this cadre of medical staff, it should be noted that by and large, if not entirely, they fall outside the BCEA because of the gross earnings threshold above which the provisions of the Act on basic working week, overtime hours, compressed working week and hours averaging do not apply. This threshold was established by the Minister of Labour in 2008 at 149,736 rand per annum (index linked).¹⁵ Since most doctors employed by the public health service earn above this threshold, their working hours are essentially an internal matter decided by the senior management members of their profession, as expressed in their professional association, the Health Professions Council of South Africa, which has its own internal disciplinary mechanisms for members, and which hears complaints and decides on resolutions from its membership on matters of common concern.

Hospital doctors are organized in what are called “firms” according to specialties in public hospitals, each firm having its cadre of trainees at various stages of their professional progression. After graduation from medical school following five years of university training, interns work for two years in public hospitals as trainees as part of their seven years of academic training towards qualification. They then have to do a year of community service in public hospitals. On completion of this year of community service they can register to practise medicine in South Africa. Following community service they may select to continue working in hospitals as medical officers. Many medical officers select a path of specialization and then register to become registrars. To become a registrar you have to be fully qualified and register for a five-year in-post training contract in the particular discipline you wish to specialize in. Box 10 presents the outcomes of an interview with interns at a tertiary public hospital.

Box 10. Interview with interns at a tertiary public hospital
For interns the working hours arrangement is different with every rotation, and with every firm. Some start at 5 a.m. and others start at 7.30 a.m. Core hours are from 7.30 a.m. to 4 p.m. but we always work longer. On top there are around six to seven calls a month. It is usually meant to be a 48-hour working week with 16 hours overtime in addition. The average working week is actually around 80 to 88 hours or more. In trauma interns work 12-hour shifts. We also work weekends.

¹⁵ GN R300 in GG 30872 of 14 March 2008 (with effect from 1 March 2008).

We are on surgical rotation at the moment at this hospital. Our core working day is 8 hours but most times we go home late. Then we are on call every 4 days. A call is supposed to be a maximum of 30 hours but can be longer. We start at 6.30 or 7 a.m. and are allowed to leave at 1 p.m. the following day. Actually, you are allowed to phone your senior to say that you need to leave, they need to make a plan to have someone to take over from you. You go home at 1 p.m. the day after your call, you sleep, you wake up to have supper, you sleep and go to work the following day. For one day in between calls we feel we are functional. I have worked weekend calls for the last three weekends.

We don't have social or family lives. It's difficult when all your friends are going out and you can't. Sometimes you can go for weeks with having to go into work every day. At times you do not even know yourself anymore. I've put on lots of weight because of being on call. I like to exercise, but I'm too tired to go to the gym when I get home now. I know some doctors manage to, but I don't know how they do it. After I've been on call my face breaks out in a rash and my body is painful from the lack of sleep and worry about sick patients and finding beds and drips and catheters etc. We get flu all the time and take long to recover because we do not rest. We are so sleep deprived and just eat junk food because we don't have time to get to the shop to buy food to make a healthy meal. You can't even prepare for being on call because you don't have time to leave the hospital. We can't go on strike and we won't but we need change and nobody seems to hear us. We are simply at the mercy of the higher powers.

All trainees move around between different specialties to gain wide experience of the different disciplines. Over the two years of internship the young doctors move through different blocks of training of about four months each to acquire experience in different disciplines. Registrars rotate through various departments in their chosen discipline (for example obstetrics and gynaecology, surgery or internal medicine) over a five-year period. They have to pass several important examinations and have to take on major responsibilities with regard to patient care. Senior doctors at the peak of their career are designated “consultants”, dedicated to particular specialty departments.

The PSCBC (see literature review) underwent a years-long debate during the past decade about payment for doctors and skilled nurses, to define the “occupational special dispensation” – a premium payment not available to all public sector workers, designed to address the issue of the “brain drain” of qualified medical personnel from the public health sector to the private local health sector, and to the private and public sectors in economically more developed countries. This debate was sharpened by disputes declared by junior doctors’ and nurses’ unions, and was finally resolved by collective bargaining at the national level in 2011 (see the literature review for the discussion on nurses pay), in which these skilled medical staff received a one-off jump in salaries, outside the normal annual public sector wage agreement applying to all public servants.

Due to their history as a professional association, and the fact that they are excluded as relatively high-paid members of the workforce from the general legal framework governing the BCEA, doctors’ terms and conditions of employment such as working hours resemble the ancient guild form of regulation rather than the modern employer/employee form. Their training resembles an apprenticeship, with the concept of “serving your time” under the direction and supervision of a master craftsman. Their working time arrangements are therefore practically unique, and this applies globally, as well as in South Africa, though particular conditions vary according to the history of particular countries. Nevertheless, in the public health sector, their payment and working hours are partially determined by the health authorities to whom they provide their services, and who determine which of their hours will be paid at what rate, according to the operational requirements of the public hospital service as a whole, and particular facilities at different levels of service provision (district, regional, tertiary). There are also variations in working time arrangements between different specialties for doctors, according to the different patient acuity levels, and different patterns of demand for services within these specialties.

5.2.2. Doctors' working time arrangements

Consultants and registrars tend to have a fixed commuted overtime contract. Under this contract, their basic working week is defined as 40 hours, with 16 hours of commuted overtime per week paid at time+1/3 (which complies nominally with the BCEA). This overtime is not pensionable, which means that when doctors retire, around 30–40 per cent of their salary is non-pensionable. This was hotly contested in 2007/08 but was not changed. In addition, doctors work many more hours according to the demands of the work unit (firm), and undertake extensive on-call hours of work at weekends for emergencies or cases where the staffing level at the hospital at any one time is insufficient to cope with the demand for services. The fixed commuted overtime contract is standard in all the provinces.

Consultants start usually at 7 a.m. or at 7.30 a.m., depending on theatre lists or other determinants. They may work 8–11 hours per day and when they are on call this can be done from home. They are technically on call all the time, but in practice would be on call one weekend out of every two.

Registrars can work between 60 and 100 hours per week, and even more in extreme cases. Registrars start at 7 a.m. or sometimes earlier at 6.30 a.m. with ward rounds, which can take up to 3 hours, and if they are on call they theoretically work until 8 a.m. the next day. This includes being on call for the night, which may mean working throughout the night, or being able to catch some sleep if the unit is not too busy. Their on-call hours are spent on site, not at home. This is a 24-hour “shift”, though doctors do not regard themselves as shift workers because their hours are so variable according to demand at particular times. Interns can theoretically go home at 8 a.m. (if their replacement interns are there) after their 24-hour “shift”, but registrars may have to attend to theatre and other responsibilities and sometimes will not go home until after 12 noon. Total hours at post and on call are therefore 28 hours but can also be 36 hours.

There have been instances where registrars and interns have been on call every day and every night for six weeks, depending on the work unit demands, sick leave and leave schedules. This is particularly so in hospitals where there are major staff shortages. One respondent calculated that his average working week was 85 hours. With the commuted overtime contract, only 56 of these hours are paid, the last 16 at T+1/3. Registrars' workload is allowed to ease off during the time they take their final examinations, but this is not formal enough to be regarded by them as a “time banking” arrangement, is not accurate in terms of hours taken back, and is discretionary and distributed according to the firm's requirements.

Interns' starting times vary by department from 5 a.m. to 7.30 a.m. Core hours for them are 7.30 a.m. until 4 p.m. In addition they work six on-call shifts per month, which begin at 4 p.m. and can continue up to midday the following day or even until 7 p.m. The interviews revealed that in some very busy hospitals interns regularly only go home after an on-call shift at 7 p.m. the following day.

Their basic working week is also 40 hours, with 16 hours commuted overtime per week (56 hours per week total), but their actual working week is more like 80–88 hours. There is a nominal limit of 80 hours total per week. In box 11, an intern describes a typical work schedule.

Box 11. An intern in a tertiary public hospital describes the current work schedule

In obstetrics and gynaecology I was on call Monday, Wednesday, Friday, Sunday, Wednesday. This is quite common in this hospital. You come in at 7.30 a.m. and you work through the night. Then the next group of doctors comes at 7.30 a.m. and then you stay on the post-intake ward round until about 1 p.m. If you had 1 hour of sleep you were lucky. We are used to doing 140 hours overtime! There are too few interns. There is no set programme for the on-call programme.

Our standard day is supposed to be from 8 a.m. to 4 p.m., but it could continue to 5, 6 or 7 p.m. No lunch, no tea. Ideally we should have 16 interns, but we only have 13 interns. We don't have enough interns in the hospitals as a whole. Some smaller hospitals didn't get any interns at all. We do at least two weekends per month. On call either a Saturday or Sunday. You do ward rounds one weekend, independent of being on call. In effect we work three weekends per month. We are not free to go away at all.

Interns have challenged the Health Professions Council of South Africa on their working hours because these violated the standards in the BCEA. The Health Professions Council standard for interns is a maximum of 80 hours per week, but this too is regularly violated. The challenge has not been successful, however, and there has been no change in the working time arrangements in practice in the workplace.

Nevertheless, registrars and interns interviewed in some hospitals perceive that they take strength from the realization that the long hours they work gives them “exposure” and accelerates their acquisition of knowledge and skills while providing a much needed service. This is to them a motivating factor, despite the experience of fatigue and disorientation, and despite the possibility, which they acknowledge, of errors they may make due to challenges with patient care at important, perhaps critical, moments, or the possibility that they themselves are often not safe to drive when they finally go home after a work assignment. Many interviewees were distressed at the level of fatigue and incoherence they experience at the end of perhaps a 30- or 36-hour duty call (unacknowledged) when they have to drive themselves home. They feel especially let down by senior hospital and provincial health management, who they feel are distant, absent and not systematically engaging with the challenges.

In boxes 12 and 13, registrars and interns reflect on the issues raised above and the problems they face in their work.

Box 12. Interview with a group of registrars in a tertiary hospital

We are registrars but are still on medical officer salaries. We are chronically short staffed and so are the nurses, the pharmacists, the porters and other categories of workers. The biggest problem is that the patients are suffering. There is no accountability. No one is doing the stats to show that patients are lying in the wards for far longer. Essentially management said that they are not going to appoint more staff. That this is going to be the new norm, the current complement of staff.

The primary and secondary care clinics and hospitals are not functioning optimally and often do not have equipment for investigations. Many patients therefore end up at the tertiary hospitals. In April I worked 98 hours overtime, in May it was 100 hours overtime. Sometimes you can't go home at all because there are still sick patients waiting. We don't care about working to rule. We are already limiting our time with the patients to give each one some time at least. Patient care is suffering so much. How do you tell the family that you cannot look properly after their sick relatives.

Recently in emergency care the intern was called away to take care of a CT scan for a sick patient from a rural hospital. You receive a call from a nurse that they have a patient with heart failure in need of help. You now need to decide from the nurse's telephonic report whether to leave the resuscitation of the patient you are busy with and attend to the patient they are calling you for. There is no one else to help. You have only one sister and she is busy attending to a patient who has just died. We all suffer when we go home. If we do suffer from it, we don't recognize that we are suffering from post-traumatic stress. I think that a lot of what we are feeling could be prevented with proper organization. We are seeing a lot of unnecessary patients. Your hospital is as good as your casualty and they don't have a proper work-up and they are too short staffed.

Box 13. Interview with interns at a tertiary public hospital

When we are on call we have to see about 60 very sick patients. We have to get a patient to X-ray, so we take them ourselves as the porters are short staffed. Theatre is stopped because the only porter is on tea. Then other times the porters are sick because they are too short staffed and become exhausted. There is only one or two of them. I have injured myself, taking a patient to X-ray, lifting the sick and heavy patient myself. There is no nurse to help with resuscitation so you do the resuscitation all by yourself. The nurses are completely short staffed. Parts of the administration do not seem to work. The lower level of paid workers seem to have fallen out of the system so doctors try to cover and do their work. The laboratories do not come to fetch bloods, and the intern has to wait an hour to get the urgent blood results of a critically ill patient. This hour the intern could have spent taking care of patients. The laboratories are privately run but the service is unreliable. Will be better if the public service can run it. If the foundation parts of the system (medical support services) works then doctors would not be as stressed out. For example, a very sick patient can spend a day waiting for an ambulance to transfer him or her to a specialist unit. We can have three to four deaths per day. in the medical department it is not uncommon as patients are so very sick. Ambulance services are not working. Patients come late and they are very, very sick. In casualty there is no adequate triage and no adequate resuscitation as they are short staffed. At the end of your shift you cannot think beyond just seeking some food and rest.

5.2.3. Implementation of working time arrangements

Respondents in the interview programme listed the following characteristics of how their working time arrangements are actually implemented:

- Actual hours do not conform to the contracts, but relate to the demand for services by the hospital at any one time in the different departments. Actual hours are significantly longer than allowed for in the contracts, or paid for and remain mostly unacknowledged.
- Actual hours are not recorded by any clocking system, making it more difficult to regulate hours in firms, and to share the workload transparently and fairly.

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- Overtime is undercounted, and absolutely regular (not just for irregular emergencies) but is non-pensionable.
 - There is insufficient provision for sleeping quarters for doctors working at night on call.
 - Absenteeism is not planned for, and when it occurs translates to even longer hours for colleagues.

5.2.4. Flexibility

The head of the human resources department at a tertiary hospital reported that there has been a steadily increasing female cadre of doctors (as well as senior administrators), which will ratchet up the conflicts that already exist because of lack of work–life balance, and also exacerbate the problem of maternity leave cover, which at present is inadequate, adding to the workload of colleagues. As a result the provincial Department of Health has issued a draft policy on flexibility in working hours. This policy has however not progressed further in the two years since it was first circulated among stakeholders in the department. Notwithstanding this, the tertiary hospital management reports that they are open to discussing flexible working hours if the medical staff member cannot work part of the core hours that are expected, and that each case is considered on its merits and a decision handed down on a request.

Job sharing with part-time work was been mooted by the human resources manager at a tertiary hospital as a possible solution for women medical staff, but this has not been progressed as an issue at a policy level. Evidence was given by respondents of women leaving the public sector because they were not permitted to have reduced-hour contracts when they had children. There is a natural flexibility in that senior doctors can leave the hospital if there is a low workload and their duties are complete, but it is much more frequent that they have to extend working hours because of patient load.

In special cases, there are reduced overtime packages, but this has to be individually agreed by the department.

5.2.5. Work–life balance

For registrars and interns there is very little balance or accommodation of their personal lives. They live their training and very little else. There is almost an unspoken rule that trainee women doctors “do not get pregnant”. It is easier for senior staff (consultants), though most of them have to have child support to assist with child care. The high and unpredictable workload causes problems for family life in that it is impossible to be reliable for family events and outings, including supporting children at school events. When doctors with families are at home, they are too tired to give attention to children. Male doctors get perhaps 5 days’ paternity leave when a child is born, but they would like more flexibility to be granted more time off for this.

There are concerns that the extreme working hours, especially of trainee doctors, affect their health in that they eat poorly (junk food taken on the run), and that they are not able to exercise regularly.

5.2.6. Staff shortages, workload, scope of work, stress

A senior woman doctor interviewed estimated that stress disorders and depression are common among trainee doctors, as are skeletal disorders, and possibly drug and alcohol abuse (“which we don’t talk about”). With increasing age, the problems move to diabetes, hypertension and cardiac issues. Energy levels, competence and concentration are all adversely affected, according to her, and burnout ensues.

In a tertiary hospital, registrars have to take examinations, and consultants have to produce new knowledge and teach. This increases the scope of their duties, and these duties do not naturally merge with clinical work. Most if not all of this work has to be done after hours.

A major source of stress is the “multiple systemic failures and inadequacies of the public health system”, as a female consultant surgeon put it. There is a lack of basic equipment, insufficient bed space, long clinic waiting times, inability to obtain relevant radiological investigations for several months, and the lack of adequate theatre time to operate on cancer patients or patients with other chronic health problems.

A registrar pointed out that due to the economic downturn since 2008, there has been an increase in the number of people wanting access to the public health service, because people are leaving medical aid schemes as they cannot manage the premiums, or because their employers have cancelled health benefits as their companies are struggling. But this increase in demand for services has not been met in the public sector by an increase in hospital beds or medical staff, leading to a steady increase in workload, and therefore ever-longer working hours for existing staff. The only way, in the opinion of this registrar, to reduce working hours is for the public sector to increase the supply of medical staff.

Staff reported that public hospitals and clinics in some of the provinces have seen a significant increase in the number of patients from beyond the borders of South Africa. It is their assessment that no contingency plans are made to cope with this increase in patients who are in great need of medical help.

Several of the junior doctors interviewed have a sense of being totally undervalued and unacknowledged and feel that the system expects so much of them and yet their most basic needs as human beings are overlooked. Many of them find the system uncaring and feel dehumanized by an inadequate system that makes it difficult for them to care for their patients in the manner that they think they should.

An intern in another department described how she could not give proper attention to young mothers who have lost their babies, as she had to do the required gynaecological surgery after she had already been on duty for 24 hours. They feel they are caught up between their wish to provide decent care to their patients and the demands of an uncaring system that expect them to work the hours without consideration as to how they get through all those hours. Box 14 expands on those views.

Box 14. An intern relates her experience of the health services as uncaring
After 12 hours on duty, I now just manage to do the bare minimum. When I started out I wanted to do my utmost for everyone. Between three of us we can see up to a hundred sick patients during a call. I’m now not capable to take care in the same way as before and cannot always listen to the full details of everyone’s problem. I just can’t do it in the same way. I have changed from someone a year ago who could spend 45 minutes listening to a complaint about a headache. I could use all my medical skills to get to the bottom of it. Now it is just a headache for which the patient

will often get paracetamol as a start. My capacity to be compassionate and caring has diminished dramatically! This is of great concern to me! I want to care for people. I want to really listen to their experiences and use my skills to help resolve their problems with them. But I am completely drained. I feel like I'm being dehumanized by an uncaring system. I spend my working days and nights making difficult decisions about the lives of patients and when I get home then I don't want to make any decisions and I don't want anyone to have expectations. I just want to sleep. It is difficult for my family.

My experience of the health care system has been that it is most uncaring. It is a service of some nature we are providing but there is no care! No one cares about anyone. It's about patterns of behaviour. If people cared about the person they were helping, they would care that things are there. It's about the way you speak to people. There are isolated pockets of caring, like with students. I treat students working with me very well and they are very helpful and they go out of their way (to help). My influence is only in this little pocket and there I try my best. As interns our sphere of influence is so very limited.

The hospital that I work in seems to be the most systematically dysfunctional. Possible avenues to register complaints or concerns are very difficult and we are overtaken by the many tasks of each day. Not having the resources, on a regular basis, to do a good job is challenging. This range from cleaning equipment to specialists who don't answer their phones when they are supposed to be on call. You probably could report them, but that is more work. You have to document what time you called them, how many times, etc. By the time you get hold of them, you just want their help. There are many things that I could do to be more proactive but I'm so tired. I am reaching my capacity just trying to do my job. Yet I'm young, only 25 years. I want to work hard, and do interesting and caring things but I'm doing boring stressful things in a broken system over and over.

5.2.7. Remuneration

The doctors interviewed did not have any complaints about their salaries but several complained that they had not received overtime pay. Some of them even went on a go-slow to bring attention to the problem. Also, the points mentioned above about non-pensionable hours and unpaid overtime have resonance in this regard.

5.2.8. Absenteeism

Absenteeism is very low among doctors because they come to work when they are sick, since not to do so would increase the workload for their colleagues (and themselves if someone else goes off sick). One intern reported coming into work when he had pneumonia. There are however a small number of junior doctors who take extended sick leave from time to time (presumably because their illness is severe enough to completely incapacitate them, taking a longer recovery time).

5.2.9. Maternity leave

Maternity leave is four months, but without the regular overtime pay in the commuted overtime contract, and when women return to work after the birth, they are not always permitted to work part-time contracts. Breastfeeding facilities are very limited, as was pointed out by the woman consultant interviewed. In the large tertiary hospital where she works, there is only one private space for breastfeeding.

Female registrars normally wait until their five-year training is complete before having babies. "As a woman registrar or intern you just do not have a baby," articulates a newly married registrar. Some young women indicated that during the year of community service it may be a little easier to consider having a baby. For many it is uncertain.

There is insufficient cover for women doctors on maternity leave, so this adds to the workload of colleagues. Women doctors find it inexplicable that their overtime pay is taken away on the basis that they are not working overtime while they are on maternity leave and yet the money is not utilized to employ replacement staff even on a part-time basis. In

box 15 Professor Del Kahn of Groote Schuur Hospital presents his thoughts on relevant matters.

Box 15. Interview with Professor Del Kahn, Head of Surgery, Groote Schuur Hospital, Cape Town

Q. People do have a great need for work–life balance. Do you think this is highlighted by the fact that there are many more women moving into specialized fields in medicine as a whole?

I do not see a gender difference; for me, men and women are equally able to do the work, even when it comes to physical strength. When someone applies for a registrar position, I see no gender. From a female point of view, women do have to put off having babies until they have finished their registrarship. This means going through five years of training, two years of internship, one year of community service and a couple of years as a medical officer. This means waiting till age around 35 years before having children. Personally I think there is something very wrong with that – people are looking at job sharing and I think that is a possibility. But I think that it would mean that top positions would be out of reach for part-timers because they would not be able to acquire the necessary experience for such positions in the time available to them in part-time work. Top positions require 100 per cent commitment – women would then be discriminated against if they are doing job sharing, with regard to gaining top positions.

Q. Do you agree though that the majority of women who go on maternity leave are not replaced?

The provincial Head of Health has said we cannot provide maternity cover – I have been taking this up at the highest level. You cannot promote having women in the workplace and not make any allowances for four months paid maternity leave. It's also a question of the workload. Nursing does make allowance for it – a budget allowing four months off for maternity leave. But there is no budget for the medical side.

5.2.10. Opportunities for staff to improve their skills or to be promoted

Several doctors interviewed were reasonably satisfied with the opportunities presented for continuing learning, skills development and specialization. Several others, however, were deeply dissatisfied and some were virtually denied the opportunity to improve their skills.

In some institutions library facilities and access to the Internet is almost non-existent. The extended working hours and the huge workload also make it difficult for some doctors to benefit from the teaching that is available, as patient care has to take priority. In most departments conducting mandatory research for their examinations adds to their workload, and time attending lectures is unpaid.

5.2.11. Patient outcomes and satisfaction

Doctors are aware that patients do not get as good a service as they should because doctors are tired and this is cumulative. Managing with limited resources means that patients do not get effective care, and this can cause burnout and attrition to the private sector, not for financial reasons but because of the working environment. Even in non-emergency departments such as orthopaedics, delays in treatment cause emergencies for patients. Mistakes occur due to fatigue in critical situations such as operations. In box 16, a senior gynaecologist comments on the negative and positive aspects related to patient outcomes and satisfaction.

Box 16. Interview with a senior gynaecologist at a tertiary hospital: Patient outcomes

HIV/AIDS and tuberculosis in gynaecology and obstetrics is sadly affecting many of our patients and they come in for delivery when many are very sick. It is affecting us as health workers psychologically because we still have a high maternal mortality ratio even though it is steadily improving all the time. We do however still see mothers with multidrug-resistant tuberculosis falling pregnant while on treatment. The advertisement of antiretroviral drugs seem to make people view that it is OK to be pregnant on those drugs. Prevention programmes should do more information sharing on the importance of the viral load.

On the positive side, we are really helping many people to have better quality of lives. You see the enormous impact in treating poor patients well. By taking care of the women we can change the country. The grandmothers are my favourite group of people. It is as if they carry the country with their unconditional commitment to care.

We are also winning on the mother-to-child combination on the fixed drug aspect but we still need to do more about change in behaviour. It has to do with the subordinate position of women, which is difficult to change without jobs and economic independence. On the other hand I see many women who may not have much formal education but they know so much practically and give so much and they have great wisdom. This is a great source of inspiration.

5.2.12. Management–worker relations, trade unions and other means of representation, and worker–worker relations

There is a “rumour” that there is a management–staff consultative mechanism in place for introducing changes in the working time arrangement, but this is not generally understood among medical staff, and has too low a profile to make any difference to the actual hours worked, or the degree of flexibility allowed for individual life preferences. Registrars report filling out management surveys, but there is no change as a result, and there are no questions on the survey about working time arrangements.

Interns and registrars at a tertiary hospital report that their only contact with management is when they are hired. Management at most hospitals is seen as unapproachable. For example, doctors see a reduction in the number of interns and registrars in particular departments due to non-replacement of staff, but there is no forum in which these matters can be discussed with management. This has a major implication for the hours they work.

Many doctors are members of the South African Medical Association (SAMA) and the Junior Doctors Association of South Africa (JUDASA) (an interest group to connect junior doctors with senior doctors), but neither of these organizations acts as a negotiating channel with hospital management on working time issues. On the contrary, they note the complaints made but conform to the notion that doctors carry particular responsibilities as caregivers and should always try their level best for the patient.

If doctors in training have challenges with members of the nursing staff about certain tasks in the wards there is no proper mechanism in place to address this in a mutually acceptable manner.

An interview conducted with the very pleasant, dedicated and well-qualified occupational health staff at an occupational health clinic at a tertiary hospital surprisingly indicated a total absence of the inclusion of shift systems or hours of work on the health outcome assessment of workers. They acknowledged this as an unfortunate oversight and will address the issue in the coming years.

5.2.13. Respondents' views on possible improvements in working time arrangements

The following suggestions were advanced by the doctors interviewed on specific issues:

- Non-emergency departments have to schedule operations in the early hours of the morning to get access to theatres. This is far from ideal for the patient or for the doctors. Dedicated daytime theatres will make a very big difference. Most registrars and interns strongly advocate filling the unfilled posts and thereby reducing the workload and the unrecognized and uncompensated overtime work, which is a source of great frustration, disappointment and at times anger towards senior hospital and provincial management.
- The increase in women in the profession, especially at trainee levels, requires more flexibility in working time arrangements, including longer duration of training, part-time work, job sharing, and more flexibility on start and end times of shifts, to accommodate women's life cycles. There is a need to have a combination of options and change the way of thinking about how to accommodate the workload, otherwise the pattern of the profession being overwhelmingly pursued by men in traditional relationships will persist, and women will not be able to advance in the profession. Flexibility is also needed for male doctors who require more paternity leave.
- There is a need for more provision for private, hygienic spaces for breastfeeding. Such facilities as bathrooms, privacy, availability of more nutritious food outlets, and basic dignity need to be considered for both male and female trainees, to ensure a healthy work environment – the issue is not just the working hours (which are seriously compromising) but the working environment.

5.2.14. Recommendations

It would seem to be hubris for a study of this kind to make recommendations on the working hours of doctors, when the issue is clearly so very complex, because it is bound up with the medium-term expenditure framework of the Treasury and large-scale demographic and economic changes affecting patient demand in the public sector, and because doctors themselves have instituted complaints procedures to attempt to get their own association's leadership to take up the issue of long and inflexible working hours, without success to date.

However, arising out of the interviews and discussions the following recommendations are put forward:

- The process for provincial Departments of Health draft policy on working time arrangements and flexibility should be prioritized, and conducted with the maximum possible information on actual working hours in the service and their effects to hand, and with the maximum possible consultative mechanisms to include both senior human resource and other relevant managerial staff in the public hospitals, as well as legitimate representatives of consultants, registrars, medical officers and interns, perhaps on a facility basis. Other stakeholders should be included in the process of consultation, such as the Labour Inspectorate, the professional associations (SAMA, Health Professions Council of South Africa) and the parties to the PSCBC.

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- Successful policies (that actually decrease doctors' working hours) in two or three provinces could stand as models for other provinces, and for a more comprehensive policy process at national level.
 - The PSCBC should proceed with its own review of working hour arrangements in the service, and feed the results into provincial and national-level consultations on this matter.

5.3. Ancillary and support staff

5.3.1. Working time arrangements

Hospital porters work 12-hour shifts on a continuous basis (7 a.m. to 7 p.m.; 7 p.m. to 7 a.m.) with compressed working weeks (three shifts on, two off, three on, two off, etc., including weekends), averaging 220 hours per month, or 55 hours per week – the maximum allowable overtime in the BCEA.

Hospital catering staff work 11-hour shifts during the day (no night shifts), including 1 hour for lunch (7 a.m. to 6 p.m.), on a roster of three shifts on, two off, three on, two off, etc., including weekends.

Cleaning staff in hospital outpatient areas and other hospital day clinics work a straight shift Monday to Friday, 7 a.m. to 4 p.m. (with 1 hour for lunch).

Cleaners in 24-hour continuous parts of the hospital's operations work 7 a.m. to 6 p.m. (11-hour shifts) during the day only. They work three or four shifts in succession, then have 2 days off, averaging 40 hours per week or 160 hours per month.

Maintenance supervisors in hospitals work from 7 a.m. to 3 p.m., but the ordinary shift workers in the department work 12-hour shifts (7 a.m. to 7 p.m., and 7 p.m. to 7 a.m.) To cover for absentees, these shift workers are offered extra shifts at overtime rates. The interviews did not yield details of the shift roster, or the average weekly or monthly hours worked.

Accounts administration clerks work from 7 a.m. to 3.30 p.m. or 4 p.m. Monday to Friday with a half-hour lunch break. There is no overtime worked and no work on weekends. However, there are some clerical staff that work shifts during the week (no details were given by interviewees about these shifts).

5.3.2. Implementation of the working time arrangement

Porters do not work overtime very much, and if they do so, they take time back rather than get paid at overtime rates. The overtime budget is strictly controlled.

In the housekeeping department (cleaning), short-staffed situations are met with overtime working from colleagues, or the use of agency staff supplied by third-party companies.

5.3.3. Staff shortages, workload, scope of tasks, stress

Cleaning staff emphasized the issue of staff shortages, which can sometimes mean that they have to manage housekeeping tasks in a ward alone for up to 3 days in a row, whereas there should be up to four cleaners on the ward. This extends to laundry staff in areas such as trauma casualty as well, as there is a lot of absenteeism in this department.

5.3.4. Opportunities for staff to improve their skills or to be promoted

In the housekeeping department, there is no opportunity for staff to gain promotion. They stay in menial jobs at low pay rates forever. Moving from a cleaner to a housekeeper, for example, means applying for a post, and many cleaners do not have the academic qualifications (school grades completed) to progress this way.

The same problem applies in clerical work, where the shift workers with significant experience on temporary contracts could not gain permanent positions because they did not have the necessary formal qualifications. They were then replaced with younger and inexperienced workers with the qualifications, which meant that their experience and knowledge of the systems was lost. There was no career progression for them.

In box 17, various ancillary and support staff share their thoughts in a focus group discussion.

Box 17. Focus group discussion with cleaners, ground staff, cooks, ward clerks, porters and their trade unions

They say you can only be trained on a skill that is relevant to your job title. We feel that sometimes it is discriminatory. For example, the general assistant does kitchen work. How can you say that the general assistant can only do skills relevant to the job of cleaning? It means that person will never get more skills. *"There is no college for brooms!"* There is no way that general assistants will get more skills unless they can get them on their own, but they have low wages so this is very difficult for them.

There is a National Skills Development Act, there is a Provincial Skills Development Plan and even a hospital-level one, but we have never been able to get hold of a copy of these plans. Some of us are in the same job and at the same level for 30 years, there is no growth. We started at level 2 and many of us are still there. Most of our staff is demoralized. They spend 20-plus years at the same level. No promotion. It is killing them, not only them, but their children. They can't afford to send their children to better schools. If they could allow the general assistants to be at level 4 instead of the current level 2 then we can also live.

As general assistants, we often don't have the proper cleaning materials and equipment to do the best job we can. We don't have the better brands as we are not given the originals to use. We don't have polishing machines. All our floors are not shining because we do not have the polishing machines. General assistants don't have uniforms. We have been crying for years and years for uniforms. The nurses get uniforms every year so why can we not get uniforms?

If you are working for the government, you can't get a Reconstruction and Development Programme house. For the past five years we only get 900 rands housing allowance. It has not increased. We fall somewhere in the middle. We also can't get loans from the bank. I don't understand the logic. I don't have a house that I can call my own.

Most of the trade union members are not happy about the staff shortages. Some of us are retiring, going on sick leave, leaving, but there are no replacements. Mainly if the vacant funded posts can be filled and also the unfunded posts and if the accruals can be paid, then the morale would improve. About six years ago, one area was covered by five people, now there is one person covering the same area. Since 2007, the staff complement has deteriorated rapidly.

5.3.5. Recommendations

- In the light of the pending alterations to the position of employment agencies (see literature review), hospital managers should minimize their use of agency workers in these ancillary and support functions, and concentrate on reviewing the number of permanent employees in these departments to ensure that sufficient cover is provided for absenteeism, which would itself act to reduce absenteeism.
- Hospital managers should review the requirements for such promotion positions as may be available for ancillary staff, to allow persons with experience in the work to progress to more senior and better-paid positions, and for subcontracted agency staff to be eligible for these positions.

5.4. Community care workers and home-based care workers

5.4.1. Working time arrangements

Among the workers interviewed the positions are of two main types: those who work attached to a fixed primary health care health facility administered by the health district authorities, such as a frail care centre or a clinic (community care workers), and those who go from door to door assisting households with sick people at home, and carrying out health promotion duties connected to this work (home-based care workers). Both of these types of employees are not directly employed by the health public authorities, but by not-for-profit agencies that are funded from several sources, including the health authorities. Nationally, some of these workers are employed on the government Extended Public Works Programme – with their stipends paid directly by provincial governments.

Those attached to a facility that is working around the clock work the same shifts as nursing staff that they assist, but none of them mentioned working nights, only day shifts. Most, if not all, of the facilities they work in are not open at night since they are primary health care, not residential care facilities. They work compressed working weeks with total hours averaging 42 per week, averaged over a two-week period (48 hours and 36 hours respectively), a total of 168 basic hours per month. These hours are worked over 15 shifts per month, each shift beginning at 7 a.m. and finishing at 7 p.m. This schedule allows them a weekend off duty in each fortnight. The 7 p.m. finish time means that they work 1 hour of this shift during the “night”, as defined in the Basic Conditions of Employment Act (see the literature review for the legal requirements regarding this).

Home-based carers are part-time day workers, working 4.5 hours per day, Monday to Friday (a total of 22.5 hours per week, or 90 hours per four-week month). This time is worked in the mornings. There is some periodic rotation in their work tasks over a period of months, between working in the community (door-to-door work), and working at clinics and day hospitals. This rotation does not change their working hours.

5.4.2. Implementation of the working time arrangement

Most of the community-based care workers and home-based carers do work overtime, either extending their morning’s work into the afternoons, or working at weekends with their clients. They expressed serious issues with overtime work, and the inconsistent ways in which it was dealt with by their supervisors in health facilities, or their non-profit-organization managers. In some instances, overtime is not paid at all, but is impossible to

avoid because of the demands of the clients, which cannot be lightly ignored by a health worker living in the community and whose neighbourhood reputation and accountability is at stake. These workers express a very considerable commitment to their clients, for whom they can be the only assistance available in serious chronic health situations. Overtime is also the result of the targets set for the job (for example, number of documented household visits per day or per month, without taking into account the workload for different client acuity levels). In other cases, overtime is paid but according to the idiosyncratic and personal approach of managers, giving inconsistent and therefore unfair results. Overtime hours are also not compensated by time off, which is provided for in the law. The actual hours they work (including overtime hours) do not seem to be recorded formally by them or their employers, though in some cases they mention signing in and out at the beginning and end of each day.

The prevalence of necessary overtime prevents these workers being able to get other work in the afternoons to make up their low stipends, and they therefore express a desire to work full time rather than part time, or to have overtime paid. It seems that they are not entirely free to take other work in the afternoons, but have to explain this to their managers.

Box 18 gives the outcomes of an interview with community care workers.

Box 18. Interview with community care workers
We report to our NGOs. You sign in on the register. You sign in at 8 a.m. and then come back and sign out. You are given perhaps an area and you go to the clients there, so on location. You report to your coordinator, the coordinator reports to management. You don't see management. Like now we are going to report on Wednesday mornings. We don't know how the coordinators are going to take it forward, but previously we did a report every day. When you sign in you give a written and verbal report. Our coordinators take our reports seriously, but management is not serious. There are a lot of cases that coordinators have reported to management. Sometimes staff will go and work door to door, but then there are gangsters around and they rob you. Then management says sorry there is nothing we can do. If your cell phone is gone you must find a new one yourself. We don't belong to trade unions. We don't talk. We don't have a place to cry. You cry to yourself and there is no place to go. We try to tell the management, but there is no money. This year they increased our money, but then in July they took it back again. If you are injured at work you go to the clinic yourself. There is nothing in our contract. The first time I went door to door, a dog bit me, then they said I must go to the clinic. The clinic treated me, the sister faxed the report to the office, but they did nothing. I was too sick to work and I needed to come back to work, I need the money. No money if you do not work.

5.4.3. Staff shortages, workload, scope of work, stress

The 12-hour shift workers in health care facilities among this group mention heavy workloads, which are unrelenting for the entire shift, or such problems as having to lift patients manually on a regular basis, there being no mechanical lifting devices available.

The home-based care workers' main concerns are with personal safety and security in dangerous areas, and having to undertake unpleasant tasks such as cleaning clients who cannot use the toilet (which may be a communal outside toilet in the neighbourhood), or dealing with emotional demands such as undiagnosed depression and other mental illnesses among clients.

An additional issue is the fact that these workers are employed on 12-month renewable contracts, which creates insecurity about their status and prospects, especially as many of them have considerable experience in their jobs.

One considerable source of stress is that their chronically sick clients sometimes vent their frustrations upon the home-based carers, and even refuse to allow them to visit.

5.4.4. Remuneration

These workers want more progression in their wage as they gain higher levels of qualification on the National Qualifications Framework, as well as higher pay as they gain experience over time. They regard their wages as very low (the figure of 45 rand per day was mentioned); low enough to encourage them to be on the lookout elsewhere for better paying work. They regard their wage as low when the commitment required (unpaid overtime, caring for others, working in dangerous areas, no health benefits) is high, and the workload is heavy (both physically and mentally), due to the targets set for documented visits, and the fact that some of their patients refuse to sign the visit reports on which their quota of clients is based.

They also want more non-wage benefits from their work, whether this is deduction at source by their employer for retail hire purchases, or access to free necessary health care for themselves and their children, and sick pay (which they do not receive beyond 1 day per month). They report that if they have an injury they do not get any support from their employer; they merely get treatment from the clinic, and will lose pay if they are off sick for more than 1 day per month. They are not covered by the workplace injury provision in the Compensation for Occupational Injury and Diseases Act.¹⁶ Such benefits are denied them particularly because they are on renewable temporary contracts, or because they are part-time workers on very low salaries. They also feel that permanent status would mean that their requests for more assistance for their clients who have special needs would be listened to, because they would have more authority.

Several workers raised the issue of chronic uncertainty as to what their actual salaries should be. They have a sense that money may be raised from abroad in their name but they are not fully benefiting from the appropriate salaries. It was difficult to obtain further details or clarity on this.

5.4.5. Absenteeism

The workers say they experience a good deal of sickness absence, which for community care workers in health facilities increases the workload of their colleagues. The home-based carers in particular regard themselves as at considerable risk from communicable diseases because they are in close contact with sick people in their own homes, and have limited resources to protect themselves from such diseases. Tuberculosis is endemic in the areas where they work, and so is a constant concern. The home-based carers also emphasize that they have to move from house to house in all types of weather, which in itself is a health risk, and many of the areas they work in are insanitary.

¹⁶ Compensation for Occupational Injuries and Diseases Act – statutory scheme in which employers pay 1 per cent of the wage bill to the Accident Fund, which pays the worker a proportion of salary for lost time due to occupational injury.

Wage penalties (as well as non-payment for sickness absence above 1 day per month) were mentioned for absenteeism (perhaps linked to non-production of sick certification from doctors).

5.4.6. Maternity leave

The workers do not get paid maternity leave from their employer, and also the employers do not seem to claim on their behalf for Unemployment Insurance Fund maternity pay,¹⁷ presumably because they do not register temporary part-time workers under the Unemployment Insurance Act, or pay the contributions to the Unemployment Insurance Fund under the scheme. Because of this, women workers in this category do not take very much leave at all when they give birth. This is clearly a very considerable health risk for both mother and baby.

5.4.7. Opportunities for staff to improve their skills or to be promoted

These workers complete short training courses (up to nine months) offered by the Health and Welfare Sector Training Authority, or organizations such as St. Luke's Hospice or St. John's Ambulance, and some progress up to level 4 on the National Qualifications Framework. This type of training however results in only small increases in stipend, and does not allow them to progress to permanent or higher-skilled jobs in the health sector. They also express problems with delays from the sector training authority in receiving their certificates.

5.4.8. Patient outcomes and satisfaction

The home-based carers have to take the brunt of client complaints, or clients who refuse to allow them to visit. When this is reported, the workers say that their employers do nothing; the workers believe that more skilled staff should investigate every case when a client refuses assistance, so that they can be brought back into the programme. They also become involved in household dynamics around the sick client, playing the role of social worker as well as primary health care worker. These aspects of the job are stressful, and there is no support in dealing with them.

5.4.9. Management-worker relations, trade unions and other means of representation, and worker-worker relations

The workers reported that they do not have clear channels for negotiating with management over their terms and conditions of work, and management does not consult with them meaningfully on these matters. Some of them are confused about who actually is their employer, and who can act on issues that arise. This is because, for example, they are technically employed by a non-profit organization, but are assigned clients by clinics. There are issues about renewal of contracts, overtime, clients who need more support, assault, injury, theft of their property while on home visits, wages, sick and maternity leave, and increases, but they report that they have no real recourse to management over

¹⁷ The Unemployment Insurance Fund is a statutory joint contributory fund which employers are obliged to pay as a payroll tax for employees. It pays unemployment insurance for up to six months and a small maternity payment (compared to salary) during maternity leave.

these issues. Reporting them has no outcome, and they do not have a representative negotiating structure through which to raise these matters and get resolution of them.

5.4.10. Respondents' views on possible improvements in working time arrangements

The clearest recommendation from the home-based carers was that their hours should be increased to full-time work, and their wage increased to 2,400 rand per month. This would be a very significant increase in stipend.

They would like to be consulted on decisions by management, and for management to communicate much better. This includes on matters related to working time arrangements.

5.4.11. Recommendations

The origin of this cadre of workers in the broad health service was the extreme crisis of the HIV/AIDS pandemic in South Africa over the past 20 years, and its associated pandemic of tuberculosis, the most common opportunistic disease in South Africa contracted by the millions with compromised immune systems. These workers have been recognized as essential health workers, providing support to clients and to nursing staff who make up the core of the district health services. They confront the burden of disease in South Africa on a daily basis personally, and were selected to do this work because of their residence in, and therefore intimate knowledge of, the communities where this burden is most severely experienced. These workers thus feature strongly in the future plans of the public health sector, the National Health Insurance and also the National Development Plan, which guides government till year 2030 (see the literature review).

Yet the status of these workers is precarious, and their advancement as health professionals very limited. A key to this is the limited sustainability of funding for their positions, and their marginal status as temporary or part-time workers, or both. Their precarious status compromises their ability to maintain the respect of their communities, and to deliver adequate services.

In the light of this, the following recommendations are offered with regard to these workers:

- The debate about whether and if so how these workers can be incorporated into the public health service as direct employees of provincial Departments of Health should be prioritized and resolved one way or the other. As direct employees, they would be entitled to better employment-related non-wage social security benefits, would have better security of employment, and would have greater possibility of advancement in the service.
- However this debate is resolved, robust representative channels must be established for mutual consultation and negotiation between these workers and other stakeholders, including their non-profit-organization coordinators and managers and the institutions in the public health sector that use or refer clients to their services. These channels must be capable of dealing with industrial relations issues in terms of the labour laws (such as those outlined above), as well as issues relating to client care and follow-up. The present system whereby workers merely give verbal and written reports of their client visits is not nearly adequate for these purposes.

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- The actual hours that home-based carers (and community care workers) work should be properly recorded, and their overtime work should be regulated and remunerated according to the BCEA.
 - The quota of visits for home-based carers should be examined to see whether it is realistic, taking into account the categories of clients according to the extent of their health care needs. If it is found that the quotas are not realistic for a part-time position with 22.5 hours per week, either the hours of work should be increased (and paid accordingly) or the quotas should be lowered. Representatives of the workers should be empowered to negotiate with managers on the findings and outcome of the review of the visit quotas.
 - There appears to be very little, if any, occupational safety and health training for the workers, and their occupational safety and health concerns, including the possibility of contracting tuberculosis, multidrug-resistant tuberculosis or extensively drug-resistant tuberculosis, appear not be adequately addressed. There are no health risk assessments done to assess issues related to ventilation and other precautions, and personal protective equipment appears to be inadequate.
 - The question of personal safety and security for the workers while at work, as well as protection from communicable disease, should be investigated with a view to addressing these problems as comprehensively as possible.
 - In the longer term, workers who are willing and able to work full-time should be offered such positions, with visit quotas designed accordingly. They should have the opportunity to enhance their skills level and should not be excluded from continuity of employment on the basis of their current level of formal education.

6. Private sector

6.1. Nursing staff in private hospitals

6.1.1. Working time arrangements

There were conflicting accounts of the actual hours and rosters worked by nurses from different informants. The shifts seem to vary from department to department as well. They may also vary from hospital to hospital, according to which company they belong to.

The chief executive officer interviewed put the nurses' hours at 200 per month averaged (50 per week in a 4-week month), with 40–42 of those hours treated as basic working hours. They work a main 12-hour shift from 7 a.m. to 7 p.m. or from 7 p.m. to 7 a.m. There is a contractual 12 hours of overtime per week for each nurse. The most common pattern with the 12-hour shifts is 36 hours in one week, followed by 48 hours in the following week, and repeated, including weekends. This amounts to a total of 14 12-hour shifts in one 4-week month.

In theatre, there are shorter shifts interspersed with 12-hour shifts. The best description given was: "They work 4 half-days (7 a.m. to 1 p.m.), then one 12-hour shift (7 a.m. to 7 p.m.), and are off on the weekend, and then 6 half-days and work the weekend, but have 1 day off."

The carers (assistant nurses) work the same hours as the registered nurses.

All nurses are expected to rotate between night and day shifts in the continuous operations, and the rotation is at the discretion of management, and seems not to be completely regular, but according to demand with regard to the patient requirements.

6.1.2. Implementation of working time arrangement

The standard is that private hospital nurses should be given one month notice of any change to their shift routines.

Hospital management attempts to get doctors not to overrun their slate bookings in theatre at the end of a day, but rather to push operations on to the next day. This controls the amount of overtime the management has to pay nurses.

Lunch breaks are discretionary according to the workload.

Nurses prefer to work a 7 a.m. to 4 p.m. shift, and sometimes agency nurses have to be sourced to complete the doctors' slates in the evenings, if nurses are working the short shift part of their rosters.

If nurses work their 12 hours overtime in one week, flexibility takes the form of individual negotiation with management about taking that time back in the following week by working fewer or shorter shifts where this is possible.

Nurses with poor attendance records are placed on 7 a.m. to 4 p.m. shifts for a time, and when their attendance improves they are placed back on the 12-hour shifts.

6.1.3. Absenteeism

Nurse absenteeism in a private hospital is high during school holidays, when crèches close, and this is obviously related to hours of work. On average, however, absenteeism is around 2-3 per cent, which is not regarded as high. Sickness absence climbs in the winter.

Absenteeism is highest among the enrolled nursing auxiliaries, and assistant nurses. This is related to child care issues. But these are not the "essential caregivers" (registered nurses), and these staff members have lower and acceptable absenteeism rates.

Transport is another issue because of safety and security. Nurses expressed a preference for starting work later in the winter, and ending their shift at 6 p.m. because of these concerns.

6.1.4. Opportunities for staff to improve their skills or to be promoted

Nurses permanently employed in the private hospital included in the survey are encouraged by management to pursue studies and gain further qualification. They are given study leave. Bursaries are offered under some conditions, if the hospital management approves the course of study.

There are bridging courses such as theatre diploma, intensive care unit diploma, further education and training course and scrubbing course. There is also a one-year front-line management course approved by hospital management.

Enrolled auxiliary nurses and assistant nurses undergo an in-work training course to distinguish their functions.

6.1.5. Patient outcomes and satisfaction

The majority of complaints from patients about staff are directed at the agency staff who are used by the hospital to cover gaps in staffing. This is because they work in many different locations and are very tired compared to permanently employed nurses. This problem is greatest in the intensive care unit and emergency departments, where agency staff are used the most.

6.1.6. Management–worker relations, trade unions and other means of representation, worker–worker relations

According to the chief executive officer of a private hospital included in the survey, there are no trade unions for nursing staff operating in this particular private hospital. Instead there are staff consultant forums. The chief executive officer indicated that the preference is to liaise directly with workers and through trade unions. The subject of working hours only comes up in these forums with pathology laboratories and theatre staff when these departments are particularly busy. Staff representatives on the forums meet with their sections before meeting with management on the forum, and they come mandated on the agenda items.

However, a senior matron at another private hospital said that nurses were joining trade unions and that management has no problem with it. They are concerned, though, that health workers meet with trade union shop stewards about their problems without first discussing these with management. They look forward to good social dialogue to resolve problems. There is no doubt that trade union consciousness is beginning in the private hospitals, though in one of those hospitals included in the survey, this was far from being the formal recognition stage for collective bargaining purposes.

6.1.7. Respondents' views on possible improvements in working time arrangements

The nurses interviewed at a private hospital expressed the need for more flexibility in their start and end times for shifts to improve their work–life balance, and increase their security and safety commuting to work.

7. Subcontracting and agency staff

Agency workers work illegal numbers of consecutive long shifts (sometimes seven 12-hour shifts in a row) and their wages are very low – lower than the permanent staff employed by hospitals. They have insecure temporary contracts, and can be fired arbitrarily, and have no trade union representation (active trade union membership would endanger their jobs). If they attempt to apply for permanent jobs in the hospital, they are often removed by their employer. If they complain they can be punished by being sent home, and not called to work for several days, so that they lose pay. They may work long hours at the hospital, and then be sent to another cleaning job for another employer with no rest.

Agency workers have no recourse to the hospital if they are injured or get sick due to their work there. They have no sick pay, and have to pay private doctors for any treatment they need, whether or not their illness or injury is due to their work. They suffer needlestick injuries because of inadequate training and long shifts, and are not part of the permanent

staff system of reporting, testing and treatment should this be necessary for illnesses resulting (which can include HIV and hepatitis infection).

In one interview, it was stated that agencies apply for exemptions from the Department of Labour to allow them to breach the paid annual leave, public holidays, and PAYE requirements in the Basic Conditions of Employment Act. This exemption however is meant to be for short-term periods only. Some agency workers work for years with temporary contracts renewed again and again (see the section in the literature review on the amendments to the legal regulation of employment agencies, which are designed to partially address the issues mentioned here).

D. Conclusions and recommendations

8. Challenges, positive aspects and overall recommendations

8.1. Challenges identified

Challenges identified include the following:

- The 12-hour shift system in combination with long distances away from work, poor public transport systems, absence of on-site child care facilities and unsafe travel and living environments makes this shift system unsustainable and too costly in terms of health and safety (physical and psychosocial), work–life balance and institutional delivery.
- Of almost greater importance than the arrangement of working time for many staff members is the major staff shortages (more so in some provinces), the increase in the workload, the degree of illness of patients and the often inadequate health infrastructure.
- Different contractual arrangements (subcontracting) have a most profound impact on work–life balance and patient care.
- There is inadequate recognition of the importance of the organization of working time for both physical and mental health.
- The unity that was so evident during the anti-apartheid struggle seems elusive now and departments and individuals start to blame each other while the situation deteriorates, which requires a common approach and commitment for resolution.
- There is evidence of an often simplistic and legalistic interpretation of working hours and lack of adequate engagement with staff to find common solutions to the many different challenges of a country with a heavy disease and trauma burden.
- There is little indication of regular and inclusive meetings to communicate and discuss possible solutions.
- Training and skills development for workers and management are inadequate.
- Lack of child care facilities, poor public transport facilities, safety and security concerns and lack of maternity cover are major issues in a work environment where the majority of workers are women.
- Patients do not seem to exercise their constitutional rights to health care in an informed and systematic manner.
- The prevailing sentiment is that there is no alternative to the current challenges of working hours and innovative new approaches are therefore missed.

8.2. Positive aspects identified

Some positive aspects identified include:

- In all the institutions the research team was humbled by the commitment and the resolve by the majority of health workers to give of their very best, and we want to salute them unconditionally for their efforts.
- We took pride in seeing the efforts being made at so many different levels of the health service to improve the infrastructure and the overall cleanliness of hospitals and clinics.
- A visit to health facilities in Soweto was particularly pleasing as the overall ambience has changed so much for the better.
- Attempts to investigate greater flexibility of working hours by management in some institutions are laudable.
- The continuing and intense engagement of trade unions with the challenges are really commendable and their exceptional understanding of the challenges are reassuring.
- Continuing attempts by many staff members to support each other and to minimize absenteeism are highly commendable.

8.3. Overall recommendations based on the study

- Perhaps the most striking observation is how many health workers and line managers feel totally unheard, undervalued and at times dehumanized. It is therefore essential to find innovative and inclusive ways to nurture a greater culture of care, respect and appreciation at all levels of the health service. In a most fundamental way it is really to find ways to live our constitution in health services and is more a mindset change and should not involve major financial resources.
- Systematic and continuing training for health workers and management on the arrangement of working time can contribute to positive health and safety outcomes. This should include information on the Codes of Good Practice on the Arrangement of Working Time and on Pregnancy and Breastfeeding under the BCEA. Collaboration between the ILO, the Department of Labour and the Department of Health will greatly facilitate this.
- The arrangement of working time and its potential impact on health and safety should be included in the health profile survey that is conducted by health institutions.
- Staff shortages and health infrastructure concerns have been identified by health workers in most institutions to be among the biggest and most critical problems facing them. Addressing this in an inclusive, consultative and systematic manner will not only help to boost the morale of staff but will help retain the very excellent health workers who are trying against all odds to provide a good service to the South African people.
- Different contractual arrangements in the same institution – such as those for health workers with permanent contracts, secure benefits and trade union

representation on the one hand, and for agency staff with short-term contracts, no benefits and no trade union representation on the other hand – have been identified by respondents as a worsening problem. It not only compromises service delivery and health and safety but contributes to greater inequality and poverty in South African society. Innovative approaches by different institutions, such as more targeted in-service training, is laudable, but a more systematic medium- to long-term approach to address staff shortages should be embarked upon. The implementation of the new Labour Relations Amendment Draft Bill should assist with this in a positive way.

- Meaningful direct and personal communication between hospital management and staff should be prioritized. The majority of health workers do not know and never see senior hospital management. Many feel not only alienated but also undervalued and exploited. Opportunities for greater engagement and listening to staff in spite of the heavy workloads should be explored.
- Opportunities for systematic training and skills development during working hours for all categories of health workers will help to address the basic human needs for self-improvement, skills upgrading and promotion.
- There can be greater emphasis on common humanity and the need for continuing support for social justice and the protection of human rights, rather than emphasizing personal and social differences.
- The BCEA should be assessed with regard to possible loopholes that can be exploited, for example taking as the norm a working time arrangement that is really intended for emergency situations.

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