Chris Hani Baragwanath Hospital is in crisis. The world-famous public health institution, which is vitally important to the poor communities of Soweto and beyond, suffers from a desperate staff shortage, deep managerial weaknesses and inadequate budgets. **Karl von Holdt** explains that an innovative partnership between trade unions, management, staff and the Department of Health (DoH) is seeking to transform the institution by creating new ways of managing and working. This transformation project may hold wider lessons for the reconstruction of the public service.

Crisis at Chris Hani

In 2000, the National Education Health and Allied Workers Union (Nehawu), frustrated by its members' poor working conditions and by poor health care at the institution, requested the Cosatu research institute, Naledi, to assist in developing a transformation plan for the institution. The other trade unions at the institution, the Democratic Nurses Organisation of SA (Denosa), the Health and Other Service Personnel Trade Union of South Africa (Hospersa), and the National Union of Public Servants (Nups), rapidly joined in.

When we started investigating conditions at the hospital we found a very low staff morale, from the cleaners to the CEO. There are two key reasons for this situation: a dire shortage of staff and a very low level of managerial capacity.

There is an average 30% shortage of staff in all categories, with a 36% shortage of nurses, 30% shortage of support staff, and a staggering 73% shortage of pharmacists. Under funding is the chief reason. The hospital budget is clearly inadequate for the patient load it has to service. Hospital budgets in general have been hard hit by government policy of redirecting spending towards primary healthcare and clinics, as well as to under-resourced and more rural provinces. In addition, as a former black hospital Chris Hani Baragwanath remains under-funded by comparison with a former white hospital such as Johannesburg General. Whereas the former has 21/2 times the number of beds, its budget is only 14% greater than that of the latter.

Staff shortages place an enormous pressure on existing staff, as a nursing auxiliary explained: 'We have to ignore the rules we were taught in our training. I have to rush time – I must stop washing and serve tea. If there are no ward attendants I must make tea for the patients myself. There's no point in washing the patient and giving medication, but failing to feed him. You cannot leave the patient with an empty stomach. Again, how can you leave a sick person in a wet bed and go for lunch?'

The result is that nurses have to 'prioritise' ruthlessly – those being prepared for theatre, and then the critically ill and very ill. The others must just wait.

Sometimes nurses just 'top and tail' patients instead of giving them a full wash. Forfeiting tea and lunch, working overtime, working extra weekends – the workload and stress are 'unbearable'. Nurses respond by avoiding work – through resigning, coming late or absenteeism – by becoming irritable, aggressive and uncaring at work, and in some cases turning to alcohol. This pressure makes it even more difficult to recruit staff, as new staff are so shocked by their working conditions that they very quickly resign.

But even more important than the shortage of staff is the lack of managerial capacity. There are several reasons for this. Firstly, there is a plain shortage of managerial posts, and a large number of existing posts are unfilled. Managers are simply overextended. Secondly, management structures are ineffective. The traditional silo system of management in the health sector means that nurses, doctors and support workers are each managed in separate and parallel managerial structures. This fragmentation of management undermines the integrated functioning of operational units such as a ward or the surgical department. The lack of a clear line of

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accountability for decision-making means that problems are shuttled from one manager to another, with no one taking responsibility. Finally, and partly as a result of the silo system, managerial practices focus on the administration of rules and personnel, rather than the management of operations and people. The managerial culture is hierarchical and authoritarian.

The result of all of this is a kind of managerial vacuum, and an endemic sense of disempowerment. No one believes change is possible. Staff experience an enormous frustration in this situation. They are crying out for managers to take responsibility. As a chief professional nurse explained: 'When we meet with management we complain about the shortage of staff, the linen, and cleaners – they tell us to try your best! It's a joke! They come with no solutions. Who do we cry to?'

Workers are also crying out for supervisors to exercise their disciplinary powers. According to a nurse: 'There are no disciplinary measures from top to bottom. If a nurse steals the clothes of a patient there will be no disciplinary action, they will give us a lecture on how to conduct ourselves. But the culprit is known.' The majority of workers are committed and honest, but feels that the institution does not value these qualities because it fails to discipline those who are corrupt or do not work.

Supervisors on the other hand feel disempowered because dismissal cases have to be referred to the Department of Health where there are lengthy delays, undermining their authority. At the same time, they are exposed to intimidation by workers.

It is clear that many of the hospital's problems arise from its inability to manage people. This is not surprising, because the institution lacks an HR department. It has something called an HR department, but in reality this is simply a personnel administration department dealing with issues such as pay roll queries, pensions, leave etc. It has no effective labour relations capacity, nor does it have any HR development, skills planning or training capacity. Apart from anything else, the lack of HR capacity means there is neither a skills development plan nor an employment equity plan.

The result is that management is unable to address problems of supervision, morale, labour relations conflict or training. This is a major legacy of the apartheid approach to managing people. One recalls that 30 years ago, most private sector companies in South Africa were managed in exactly the same way. The difference is that when militant black unions emerged in the private sector, management responded by investing in sophisticated industrial relations and human resources departments. The public service, at least in this particular hospital, has not yet made the transition from deep apartheid. Until it does, there will not be a motivated, skilled and caring public service in South Africa.

The apartheid system of authoritarian supervision at the hospital was destroyed under the hammer blows of militant trade unionism. In 1992 Nehawu led a militant hospitals strike demanding collective bargaining rights, which had been denied workers under apartheid. The confrontation between militant workers and an intransigent old-order management, which

Celebrating a decade of effective *Social Dialogue*

In February 1995, the National Economic Development and Labour Council (Nedlac) was launched, ushering in a new era of inclusive decision-making and consensus-building in the economic arena of South Africa. It had (and still has) unique features aimed at meeting particular national needs. Nedlac is composed of representatives from organised labour, business, community and government sectors. The institution was created to enable representatives of all non-governmental sectors to play a key role in developing effective and sustainable public policies that will support and promote economic growth. This unique form of decision making at national policy level (a global first) continues to provide an opportunity for all the major stakeholders in South African society to have a voice at government level and to make a dynamic contribution towards reconstruction and development.

Nedlac as an institution is highly context-specific. Its origins are in the struggles against both apartheid and the unfairness of unilateral decision-making processes throughout society. In this respect, it may be that Nedlac's development has only been possible because of the comparative strengths of the unions, the NGOs and business sector at that time. The transition to democracy brought with it confidence and energy in which people demanded inclusive and transparent decision-making processes as well as a striving for cross-sectoral consensus bringing with it active engagement in, and shared ownership of, the country's new policy agenda.

As President Mandela said at the launch of Nedlac "Our democratic gains will be shallow and persistently threatened if they do not find expression in food and shelter, in well-paying jobs and rising living standards." He was positioning Nedlac as a key institution in the complex task of remaking South Africa. Experience over time has endorsed this perspective.

Key achievements to date include:

- Employment Equity Act
- Labour Relations Act
- Basic Conditions of Employment Act
- Growth and Development Summit

While recognising that Nedlac is possible because of a series of context-specific circumstances, this does not necessarily mean that its achievements are only of interest to those in South Africa. Far from it. In our view, Nedlac has many elements of real interest and potential value to the rest of this continent, indeed to the rest of the world.

18 February, 2005 will be the 10 year anniversary of Nedlac

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hired scab labour, generated high levels of violence in which 12 people died.

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

Yet management, lacking HR capacity, has not been able to establish a new mutually acceptable system of discipline in cooperation with the unions.

Staff shortages, ineffective management and the breakdown of discipline have created high levels of stress, conflict and anger among staff. The workload and stress have exacerbated tensions between the different occupational categories in the wards as workers, overwhelmed by their own tasks, refuse to assist others. The result, according to a chief clinician, is 'work fragmentation'.

'The focus is not service to the patient,' he said: It's 'I do my job, you do yours'. This attitude has emerged in response to staff shortages. It was the impact of budget cuts'. The chief professional nurses agreed. Asked what the most important change since democracy has been, they said, 'posts were frozen; the most important change is the shortage in staffing levels'.

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The evidence from various commissions, press reports and pieces of research is that the situation at Chris Hani Baragwanath Hospital is broadly similar to that in many other public hospitals, particularly formerly black hospitals. The biggest problem is inadequate budgets and concomitant staff shortages. While the policy of redirecting public spending appears to be progressive, in practice it amounts to the destruction of already-existing institutional capacity, which is extremely shortsighted, particularly because institutional decay leads to greater wastage of resources. Investment in management capacity and systems would greatly reduce wastage and theft, generating multi-year savings down the line.

A team of new executive managers was put in place at Chris Hani Baragwanath about a year ago. They have made valiant attempts to introduce efficiencies, improve security and reform the silo system at ward level. However, structural and resource constraints limit what can be done.

A PARTNERSHIP FOR TRANSFORMATION

The evolving partnership between trade unions, management and DoH provides hope that the hospital crisis can be averted. Management supported Naledi's investigation at Chris Hani Baragwanath Hospital, and its proposals were developed in consultation with trade unions, staff and managers. The surgical department was chosen as a pilot for implementing new ways of managing and working based on integrating and focusing the formerly fragmented management structures, developing new forms of team work in the wards, and establishing a more consultative and participatory management culture which emphasises problem-solving rather than the policing of rules.

A new management team has been established to manage the surgical department in an integrated way. Ward managers – all professional nurses – have been appointed to manage each ward, and cleaners, clerks and ward attendants are being integrated into the ward nursing team, working under the authority of the ward manager. A new human resources officer, also a professional nurse, has been appointed to bring this function out of the administration block and into the workplace where supervisors and workers interact daily in caring for patients. Her job is to support these changes, facilitate a new labour

relations and disciplinary regime, and to develop a skills development programme.

Progress is slow. Public service processes are time-consuming. Desperate staff shortages place huge pressures on both the management team and the new ward managers – the latter frequently find that they cannot step back and perform their managerial functions because they are needed at the bedside of patients. Nonetheless, the modest progress so far has already boosted morale. Comments by some of the ward managers illustrate this:

- 'The project is something that brings us together and gives us hope.'
- 'We are not doing badly; in fact we are doing very well, because we are the starting group. That is why we are having problems. We are the starting group for the whole hospital. So let us hold our heads high and go forward.'
- 'This is a transformation project, which means change, so there will be resistance. Where there is change you will always get resistance. We must go forward, we will conquer everything.'

Additional impetus has been given to this transformation project by the growing support from the Gauteng MEC for Health, Dr Gwen Ramokgopa, and the Gauteng DoH. The provincial leadership of Nehawu, the biggest trade union in Cosatu, has played a key role in bringing the project to the attention of government and lobbying for its support. The tripartite alliance has proven to be an important asset in framing the partnership for transformation.

Indeed, on the basis of the progress and commitment shown by the surgical department pilot project, the MEC mandated the institution's senior management, with the assistance of Naledi, to develop a strategic plan for transformation of the hospital as a whole, and has indicated that if this is coherent and convincing, the necessary resources will be made available to implement it. This has provided a tremendous boost for all the leadership groups in the hospital, and a new sense is growing that indeed change is possible.

The strategic plan has now been developed through a process involving all stakeholders, and focuses on four key areas:

- develop a new model for interfacing with DoH which promotes management initiative and accountability at the institution
- develop and implement a new budgeting system founded on services required and which promotes effective financial management
- design and implement a new organisational structure which eliminates the silo system and establishes focused operational units
- develop and implement a new HR strategy, which supports operational delivery.

Thus Chris Hani Baragwanath provides us with two images of the future of public hospitals in South Africa. On the one hand, there is permanent crisis, desperate work conditions, frustration, anger, hopelessness, poor labour relations and discipline, and the flight of staff to the private sector or overseas. On the other hand, there is the potential of a partnership between public service trade unions, workers, managers and government to transform and reconstruct public hospitals. Chris Hani Baragwanath could serve as a pilot for a broader process of change, if sufficient resources are directed into public hospitals to make this possible.

The stamina, commitment and resourcefulness of the nurses at the centre of the surgical transformation project have been truly impressive. Indeed, working on this project has given us at Naledi an insight into how abused the nursing profession in particular is. Politicians, research surveys, the press and the public at large are fond of berating them for their attitude and behaviour to patients, and lament the loss of the 'culture of care' among nurses and the public service more broadly. This is grossly unfair. Nurses in public service hospitals work under appalling pressure in a state of continual crisis and are deeply distressed at their inability to provide a professional service.

When they complain they are lectured and hectored. Most ordinary mortals would long since have abandoned their jobs in despair. The fact that they are still there in hospitals like Chris Hani Baragwanath is a tribute to their profound commitment to a 'culture of care' and the sense of discipline and responsibility that this involves. They are indeed the backbone of the public health system, and the only reason it has not yet collapsed. It is time that our society recognised this. The real problem for the 'culture of care' is that we seem not to care about our nurses. It is the desire of the majority of hospital workers – doctors, cleaners, clerks, nurses and other professionals – to feel proud of their work and their hospital that will prove the most important motor of change – if they are given the chance.

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Von Holdt is a senior researcher at Naledi. An earlier version of this article is to appear in a book entitled '2014: The story of our future.' Von Holdt has devoted many years to the Bulletin and was editor for a significant period and continues to be involved as an active board member.