THE EFFECTIVENESS AND EFFICIENCY OF LABOUR RELATIONS PROCESSES AND PRACTICES IN THE PUBLIC HOSPITAL SYSTEM WITH SPECIFIC REFERENCE TO PELONOMI HOSPITAL (BLOEMFONTEIN, FREE STATE)

SZ MATEBESI

THE EFFECTIVENESS AND EFFICIENCY OF LABOUR RELATIONS PROCESSES AND PRACTICES IN THE PUBLIC HOSPITAL SYSTEM WITH SPECIFIC REFERENCE TO PELONOMI HOSPITAL (BLOEMFONTEIN, FREE STATE)

SETHULEGO ZACHEUS MATEBESI

Dissertation submitted in
accordance of the requirement of
the degree

MAGISTER ARTIUM

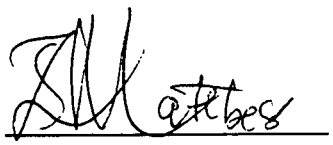
in the
FACULTY OF HUMANITIES
(DEPARTMENT OF SOCIOLOGY)

at the
UNIVERSITY OF THE FREE STATE

Study leader: Mr. JC Heunis

APRIL 2001

I declare that the dissertation hereby submitted by me for the Master Artium degree at the University of the Free State is my own independent work and has not previously been submitted by me at another university/faculty. I furthermore cede copyright of the dissertation in favour of the University of the Free State.



Financial contributions by the National Research Foundation are acknowledged. Opinions expressed and conclusions made are that of the authour and should not in anyway be attributed to the National Research Foundation.

ACKNOWLEDGEMENTS

Virtually no research project is completed without the assistance of others. In this regard the researcher would like to extend his deepest gratitude to the following people and institutions:

- Mr. JC Heunis, for exceptional study guidance and motivation.
- Prof. GW De Klerk, Head of the Department of Sociology
- Michelle Elgelbrecht, for the proofreading and layout of the final dissertation
- Mr. M Musapelo, Deputy Director of the Sub-Directorate of Labour Relations of the Free State Department of Health and other managers.
- Mr. Tlhogo, Director at Pelonomi Hospital.
- The Centre for Health Systems Research & Development for infrastructural support and its staff for their motivation.
- All the trade union representatives at Pelonomi Hospital and at provincial level.
- Nurses and blue-collar workers at Pelonomi Hospital who unselfishly participated in the study.
- The Health Systems Trust for providing the researcher with the opportunity to develop into an independent researcher.
- Mrs. Kate Smith for the statistical analysis of the data.

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION AND METHODOLOGY

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

The general aim of this study is to analyse and assess the factors/issues that have an impact on the effectiveness and efficiency of labour relations processes and practices in the public hospital system. Thus, the study is directed towards the analysis and assessment of "structural factors" (joint worker-employer committees) and "procedural factors" (discipline, dismissal, performance appraisal and grievance procedures) that direct and influence the labour relations process at public hospitals. The overall study design was first of all exploratory and descriptive, but of necessity also directed towards the development of suggestions for practical interventions in problem solving, decision-making and policy-making.

The study was conducted at Pelonomi Hospital in Mangaung, Greater Bloemfontein. Eighty nurses and forty-two blue-collar workers, were the primary respondents. Other respondents included management at provincial and national level, trade union representatives and supervisors of blue-collar workers. Data was collected by means of structured questionnaires and a focus group session with supervisors of blue-collar workers. The systems and open systems theories directed the study. In this regard five themes were identified: working conditions and remuneration, trade unionism, strikes, grievance and disciplinary procedures, and labour relations practices.

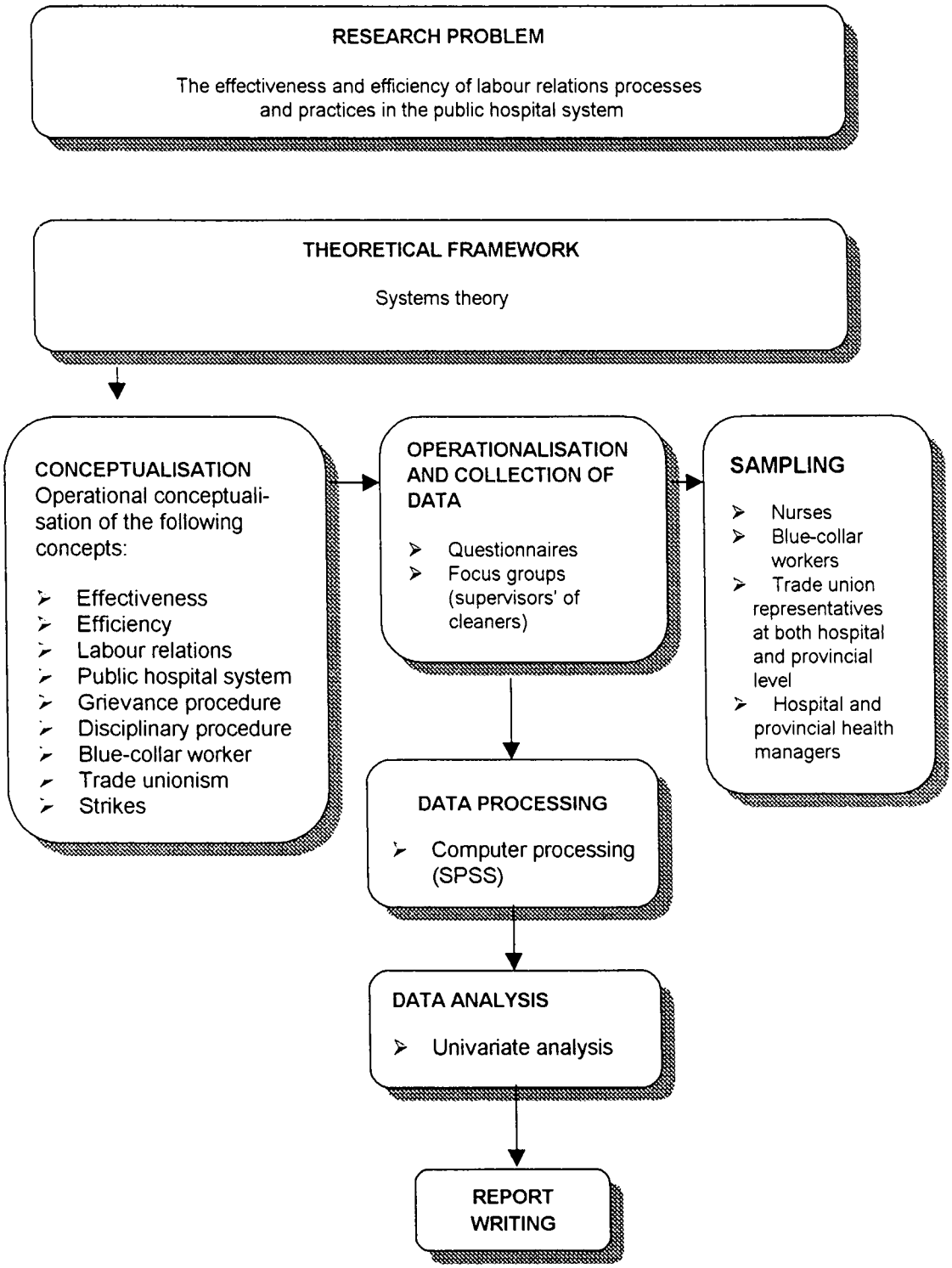
The majority of the respondents were female. Most respondents (nurses and blue-collar workers) reported dissatisfaction with their salaries and the late and/or nonpayment of allowances. Despite the important role that unions play at institutional level, there is a perception that they are fuelling discontent among workers. Potential causes of strikes appeared to be more closely linked to discrimination than to ineffective grievance and disciplinary procedures. Respondents' knowledge about the existence of grievance and disciplinary procedures was extensive. Largely because of a perception that workers are

treated differently, the vast majority of respondents indicated that these procedures are handled inconsistently. In conclusion, it is essential that the poor chain of labour relations is broken. Firm foundations have been laid for transformation of labour relations in the public health sector, in general. A healthy public hospital system can only be created and preserved if all parties embrace the current changes.

CHAPTER 1

INTRODUCTION AND METHODOLOGY

CHAPTER 1: INTRODUCTION AND METHODOLOGY



1.1 INTRODUCTION

In this chapter the general design and methodology followed, the broad questions that guided the study, and aims and objectives of the research are discussed. An outline of the literature review and theoretical framework used are also provided. This chapter also attempts to conceptualise the central terms found in the dissertation. This is followed by a discussion of the ethical considerations, the significance and values of the research and an outline an outline of the organisation of the dissertation.

1.2 BACKGROUND

Public hospitals are increasingly under pressure to provide effective and efficient health care without any disturbances. Therefore, all functions of the hospital (including labour relations) need to be managed in the most effective and efficient manner possible. Public hospitals remain central to the health care system, as accessible, adequate and appropriate health care cannot be provided without them. It is also evident that the complex organisation of the public hospital system involves power, strain, conflict and tensions at all levels. As a result, public hospitals throughout South Africa had been experiencing widespread industrial action over the past few decades.

Throughout the history of labour relations in the public sector, the repressive character of the then South African government had a profound effect on labour matters. Apartheid legislation, amongst other, led to the inequitable distribution of health staff and left a legacy of ineffective structures and procedures within the South African health sector (Macun & Psoulis, 1998:25).

Generally, public service workers and administrators have long been wielders of unquestioned authority and unilateral decision-making powers. Black workers in particular have been subjected to a wide range of discriminatory labour practices by the state. Wood (1997:12) asserts that a large component of black workers, with several years of services are still "clustered" in lower job grades.

The widespread industrial action that public hospitals have been experiencing in the past few years is the result of antagonistic labour relations. Almost 25 000 general assistants at public hospitals went on strike in 1990, and more than 29 000 health workers were involved in strikes in the health sector in 1992 (Critical Health, 1992:6-10; Nyembe, 1992:41). This situation can be linked to problems in labour relations policy and management (Forrest, 1996:59; The Hospital Strategy Project, 1996:11).

As part of the broader transformation agenda, the government undertook to overhaul the public service. In this regard, more than 20 pieces of legislation and policy documents have been propelled through parliament over the last five years. Many of these had a direct impact on the legal and policy environment of human resource management in the public health sector, for example, the Public Service Act (1994) and the Labour Relations Act (1995); and white papers on Public Service Transformation (1995) and Human Resource Management (1997) (Adler, 1998:18; Swartz, 1998:19).

According to Van Rensburg & Van Rensburg (1999:205), the 'new" and "old" management styles and organisational cultures had and still have adverse effects on management-worker relations. A disturbing point about the current transformation of health services is that there is no clear synergy between policies and their implementation. Too many policies are

being formulated, but, as Tilley (1998:4) notes, their implementation pace and effectiveness lag behind.

While the role of the state is acknowledged and appreciated by setting a national policy framework for the conduct of labour relations, this effort is hopeless if there is lack of a clear conceptual understanding of labour relations at the workplace. Scientific knowledge about the role of hospital management, nurses and blue-collar workers and their organisations, is crucial to understand the effective and efficient management of labour relations. Such an understanding would, perhaps, curb the chain of poor labour relations at public hospitals.

1.3 PROBLEM FORMULATION

Human resource management in general and labour relations specifically are about human beings (Van Rensburg & Van Rensburg, 1999:224). Questions pertaining to aspects such as worker representation in the workplace (trade unionism), unrest (strikes) and nepotism, overload, misconduct (grievance and discipline) are important dimensions that directly impact on the effectiveness and efficiency of labour relations processes and procedures.

1.3.1 In preparation of the research – a situational analysis

A situation analysis comprising consultation with middle and higher level health managers, health workers as well as various concerned labour organisations admitted to the Free State Provincial Bargaining Council, informed the formulation of the research problem. During the course of the situation analysis of labour relations problems at public hospitals in the

Tshepo Health District[1] and Greater Bloemfontein[2], which was undertaken by the researcher, several critical issues/problems came to the fore. These included traditional "content" issues such as under-staffing, low wages, promotion requirements, absenteeism and alcohol abuse. According to the Hospital Strategy Project (1996:60), a number of "procedural" issues are also of concern. These include lack of effective participation of workers in policy-making processes and weaknesses in grievance and disciplinary procedures.

1.3.2 Problem statement and rationale of the research

The effectiveness and efficiency of labour relations processes and practices at public hospitals are central to the sound operation of such institutions. Labour relations in the public sector is one of the most significant but least understood areas of worker struggle in South Africa (Adler, 1998:8). The dynamics of change in the broader public service system also call for changes in the manner in which labour relations are conducted. Due to the decentralisation of hospital management, public hospitals are firmly located within the contexts of developments in the broader public service. Thus the conditions of service of health workers is largely a product of the central bargaining process for the public service. As such, processes outside the direct control of national or provincial departments of health play a crucial role in the state of labour relations within individual hospitals (Ray, 1997:32).

While the transformation of the public health services accelerated the process of restructuring, the latter had disruptive effects on labour relations at hospital level. Transformation has created an environment of inflated

[1] The Tshepo Health District is one of the 14 health districts in the Free State and 170 in South Africa, which represents the crux of current health reforms in the country. This district consists of 7 towns: Bothaville, Boshof, Bultfontein, Dealesville, Hertzogville, Hoopstad, and Wesselbron.

expectations, job security and affected worker morale. Indeed, public health services workers are currently experiencing the greatest uncertainty ever over their jobs (*Government Gazette*, 1997:17).

Individual public hospitals now have the responsibility of managing labour matters (grievances and misconduct, for example) at institutional level. However, the inadequate understanding of basic labour relations principles and procedures remain a major weakness in the public hospital system (*The Hospital Strategy Project*, 1996:4). The problem is exacerbated by the fact that hospital and provincial managers view labour relations as a highly regulated and legislated area. As a result, labour relations is addressed from a highly procedural, legalistic perspective, rather than being seen as an essential component of human resource management within the hospital setting (*The Hospital Strategy Project*, 1996:4).

The effectiveness and efficiency of labour relations processes and practices are also compromised by the complex organisation of the public hospital system. As a result of the many heterogeneous groups – including the highly fragmented labour organisations – relations at hospitals involve power, strain, tension and conflict at all levels. This perhaps explains why the public sector - especially public hospitals – experienced such a large number of strikes in the past few years.

Traditionally, investigations into labour relations issues have focused on sectors of the economy where labour relations have been volatile. Little attempt, until recently, has been made to examine labour relations practices in the public health sector, let alone at hospital level. Poor labour relations processes and practices, and ineffective communication structures, damage and disrupt health care.. These scenarios in the public health

[2] Bloemfontein is the capital city of the Free State province. Greater Bloemfontein consists of all the surrounding suburbs in Bloemfontein, Mangaung and Heidedal.

sector, particularly at public hospital level, present an interesting study area for the sociologist.

This study is a response to the perceived threats of transformation to the effectiveness and efficiency of labour relations processes and practices at public hospitals. While notable improvements have been attained in the establishment of effective and efficient structures and measures of managing labour relations, the threat of worker unrest remains. Thus, scientific knowledge about the functioning and management of labour relations at public hospital level might prove to be an important tool for stakeholders to understand and improve on the current situation. This may encourage enlightened and responsible management. In turn, responsible management may create conditions of employment that are comfortable to both management and labour. This may go a long way in achieving the government's objective of providing effective and affordable health care to all South Africans. Other dimensions which have an impact on the effectiveness and efficiency of labour relations processes and practices is discussed in the following section.

1.3.2.1 Trade unionism

Labour relations usually implies dealing with collectives. One such collective with a high profile is the union, which is both a proactive and reactive participant in the employee-employer relationship (Bendix, 1996:164-167). One of the central goals of trade unions is to improve the socio-economic conditions of their members and protect their rights in the workplace. In South Africa, issues about improved working conditions traditionally evolved around the demand for a living wage for all workers and reducing the gap created by apartheid in the workplace.

Despite the important role unions have to play in labour relations, attempts to pursue their goals often lead to conflict with management (Wiehahn, 1982:36). A study by Osterhaus (s.a.) reveals that attitudes reflected by hospital management toward unions included, amongst others, violent opposition and toleration as long as there is no interference from individual union workers in the operation and management of the institution.

Throughout the decades various policies and legislation were adopted as a means to control labour, and in particular the black labour movement (Grossett & Venter, 1998:36). However, the post-election period came to have tumultuous consequences for labour in South Africa. The Congress of South African Trade Unions (COSATU) to which six public sector unions are affiliated, experienced an exodus of leaders to Parliament. This has led to fears of co-option by the African National Congress (ANC) which could reduce organised labour to a "conveyer belt" for government (New Nation, 1997:23). The federation is continuously faced with the dilemma of either furthering the objectives of the alliance at the expense of its members, or *vice versa*. Moreover, the issue of privatisation lends credence to this assertion. According to Singh (1997:12), COSATU reluctantly endorsed a process of privatisation despite a long campaign of protest.

During 2000, the government and big business were the target of labour's wrath on numerous occasions. Some of the thorny issues included privatisation, retrenchments and salary increases. The wrangle between government and public sector unions was mostly over wages. It took threats of a week-long public sector strike before a settlement was reached (City Press, 2000:13). There are strong indications that unresolved disputes such as the proposed amendments to labour laws will spill over to the future. Therefore, much labour turmoil can be expected.

In line with the decentralised management strategy of the country, the Free State public health sector unions, in collaboration with the Labour Relations Sub-Directorate of the Free State Department of Health established Shop Stewards'-Management Committees at hospital level. This is seen as an attempt to reduce conflict at the work place (Musapelo, 1999). These new decentralised structures in the public service provide the Minister of Public Service and Members of Executive Council (MECs) the power to organise their respective departments, and employ and dismiss workers (Ray & Aldair, 1998:53). Most managers in the public health sector have been trained to function within a highly regulated centralised system of public administration (The Hospital Strategy Project, 1996:2). In addition, lack of capacity by hospital managers to handle labour matters has a profound impact on the effectiveness and efficiency of labour relations in general.

The presence of trade unions at hospital level poses several challenges to both management and employees (even society at large). Critics of trade unions maintain that unions create a difficult work environment, weak or bad relationships and the "gimmicking" of management. Unions also create breading-ground for absenteeism, low work standards and lack of discipline as result of the protection against dismissal. Once again, there is a constant threat of strike action, which may endanger the lives of patients. However, trade unions also play a crucial role in enhancing the involvement of health workers in the work place. They may also present management with an opportunity to reflect on their management capabilities and the quality of management (De Villiers, 1993:22-23).

1.3.2.2 Strikes

There have been three stages of development in law on strikes in South Africa. Firstly, the right to strike for employees in the private sector has

been guaranteed since 1924 by the Industrial Conciliation Act (ICA). This right was, however, only extended to whites. Secondly, with the amendment of the ICA of 1979, the Labour Relations Act (LRA) of 1981 recognised strike action if it complies with the procedures of the Act. Thirdly, the LRA no 66 of 1995 extended the right to strike to every worker (Grossett & Venter, 1998; Kearney, 1984:213; Levy & Associates, 1998:38; Mischke, 1996:5; Sullivan & Dekker, 1985:461).

Strikes in the public service have traditionally been viewed as unlawful. There is, however, considerable difference of opinion amongst experts on this issue. While some believe there should be no distinction between strikes in the private and public employment, others argue that public sector bargaining is not analogous to private sector bargaining. In an attempt to reconcile these differing contentions, Burton & Krider (in Reynolds, 1982:290) and Kearney (1984:215) divide the public service into three categories. Firstly, **essential services** (i.e. police and fire) – where strikes immediately endanger public health and safety, and thus not tolerated. Secondly, **intermediate services** (i.e. hospitals, water and sewage) – where strikes for a few days may be tolerated. Thirdly, **non-essential services** (i.e. education, housing, and welfare) – where strikes of indefinite duration could be tolerated.

In South Africa, the direct prohibition on strikes by nurses was scrapped from the Nursing Act in 1992. However, in general the right to strike was not recognised in the public sector, until 1993. The extension of this right was soon followed by unprecedented industrial unrest within the public (health) sector before the 1994 elections (Logart, 1995:11) and afterwards. Long before 1993, nurses had already been challenging the ideology of professionalism[3] and controls imposed by bodies such as the South African

[3] Nursing has its roots in a Victorian concept of professionalism which entailed "altruism, service, womanly devotion and dedication to the sick under the tutelage of the all-wise physician" (Rispel & Schneider, in Critical Health, 1992:11)

Nursing Council (SANC) and the South African Nursing Association (SANA) (Critical Health, 1992:6-10; Nyembe, 1992:41).

The history of labour relations in the public sector, as in other sectors, has been marked by gross racial and gender distortions (Adler, 1998:18). Indeed, since the establishment of the public service, whites occupied most senior management positions. As a result, the public service experienced a legitimacy crisis (Cloete, 1995:193; Jacklin & Machin, 1998:36-37).

Strikes may be regarded as examples of the radical politisation of trade unionism (Slabbert, 1987:81). Strikes and other forms of industrial action can present a variety of causes and subsequent events (Hyman, 1989:120). Factors contributing to strikes at public hospital are rooted in the problems that South Africa faces as a nation. These problems include the difficulties in bridging the wage gap, lack of skilled managers and poor worker-management communication (*The Hospital Strategy Project,* 1996:3). Generally, insecurity of employment, late payment of staff, misunderstandings and prejudice between management and workers, and the high level of expectations which appear unrealistic to management often lead to unrest. This is further compounded by insufficient systems to resolve disputes and ineffective communication channels (City Press, 1999:14; SALB, 1988:29).

Strikes at public hospitals affect the morale of workers and, therefore, the quality of service. Any unrest at public hospitals poses a serious threat to the health of vulnerable patients. Despite being economically harmful, strikes at public hospitals may adversely affect the image of a hospital and ultimately lead to its closure (Crouch, 1982:89, Tonder, 1992:28-30).

The decrease in the incidence of strikes, unrest and man days lost in recent years is an indication that conflict in the public health sector is efficiently

structured. However, prospects of increasing labour unrest are strengthened by continuation of restructuring and periodic staff retrenchments (Van Rensburg & Van Rensburg, 1999:22-227). There also remain dissatisfaction among public service unions over the government's handling of the wage negotiations for the 2000/2001 financial year (City Press Business, 2000:1; City Press, 2000:13). There is a strong indication that this dissatisfaction may trigger widespread industrial unrest if not addressed properly.

1.3.2.3 Grievance and disciplinary procedures

The Public Service Act and the Public Service Regulations provide a uniform framework for dealing with grievances. Grievance profiles of nurses and blue-collar workers at public hospitals reveal that issues pertaining to salaries, promotions and the poor management of hospitals top the list of grounds for disputes. These are followed by disputes over the lack of worker participation in management decision-making structures, lack of training opportunities, unbearable workload, and the non-translation of salary to new rank (City Press, 1999b:2; Musapelo,1999; *The Hospital strategy Project*, 1996:9).

Existing constraints and deficiencies in dealing with the implementation of grievance procedures relate to the complex nature of the procedures. Another general shortcoming is the long time lapses before action is taken in response to grievances. One worker who complained about the non-payment of overtime illustrates this: "I enquired about six months ago for the first time about the problem [overtime payments], but have until now not yet received any response. Every time you enquire you walk into a *cul de sac.* I am already working 19 years for the hospital...but that is the way one

is treated these days. Payment, if any, occurs just as it wishes" (*Die Volksblad*, 1999b:3).

Disciplinary matters are also guided by the Public Service Act (Van Rensburg & Van Rensburg, 1999:230). In practice, the public health sector is still plagued by disciplinary problems due to the lack of competencies, effectiveness and efficiency of the units that deal with misconduct. According to Musapelo (1999), this problem is exacerbated by the fact that, previously, the management of discipline was centralised and the authority to execute disciplinary action was vested in the Director General. Hospital managers addressing labour relations matters from a highly procedural, legislated perspective, rather than seeing it as an essential component of the human resource management, is not helping the situation (*The Hospital strategy project*, 1996:4).

The nature of reported cases of misconduct vary in the public hospitals. At the forefront of misconduct is theft and fraud, misuse of state property, absenteeism and absconding, and alcohol abuse. Much of this culture of misconduct was carried over from the previous dispensation in which action was not always taken against offenders. New measures that have been in effect from 1 July 1999, provide executive authorities (MECs) with more power to deal with disciplinary issues (Ray & Aldair, 1998:53). In order to prevent the loss of organisational effectiveness and efficiency, labour relations processes and practices should form an integral part of the human resource system of public hospitals.

1.4 LITERATURE REVIEW

This study has been conducted mainly within the quantitative and to a lesser extent qualitative research framework. The study was preceded by a

literature review on the topic of labour relations at public hospitals. No literature could be found dealing specifically with the effectiveness and efficiency of labour relations processes and practices at public hospitals. Literature on studies in which hospital and provincial management, nurses, blue-collar workers and labour organisations are subjects under study, is a scarcity. As a result, literature broadly related to the study was reviewed.

The bibliography provides an indication of the literature consulted. More specifically, research conducted by the National Assembly Portfolio Committee on Health, 1995 (industrial action by nurses), The Hospital Strategy Project, 1996 (equity, efficiency and accountability: A vision and strategy for South Africa's public hospitals) and Van Rensburg & van Renburg, 1999 (distribution of human resources) played a significant role in the development of the study. These studies, and others not mentioned, have extensively explored certain aspects of labour relations at public hospitals. What remains to be explored, however, is what factors have an adverse impact on the effectiveness and efficiency of labour relations processes and practices in the public hospital system.

1.5 THEORETICAL PERSPECTIVE[4]

Broadly, any labour relations system is based on five cornerstone principles which have to be adhered to at all levels of interaction in the relationship. According to Buys, Ehlers & Schaap (1998), these cornerstone principles are the following:

- Understanding the reason for the existence and the need to manage labour relations

[4] A more detailed discussion of the theoretical framework of the study is provided in chapter 2.

- Applying the principles of fairness, non-discrimination and respect for human dignity in all facets of human interaction within a labour relationship
- Understanding that labour relationships are tripartistic
- Parties need to claim their respective rights with the accompanying duties
- Understanding that there are different approaches to labour relations management

This study has been conducted keeping in mind the different approaches to labour relations management. In the formulation of a theoretical perspective for studying the effectiveness and efficiency of labour relations processes and practices, Dunlop's systems theory and Craig's open systems theory provide a useful prototype. Implicit in these models is that labour relations should be viewed as a system comprising actors or input factors (i.e. employees, employers and the state), an environmental context or through-put factors (i.e. economic, political and legal systems) and a common ideology or output factors (i.e. labour peace) (Singh, 1976).

Dunlop's systems theory conceptualises the linkage between the environmental factors, which impinge upon the labour relations actors, their goals and power bases. This model also conceptualises structures (forums for management and unions) and procedures (collective bargaining, grievance and discipline) which have developed to institutionalise and control conflict. According to Dunlop, actors interact within an environment that comprises interrelated elements bound together by a common ideology (Beaumont, 1990:5; Bendix, 1996:13; Finnemore & Van der Merwe, 1996: 4; Green, 1987:7; Jackson 1991:4; Johnston, 1981:6).

The open system theory of Craig seeks to describe and address techniques which actors utilise in their day-to-day interpersonal relations to satisfy individual goals. This theory also places special emphasis on the important role that negotiating structures play in achieving desired outcome, which is labour peace. Due to the different primary interests of workers and managers, relationships between the two are inherently conflictual. In this regard, the feedback loop serves as a mechanism for the settlement of disputes (Finnemore & Van der Merwe, 1996:14-17; Grossett & Venter, 1998:25-26).

The systems theory has been useful in describing complex organisational contexts (such as hospitals, for example). It has also been used as a conceptual framework for single industry empirical studies (Beaumont, 1990:5). The open systems theory, on the other hand, serves as a predictive tool at both micro and macro economic levels. At the micro-economic level, it serves to illustrate that "the closer the goals and ideals of the parties to the employment relationship, the smaller the likelihood of conflict occurring" (Grossett & Venter, 1998:25-26). At the macro-economic level, the model suggests that governments and policy makers often react upon the effects of outputs (such as increased wages) on economic factors. (Finnemore & Van der Merwe, 1996: 14-17; Grossett & Venter, 1998:25).

It should be noted that the mechanisms for converting inputs into outputs are heavily relied upon. These mechanisms, as explained earlier, form an integral part of the effective and efficient management of labour relations. As applied to this study, both theoretical models hold that it can be expected (as a result of transformation in the public health sector) that the different interest of workers and managers at hospitals would clash. Thus, if the structures and procedures that aim to harness these conflicting interests are not realistic, the effectiveness and efficiency of labour relations processes and practices at public hospitals remains under threat.

1.6 RESEARCH QUESTIONS

The following research questions arise from the problem statement and theoretical perspective.

- What is the attitude of hospital management and health worker labour organisations towards and the main problems they experience regarding the highly centralised nature of bargaining in the public health sector?

- What factors/issues at public hospitals contribute to industrial unrest and what dispute resolution measures are in place?

- What grievance and disciplinary procedures are in place and how amicably are they handled?

- Which work-related grievances do workers (nurses and blue-collar workers) at public hospitals experience?

- What are the most common offences committed by health workers at hospital level?

- What is the nature of communication between management and workers and how is it handled?

- Do management/employee committees or workplace forums exist? If so, in what form? What functions are performed by these structures?

- What is the nature of the relationship between hospital management and health worker labour organisations? What are their role regarding the general improvement of labour relations at hospitals?

- What factors relating to labour relations hamper service delivery at public hospitals?

- What is the role of the government at provincial level regarding the operation of sound labour relations at public hospitals?

1.7. AIMS AND OBJECTIVES OF THE RESEARCH

The general aim of this study is to analyse and assess the factors/issues that have an impact on the effectiveness and efficiency of labour relations processes and practices in the public hospital system. Thus, the study is directed towards the analysis and assessment of "structural factors" (joint worker-employer committees and workplace forums) and "procedural factors" (discipline, dismissal, performance appraisal and grievance procedures) that direct and influence the labour relations process at public hospitals.

Within this general aim the study has the following specific objectives:

- To determine the role played by trade unions in satisfying their members and in the establishment of effective and efficient labour relations at public hospital level;

- to determine and describe why nurses and blue-collar workers join trade unions;

- to determine and describe the working conditions of nurses and blue-collar workers;

- to identify and describe what formal and informal dispute resolution structures, and grievance and disciplinary procedures are in place for nurses and blue-collar workers, and assess how well they are functioning in practice;

- to examine and assess the knowledge and perceptions of nurses, blue-collar workers, hospital management and health-related labour organisations with regard to the general functioning of and/or handling of labour-related grievances at public hospitals;

- to determine and describe what factors contribute to adversarial relations (including discipline and dismissals) at public hospitals; and

- to disseminate the research results to all stakeholders. To this end, a workshop involving all stakeholders was organised.

1.8 CONCEPTUALISATION

Conceptualisation is regarded as one of the most important components of the research process as it provides an indication of what is meant by terms that might be confusing. According to Babbie (1989:109), answers to the research questions can only be found if there is consensus over the meaning of the terms and concepts which are used. A conceptualisation of key terms that feature in the study follows:

1.8.1 Effectiveness

The emphasis on improved public sector performance by states and the ever-increasing demands for public services calls for effectiveness and efficiency. Hardiman & Mulreany (1991:viii) state the search for increased effectiveness and efficiency has brought with it the need to clarify objectives and set priorities.

Effectiveness is a process of having a powerful and/or positive effect on something. It relates outputs to effects, or desired outcomes. Effectiveness is also the extent to which outputs achieve objectives or policy aims. For example, if the backlog of disciplinary cases is higher than planned, then the handling of disciplinary outputs may be said to be ineffective. For the purpose of this study, effectiveness is conceptualised in terms of quality - it is the utilisation of all relevant knowledge and techniques available to produce the most favourable result.

1.8.2 Efficiency

Efficiency relates inputs to outputs. Efficiency is the act of producing favourable results with minimum waste or effort. It can also be considered as obtaining the maximum output from given inputs. Short-term efficiency gains, however, may lead to long-term negative consequences (Hardiman & Mulreany, 1991:19-21).

In this study, efficiency entails having easy access to labour relations machinery and that all labour problems are resolved as quickly as possible. This implies that all employees should know who to approach and how to utilise the labour procedures at public health institutions.

1.8.3 Labour relations

Generally, labour relations[5] deal with the relationships encountered by people at the workplace. Labour relations have also been conceived as the study of trade unions. However, Flanders (in Palmer, 1983:2) maintains that it should be seen as the study of the "institutions of job regulation". This then include other aspects such as employers' organisations, the state and any other institution concerned with terms and conditions of employment. In short, Palmer, (1983:2) defines labour relations as "the processes of control over the employment relationship". The concept "labour relations" refers to all the aspects that relate to all the activities involved and interaction between management and employees (and their representatives) in an employment relationship.

1.8.4 Public hospital system

Hospitals are not only institutions for high-quality care of patients but also a social institution of comprehensive community health care (The Hospital Strategy Project, 1996). . A public hospital system shall therefore be known as the pattern of hospital management and institution whose elements are mutually interactive.

1.8.5 Grievance procedure

A grievance may be defined as "any dissatisfaction or feeling of injustice which has been experienced by a worker or group of workers and has been brought to the attention of the employer" (Finnemore, 1996:199). On the other hand, Bendix (1996:349) defines a grievance as "a complaint, other than demands formulated by a collective body, which is related to the

[5] The terms "labour relations" and "industrial relations" are used interchangeably in all the chapters.

employee's treatment or position within his daily working routine and which, because it may result in a dispute, warrants the formal attention of management". In this study, a grievance procedure is defined as the process in which workers' complaints and grievances are handled.

1.8.6 Disciplinary procedure

According to Nel (1992:418), discipline is the sanctions imposed on employees by an employer or someone with authority. Discipline is aimed at withholding employees from indulging in conducts that would affect the functioning of the organisation or which would harm any other individual or party in the work context. A disciplinary procedure describes the method according to which discipline will be enforced. Bendix (1996:353) defines a disciplinary procedure as outlining "the formal process adopted whenever an employee breaks the rules of the undertaking or commits any other act which might be in breach of his [or her] contract of employment...". In this study, a disciplinary process is defined as all the activities related to taking action against an employee who has allegedly misbehaved.

1.8.7 Blue-collar worker

A blue-collar worker is regarded as someone who does manual work and earns a low salary. However, the latter argument could be misleading if presented without further qualification. It is not conclusive that all blue-collar workers earn less. For the purpose of this study, blue-collar workers are defined as workers who perform manual work and are in the lowest job categories. For example, this refers to cleaners, porters and ambulance drivers.

1.8.8 Trade union

Sidney and Beatrice Webb, the famed historians of the British labour movement, reputedly coined the term "trade union". They defined a trade union as "...a continuous association of wage earners for the purpose of maintaining and improving the conditions of the working lives" (Finnemore & Van der Merwe, 1996:73). Closely linked to this definition is the one by Albert Rees. It is claimed that this definition is appropriate in the South African context: "A trade union...is an association of employees that seek to improve the economic position of their members primarily by bargaining with employers within the broad range of the existing economic system (Sauer & Voelker in Grossett & Venter, 1998:73).

Other authors (Bendix, 1996:167, Grossett & Venter, 1998:73) regard the definition of Salamon as being the most appropriate. He defines a trade union as "...any organisation, whose membership consists of employees, which seeks to organise and represent their interests both in the workplace and society, and, in particular, seeks to regulate their employment relationship through the direct process of collective bargaining with management". This definition is applicable for the purpose of this study.

1.8.9 Strikes

Various definitions of strikes indicate that it has to do with the stoppage or withholding of work for whatever reason. Section 1 of the LRA 23 of 1956 defines strike action as any one or more of the following acts or omissions by any body who is or has been employed: "the refusal or failure by them to continue to work and the breach and termination of by them of their contracts of employment (Grossett & Venter, 1998:495).

The 1995 LRA defines a strike as "the partial or complete concerted refusal to work, or the retardation or obstruction of work, by persons who are or have been employed by the same employer or by different employers, for the purpose of remedifying a grievance or resolving a dispute in respect of any matter of mutual interest between employer and employee..." (ILO, 1993; Levy & Associates, 1998:38; Mischke, 1996:5; Myburgh & Wade, 1996:22-26; The Star Workplace, 1999c:6).

1.9 RESEARCH DESIGN

This section of the chapter discusses the methodology, sampling, data collection methods and data analysis used.

1.9.1 Methodology and research strategy

The study consists of two parts. The first part entails a **literature study**. The second part embodies an **empirical investigation** with the aim of testing the research questions in practice. The empirical investigation was conducted using a quantitative and, to some extent, qualitative methodology. The overall study design was first of all exploratory and descriptive, but of necessity also directed towards the development of suggestions for practical interventions in problem solving, decision-making and policy-making.

1.9.2 Site of the study

Following on the situational analysis in Tshepo and Greater Bloemfontein, the empirical part of this study was conducted at Pelonomi Hospital in Mangaung (Bloemfontein) in the Free State. Pelonomi Hospital is a regional hospital of large size and represents one of the previously

disadvantaged health institutions in the Free State. Also, this institution has been experiencing high levels of industrial action in the past years. The researcher opted for an in-depth case study of this institution rather than focusing on many institutions.

1.9.3 Target population and sampling

The major target groups in this study were strategic informants and managers at provincial level, the Pelonomi Hospital management, health worker labour organisation representatives, and health workers, which include both nurses and blue-collar workers. While not underestimating the labour problems encountered by other categories of health workers, nurses and blue-collar workers have traditionally been worst off in terms of conditions of employment, and also most inclined to embark on industrial action.

A **stratified proportional random sample** (in terms of job description) was drawn from the different categories of nurses and blue-collar workers. The sampling framework was a computer printout of all workers at Pelonomi Hospital. This list was obtained from the Pelonomi Hospital's personnel division. The sampling process entailed the following steps:

Step 1: Firstly, the demarcation of the different categories of nurses (Chief Professional Nurse (Post), Chief Professional Nurse (Rank)[6], Senior Professional Nurse, Professional nurse, Enrolled nurses, and enrolled Nursing Assistants. Secondly, the demarcation of the different categories of blue-collar workers (cleaners, porters, general workers, messengers and drivers). To this end, the personnel division of Pelonomi Hospital was consulted.

[6] Chief Professional Nurse (Post) is a nurse who has applied for such a post, while a Chief Professional Nurse (Rank) is a nurse who has been promoted to the post.

Step 2: Counting (and numbering) the names in each job category to determine the proportions of respondents come from each. The sample size from each job category constituted 8% of the total number listed.

Step 3: Random sampling of the indicated number of respondents from each job category. The workplaces of the selected respondents were obtained from the Nursing Department and the Supervisory Division of Pelonomi Hospital.

Table 1.1: Sample proportions per job category

Job category (NURSING)	Total number of workers	8% of population	Number of workers interviewed
Chief Professional Nurse (Post)	32	3	3
Chief Professional Nurse (Rank)	225	18	18
Senior professional Nurse	253	20	20
Professional Nurse	57	5	4
Enrolled nurse	65	5	5
Enrolled Nursing Assistant	379	30	30
Total	**1 011**	**80**	**80**
Job category (BLUE-COLLAR WORKERS)	**Total number of workers**	**8% of population**	**Number of workers interviewed**
Cleaners	389	59	31
Porters	66	10	5
General workers	35	5	3
Messengers	28	4	2
Drivers	10	2	1
Total	**528**	**80**	**42**

As the population of hospital managers at Pelonomi Hospital and the Labour Relations Sub-Directorate of the Free State Department of Health is relatively large, only those who are directly involved in labour and personnel matters were interviewed. With regard to trade unions, a representative at provincial level and a shop steward at Pelonomi Hospital were interviewed.

1.9.4 Data collection

Data were collected by means of both quantitative and qualitative methods (see **appendixes A** and **C**). Structured interviews, guided by interview schedules, were used to collect data from nurses and blue-collar workers. In-depth interviews were conducted with managers at both provincial and institutional level, and with union representatives. One focus group session was also conducted with the supervisors of blue-collar workers. This was done in order to gain in-depth knowledge of possible problem areas and to complement the quantitative data collected.

Before data collection could commence, interview schedules were forwarded to experienced researchers in the Department of Sociology, Labour Relations Sub-Directorate of the Free State Department of Health, Labour Relations officer at Pelonomi Hospital, and all trade union representatives, for comments. The final interview schedule was a product of this process.

Workers at Pelonomi Hospital were informed about the study by their respective union representatives and through circulars placed at strategic points on notice boards. This facilitated easy access to wards and other places where selected respondents worked. Data collection amongst nurses and blue-collar workers started on the 19th August 1999 and was

completed on the 5th November 1999. The general strike of public sector trade unions in July 1999 made it impossible to continue with fieldwork. This contributed to the lengthy time-period that the fieldwork process took to be completed. Data collection amongst trade union representatives was only completed on the 30th March 2000. Interviews with nurses and blue-collar workers lasted approximately 50 minutes each. In most cases, the supervisors of blue-collar workers organised selected workers to meet the researcher. Being able to speak the concerned languages, the researcher conducted the interviews himself. The latter decision proved to have the following advantages:

- The researcher had control over the entire situation and could easily address problems that arose;
- Enabled the researcher to record spontaneous answers which were more informative and less normative;
- Researcher gained insight into the general operation of the hospital and the environment within which workers functioned.

Managers at both Pelonomi Hospital and the Labour Relations Sub-Directorate of the Free State Department of Health, and labour representatives were contacted telephonically for appointments. Questions, informed by the literature study and situation analysis were prepared in advance for the focus group session (see **appendix B**). A total of eight supervisors of blue-collar workers participated in the focus group session, which lasted about one hour. The focus group discussions were tape-recorded for transcription purposes.

1.9.5 The questionnaire

For the purpose of this study, three sets of questionnaires, namely for (i) nurses and blue-collar workers; (ii) trade union representatives, and (iii) managers, as well as a focus group discussion guide, were utilised. However, the focus in this section is only on the primary data collection source, namely, the nurse and blue-collar worker questionnaire (see **appendix A**). This questionnaire was twenty-five pages in length.

In the construction of the nurse and blue-collar workers questionnaire extensive use was made of the literature, the theoretical framework and various unpublished dissertations. The questionnaire consisted of six broad sections:

Section A: Work history: questions 1 – 10.

Section B: Working conditions and remuneration: questions 11 – 19.

Section C: Attitudes towards and involvement in trade unions: questions 20 - 43

Section D: Strikes: questions 44 – 55.

Section E: Grievance and disciplinary procedures: questions 56 – 78.

Section F: Labour relations practices and procedures: questions 79 - 93.

1.9.6. Pilot study

A pilot study was undertaken by conducting preliminary interviews with ten nurses and five blue-collar workers not included in the sample. This exercise was important in that it determined the relevance of the study in practice. Moreover, the gathered information assisted in reconstructing the questionnaire and excluding possible problems with the formulation and interpretation of questions.

1.10 DATA ANALYSIS

Data are analysed, firstly, to answer research questions and, secondly, to present the results of the study in an understandable way and convincing form. In this regard, "statistical analysis is the culmination of the long process of hypothesis formulation, instrument construction, and data collection" (Bailey, 1987:370).

The quantitative data was coded and statistically processed using the SPSS computer package. Thereafter, the information was analysed, interpreted and compiled into a report. Content analysis was used to analyse the focus group data. This method is a systematic procedure, which is devised to analyse, amongst the other, audio recordings or any other interpretable communication media (Walizer & Wienir, 1978:343-344). The focus group data was first transcribed, after which central themes, problems and matters of importance were extracted. Generally, the purpose of the data analysis was to describe the factors and/or issues that have an impact on the effective and efficient management of labour relations at public hospitals.

1.11. ETHICAL CONSIDERATIONS

Researchers face many ethical dilemmas in the course of their interaction with their subjects. While codes of ethics and other researchers provide guidance, Neuman (1997:443) maintains that ultimate ethical responsibility depends on the individual researcher. Ethics is typically associated with morality and it is for this reason that the researcher applied the following ethical considerations: allowing for voluntary participation; causing no harm to participants, guaranteeing the anonymity and confidentiality of participants, and not deceiving participants in any way.

1.12 SIGNIFICANCE AND VALUE OF THE RESEARCH

In this study, the researcher obtained skills and experience in the field of health service management through interaction with the Labour Relations Sub-Directorate of the Free State Department of Health. Interaction with managers at provincial, district and hospital levels increased the researcher's knowledge of the administration of the health system and the day-to-day challenges facing the health sector in South Africa. In addition, the researcher also gained valuable insights into the general organisation, aspirations and fears of trade unions representing workers at public health institutions.

On a general note, this study is a significant contribution to the discipline of industrial sociology for a number of reasons. Firstly, there are few, if any, case histories in literature concerning labour relations at public hospitals. Secondly, while there are empirical studies of nurses as strikers, such studies do not include blue-collar workers. Thirdly, the militancy of nurses has been explored nationally with no link to the role of the workers' representatives and their employees (hospital management and/or

Provincial Government). This study attempted to explicate the reaction of nurses and blue-collar workers to the total and multifaceted labour relations environment within which they operate.

This research can also be regarded as being timely. Workers at public hospitals are now protected under the LRA of 1995. They are thus guaranteed the right to representation and collective bargaining with the government. These rights and the the transformation that the public health sector is undergoing, may lead naturally to impasses. The study can serve as a departing point from which policy-makers, hospital management and workers can discuss issues pertaining to labour relations at public hospitals. Sound labour relations in the public hospital system will benefit the continuity and quality of care. Thus the study is also seen to be in the interest of the broader Free State community.

1.13 ORGANISATION OF THE STUDY

This dissertation is divided into four parts. The first part comprises of the problem formulation, research strategy and methodology (chapter one). The second part entails the formulation of the theoretical framework (chapter two). The third part presents the findings of the study (chapters three, four and five) and the fourth part focuses on the conclusions and recommendations (chapter six).

Chapter One provides a background to the study and the methodology followed. In Chapter Two, an attempt has been made to develop a theoretical framework primarily on the basis of Dunlop's systems theory and Craig's open systems theory. The theory guides the study and the interpretation of the results.

The findings of the research are presented in Chapters Three, Four and Five. Chapter Three focuses on the background variables of the respondents. As a result, a profile of the population is created in this chapter. This chapter also presents the findings on the working conditions and remuneration of the respondents. Chapter Four presents the findings on trade unionism and Chapter Five focuses on the mechanisms to convert, as stated by Dunlop and Craig, inputs into outputs. These mechanisms are strikes, grievance and disciplinary procedures and labour relations practices. The final chapter of the dissertation (Chapter Six) attempts to reconcile theory and practice by making several recommendations that can contribute to the sustainability of effective and efficient labour relations management practices in the public hospital system.

1.14 CONCLUSION

An attempt was made in Chapter One to provide background information about the study and explain the methodology and research strategy followed. The concepts used in the study were also explained. It should be noted that although effectiveness and efficiency are both aspects of performance and that the former is often used as a criterion and measure of the latter, the position taken in this study is that these two concepts are not synonymous.

This chapter has also attempted to present the dimensions of labour relations that play a significant role in the overall conduct of labour matters at hospital level. In this regard, issues pertaining to trade unionism, strikes, and grievance and disciplinary procedures, have been examined. These issues do not only pose a threat to the effectiveness and efficiency of the management of labour relations, but remain highly contentious issues at

the Commission for Conciliation, Mediation and Arbitration (CCMA)[7]. The following chapter focuses on the theoretical framework that guides the study.

[7] The CCMA is a statutory body which has replaced the Labour Court. This body serves to resolve disputes such as dismissals connected with conduct or incapacity (Grossett & Venter, 1998:407).

CHAPTER 2

THEORETICAL FRAMEWORK: SYSTEMS THEORY

CHAPTER 2: THEORETICAL FRAMEWORK

2.1 INTRODUCTION

Chapter One outlined the methodology that was followed in this study. An attempt was also made to conceptualise the terms utilised throughout the study. Emphasis was especially placed upon the four major concepts of the study, namely effectiveness, efficiency, labour processes and labour practices. In this chapter, the theoretical framework that guides the study is presented.

The focus in the development of the theoretical framework has been mainly on Dunlop's (1958) **systems theory** and Craig's (1975) **open systems theory**. In his work, *Industrial Relations Systems*, Dunlop attempted to provide an integrated theory of industrial relations. This theory focuses on the systems of rules which governs the workplace and work community. The systems theory was prompted by the apparent ignorance of the role of trade unions and their influence on an organisation as seen in the theories of Mayo, Fayol, Barnard and Weber. Mayo's theory emphasised the necessity of providing a satisfactory social environment as a prerequisite for a motivated workforce. Fayol, Barnard and Weber emphasised the existence of the organisation's goals and the means by which man could efficiently attain these goals.

Dunlop's systems theory postulates that there are several cornerstones, which function in industrial relations at any given time. These cornerstones, according to Dunlop, are the **actors**, the **environmental context** within which actors act, a **common ideology** and **a set of rules to regulate labour relations**.

Despite its usefulness in describing complex organisational contexts such as hospitals, the systems theory is under severe criticism. Thus, a discussion of the critique against the systems theory seems logical at this point. In this regard, the

focus is mainly on the arguments of individuals such as Bain, Clegg, Banks and Hyman. These authors argued that Dunlop's theory is deficient in certain respects and needs modifications (Beaumont, 1990:5, Clegg, 1972, Hyman, 1975, Jackson, 1991:5, Johnston, 1981:7).

This chapter also attempts to examine and discuss the open systems theory as suggested by Craig. According to Craig (1975), an open system is any system that has inputs and outputs. This theory focuses on the environmental systems (the legal system, for example) which prescribe or prohibit certain kinds of action and the actors with different goals and power bases. In addition, this theory also seeks to describe how mechanisms (i.e. collective bargaining and grievance and disciplinary procedures) for converting inputs (i.e. goals and power) into outputs (i.e. working conditions and wages) operate.

Health care organisations such as hospitals can be conceived as open systems (Katz & Kahn, 1978). Indeed, hospitals are unique, complex, social institutions that usually function as bureaucracies (Sullivan & Decker, 1985:xxi). Therefore, it is often very difficult for nurses and blue-collar workers to function effectively as employees.

General systems have certain characteristics. Firstly, all systems are organised into units comprising components that mutually react. The system acts as a whole and a dysfunction in one part causes a system disturbance rather than the loss of a single function (Putt, 1978:19-21). The same logic applies to labour relations.

Contrary to the principle of consensus and motivation, as the systems theory emphasises, the historical practice of job reservation led to conflict between employers and black workers over several decades.

2.2 DUNLOP'S SYSTEMS THEORY

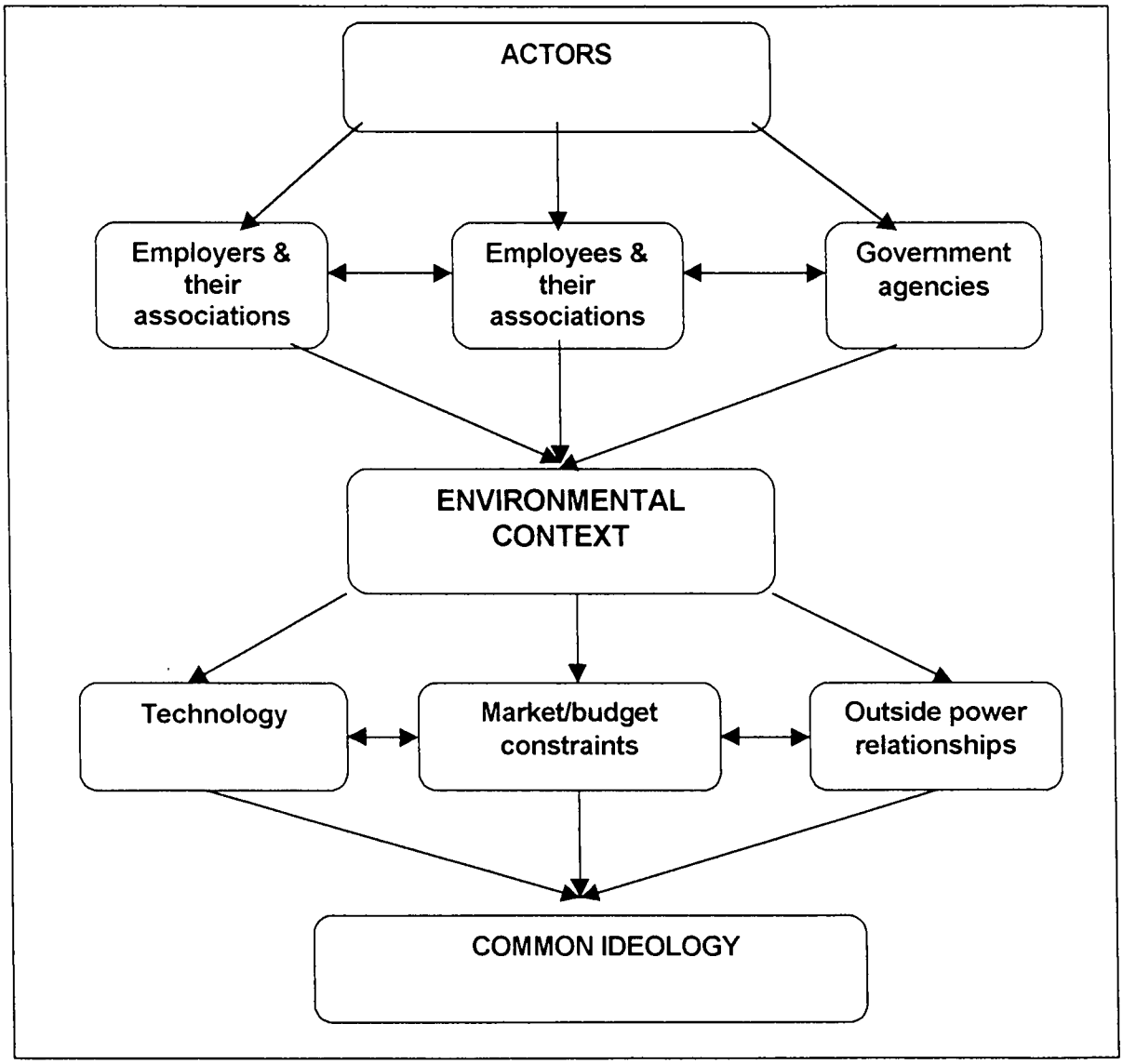
Dunlop's theory was the first most influential challenge to the institutional approach to industrial relations. Individuals such as Clegg, Flanders, Fox, Marsh, Hughes and McCharty – the so-called 'Oxford Group' – exemplified the institutional approach to industrial relations. In challenging the institutional approach, Dunlop made use of the work of Parsons and Smelser to discuss the industrial relations system (Hyman, 1989:121, Jackson, 1991:2-3, Palmer, 1983:15). His basic point of departure was that "to date the study of industrial relations has had little theoretical content. At its origin, ...it has been largely historical and descriptive.... It has lacked any central analytical content. It has been a crossroads where a number of disciplines have met..." (Dunlop, 1958). Above all, Dunlop intended to counteract the problem of competition between the contributing disciplines with regard to industrial relations (Beaumont, 1990:5).

Dunlop's theoretical framework viewed the industrial relations as a subsystem of wider society, parallel to but distinct from the economic system (Palmer, 1983:15). The wider society is seen as providing certain external influences and constraints but does not dominate industrial relations completely (as the economic system does). According to Dunlop, the industrial relations system has a similar status to the economic and political systems, with which it can overlap (Beaumont, 1990: 5, Jackson, 1991:2-3, Johnston, 1981:6).

At any given time in its development, an industrial relations system - which is a sub-system of the social, political, economic and legal systems – comprises three fundamental factors that influence the system. Dunlop identified these factors as **actors, context** and **ideology**. The actors include employers and their associations, employees and trade unions, and government agencies. These actors create the rules within which the system operates. Actors are confronted by the environment and are influenced and limited by it. The environmental context comprises three

interrelated elements; namely **technology**, **market/budget constraints** and **outside power relations**. The system is bound together by an ideology or shared understanding between the actors (see **figure 2.1**, below) (Beaumont, 1990:5; Bendix, 1996:13, Finnemore, 1996: 4; Green, 1987:7; Jackson 1991:4, Johnston, 1981:6). The next section describes the sactors in the industrial relations.

Figure 2.1 Systems approach to labour relations



Adapted from Bendix., 1996, Finnemore & Van der Merwe, 1996, Grossett & Venter, 1998).

2.2.1 Actors

Dunlop defines the actors as people and organisations that are involved in labour relations. The actors include employers and employer organisations, employees and employee organisations, managers and government agencies. These actors are regarded as the primary input factors since no labour relation is possible without their participation. The state provides a legal framework that guides and regulates the actors in the labour relations system. The actors' behaviour is constantly influenced by their own perceptions of reality, which are based in the labour market, historic and international influences on labour relations (Allen & Keaveny, 1983: 19, Bendix, 1996:13, Dunlop, 1958, 12, Green, 1987:7; Jackson, 1991:4; Johnston, 1981:6).

In the South African public health service context, actors might include management and their representatives, employees and their organisations, and other individuals and groups, usually government agencies. Greater variety exists within each of the three groups of actors than in any other sector. Management in the public sector can mean an elected legislative body, a single elected official, or an elected or appointed board such as a hospital board (Forrest, 1996:63, Logart, 1995:18).

Employee organisations in the public sector include both professional associations and unions. Some unions enroll only public employees (i.e. the Public Servants Association), while others enroll both public and private employees across sectors (i.e. National Education, Health and Allied Workers Union) (Forrest, 1996:63; Logart, 1995:18; Macun & Psoulis, 1998:26-30; Ray & Aldair, 1998:53).

For a union to pursue a certain strategy, it will have to weigh its power resources to achieve a particular goal. The power that trade unions possess is usually obtained from the solidarity of their members and their willingness to engage in collective action. Moreover, the depth and extent of their organisation, their ability to evoke sympathetic action from other organisations and their ability to influence government

agencies are also important factors that determine the power possessed by a union (Grossett & Venter, 1998:80).

The strategies unions use to achieve their objectives are interactive, and include the following. Firstly, through **collective bargaining**, trade unions are able to negotiate and improve the working conditions of their members. By concluding collective agreements with employers, unions also protect their members from the tyrannies of discrimination and arbitrariness. Collective bargaining is a continuous process and the fundamental, but not exclusive, reason for their existence. Secondly, a threat of **industrial action** (e.g. go-slows and strikes) is an important weapon that unions can utilise to achieve their objectives (Booth, 1995:72, Crouch, 1982:110-113). As industrial action has disruptive consequences, employers will do anything in their power to avert such action. One manner of doing this is to give in to the demands of labour. Thirdly, it is very important for trade unions to be up-to-date with the **factors that affect their members at the work place**. In this regard, unions may bargain for representation at plant level. Here the specific objective is to secure the sharing of decision-making with management on issues that relate to employment and the day-to-day operation of the plant. For this purpose, unions with a large following may select shop stewards who will represent workers locally and interact with the union leadership (Bendix, 1996:175-176; Grossettt & Venter, 1998:80-81).

In trying to assist their members, trade unions may establish benefit funds such as pension, medical and provident aid funds. They may also institute their own general social and education programmes that may range from basic programmes on personal hygiene and health to more advanced courses on economic and social development. Finally, but not least, trade unions may become involved in politics to further their members' political aspirations. In this regard, trade unions form alliances with political parties. This often leads to union leaders becoming members of parliament (Bendix, 1996:177, Grossett & Venter, 1998:81). Notable examples in South Africa are Jay Naidoo, Sam Shilowa and previously Cyril Ramaphosa.

Hospitals are undoubtedly the dominant institutions in the provision of health service (Cloete, 1993:4). However, due to the divergent primary interests of workers and management, there is a constant threat to the effective and efficient operation of labour relations. The role of hospital management is not only to ensure the provision of quality care, but also to ensure that the providers of such care are motivated. Therefore, the quality of care patients receive is very much dependent on the ability of managers to motivate their workforce (Rovin & Ginsberg, 1991:175). Conversely, it is also the responsibility of workers (nurses and blue-collar workers in this regard) to approach their work in a most dedicated, caring and professional manner. Douglas (1995:65) states that it is, unfortunately, the very same qualities that often lead people to underrate and undervalue the work of nurses and blue-collar workers.

2.2.2 The environmental context

The environment in which hospitals operate continuously influences them. The survival of such institutions is largely dependent on their monitoring of the environment, and determining how each variable impacts on the various facets of the institution. While the environment can be defined by a number of different factors, Dunlop focussed on four: technological characteristics of the workplace, market or budgetary constraints, the distribution of power in the larger society and an output occurring as a result of the interaction of the actors.

2.2.2.1 Technology

Very specific conditions exist which affect work situations. One of these conditions is technological change. Technology can influence the form of management and employee organisations (Jackson, 1991:4). Indeed, many organisations and unions view technology as replicating workers, rather than complementing their productivity. Irrespective of good intentions, the implementation of new technology may lead to conflict in the workplace if not handled properly (Grossett & Venter, 1998:13).

Restructuring as a result of transformation has led to an era of unprecedented training and development of human resources in the public health sector. Over the past few years, thousands of health care workers have been trained in a variety of programmes (van Rensburg & van Rensburg, 1999:222). Contrary to the popular assumption of Braverman (1974) that technological advances lead to a deskilled workforce (Horne, 1987:38-40; Martin, 1995:61; Rainnie, 1989:39), it has not been the case with nurses.

Nurses operate in an extremely competitive and rapidly changing high-techonology environment (Last, 1988). The implementation of any new technology is either preceded or followed by some form of formal or informal training (Rovin & Ginsberg, 1991:171). In fact, the knowledge and skills expected of nurses in recent times is far more complicated than a few decades ago (Van der Merwe & Muller, 1997:8). Thus, nurses have to adapt with any technological change in the nursing service.

Even though blue-collar workers may not directly be affected by technological developments, their normal job routines may be affected. For example, in order to prevent fatalities in intensive care units and other wards with sophisticated life-saving equipment, cleaners may receive formal training on the importance of such equipment.

It can be contended that the problems that nurses and blue-collar workers experience, it can be contended, may stem from the conventional grievances identified in the Fordist approach – monotomy and degradation. This degradation stems not from technological advances, but from the injustices of the job grading, rewards and promotion. The formal job grading system indicates no similarity between the actual tasks performed by nurses and the salaries they earn, thereby ignoring their tacit skills. There also appears to be no similarity between jobs and level of education. Performance appraisal is currently one of the most fundamental sources of conflict among nurses (*Sowetan*, 2000a:11).

2.2.2.2 Market or budgetary constraints

As the entire managerial process functions within a larger organisational and environmental context, the latter needs to be understood and constantly monitored. The environmental context sets the limits as well as the opportunities for acquiring and using resources. There are two types of planning activities that directly affect financial resources: proactive and reactive planning (*see* **table 2.1**, below). Proactive planning attempts to avoid or minimise a set of problems in the future by either influencing the change process and/or planning organisational responses to possible environmental changes (Kaluzny & Arnold, 1982:104).

Table 2.1 Possible organisational planning responses to the change process

Planning	Influences environmental change	Planning responses to environmental change
Proactive	Attempts to influence the change process	Plans organisational responses to possible or impeding changes
Reactive	Does not attempt to influence the change process	Plans organisational responses after changes have occurred

Source: Kaluzny & Arnold (1992:107)

Local health departmental directors, for example, are engaged in proactive financial planning when they lobby to change funding patterns by which states and/or local government units provide money to their organisations. Much of financial planning is limited to responding to changes that have already occurred. Reactive planning is when the problem is already at hand and the organisation has to determine how to cope with the situation. It is imperative for organisations to take into account its external and internal environment in order to develop reasonable courses of financial action (Kaluzny & Arnold, 1982:104).

According to Kaluzny & Arnold (1982:108) all health care providers have at least one, and often two, major markets. The first is the consumer, usually called the client or patient. The second market is the source of funding, which may or may not be the same as the consumer. These two markets have to considered and monitored whenever certain decisions are taken. In the South African health sector, the government's shift in policy has put emphasis on primary health care (PHC), which means, amongst others, building clinics in remote areas. Since 1994 hospitals have received fixed budgets, while the bulk of the health budget had to be directed to building new clinics and health centres (*Sowetan*, 2000:9). This, one can contend, might have had serious operational repercussions for hospitals. The reason for this is that the shift towards PHC does not imply that fewer patients are seen at hospitals.

The hospital system in South Africa is characteracterised by an insufficient and inequitable distribution of financial and human resources (The Hospital Stategy Project, 1996:i-ii). In the long run, budgetary constraints may impact negatively on the hospital system. Hospitals may ultimately fail to retain adequate numbers of skilled and motivated staff and, thereby, not meet their objectives.

2.2.2.3 Power relations (and status) of actors

As stated earlier, both Dunlop and Craig indicated that there are environmental factors which impinge upon labour relations actors, their goals and power bases. Among the many human motivations, the desire for power is one of the commonly identified mainsprings of social behaviour in the workplace. This desire is developed in different combinations in each individual, and is directed within social organisations in which positions can be attained on various ranking structures as power, status and economic class (Miller & Form, 1980:543).

Power is the prime dynamic in the conflict process. Leap & Grigsby (1986:202) classify the factors which affect the power held by either employers or workers as

falling into three groups: uncontrollable, controllable in the long run only, and controllable in the short run. They maintain that the total sum of power is rarely, if ever, brought into play because of the existence of transformational factors which operate to influence the amount of power a party is willing or able to bring to bear on the other.

The distribution of power within the labour relations system is affected to a large extent by and is responsive to the *locus* and distribution of power in wider society (Jackson, 1991:4). At the workplace, the power of individuals is based on their positions. Administrators or managers - as they are commonly known in the public service - possess greater power than those below them in the hierarchy. The rules and procedures of the institution are structured in such a way as to ensure the gradual increment of power as one move up the hierarchy. Managers are allocated resources, assigned roles, and granted the right to sanction those in lower positions under their jurisdiction (Miller & Form, 1980:546). In the health care services, the nursing service manager is responsible and accountable for the quality of nursing care being rendered in the nursing service (Van der Merwe & Muller, 1997:4).

On the side of employees, legitimacy – the right to exercise control – and commitment to the broad goals of the organisation are more often perceived as reasons for their continued acceptance of organisational power (Miller & Form, 1980:556). The state's labour relations policy, conflict-handling structures and legislation play an important role in determining the relative power of the actors. In the public sector, the state's role is further complicated by the fact that it is also an employer. Power testing occurs at all levels of an organisation and, if problems are not resolved at shop floor level, they might become the subjects of formal disputes (Finnemore & Van der Merwe, 1996:19). Despite the presence of mechanisms to resolve disputes, as Dunlop and Craig postulated, unresolved problems at hospitals contribute to ineffective and inefficient management of labour relations.

Thus, it is logical to state that due to the dynamic environment that nurses, blue-collar workers (employees) and hospital management find themselves in, there will be some form of power testing between the parties. While management has the backing of government policies and labour legislation, employees can make use of their representatives to counter any threat. The fact of the matter is, despite seeing that their members have acted wrongly, trade unions often side with their members for fear of losing them. This does not mean that unions always take the side of their members. But the fact is they act diplomatically and this could lead to more problems and, ultimately, to strikes[1].

2.2.2.4 A common ideology

Central to the process of stabilising labour relations is a binding ideology which all parties share on the basic need for mutual survival and for procedures for conflict resolution (Palmer, 1983:15). Dunlop defines an ideology as a "set of ideas and beliefs commonly held by actors that helps to bind or integrate the system together as an entity" (Allen & Keavenly, 1983:20; Dunlop, 1958:23).

Hospitals operate in a peculiar setting and have to create a unique environment for themselves. There is pressure on their administrative functions to meet specific requirements. One requirement is to value the role of nursing services conducted in the hospitals. (Cloete, 1993:13). Competitive pressures for the ill, dramatically increase interdependence among functions, levels and roles in hospitals. As health care grows increasingly specialised, those institutions that can effectively manage interdependence (and instill a common ideology) will have a distinct competitive advantage. It is of the utmost importance for public hospital employees to have a common ideology especially since customer orientation is taken seriously (Rovin & Ginsberg, 1991:201).

[1] For more information on strikes and trade unionism consult chapters 4 and 5.

In fact, public health institutions are primarily established to render a service to the community. The manner in which health services, particularly nursing services, are rendered is of vital importance not only to the patients but also to their relatives and friends. The quality of nursing care and the behaviour of the personnel will always create either good or bad public relations. A definite common ideology among hospital personnel should be that every member promotes good public relations. In fact, the efficiency and effectiveness of the nursing service is judged on integrity, kindness and empathy and not on mere outputs attained with particular inputs (Cloete, 1993:50-51).

The systems theory maintains that in the day-to-day interaction between management and workers, labour relations is the key process of determining the rules that govern the actors and the workplace (Finnemore & van der Merwe, 1996:18-19). Due to the relationships of management and workers which is inherently conflictual, a common ideology may ease the situation.

2.2.2.5 A set of rules to regulate labour relations

The output resulting from the interactions among labour, management and government is a set of rules governing the workplace and work community. This set of rules includes very diverse elements such as the nation's labour policy and the labour agreement establishing the major conditions of employment in a specific organisation (Allen & Keaveny, 1983:20).

The legal framework within which labour relations operate is in a constant flux. Actors establish substantive and procedural rules to govern the employment relationship, by unilateral control, bilateral collective bargaining or tripartite control involving the state (Palmer, 1983:15). Rules are not ends in themselves, but a way of achieving ends and objectives. While workers may see the main objective of rules as security and

stable terms of employment, employers may aim at efficiency in their interaction with the other actors (Johnston, 1981:6).

Dunlop's model describes a situation at a point in time. When labour-management relations are examined over time, three distinct phases can be identified. Before a union has the right to participate with management, it has to demonstrate that it represents sufficient employees of the organisation. It is only after having proved its representativeness that unions can insist on access rights to its members (Grossett & Venter, 1998:71). In the second phase, labour and management works through the negotiation process to jointly determine the major terms of employment, that is, the rules of the workplace. Once agreement is reached on the conditions of employment, labour relations enter its third phase. During the life of the labour agreement, the parties will have to resolve disagreements over the interpretation and application of the contract. During each phase of the labour relations, the problems confronted by labour and management are basically different. The approaches for resolving the problems are also different (Allen & Keaveny, 198329-21). Thus, the approach taken by a party will, to a large extent, be determined by the objective that each party wants to achieve.

According to Van Uytrecht (1995:29), "law is a technique for the regulation of social power". However, power - the capacity effectively to direct the behaviour of others - is unevenly distributed in all societies. Like the Philadelphia Declaration[2] the new LRA contains most of the ideals that elevate workers' rights and guarantees constitutional protection (South African Institute of Race Relations 94/95, 1995: 467). In the South African context, one can contend that the LRA is an attempt to redress the imbalances of the past. Organised labour in the country has obtained considerable gains in terms of the rights of workers. Six pieces of legislation, in conjunction with the LRA of 1995, come into the picture here. These are the Public Service Act

[2] The Philadelphia Declaration is regarded as the founding document of the ILO. It also reaffirms the main principles on which the latter is based. Amongst other, Part 1 of the Declaration states "labour is not a commodity" and that "freedom of expression and association are essential to sustained progress" (Bendix, 1996:108-109).

(1994), the Public Service Amendment Act (1997), the Employment Equity ACT[3] (EEA) (1998), the Basic Conditions Employment Act (BCEA) (1998), the Skills Development Act (SDA) (1999), and the Public Service Regulations Act (1999) (Van Rensburg & Van Rensburg, 1999:204).

Whilst the BCEA lays down minimum working standards in all sectors, the SDA seeks to increase the general level of skills and competence of all South African workers. The EEA, on the other hand, outlaws discrimination and ensures that necessary steps (i.e. affirmative action) are taken to address the imbalances of the past (Department of Labour, 1998:9). The purpose of the latter act is also to achieve equality in the workplace by promoting equal employment and fair treatment (Government Gazette, 1998:12). Undoubtedly, these innovations will go a long way in challenging the factors that lead to the ineffective and inefficient management of labour relations. The reduction in strike incidences at public hospitals since the introduction of the LRA is encouraging.

With the new dispensation in South Africa, the formulation of labour legislation has been vital in the way labour relations are conducted at workplace level (Sibaya & Muller, 2000:6; Stuurman-Moleleki, Sait & Long, 1997:29.). There is no doubt that the day-to-day activities of management and employees at health care services such as hospital are greatly influenced by such legislation. Legislation, however, only provides guidelines. In the absence of effective and efficient governance and management structures legislation becomes obsolete. The subsequent focus is on critique against the systems theory.

2.3. CRITICAL EVALUATION OF THE SYSTEMS THEORY

As stated earlier, despite attracting favourable comment, Dunlop's theory also attracted a great deal of trenchant criticism. One of the most "damaging" criticisms is

[3] The Employment Equity Act is in line with the directive contained in section (4) of the Constitution.

the claim that Dunlop's theory is "an empty box" or "a mysterious black box" (Beaumont, 1990:6). This theory has also been criticised for not providing enough explanations where it is mostly needed. For example, while the actors make the rules, little light is shed on the behaviour, motivations and attitudes of the participants (Jackson, 1991:5, Johnston, 1981:7). By specifying three types of actors, Dunlop's model does not take into consideration that the different interest groups may not be in harmony (Palmer, 1983:16).

It also has been criticised as being a static view of the industrial relations system "that provide no basis for change or help to predict what policies ought to be pursued in times of change" (Beaumont, 1990:7, Green, 1987:7). Bain and Clegg highlighted two defects in Dunlop's work. Firstly, they maintain that there are certain ambiguities in the way the concept of a 'system' is used". Bain and Clegg argue that Dunlop creates the impression that an industrial relations system was 'naturally' stable and integrative (Clegg, 1972:32). According to them, such a notion had "conservative implications" and was unacceptable. To emphasise their point, these authors elaborated on Eldrige's argument that "in sociology, the sources of conflict and cooperation, order and instability must have equally valid claim to problem status". Secondly, the systems concept does not refer to all of the important explanatory variables such as human motivations, perceptions and attitudes (Jackson, 1991:5).

What Dunlop could have meant with the notion of a common organisational ideology, is that it is assumed that all employees know about the goals of the organisation. Therefore, it is highly unlikely to find employees who overtly work towards the downfall of the organisation that employs them. In the case of nurses, for example, they clearly know that it is their responsibility to provide quality patient care at all times. This, to a large extent, represents a common ideology among nurses and serves as a basis for organisational goal attainment. It would be myopic to ignore the fact that not all nurses, or employees for that matter, would whole-heartedly work towards the achievement of goals. In such cases, corrective steps may be taken against such employees.

Another writer, Banks, also criticised Dunlop's work. According to him, Dunlop identifies three main sets of actors (employers, employees and the state), in the industrial relations system, thereby failing to make reference to the owners of industrial property. According to Banks, this failure stems from the fact that Dunlop believes that decisions in the industrial relations system are made by managers, and not by owners (Jackson, 1991:11). In the public health service, managers have the authority to make certain decisions according to their positions. Therefore, Banks' criticism of Dunlop is not really applicable in this investigation.

Despite all the criticism, Palmer (1983:16) maintains Dunlop's work has proved "extremely suggestive". It identified the main pressures of technology, market forces and power which influence the actors. Dunlop's approach also had the merit of stimulating others (Johnston, 1981:7). His work can also be viewed as helping to delineate the central subject matter of industrial relations, which is the web of rules governing job regulation that emerges from the interaction of actors. Above all, despite all the defects noted by commentators, the system theory has remained influential (Allen & Keaveny, 1983:19-20, Beaumont, 1990:6, Bendix, 1996:14, Finnemore, & Van der Merwe, 1996:14).

2.4. CRAIG'S OPEN SYSTEMS FRAMEWORK[4]

In his point of departure, Craig (1975) postulated that labour relations were considered to be a set of interrelated parts that operated in an environment. His framework consisted of four components: the inputs from both the system and the environmental substructures; the various procedures involved in converting inputs into outputs; the outputs of the system; and a feed backloop (Craig, 1975:9-15).

According to Craig, inputs are from both the system and the environmental substructures. The within-puts from the labour relations system itself consist of the

parties to the relationship – which Dunlop call actors - and their differing goals, values and powers. The parties include employees and trade unions, management and the government. The within-puts are, in turn, conditioned by the various environmental factors such as the natural environment, the political system, the legal system, the economy, and the social system (Craig, 1975:14-17). These environmental factors play an influential role on the activities of the parties to the employment relationship. For example, the role of the legal system is to prescribe or prohibit certain kinds of action (Grossett & Venter, 1998:26). These prescriptions and prohibitions, one may argue, are attempts to ensure the effective and efficient conduct of labour relations in the workplace.

In the South African context, the economic environment, political factors, legal factors and social factors typically impact on the labour relationship. Of these environmental factors the political arena has the most profound impact on labour relations. The reason for this is that employees have the vote and can actively influence the political scenario (Grossett & Venter, 1998:13). These factors also provide a fertile ground for almost every source of conflict (Finnemore & Van der Merwe, 1996:17).

As in the case of Dunlop's model, the concept of power and its use by the parties is also a major feature of Craig's model. The procedures involved in converting inputs into outputs are primarily focussed on creating a solid foundation for interaction between employers and employees at enterprise level. To achieve this objective the parties have to define the rights and responsibilities of each party to the relationship. Rights and responsibilities are normally defined in explicit contracts and tacit expectations formed by the parties during initial interaction. According to Grossett & Venter (1998:25), the various procedures involved in converting inputs into outputs might typically include the following:

[4] It should be noted that Craig's framework incorporate many aspects of Dunlop's theoretical framework and, as a result, overlaps between the two theories do occur.

- unilateral action on the part of the employer in altering a contract or imposing new terms and conditions of employment;

- the reaching of agreement through bilateral negotiation such as collective bargaining; and

- the intervention of outside agencies such as government or the Commission for Conciliation, Mediation and Arbitration in facilitating agreement between the parties.

With regard to mechanisms for converting inputs into outputs, the grievance and disciplinary procedures are important. According to Bendix (1996:349-350) and Grossett & Venter (1998:293-296), the grievance procedure is important and beneficial for the following reasons:

- It facilitates two way communication between employee and employer.

- It renders the disciplinary procedure more acceptable, since employees also have a means of objecting to management performance. It facilitates the development of positive worker morale.
- It deals with matters that do not constitute material for collective bargaining.

- It ensures management's involvement in the day-to-day operation of the organisation.

- It obliges the supervisor to put in real effort to solve a grievance.

- It emphasises management's concern for the well-being of employees.

- It prevents potential disputes from arising.

Discipline and all matters related to it (i.e. hearings, procedures, codes, actions) play a major role and have far reaching effects for any workplace (Bendix, 1996:353-354, Grossett & Venter, 1998:297). The main purpose of a disciplinary procedure is not merely to punish but to rectify. It is aimed at constructive support of offenders and the reinforcement of approved action (Bendix, 1996:353: Finnemore, 1996:189; Landman, 1989:68-85).

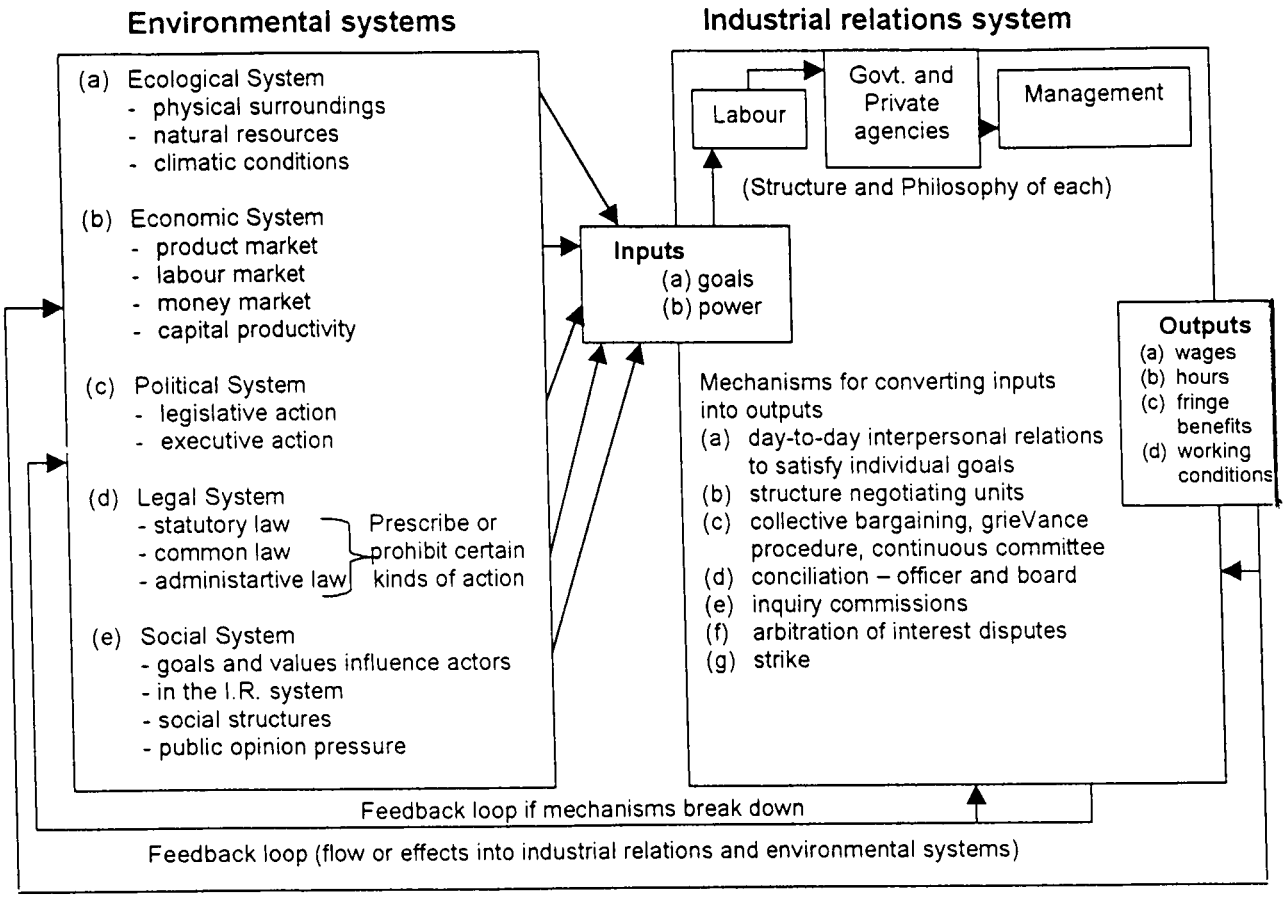
As a mechanism for converting inputs into outputs, the disciplinary procedure has certain benefits for both workers and employees. According to Nel (1992:419), the benefits of discipline for employers is that it promotes productivity, creates stability amongst the workforce and limits labour turnover to the minimum. For employees, one advantage of discipline is that they will not be harassed by unfair dismissals. In relation to this, there would not be unnecessary suspicion on their part when some of their colleagues are dismissed.

Currently, all health departments have components to deal with labour relations, grievances and discipline. In most provinces of the country, institutions such as hospitals have decentralised labour relations units (Van Rensburg & Van Rensburg, 1999:227). These units, one can contend, are attempts to ensure the effective and efficient operation and management of labour relations in the public hospital system.

Craig's model also points out that the effectiveness and perceived legitimacy of structures and procedures of conflict resolution are fundamental to the success or failure of any given labour relations system. These structures range from workplace structures at shop floor level, such as shop steward/management committees and workplace forums to the National Economic and Development Labour Council. The parties may use processes such as consultation, joint-decision making, conciliation, negotiation, mediation, strikes, lockouts and arbitration. The eventual choice of process is often part of the strategic power play between the parties (Finnemore & Van der Merwe, 1996:19). A major problem concerning these structures and procedures in the public health sector is that they are still emerging. Furthermore,

hospital management still lacks the capacity to handle labour matters effectively at institutional level (Van Rensburg & Van Rensburg, 1999:227).

Figure 2.2 A framework for analysing labour relations



(Source: Grossett & Venter, 1998:26)

The last component of Craig's model relates to outputs. According to Craig (1975), mechanisms such as collective bargaining play an important role in producing outputs such wages, working hours, fringe benefits and working conditions. Craig's model suggests that the desired output of any labour relations system, which is labour peace, is achieved when there is agreement on these issues. Labour peace is a prerequisite for achieving organisational objectives and productivity (Clegg, 1972:8; Grossett & Venter, 1998:25; Miller & Form 1980:546).

Indeed, labour peace is the vital outcome that should arise from the interaction between the parties. However, the settlement of disputes arising from such interaction is not often accepted by both parties. The open system model also indicates that a total breakdown in relationships is possible which could lead to violence and mass dismissals. If the mechanisms for handling such disputes fail, the model indicates that a feedback loop enables outputs to flow back into the system itself as well as into the environment (Clegg, 1972:8, Finnemore & Van der Merwe, 1996:17, Grossett & Venter, 1998:25, Miller & Form 1980:546). **Figure 2.2**, provides an illustration of the various facets of Craig's labour relations system, and how they function to influence one another.

Craig's model is of value to the analysis of labour relations. It serves as a predictive tool at both the micro and macro-economic levels. At the micro level, it illustrates that the closer the goals and ideals of the parties are to the labour relationship, the less likelihood there is of conflict occurring. At the macro level, the model suggests that governments and policy makers can counter any adverse output. For example, as stated in Chapter One, if increased wages have any negative impact on economic factors, necessary steps to keep wages down could be taken. The feedback loop therefore lends the necessary credence to state intervention in the labour relationship and the settlement of labour disputes (Finnemore & Van der Merwe, 1996:14-17; Grossett & Venter, 1998:25-25). According to Finnemore & Van der Merwe (1996:19), an open systems framework of labour relations, incorporating both pluralist and societal corporatist elements, has been operating in South Africa since 1994.

2.5. SUMMARY AND CONCLUSIONS

An attempt was made to analyse industrial relations using the systems theory approach. It was pointed out that Dunlop placed particular emphasis on the interrelationship between institutions and behaviour and the rules that develop from

these. Various factors impacting on and contributing towards the formation of a labour relationship within the organisational context was examined. These factors are broadly divided into two categories, namely, the internal inputs (i.e. the employer, the employee and the state) and the external inputs in the form of environmental factors impacting on the relationship. These two sets of factors interact with each other and translate into various outcomes that ultimately create a labour relations system.

Certain aspects of Dunlop's theory were also criticised by various authors. However, it was argued that despite the shortcomings, the systems theory approach provides an impeccable point of departure from which researchers can draw from. Craig's model, on the other hand, has been regarded as being useful in the analysis of the labour relations system.

Both models indicate that under certain circumstances a major breach of trust or contract can occur in a labour relationship that will necessitate the termination of a relationship or even an organisation. This is unlikely to occur often at hospitals. However, if it does occur, it would be a disastrous outcome for all parties.

Both models suggest that management and employees (nurses and blue-collar workers in this regard) do not operate in a vacuum. The environment in which they operate influences their day-to-day activities and interaction. The parties have different power resources and, as a result, conflict is inevitable. Conflict among the parties is, however, minimised by the presence of a common ideology (i.e. the provision of effective and efficient health care). The common ideology is further enhanced by procedures such as collective bargaining. Indeed, the collective bargaining wedge involves power and must be a definite consideration at any bargaining table. Other environmental factors such as technology, market and/or budgetary constraints and labour legislation also impact on the labour relationship at hospitals. An understanding of the changing environment and the factors (inputs and outputs) at play, is of the utmost necessity among health managers and health workers.

CHAPTER 3

DATA PRESENTATION:

DESCRIPTIVE VARIABLES

CHAPTER 3: DESCRIPTIVE VARIABLES

3.1 INTRODUCTION

This section of the dissertation presents the empirical findings of the study. As stated before, the study was conducted at Pelonomi Hospital in Mangaung (Bloemfontein) in the Free State. The aim of the study is to analyse the effectiveness and efficiency of labour relations processes and practices in the public hospital system.

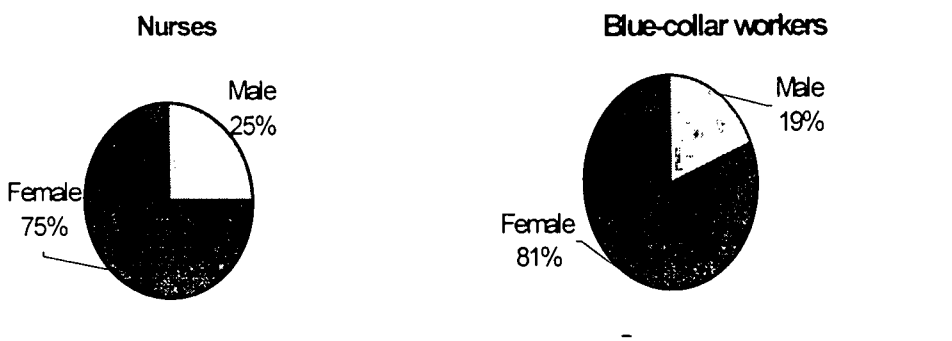
For purposes of this explorative and descriptive study, interviews were conducted between the 19th August and the 5th of November 1999 with the following categories of respondents: nurses, blue-collar workers, supervisors of cleaners, hospital and Provincial Government management, and trade union representatives. It is from this broad spectrum of sources that the research findings are informed and from which subsequent conclusions are drawn. The analysis and discussions in the report are based on careful interpretation and weighing of the material emerging from the mentioned sources.

In terms of Dunlop and Craig's models, this chapter provides a description of the actors or parties to the employment relationship (nurses, blue-collar workers, supervisors of cleaners and Provincial and hospital managers). An attempt is also made to develop a profile of the respondents in terms of gender, academic qualification, occupation and period of employment. In addition, this chapter also reports on the findings on the working conditions and remuneration of nurses and blue-collar workers – the two primary respondents in the study. According to the open systems model, working conditions and wages form part of the outputs of the industrial relations system.

3.2 BIOGRAPHIC DETAILS, CHARACTERISTICS AND WORK HISTORY OF TARGET POPULATION

3.2.1 Gender

Figure 3.1: Gender structure of target population



From **figure 3.1** it can be seen that the gender structure of the sample shows a significant distortion in favour of the female participants. Of the 80 respondents from the nursing population, 75% (n=60) were female and only a quarter (n=20) were male. Of the 42 blue-collar workers, 81% (n=34) were female and eight (19%) were male. Certainly due to the employment history of hospitals, 54% more females than men formed part of the study.

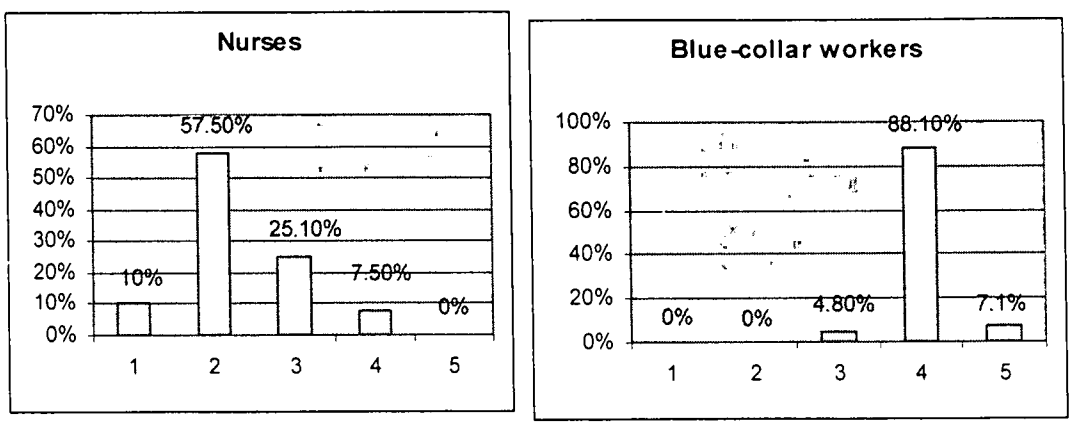
All eight supervisors of cleaners were female. Of the six managers interviewed, two were female and the remaining three were males.

3.2.2 Academic qualification

Question 2 of the nurse and blue-collar questionnaire was included to determine the academic qualifications of the target group. **Figure 3.2** below depicts that 10% (n=8) of the nurses obtained a degree and more than half (57.5%, n=46) a diploma. A quarter (25.1%, n=20) of the nurses passed matric and only 7.5%

(n=6) had a std9/grade 11 or lower qualification. As expected, not a single blue-collar worker has a degree or diploma. However, the majority of blue-collar workers (88.1%, n=37) had a std9/grade 11 or lower qualification. Of the remaining proportion of blue-collar workers, three (7.1%) had no education and only two (4.8%) had a matriculation qualification. All the managers interviewed possessed a tertiary qualification.

Figure 3.2: Academic qualification



1. = *Degree 2. = **Diploma 3. = Std 10 4. = Std 9 and lower 5 = No education

* The category "degree" includes all categories with B, honours, masters and doctorate.degrees

** The category "diploma" includes all diploma categories from one year to four – year diplomas

3.2.3 Occupation/rank

According to **tables 3.1** and **3.2** below, the nursing population (all the different categories) consisted of 65.6% (n=80) of the total sample. Within this group enrolled assistant nurses composed the greatest proportion (37.5%, n=30). Blue-collar workers formed 34.4% (n= 42) of the sample. Within this group, cleaners composed the largest proportion (74%, n=31).

Table 3.1: Occupation/rank

Occupation	N	%
1. Nurse	80	65.6
2. Blue-collar workers	42	34.4
Total	122	100

Table 3.2: Job description of respondents

Job description of nurses	N	%
1. Chief Professional nurse (Post)	3	4
2. Chief professional nurse (Rank)	18	22.5
3. Senior Professional nurse	20	25
4. Professional nurse	4	5
5. Enrolled nurse	5	6
6. Enrolled Assistant nurse	30	37.5
Total	**80**	**100**
Job description of blue-collar workers	**N**	**%**
1. Cleaner	31	74
2. Porter	5	12
3. Driver	1	2.3
4. Messenger	2	4.7
5. General worker	3	7
Total	**42**	**100**

Table 3.3 below, provides an illustration of the job descriptions of managers interviewed.

Table 3.3: Occupations of managers

Occupation	Work place
1. Deputy-Director: Labour Relations Sub-Directorate of the Free state Department of Health	Free State Department of Health
2. Senior executive Officer	Oranje Hospital
3. Deputy director	Pelonomi Hospital
4. Head Administration of Nursing Services	Pelonomi Hospital
5. Senior Administrative Officer	Pelonomi Hospital
6. Labour Relations Officer	Pelonomi Hospital

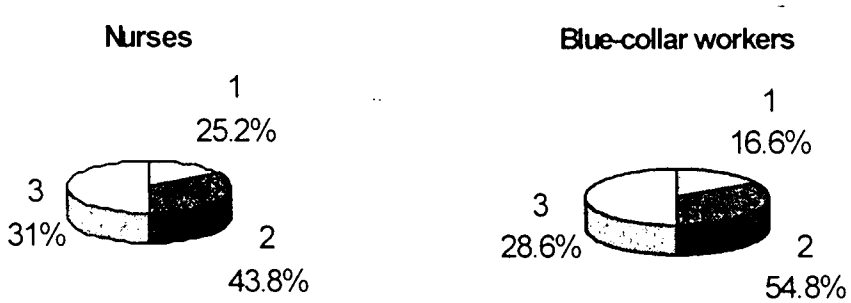
3.2.4 Workplace

More than a quarter of the nurses (32.7%, n=26) worked in the normal patient wards and slightly less than half (46.3%, n=19) of the blue-collar workers worked at places other than wards (i.e. linen room, laboratory and main kitchen).

3.2.5 Total number of years employed at Pelonomi Hospital

Regarding the duration of employment, the results indicate that somewhat less than half of the nurses (43.8%) and slightly more than half of the blue-collar workers (54.8%) had been employed between 11 and 20 years at Pelonomi Hospital. Only more than a quarter of the employees (31% of nurses and 28.6% of blue-collar workers) had been employed for more than 20 years at Pelonomi Hospital.

Figure 3.3: Duration of employment at Pelonomi Hospital



1 = 1-10 years 2 = 11-20 years 3 = 21 years and above

3.2.6 Training/in-service training

Except for one manager at hospital level, all of the managers who participated in the study had obtained training in labour relations. All regarded themselves as having a good knowledge of the LRA.

With regard to in-service training at Pelonomi Hospital, nurses (50%, n=40) had benefited more than blue-collar workers (33.3%, n=14). Of the nurses and who had obtained in-service training over the past two years, the majority (45%, n=18) received training in general nursing practice while the majority of blue-collar workers (76.5%, n=11) had received training in first aid. The remaining proportion of nurses had received training in computer literacy (37.5%, n=15) and communication and supervisory skills (17.5%, n=7). The remaining proportion of blue-collar workers had received training in computer literacy (7.7%, n=1), grievance and disciplinary procedures (7.7%, n=1) and general nursing practice (7.7%, n=1).

A study conducted by Van Rensburg & Van Rensburg (1999:222-223) reveals that many capacity- and skills-building courses aimed at public health sector staff had been initiated over the past few years. In the Free State, specifically, the *Free State Gold Fields Management Development Programme* trained 244 middle and junior health and welfare managers. In addition, 182 hospital managers were trained in the *Sub-programme for Hospital Managers*. Apart from upgrading the skills of individual managers, collectively, these training programmes may ultimately play a crucial role in the effective and efficient functioning of the public hospital system.

3.3 WORKING CONDITIONS AND REMUNERATION

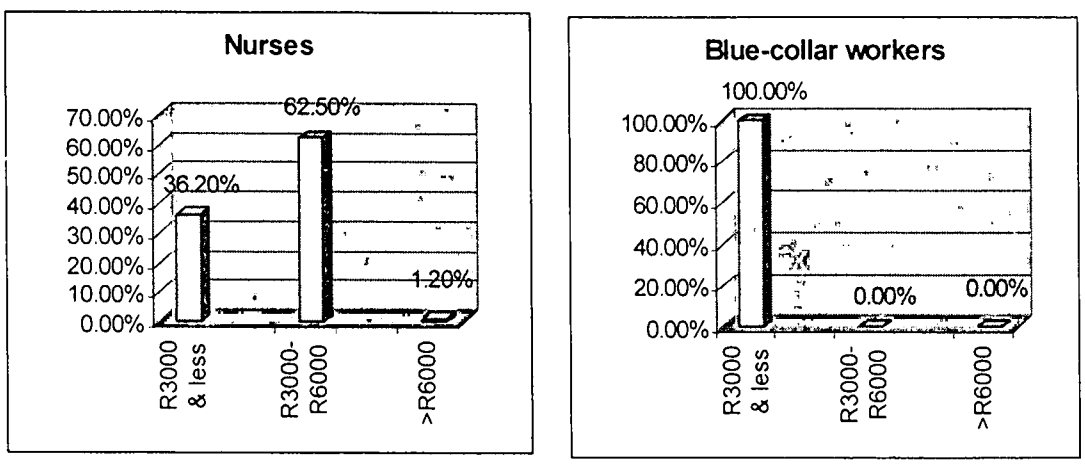
In this section, the working conditions and remuneration of workers at Pelonomi Hospital are explicated. As stated before, the open systems theory regard the working conditions and remuneration as central aspects of the output of any industrial relations system. The issues that receive attention include the type of appointment, monthly salary, extra income, knowledge about the types of leave days, and opinions about various factors relating to the working environment.

3.3.1 Type of appointment

The majority of the employees interviewed were permanently employed at Pelonomi Hospital (74.7% of nurses and 92.9% of blue-collar workers). Only three (7.1%) of the blue-collar workers and a quarter (25.3%) of the nurses were in supernumerary[1] posts.

3.3.2 Income

Figure 3.4: Monthly salary



As expected, all blue-collar workers indicated that they earned less than R3000 per month. The findings in **figure 3.4** also indicate that the majority of nurses (62.5%, n=50) earned between R3000 and R6000, 36.2% (n=29) R3000 and less, and one (1.2%) above R6000.

Of the eighty nurses interviewed, night duty allowance was applicable to 95% (n=76). However, 80% (n=64) of the nurses who qualified for night duty allowance indicated that they did not regularly receive it. In the case of blue-collar workers, the majority (88.1%, n=37) stated that night duty allowance was not

[1] Supernumerary personnel refer to those officials appointed in terms of the provisions of the Public Service Act, 1994. They are employed as supplementary employees, due to the fact that they had not been absorbed into the rationalised structures of the department

applicable to them. Of the remaining five blue-collar to which night duty allowance was applicable, only two regularly received it.

All the respondents indicated that they received a bonus during their birthday month. Employees whose birthdays fall between January and March only received their bonus at the end of April because of the financial book year. The majority of the respondents (44.3% in the case of nurses and 54.8% in the case of blue-collar workers) stated that their annual bonuses were the same as their monthly salary. Twenty three (29.1%) of the nurses and fifteen (35.7%) of the blue collar workers indicated that their bonuses were less than their monthly salaries.

3.3.3 Knowledge about leave days available

The majority of the sampled respondents (95.2% of the blue-collar workers and 96.3% of nurses) were knowledgeable about the type of leave available to workers[2] at Pelonomi Hospital.

3.3.4 Satisfaction and/or dissatisfaction with working conditions

The purpose of question 17 in the questionnaire was to determine how satisfied and/or dissatisfied employees at Pelonomi Hospital were with certain aspects pertaining to their working conditions.

[2] Unless stated otherwise, the category 'workers' refer to both nurses and blue-collar workers.

Table 3.4: Experience of working conditions

	Nurses				Blue collar workers			
ASPECTS	**S %**	**U %**	**D %**	**COL. TOT**	**S %**	**U %**	**D %**	**COL. TOT**
1. Salary	22.8	2.5	74.7	**100**	14.3		85.7	**100**
2. Working hours	75.9	1.3	22.8	**100**	69	2.4	28.6	**100**
3. Numbers of annual leave days	97.5	1.3	1.2	**100**	92.9	–	7.1	**100**
4. Annual increment	13.9	16.5	69.6	**100**	59.5	40.5	–	**100**
5. Housing allowance	21.5	34.2	44.3	**100**	7.1	66.7	26.2	**100**
6. Medical allowance	16.7	41	42.3	**100**	2.4	71.4	26.2	**100**
7. Relationship with colleagues	82.3	1.3	16.3	**100**	69	–	31	**100**
8. Attitude of immediate super-visor	86.1	–	13.9	**100**	78.6	–	21.4	**100**
9. Condition of equipment that you work with	59.5	2.5	38	**100**	47.6	4.8	47.6	**100**
10. Involvement in decisions that affect you	62	1.3	36.7	**100**	33.3	2.4	64.3	**100**

S = satisfied **U** = uncertain **D** = dissatisfied **Col. Tot** = column total

* Please note that the categories "very satisfied" and "reasonably satisfied" had been combined into one category "satisfied", and the categories "reasonably dissatisfied" and "very dissatisfied" as "dissatisfied".

If placed in rank order, the degree to which respondents were satisfied with working conditions is illustrated as follows:

	Satisfied %
Nurses	
1. Numbers of annual leave days	97.5
2. Attitude of immediate supervisor	86.1
3. Relationship with colleagues	82.3
4. Working hours	75.1
5. Involvement in decisions that affect you	62
6. Condition of equipment that you work with	59.5
7. Salary	22.8
8. Housing allowance	21.5
9. Medical allowance	16.7
10. Annual increment	13.9

	Satisfied %
Blue-collar workers	
1. Numbers of annual leave days	92.9
2. Attitude of immediate supervisor	78.6
3. Relationship with colleagues	69
3. Working hours	69
4. Annual increment	59.4
5. Condition of equipment that you work with	47.6
6. Involvement in decisions that affect you	33.3
7. Salary	14.3
8. Housing allowance	7.1
9. Medical allowance	2.4

The above illustration indicates that employees at Pelonomi Hospital (both nurses and blue-collar workers) were mostly satisfied with their annual leave, the attitude of their immediate supervisor and their relationship with colleagues. The number of annual leave days employees receive at Pelonomi Hospital depends

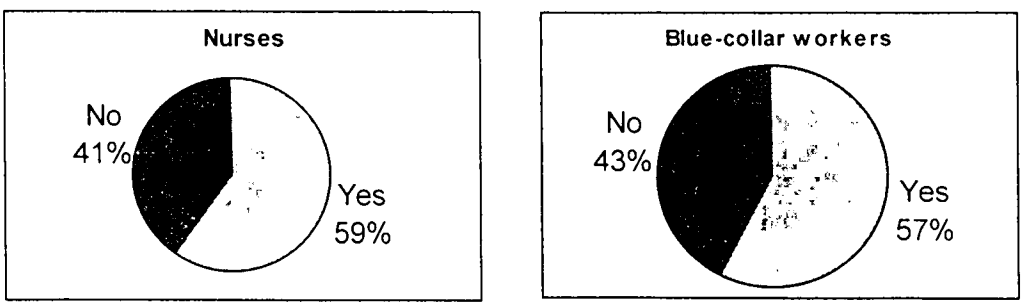
on the number of years of service[3]. These days are far more than the maximum annual-leave days stipulated by the Basic Conditions of Employment Act (BCEA).

Regarding issues that respondents are dissatisfied with, **table 3.4** indicates salaries ranked number one (74.7% of nurses and 85.7% of blue-collar workers). Huge discrepancies were found with other aspects that respondents were dissatisfied with. For example, while 69.6% (n=55) of the nurses were dissatisfied with their annual increment, while none of the blue-collar stated likewise.

3.3.5 Termination of employment

Questions pertaining to aspects such as interaction in the workplace, worker morale and efficiency of staff, work satisfaction and dissatisfaction are important elements of labour relations. These dimensions directly or indirectly influence the decision of individual employees to remain working at the same workplace or to decide to seek employment somewhere else.

Figure 3.5: Whether ever seriously considered leaving Pelonomi Hospital



Respondents were asked whether they ever seriously considered leaving Pelonomi Hospital to work elsewhere. **Figure 3.5** shows that the majority of employees (59% of nurses and 57% of blue-collar workers) once considered leaving Pelonomi Hospital to work elsewhere.

[3] Personnel who had been employed since 1968 and before are entitled to 38 days while those who had completed 10 years of

The respondents were also granted the opportunity to share the reasons why they wanted to leave Pelonomi Hospital. These responses are outlined in **table 3.5**. It is clear from this table that a significant proportion of nurses (44.7%) and the majority of blue-collar workers (70.8%) had thought of leaving Pelonomi Hospital to work elsewhere because of the negative attitude and bad treatment from supervisors and colleagues, and not receiving any recognition for work done well.

Table 3.5: Reason for wanting to leave Pelonomi Hospital[4]

	Nurses		Blue-collar workers	
Reason	**N**	**%**	**N**	**%**
1. Negative attitude and bad treatment from supervisors and colleagues and not receiving recognition for work done well	21	44.7	17	70.8
2. Lack of promotions, incentives and training opportunities	12	25.5	3	12.5
3. Low wages	4	8.5	1	4.2
4. Poor health	1	2.1	2	8.3
5. Bad image attached to Pelonomi Hospital, general lack of discipline	1	2.1	1	4.2
6. Shortage of linen, dispensary and uniforms; and transport problems	8	17	–	–
Total	**39**	**100**	**24**	**100**

3.4 IN CONCLUSION

An attempt was made in this chapter to provide a profile of the target population. Of the total 122 respondents, almost 66% (n=80) were nurses and 34% (n=42) blue-collar workers. There was a large distortion in the spread of male (25% of

service are entitled to 30 days. Pregnant workers are also allowed 84 days maternity leave.

[4] All frequencies in table 5 add up to 39 (in the case of nurses) and 24 (in the case of blue-collar workers)- the numbers of respondents that indicated in **Figure 3.5** that they had ever thought of leaving Pelonomi Hospital to work elsewhere.

nurses and 19.1% of blue-collar workers) and female (75% nurses and 81.9% of blue-collar workers) respondents.

The majority of nurses (57.5%) had a diploma while the vast majority of blue-collar workers (88.1%) only had a std 9/grade 11 or lower qualification. Almost 93% of blue-collar workers and 75% of the nurses worked permanently at Pelonomi Hospital at the time of the survey. Furthermore, the majority of blue-collar workers (54.8%) and 43.8% of nurses had worked between 11 and 20 years at Pelonomi Hospital.

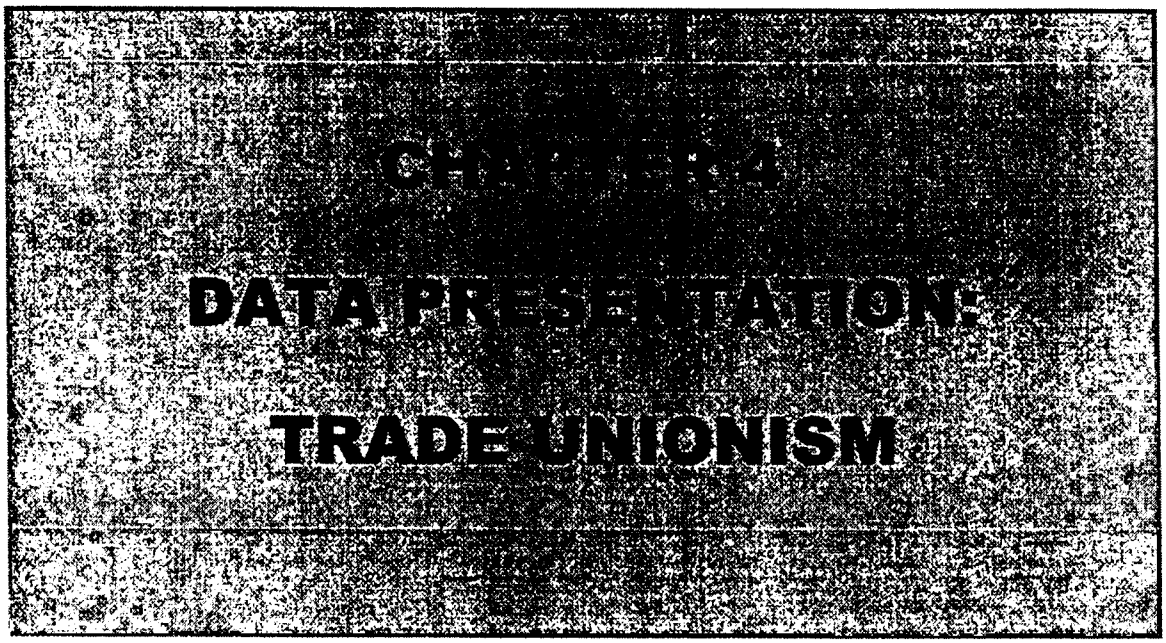
Quite obviously, all blue-collar workers indicated that they earned less than R3000 per month. Of the eighty nurses, fifty (62.5%) earned R3000 and lower per month, twenty nine (36.2%) earned between R3001 and R6000 per month, and only one (1.2%) earned more than R6000. Night duty allowance was applicable to 95% (n=76) of the nurses. However, the vast majority (80%, n=64) indicated that they did not regularly receive the night duty allowance owing to them. The majority of blue-collar workers (88.1%, n=37) stated that night duty allowance was not applicable to them.

With regard to job satisfaction, three of the factors that the respondents (nurses and blue-collar workers, respectively) were mostly **satisfied** with were: the number of annual leave days (97.5% and 92.9%), attitude of immediate supervisor (86.1% and 78.6%), and the relationship with colleagues (82.3% and 69%). Respondents also indicated that they were mostly **dissatisfied** with their salaries (74.7% and 85.7% in the case of nurses and blue-collar workers, respectively).

Slightly less than sixty percent of the respondents had ever thought of leaving Pelonomi Hospital to work elsewhere (59% of nurses and 57% of blue-collar workers). One of the major reasons for thinking about leaving was prompted by

the negative attitude of and bad treatment from supervisors and colleagues (44.7% of nurses and 70.8% of blue-collar workers).

The following chapter focuses on one aspect of what Dunlop and Craig call actors or parties to the employment relationship: trade unions. The role of trade unions at Pelonomi Hospital and their impact on the effectiveness and efficiency of labour relations processes and practices are explicated in this chapter.


CHAPTER 4
DATA PRESENTATION:
TRADE UNIONISM

CHAPTER 4: TRADE UNIONISM

4.1 INTRODUCTION

According to the Dunlop and Craig's models, the labour relationship is usually described as a tripartite relationship between employers (and employers' organisations), employees (and trade unions) and the state. Each of these three parties has a clearly defined role to play, the exact nature of which is influenced and affected by the economy and social systems within which they operate. Workers and management are the primary actors and the state is the secondary actor. In the South African public health context, however, management at institutional level is often seen as being part of the state, hence the focus only on trade unions in this chapter.

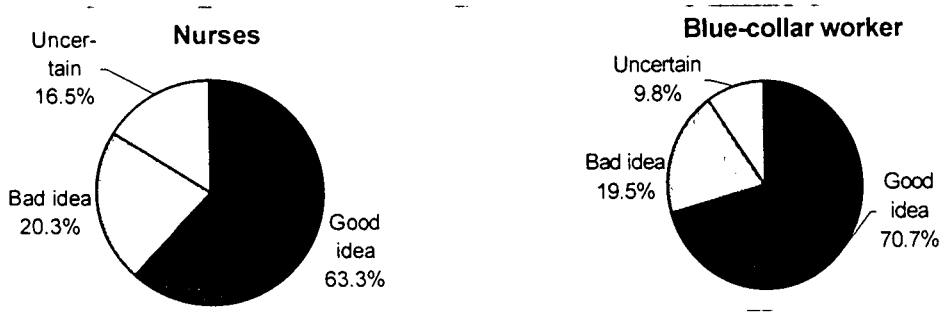
The systems theory indicates that the struggle for power between workers and their employers is central to industrial relations. An analysis of the labour relationship reveals that the power of the employer is best matched by a combination of workers who, by collective action, obtain concessions, which would not otherwise have been granted. Grossett & Venter (1998:70-71) maintain it is this collective organisation which forms the basis of trade unionism. Workers thus join trade unions in order to achieve power.

More specifically, this chapter deals with the views of respondents on various issues relating to trade unionism. This includes affiliation to unions, loyalty to a union, the approach of unions to negotiations and an evaluation of the union. In addition, the perceptions of workers regarding the relationship between management and trade union representatives are also presented.

4.2 ATTITUDES TOWARDS AND INVOLVEMENT IN TRADE UNIONS

4.2.1 Opinion about involvement in trade unions

Figure 4.1: "Good/bad" idea for workers to belong to trade unions



With regard to **figure 4.1**, the majority of respondents indicated that it was a good idea for nurses (63.2%, n=50) and blue-collar workers (70.7%, n=29) to belong to a trade union. **Table 4.1** below, depicts the reasons for the above standpoints:

Table 4.1 indicates that slightly more than half of the nurses (53.4%) and almost half of the blue-collar workers (49%) indicated that it was **good** to belong to a trade union as they fight for and protect workers' rights. On a negative note, slightly less than a quarter of nurses (21.3%) and only fifteen (15.3%) of the blue-collar workers cited that trade unions create an ill-disciplined workforce. There is a great difference between the percentage of nurses (5.8%) and blue-collar workers (22.4%) who agree with the statement that "workers are exploited in the absence of trade unions".

Table 4.1: Perceptions about belonging to trade unions

	Nurses		Blue-collar workers	
Reasons	**N**	**%**	**N**	**%**
1. Trade unions fight for and protect their basic rights	55	[illegible]	48	[illegible]
2. Trade unions are part of industrialisation	9	8.8	5	5.1
3. Workers are exploited in the absence of trade unions	6	5.8	22	22.4
4. Presence of unions creates an ill-disciplined workforce/make workers neglect their duties	22	21.3	15	15.3
5. Trade unions promote professionalism and instill discipline among workers	9	8.8	5	5.1
6. Uncertain/Do not know	2	1.9	3	3
Total	**103**	**100**	**98**	**100**

According to the supervisors of cleaners, trade unions at Pelonomi Hospital poses several challenges to them. It appears that the major problem relates to the interference of shop stewards in the work of supervisors. Results of Van Rensburg & Van Rensburg's (1999:225) study also reveal that there is a widespread perception that the role of trade unions is sometimes one of collectively fuelling discontent and demoralising staff. The following statements of supervisors lend credence to this assertion:

> "Yes, they [shop stewards] affect our work, if you are a supervisor, you are a supervisor, unions should not tell me what to do. I know what is expected of me. They can come and ask when there is a problem, but they tend to stand by their members irrespective of the misconduct. In fact, we do not see eye to eye with shop stewards, we are enemies, great enemies. The problem is this situation is even affecting our families

because if you encounter a problem with a shop steward, he/she would try to cause trouble to you outside the work...."

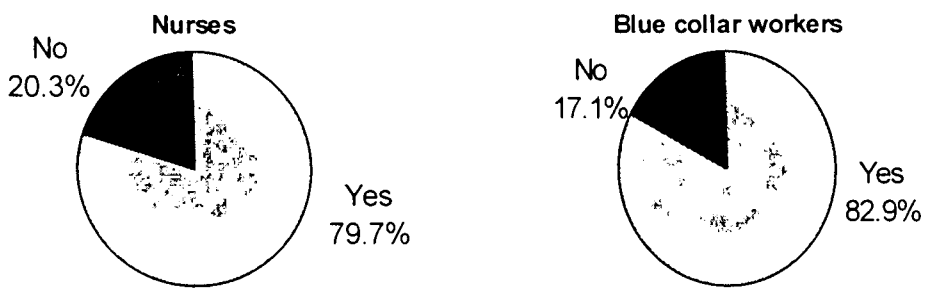
Another supervisor stated the following:

"The problem is that we as supervisors do not decide where we want to work or not. Again, we cannot walk after each and every cleaner under your supervision. However, we often receive phone calls from matrons telling us that such and such a ward has not been cleaned properly.... If we take up such matter with the cleaner who is responsible, shop stewards say we are harassing their members. We as supervisors are also rotated but we never complain...we also belong to trade unions, but they never interfere with our work".

The next paragraph focuses on trade union affiliation.

4.2.2 Trade union affiliation

Figure 4.2: Membership of trade union



According to **figure 4.2**, more than three-quarters of the respondents 79.7% of nurses and 82.9% of blue-collar workers, were members of trade unions at the time of the interviews. The reason for the high number of unionised employees at

Pelonomi Hospital can be ascribed to agency shop[1] agreements between management[2] and unions.

Of the employees who indicated that they do not belong to a union, more than a third (37.5%, n=6) of the nurses and somewhat more than half (57.1%, n=4) of the blue-collar workers indicated that they could stand up for their own labour rights. Whilst a third (25%, n= 4) of the nurses stated that unions were useless and did not see their importance, 42.9% of blue-collar workers indicated that they did not belong to unions because they create an ill-disciplined workforce.

Table 4.2: Trade union membership

Trade Union	Nurses		Blue-collar workers	
	N	%	N	%
1. National Education, Health and Allied Workers Union (NEHAWU)	24	38.1	33	97.1
2. Democratic Nursing Organisation of South Africa (DENOSA)	18	28.6	1	2.9
3. Public Servants Association (PSA)	12	19	-	-
4. South African Democratic Nurses' Union (SADNU)	6	9.5	-	-
5. Public Servants And Allied Workers' Union (PAAWU)	3	4.8	-	-
Total	**63**	**100**	**34**	**100**

Table 4.2 clearly indicates that an overwhelming majority of the blue-collar workers (97.1%, n=33) and only 38.1% of nurses are members of NEHAWU. The remaining proportion of nurses belongs to DENOSA (28.6%), PSA (19%), SADNU (9.5%) and PSAAWU (4.8%). This is also a true reflection of the current

[1] Agency shop agreements are closely related to the closed shop agreement which the LRA makes provision for. The rationale for the agency shop is that employees who acquire the benefits of collective bargaining but who are not members of a trade union recognised as the collective bargaining representative should be required to pay a fee. According to Finnemore & Van der Merwe (1996:93), this fee by non-union members is an attempt to counter-act the so-called "free-ridder" problem.

situation regarding union membership. In terms of numbers, NEHAWU is currently the majority representative union of workers in the Free State Bargaining Council. **Table 4.2** also reveals the fragmentation of labour organisations as highlighted in Chapter One.

4.2.3 Years of membership and loyalty to trade union

Questions 26 and 27 of the questionnaire were designed to determine the number of years of membership and loyalty to the union. The findings reveal that the majority of nurses (84.1%) and blue-collar workers (70.6%) have been members of their respective unions for less than ten years. Only ten (15.9%) nurses and ten (29.4%) blue-collar workers have been members of their respective unions for more than ten years.

Regarding loyalty to their respective unions, thirty one (91.2%) blue-collar workers compared to fifty-two (82.5%) nurses indicated that they would still remain members of their present unions. Only seven (11.1%) nurses and two (5.8%) blue-collar workers stated that they would join another union in the near future and four (6.3%) nurses and one (3%) blue-collar worker that they would withdraw totally from union activities.

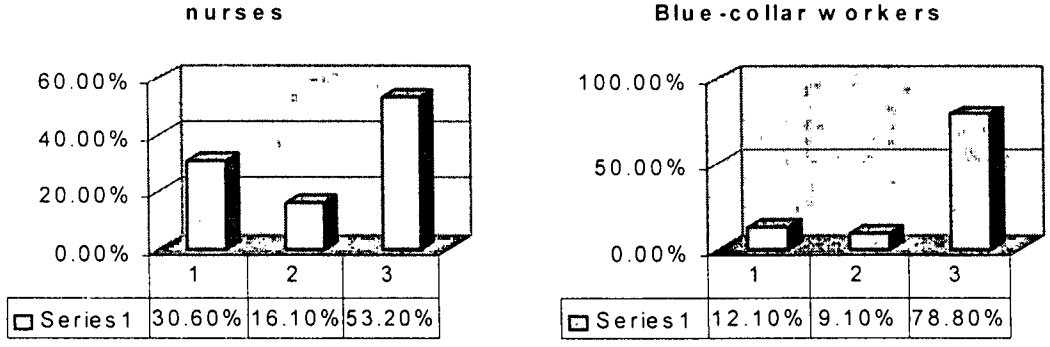
If the history of labour relations within the public service, particularly the public health sector, is taken into consideration, it can easily be understood why the majority of respondents indicated that they would remain members of their respective unions. One possible reason is that trade unions within the public health sector have achieved considerable gains in terms of fighting for workplace democracy over the past few years. Indeed, as stated in Chapter Two, labour has gained considerable organisational rights.

[2] Unless stated otherwise management, throughout this dissertation, refers to hospital management.

According to trade union representatives, the following features of their unions make them popular amongst workers:

- An open door policy (being always 'available')
- Providing prompt feedback to members
- Addressing the concerns of employees
- Being a staff association which is non-violent
- Effectively handling the grievances of workers

Figure 4.3: Perceptions of trade union's ability to take care of the needs of workers



1 = Uncertain 2 = Does not properly take care of needs 3 = Properly take of needs

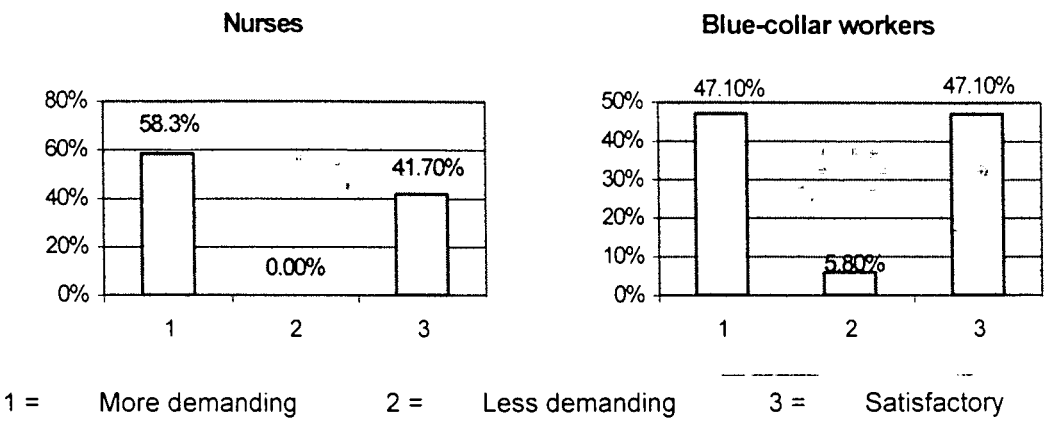
Respondents who indicated that they are members of trade unions were asked their opinion regarding the ability of unions to address their labour needs. **Figure 4.3** depicts that the majority of blue-collar workers (78.8%, n=26) and slightly more than half of the nurses (53.2%, n=33) emphasised that their unions properly took care of their labour needs. Ten nurses (16.1%) and three blue-collar workers (9.1%) indicated that they were unhappy about the way unions took care of their labour needs. The reasons cited by respondents for the above responses were the following:

	Nurses	Blue-collar workers
➢ Union is always there for me/provides important benefits	(31.1%, n=14)	(34.5%, n=10)
➢ Protects me from unfair labour practices/ feel secured	(40%, n=18)	(44.8%, n=13)
➢ Union is educative	(15.6%, n=7)	(13.8%, n=4)
➢ Union does not fulfill its promises/its approach is pathetic	(8.8%, n=1)	(3.4%, n=1)
➢ Not clear whether unions addresses their labour needs properly	(2.2%, n=1)	(3.4%, n=1)
➢ Union is discriminatory/more interested in people in higher positions	(2.2%, n=1)	---

4.2.4 Trade union approach to negotiations

Respondents were asked what the nature of their unions' current approach to negotiations was. As depicted in **figure 4.4** below, somewhat more than half of the nurses (58.3%, n=35) and slightly less than half of blue-collar workers (47.1%, n=16) wanted their unions to become more demanding in their approach to negotiations. Almost the same proportion of nurses and blue-collar workers (41.7% and 47.1%, respectively) were satisfied with the current approach of their unions to negotiations. It is interesting to note that the same proportion of blue-collar workers was either satisfied or dissatisfied with their unions' approach to negotiations.

Figure 4.4: Trade union approach to negotiations



4.2.5 General (worker) meetings

Respondents where asked how often their unions held general (worker meetings at Pelonomi Hospital (question 32). **Table 4.3** below depicts that a substantially percentage of blue-collar workers (54.2%) than nurses (33.3%) indicated that their unions held meetings on a monthly basis. Almost the same proportion of nurses (39.3%) and blue-collar workers (32.4%) stated that their unions only held meetings with members when necessary.

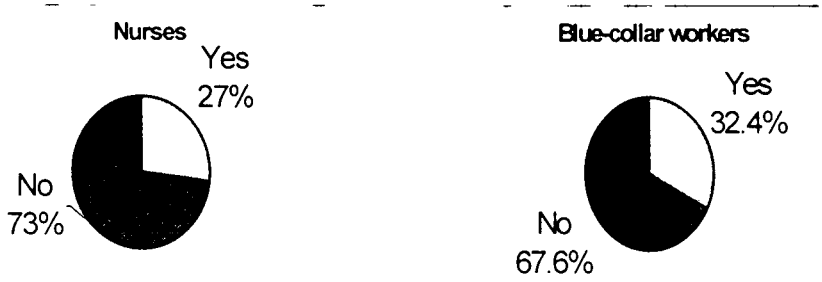
Table 4.3: Regularity of general (worker) meetings

	Nurses		Blue-collar workers	
Periods	**N**	**%**	**N**	**%**
1. More than once a week	1	1.7	1	2.8
2. Every two weeks	10	16.6	2	5.8
3. Monthly	20		19	
4. Only when necessary	24		11	31.4
5. Quarterly	1	1.7	2	5.7
6. Once a year	3	5	-	-
7. Do not know	1	1.7	-	-
Total	**60**	**100**	**35**	**100**

4.2.6 Handling of work-related complaints

According to **figure 4.5** below, a substantial percentage of respondents had never taken any work-related complaint to their trade union representatives (73% of nurses and 67.6% of blue-collar workers). Thus, it can be concluded that the complaints of workers were addressed properly by supervisors. Conversely, this can be an indication that workers only report their complaints to shop stewards when it is too late (i.e. when a strike is already looming).

Figure 4.5:Ever taken a work-related complaint to a union representative



4.2.6.1 Nature of work-related complaint

Table 4.4: Complaints taken to union representatives

	Nurses		Blue-collar workers	
Complaint	**N**	**%**	**N**	**%**
1. Negative attitude of supervisor and/or ward matron	8	[illegible]	8	[illegible]
2. Restructuring/changes made without being informed	2	11.8	1	9.1
3. Lack of promotions, incentives and training opportunities	7	[illegible]	1	9.1
4. Fighting among union members	-	-	2	18.2
Total	**17**	**100**	**12**	**100**

Of the seventeen nurses and twelve blue-collar workers who had previously taken a work-related complaint to a union representative, eight nurses (47%) and eight blue-collar workers (63.7%) complained about the negative attitude of their supervisors and/or ward matrons. A vast proportion of nurses (41.2%) complained about the lack of promotions, incentives and training opportunities.

4.2.6.2 Way in which complaints were handled

The majority of the respondents (64.7% in the case of nurses and 81.8% in the case of blue-collar workers) were satisfied with the manner in which their complaints were by union representatives. Five nurses (29.4%) and two blue-collar workers (18.2%) were uncertain as to how their complaints were handled, as they never received feedback. Only one nurse (5,9%) stated that her complaint was dealt with in an unsatisfactory manner.

4.2.7 Knowledge about the Labour Relations Act

The LRA consists of 214 clauses and regulations, which are too much to deal with, even for the most liberal worker. Thus, an attempt was made determine whether workers at Pelonomi Hospital were aware of the existence of the Labour Relations Act (question 37) and not whether they knew the contents of the Act. Respondents were also asked to indicate their sources of information about the LRA (question 38). The data pertaining to this is presented in **figure 4.6** and **table 4.5** below.

Figure 4.6: Awareness of LRA

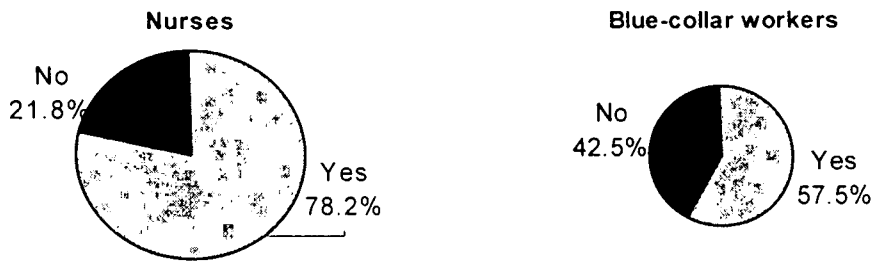


Figure 4.6 reveals that the vast majority of nurses (78.2%) and somewhat more than half of the blue-collar workers (57.5%) was aware of the LRA. As depicted in **table 4.5**, the vast majority of nurses (45.8%) had become aware of the LRA through the mass media, newsletters and circulars. In the case of blue-collar workers, 58.3% had gained knowledge of the LRA through trade union officials and shop stewards.

Table 4.5: Sources of information about the LRA

	Nurses		Blue-collar workers	
Source	**N**	**%**	**N**	**%**
1. Management/Labour relations Officer/colleagues	8	13.5	4	16.7
2. Mass media/ news letters/circulars	27	45.8	6	25
3. Trade union officials and shop stewards	11	18.6	14	58.3
4. Government Gazette and PAS document	9	15.2	-	-
5. Course in Human Relations	4	6.8	-	-
Total	**59**	**100**	**24**	**100**

4.2.8 Workers' perceptions of the relationship between management and trade union representatives

Question 39 of the questionnaire was constructed with the aim of determining the attitude of both hospital management and trade union representatives towards each other. In both instances, similar situations prevailed. The majority of the respondents stated that they were uncertain about management's attitude towards union representatives (75.6% of nurses and 53.7% of blue-collar workers) and union representatives' attitude towards management (76.9% of nurses and 51.2% of blue-collar workers). Seventeen percent more blue-collar workers than nurses indicated that the Pelonomi Hospital management's attitude towards union representatives was good (36.6% compared to 17.9%).

According to management at both hospital and provincial level, their relationship with trade unions was satisfactory. Trade union representatives also regarded their relationship with management as being satisfactory. One of the spin-offs of this good relationship at provincial level, one manager said, was the co-drafting of the Management Plan for the Rationalisation and Re-organisation (MPRR) of the Free State Department of Health (DoH)[3]. According to the systems theory, it is such structures that play a crucial role in the maintenance and achievement of organisational effectiveness and efficiency.

Table 4.6: Suggestions to improve on the relations of the parties

	Nurses		Blue-collar workers	
Suggestion	**N**	**%**	**N**	**%**
1. Both parties should respect and listen to each other/work within the framework of the LRA	12	15.3	14	36.8
2. Relocate managers who do not have the interests of workers and patients at heart	2	2.5	3	7.9
3. Parties should meet more often and not only when there are problems	23	29.5	7	18.4
4. No suggestion	37	47.5	13	34.2
5. Management should treat all trade unions equally	4	5.2	1	2.6
Total	**78**	**100**	**38**	**100**

Nearly half (47.5%) of the nurses and more than a quarter (34.2%) of blue-collar workers did not know what could be done to improve the relationship between hospital management and shop stewards. Foremost among the suggestions by nurses was that the parties should interact more often (see category 3). Mutual respect and working within the framework of the LRA (see category 1), was in the forefront of suggestions from blue-collar workers

[3] The purpose of the MPRR is to provide measures and procedures to followed during rationalisation and the re-organisation process that the Free State Department of Health is, or may be engage in, in future, that will result in the reduction and redeployment of personnel.

4.2.9 Workers' perceptions of the influence of trade unions

Table 4.7: Level of influence of trade unions

Area of influence	Influential		Uncertain		Not influential		Column total
	N	%	N	%	N	%	%
1. In securing higher pay	46 *23	71.8 *67.6	6 *3	9.4 *8.8	12 *8	18.8 23.5	100
2. In securing satisfactory working conditions	49 *32	76.6 *94.1	3 -	4.6 -	12 *2	18.8 *5.9	100
3. In communicating a good image of health services	42 *20	65.6 *58.8	17 *4	26.5 *11.8	5 *10	7.8 *29.4	100
4. In securing benefits for its members	57 *32	89 *94.1	1 -	1.6 -	6 *2	9.4 *5.9	100
5. Creation of promotion opportunities	28 *11	43.7 *32.4	5 *3	7.8 *8.8	31 *20	48.4 *58.8	100
6. Influence on management practices	46 *31	71.8 *91.2	7 *1	10.9 *2.9	11 *2	17.2 *5.9	100
7. Handling of disciplinary cases against members	55 *32	85.9 *94.1	5 *1	7.8 *2.9	4 *1	6.2 *2.9	100
8. Protection from unfair labour practices	59 *32	92.1 *94.1	1 *1	1.6 *2.9	4 *1	6.2 *2.9	100
9. In educating members about their rights at the workplace	61 *31	95.3 *91.2	1 -	1.6	2 *3	3.1 *8.8	100
10. Promotion of good relations between workers	56 *25	87.5 *73.5	1 *2	1.6 *5.9	7 *7	10.9 *20.6	100

* These are responses of blue-collar workers. The other responses are for nurses

In almost all cases, the majority of the respondents stated that their trade unions were influential. Based on the figures in **table 4.7** above, it is clear that it was only with regard to the creation of promotion opportunities that more than half of

the blue-collar workers (58.8%, n=20) and nearly half (48.4%, n=31) indicated that their unions are not influential. As depicted by table 4.7, the majority of the respondents believe that their unions are influential in all the other areas listed. Broadly speaking, it can be concluded that workers at Pelonomi Hospitals regard their respective unions as being influential in almost all the aspects.

4.2.10 Management and workers' perception of trade unions

As far as it could be observed, eight trade unions represent workers at Pelonomi Hospital[4]. As trade unions were not formally recognised in the public health sector, they had to fight many recognition battles with the Government. Black trade unions also fought many battles with intransigent employers and the government. By the 1980's, black unions were the most solidly organised of the forces of change in South Africa. The emergence of progressive trade unions such as NEHAWU during the late eighties, also championed the cause of black public sector workers. This perhaps also explains the reason for the widespread industrial action that engulfed public hospitals during the late 1980's and early 1990's.

Emanating from their evaluation of the influence of trade unions, respondents were asked to indicate the single most important aspect that they **appreciated** about their trade union. They responded as follows:

	Nurses	Blue-collar workers
➢ Promotes workplace democracy	(**34.4%**, n=22)	(**55.9%**, n=19)
➢ It is educative/informative and accessible	(26.6%, n=17)	(26.5%, n=9)
➢ It does not protect ill-disciplined workers	(20.3%, n=13)	(8.8%%, n=3)
➢ Its non-violent approach to negotiations	(17.2%, n=11)	(5.9%, n=2)

[4] See **table 4.5**

➢ Treats all members equally	(1.5%, n=1)	(2.9%, n=1)

All the six managers stated that it was a good idea for public health sector workers to belong to trade unions. According to them, trade unions protect workers from unfair labour practices, provide workers with better negotiating power, facilitate easy communication and open more communication channels. In the case of blue-collar workers, trade unions play an important role because of the obvious lack of capacity amongst these workers in terms of labour legislation. The presence of trade unions also "make management aware of issues not previously known to them".

Conversely, respondents were also asked to state the single most **negative** aspect about their trade union. Respondents raised the following issues:

	Nurses	**Blue-collar workers**
➢ Shop stewards are uncooperative/make unnecessary promises	(**28.5**%, n=18)	(**29.4%**, n=8)
➢ Its approach to negotiations is pathetic	(**35%,** n=22)	(17.6%, n=6)
➢ It protects ill-disciplined members	(17.5%, n=11)	(11.8%, n=4)
➢ There is no single negative aspect	(12.7%, n=8)	(17.7%, n=6)
➢ Being too much involved in strikes	(6.3%, n=4)	(23.5%,n=8)

Paragraph 4.2 indicated that trade unions posed several problems for supervisors. Apparently management at institutional and provincial level also experienced problems with trade unions. According to one institutional manager, unions "do not follow proper mechanisms during deadlocks...moreover workers neglect their duties due to trade union activities". The latter was confirmed by one supervisor of cleaners who stated that "they [workers] would leave their work at 8 o' clock in the morning to attend union meetings up until 12 o' clock. When they

have returned from such meetings, they do not want to work...it is always *e shaile, e shaile* [it's knock-off time]. Think for yourself, knock-off at 12 o' clock?"

Another concern of trade unionism at institutional level relates to the abuse of power and arrogance of shop stewards. "They abuse their powers and are usually arrogant when they want to see you. They just enter your office without any prior arrangement, you have no choice but to postpone other important matters". Another concern raised by management and supervisors of cleaners was that unions instigate members to act irrational.

Some of the concerns raised at provincial level about trade unions were that they were impatient and did not share a common vision with the Provincial Department of Health. Unions also do not follow the LRA guidelines regarding conflict resolution. For instance, "they do not take the Department [of Health] to the CCMA when we have allegedly done something wrong, instead, they strike", one manager remarked.

4.2.11 Factors impeding the success of trade unions' attempt to fight for worker rights

Trade union representatives were asked to indicate what they thought affected the success of their unions in fighting for worker rights. Factors that impeded the progress of trade unions appeared to be "the fragmentation of nurses amongst unions" and the general approach of unions in that they "lack the power to re-focus their vision". The opinion raised that "there is a dire need for training at Pelonomi" points to the fact that management and employees need to be trained. Another comment that "we [trade unions] are too soft on management" illustrates the need for trade unions to change their strategies when dealing with management.

4.3 IN CONCLUSION

This chapter focused on the role of trade unions, one of the primary actors in the employment relationship. The research results have to a greater extent confirmed what the systems and open systems theories have emphasised. The notion that employees (through trade unions) and management have different primary goals and interests were also revealed in this chapter. Broadly speaking, it is evident that trade unions pose several challenges to management.

More specifically, results presented in this chapter indicate that almost 80% of the nurses and 83% of blue-collar workers were members of a trade union at the time of the interviews. A considerable proportion of respondents (53.9% of nurses and 49% of blue-collar workers) indicated that their trade unions played a significant role in fighting for and protecting workers' basic rights. However, the findings also revealed that supervisors of cleaners see trade unions as interfering with their work.

It is interesting to note that a vast majority of the respondents are loyal and would remain loyal members of their unions. In this regard, 92% of nurses compared to 83% of blue-collar workers indicated that they would remain members of their unions. It appears that the single most important aspect that encourages members to **appreciate** their unions is that they promote workplace democracy (34.8% of nurses and 55.9% of blue-collar workers). On a negative note, the poor approach of unions to negotiations and unco-operative shop stewards are regarded as the single most important **negative** aspect about unions (35% of nurses and 55.9% of blue-collar workers).

A very disturbing trend that point emerged from this chapter is the perception that trade unions interfere in the work of supervisors, fuel discontent among workers and create an ill-disciplined workforce. In addition, it is also disturbing to note that management regards unions as being impatient when they had to follow certain

procedures. The importance of following procedures in the workplace cannot be overemphasised. As the systems theory indicated, the grievance and disciplinary procedures, for example, are important in the effective and efficient management of labour relations. By not following procedures, unions are therefore indirectly challenging the very same procedures that are meant to promote worker rights.

The study also showed that the relationship between management and trade unions is less hostile after the turbulent period of the early 1990's. This can be ascribed to structures such as the MPRR that play a role in facilitating dialogue between management and trade unions. A very disturbing result is that almost 22% of nurses and 43% of blue-collar workers are not aware of the Labour Relations Act.

The following chapter focuses on what Craig calls the mechanisms (strikes, and grievance and disciplinary procedures) of converting inputs (goals and power) into outputs (better wages, working hours and fringe benefits). The latter aspects have been dealt with in Chapter Three.

CHAPTER 5

DATA PRESENTATION: STRIKES AND THE GRIEVANCE AND DISCIPLINARY PROCEDURES

CHAPTER 5: STRIKES AND THE GRIEVANCE AND DISCIPLINARY PROCEDURES

5.1 INTRODUCTION

Chapter Five focuses on what Craig (1975) calls the mechanisms of converting inputs into outputs. In the South African context, reaching of agreement through bilateral negotiation such as collective bargaining and the intervention of outside agencies such the CCMA, are also regarded as procedures involved in converting inputs into outputs. However, both are handled either at national or provincial level and, therefore, have not been part of the scope of this study.

This chapter reports on the findings on strikes and the grievance and disciplinary procedures. The chapter also deals with the findings on the labour relations practices and procedures at Pelonomi Hospital.

5.2 STRIKES

Strike action in the public health sector is no longer an unfamiliar sight. The systems theory indicates that strikes occur as a result of the failure of negotiations. The following section focuses on the role of strikes at public hospitals, the willingness of workers to strike and the factors contributing to strikes.

5.2.1 The role of strikes

To gauge the respondents' attitude towards strikes they were asked, "what purpose do you think strikes are playing at public hospitals?" A substantial

proportion of blue-collar workers (45%, n=18) and more than a quarter (32.9%, n=26) of nurses stated that strikes negatively affect the image of health care services and the provision of critical health care to patients. Thirty-six nurses (45.6%) and twelve blue-collar workers (30%) indicated that strikes were the only means available to workers to highlight their plight and make the public aware of the poor working conditions under which they are supposed to work. Fourteen nurses (17.8%) and eight blue-collar workers (20%) regard strikes as being destructive and a risk to the jobs of workers. The remaining proportion of respondents (5% of blue-collar workers and 3.8% of nurses) indicated that strikes only fulfilled the personal agendas of individual union leaders.

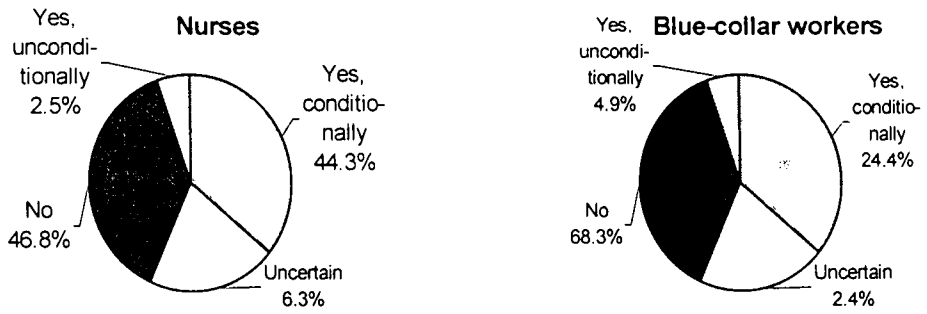
The were divergent views amongst trade union representatives with respect to the role of strikes at public hospitals. In general, opinions tended to be supportive with particular emphasis on the positive effects of strikes. For example, one trade union representative indicated that strikes "make management aware of the needs of workers". Another stated that "strikes is an important tool to indicate to management that it is important to consult with workers in the event of widespread restructuring that the public health sector is currently undergoing". However, it was also interesting to note that union representatives also regarded strikes as being destructive: "strikes assist in restraining the economical growth of our country" and "it plays in the end of socialist mission to bring about poverty to all and then introduce communism in South Africa".

5.2.2 Public hospitals and strikes

Figure 5.1 below, depicts that the majority of blue-collar workers (68.3%) and slightly less than half of the nurses (46.8%) indicated that it was **not good** for nurses to participate in strikes. This figure also reveals that far

more nurses (44.3%) than blue-collar workers (24.4%) stated that nurses could strike on a conditional basis

Figure 5.1 Opinion about whether nurses should strike



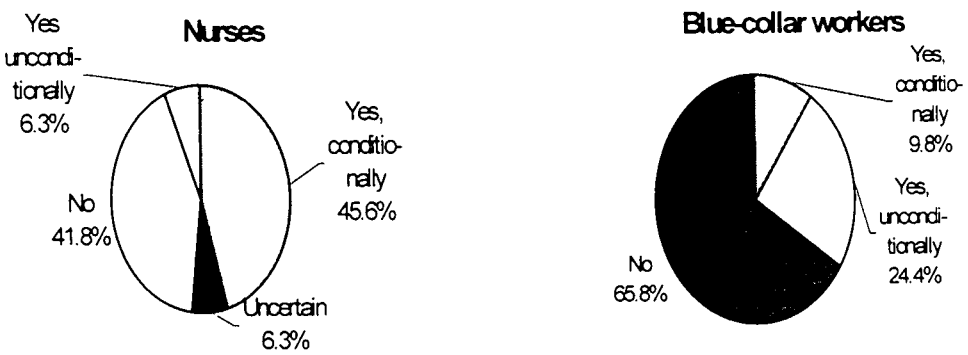
Respondents cited the following reasons for their stance above:

	Nurses	Blue-collar workers
➢ Strikes endanger the lives of patients/ insults the principle of BATHO PELE	(51.3%, n=38)	(70%, n=28)
➢ Strike action by nurses is a basic right Provided patients are not neglected	(29.7%, n=22)	(20%, n= 8)
➢ Strikes are the last resort to force management to listen to the demands of nurses	(16.2%, n12)	(7.5%, n=3)
➢ Nurses fight for their demands irrespective of the consequences	(1.4%, n=1)	(2.5%, n=1)
➢ Strikes put the jobs of nurses at risk	(1.4%, n=1)	

It is evident from **figure 5.2** below, that almost the same pattern of response emerges regarding whether it is good for blue-collar workers at public workers to strike. The majority of the blue-collar workers (65.8%, n=27) compared to 41.8% of nurses stated that it was **not good** for blue-collar workers to strike. From a further analysis of both **figures 5.1** and **5.2**, it can

be concluded that blue-collar workers are less in favour of strikes by Pelonomi Hospital workers than nurses.

Figure 5.2 Opinion about whether blue-collar workers should strike



The reasons cited by respondents for the responses above are the following:

	Nurses	Blue-collar workers
➢ Strikes endanger the lives of patients/ insults the principle of BATHO PELE	(43.4%, n=30)	(69.3%, n=27)
➢ Strike action by nurses is a basic right provided patients are not neglected	(31.9%, n=22)	(7.7%, n= 3)
➢ Strikes are the last resort to force management to listen to the demands of blue-collar workers	(20.3%, n=14)	(12.8%, n=5)
➢ Nurses fight for their demands irrespective of the consequences	(4.3%, n=3)	(10.3%, n=4)

Of the six managers, three indicated that workers in the public health sector can participate in strikes on a conditional basis. One notable condition that workers had to comply with is that patient care should not be affected in any way. Two managers stated that it is not at all acceptable for workers at public

hospitals to participate in strikes. These managers further stated that strikes should only proceed after all avenues of resolving the dispute have been utilised.

5.2.3 Willingness to participate in strike action

Respondents were asked whether they would personally be willing to strike if necessary (**figure 5.3**). Furthermore, they were asked what would encourage them to participate in strike action (**table 5.1**). Five out of ten nurses and four out of ten blue-collar workers indicated that they would be willing to participate in a strike action if necessary.

Results from **table 5.1** suggest that low wages is the most important factor that would encourage workers at Pelonomi Hospital to become involved in strike action. Somewhat more than a quarter of nurses (36.5%) and far more than half of blue-collar workers (66.6%) indicated that they would be willing to participate in strikes over low wages. Thus, blue-collar workers would be more likely to participate in strikes over low wages than nurses would. Regarding the latter, the violation of patients' rights is the second most important aspect that would encourage them to participate in a strike. The second most important aspect after low wages that would encourage blue-collar workers to participate in strikes was threats, intimidation and/or oppression by management against workers.

Figure 5.3: Personal willingness to strike

Table 5.1: Reasons for willingness to participate in strikes

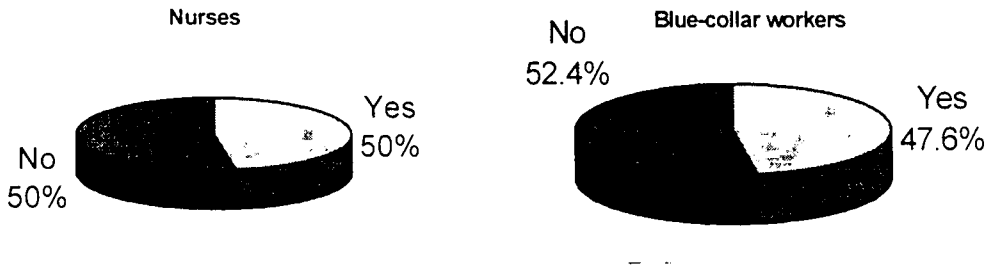
	Nurses		Blue-collar workers	
Reason for willingness to strike	**N**	**%**	**N**	**%**
1. Low wages	15	36.5	12	66.6
2. Lack of promotions, training opportunities and merit awards	8	19.5	1	5.6
3. Threats, intimidation and/or oppression by management	4	9.8	4	22.2
4. Violation of patient's rights	9	22	-	-
5. Racial discrimination	5	12.2	1	5.6
Total	**41**	**100**	**18**	**100**

Supervisors of cleaners also reiterated that low wages was in the forefront of issues over which workers generally strike at Pelonomi Hospital. They further stated "a general lack of discipline among workers, the intransigent attitude of management and misunderstandings between workers and us [supervisors] " also leads to strike action.

5.2.4 Actual participation in strike action at Pelonomi Hospital

Respondents were asked whether they had ever participated in a strike. **Figure 5.4**, depicts that half of the nurses (50%) and slightly less than half of the blue-collar workers (47.6%) have once participated in a strike while employed at Pelonomi Hospital.

Figure 5.4: Participation in strike action at Pelonomi Hospital



5.2.5 Main cause, duration and outcome of strikes in which workers participated personally

Table 5.2: Main cause of strike

	Nurses		Blue-collar workers	
Cause	**N**	**%**	**N**	**%**
1. Low salaries and small annual salary increment	19	47.5	12	60
2. Autocratic nursing managers	8	20	3	15
3. Public statement by the previous president that nurses are useless	6	15	-	-
4. Racial discrimination	3	7.5	2	10
5. Harassment of shop stewards and trade union officials	3	7.5	2	10
6. Bad working conditions	1	2.5	-	-
7. Dismissal of workers	-	-	1	5
Total	**42**	**100**	**20**	**100**

Table 5.2 reveals that financial matters have been one of the main factors that led respondents to participate in strikes. A further motivating factor for participating in a strike was identified to be the autocratic manner in which nursing managers operate. Trade union representatives also confirmed that workers at Pelonomi Hospital participated in strikes due to low salaries. In addition, one shop steward stated that workers also embarked on strikes over the placement of staff, "management, which is mostly white," and the "non-commitment of management to address the grievances of workers".

While it is the responsibility of management at institutional level to address issues such as autocratic management styles and grievances, it is unfair for workers to expect management to address issues (such as salary increases) that are handled at national level.

The majority of the respondents indicated that the most significant strike action in which they participated lasted less than a month (72.5% in the case of nurses and 73.5% in the case of blue-collar workers). Slightly more blue-collar workers (21.1%) than nurses (17.5%) participated in strikes that lasted for three years. It was only in the case of a single nurse (2.5%) and blue-collar worker (5.3%) that the strikes lasted for three months and two years, respectively.

Table 5.3 presents the findings of the outcome of strikes in which respondents participated. Workers who participated in strikes over salaries indicated that the strikes led to a salary increment. It is also clear that in some cases, strikes led to dismissals (see category 4). The results also indicate that a quarter of the nurses (25%) and 20% of blue-collar workers were uncertain about the outcome.

Table 5.3: Outcome of strike

	Nurses		Blue-collar workers	
Outcome	**N**	**%**	**N**	**%**
1. Salary was increased	9	22.5	6	30
2. Uncertain	10	25	4	20
3. Unions were later recognised	2	5	5	25
4. Workers were dismissed and later reinstated	8	20	4	20
5. Nursing Manger: transferred to Head Office	7	17.5	1	5
6. Mandela apologised	4	10	-	-
Total	**40**	**100**	**20**	**100**

5.2.6 Working conditions that contributed to strike action at Pelonomi Hospital

Table 5.4: Working conditions that contributed to strike action

Factor	Contributes		Uncertain		Does not contribute		Column total
	N	%	N	%	N	%	%
1. Ineffective grievance and disciplinary procedures	30 *13	38 *31	1 *2	1.3 *4.8	48 *27	60.7 *64.2	100
2. Low wages	61 *37	77.2 *88.1	2 -	2.5 -	16 *5	20.3 *11.9	100
3. Poor service conditions	43 *15	54.4 *35.7	2 *1	2.5 *2.4	34 *26	43 *61.9	100
4. Racially segregated facilities	62 *37	78.4 *88.1	1 -	1.3 -	16 *5	20.3 *11.9	100
5. Heavy workload	45 *15	57 *35.7	1 -	1.3 -	33 *27	41.8 64.3	100
6. Abnormal working hours	37 *13	46.8 *31	2 2	2.5 *4.8	40 *27	50.6 *64.6	100
7. Discriminatory supervision	52 *32	65.8 *76.2	2 -	2.5 -	25 *10	31.6 *23.8	100
8. Racial discrimination	64 *40	82.1 *95.2	- -	- -	14 *2	17.9 4.8	100
9. Lack of communicating information that affects workers	49 *13	62 *31	2 *1	2.5 2.4	28 *28	35.4 *66.6	100
10. Dismissal of other workers	31 *12	39.2 *28.6	2 *30	2.5 *71.4	46 -	58.2 -	100

* These are responses of blue-collar workers. The other responses are of nurses.

Question 55 of the questionnaire was designed to obtain the views of respondents with regard to working conditions that contribute to strike action at Pelonomi Hospital. According to **table 5.4**, the majority of respondents (both nurses and blue-collar workers) stated that racial discrimination, racially segregated facilities and low wages contributed to strikes. However,

there were also differing opinions between nurses and blue-collar workers about other factors that contributed to strikes. For example, 62% of nurses agreed that lack of communicating information that affects workers (category 9) contributed to strike action compared to 31% of blue-collar workers. There is also a notable discrepancy when the spread of responses of category 10 is compared. It is evident from this category that the vast majority of blue-collar workers (71.4%) compared to only 2.5% of nurses are uncertain whether the dismissal of other workers contributed to strikes.

According to management, the following factors mostly contributed to strike action at Pelonomi Hospital:

- Issues relating to promotions
- Unions wanting observer status in committees
- Salaries
- Transformation (resistance to it)
- Unhappiness over management practices, and
- Performance appraisal.

In response to the question whether Pelonomi Hospital was affected by strike action over the past twelve months, management responded affirmatively. In this regard they mentioned two strikes, the first of which was due to performance appraisals and the second, a national public sector wage strike. With regard to the latter strike, the Department of Health applied for a

Court interdict, which was granted. According to one manager, this action was necessary "because workers were misdirecting their anger"[1].

Trade union representatives were asked to indicate the main course of action their respective unions took when they had a serious dispute with management at Pelonomi Hospital and management at Provincial Government. With regard to problems experienced with management at Pelonomi Hospital, "disputes are referred to Head Office and bilateral meetings are also held with shop stewards of all the other unions". In the case of a serious dispute with management at Provincial Government, unions tend to "declare a dispute with the Conciliation Board in terms of section 18(1) of the repealed PSLRA and paragraph 15(L) of schedule 7 of the LRA". If the dispute is not resolved after conciliation "then it is referred to arbitration if not employed in an essential services, after having conducted a ballot notice given about our intention to strike in terms of the LRA no 66 of 1995, we embark on strike". The aforementioned course of action taken by trade unions when experiencing problems illustrated that, after numerous attempts to resolve the impasse, strikes were regarded as the 'last resort'.

5.3 GRIEVANCE AND DISCIPLINARY PROCEDURES

This section on grievance and disciplinary procedures is an attempt to determine whether respondents were aware of the procedures. It also focuses on the steps workers normally took when experiencing a grievance and how discipline was handled. As stated before, these procedures play an important role ensuring the effective and efficient management of labour relations.

[1] The manager was referring to action by striking workers who invaded offices at Pelonomi Hospital and physically abused two top managers".

5.3.1 GRIEVANCE PROCEDURE

With regard to grievance procedure, respondents were asked what they normally do if they have a work related grievance. All the nurses and slightly less blue-collar workers (97.6%) indicated that they normally approached their supervisor or the ward matron in charge. The remaining proportion of blue-collar workers (2.4%) indicated that they often did nothing about the grievance.

5.3.1.1 Presence of grievance procedure

Figure 5.5 below, shows that a relatively large proportion of the respondents was familiar with the existence of a grievance procedure (79.7% of nurses and 63.4% of blue-collar workers). The main sources of information about the grievance procedures were indicated to be trade union officials and the LRA Officer at Pelonomi Hospital.(33.3% of nurses 57.1% of blue-collar, respectively).

Figure 5.5: Knowledge about the presence of a grievance procedure

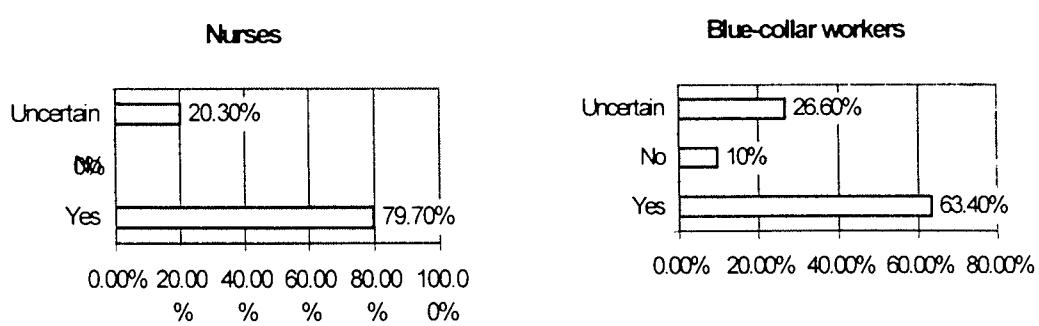
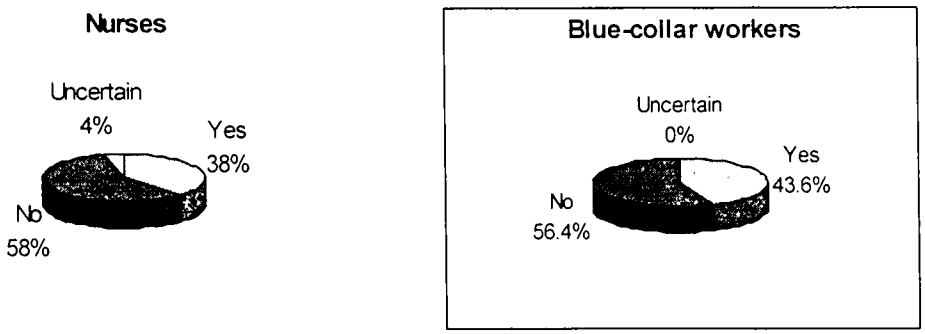


Table 5.5: Source of information about the grievance procedure

	Nurses		Blue-collar workers	
Source of information	**N**	**%**	**N**	**%**
1. Trade union officials	21	33.3	16	57.1
2. Management/Labour Relations Officer	21	33.3	3	10.7
3. Supervisors and ward matrons	11	17.5	8	28.6
4. PAS document/Governmemtn Gazette	9	14.3	-	-
5. MANCOFS[2] Supervisors' course	1	1.6	1	3.5
Total	**63**	**100**	**28**	**100**

5.3.1.2 Nature of grievances

Figure 5.6: Ever had a grievance



According to **figure 5.6**, slightly more than half of the respondents had never had any work-related grievance since working at Pelonomi Hospital (58.2% nurses and 56.4% blue-collar workers). Respondents who indicated that they had once had a grievance were asked to mention the nature of the grievance that they regarded as most important.

Table 5.6 below, depicts that the most common grievance amongst nurses were the lack of incentives, training and promotion opportunities (26.7% of

[2] Mangaung Nursing College of the Free State.

nurses compared to 5% of blue-collar workers). Regarding blue-collar workers, more than a third (45%) regarded discrimination and preferential treatment as the most important grievances.

Table 5.6: Nature of grievances

	Nurses		Blue-collar workers	
Grievance	**N**	**%**	**N**	**%**
1. Discrimination, negative attitude of and preferential treatment by supervisors	6	19.9	9	45
2. Bad working relations with nurses and doctors	5	16.7	4	20
3. Lack of incentives, training and promotion opportunities	8	26.7	1	5
4. Heavy workload	4	13.3	3	15
5. Shortage of treatment and supplies	2	6.7	2	10
6. Late payment of overtime	5	16.7	1	5
Total	**30**	**100**	**20**	**100**

Table 5.7 below, illustrates that a large proportion of respondents (20.1% of nurses and 43.8% of blue-collar workers) often complain about the shortage of supplies, treatment, equipment and linen. Another regular complaint was that workers were overloaded with work and/or performing dangerous work (category 2). Furthermore, the perceived lack of promotions, incentives and training opportunities (category 3) and the lack of discipline due to the presence of trade unions (category 4) were also among the regular complaints of the respondents.

Table 5.7: Grievances that workers usually encounter

	Nurses		Blue-collar workers	
Grievance	**N**	**%**	**N**	**%**
1. Shortage of supplies: treatment, equipment and linen	45	**20.1**	42	**43.8**
2. Heavy workload and/or doing dangerous work	68	**30.4**	27	**28.1**
3. Lack of promotions, incentives and training opportunities	39	17.4	14	14.6
4. Lack of discipline due to the presence of trade unions	33	14.7	9	9.4
5. Low wages, late or non-payment of night duty allows/no compensation for injury on duty	17	7.6	4	4.2
6. Bad working relations among colleagues and doctors	22	9.8	-	-
[3]**Total**	**224**	**100**	**96**	**100**

In response to the question as to how grievances were handled, supervisors of cleaners indicated that management did not respond promptly to grievances. It appears that the tendency of management was to wait until it was too late. The following quotations illustrate this concern:

> "When we encounter serious problems with workers and approach management, they [management] never wants to listen to us. We are often reminded that we had to follow certain channels to raise our concerns...but when shop stewards approach them, they immediately give attention to them".

[3] The total in this case does not indicate the number of respondents that answered the question, but rather the number of times respondents mentioned the specific grievance. Respondents could provide three problems that are usually encountered.

> "If we inform them about anything, they never provide feedback. Even if we inform Head Office [Provincial Government], nothing happens. However, when they [management] encounter problems with workers, we are expected to sort such problems out in no time...we are disappointed the way we are treated. There is a tendency to wait until a problem that could have been addressed easily and in time is too difficult to handle".

Another aspect that also emerged with regard to the grievances of supervisors of cleaners relates to a shortage of cleaning material. As one supervisor stated "sometimes we spent two months without liquid soap. For example, we once spent three months without floor polish...candle wax were used to polish floor as it were very untidy. If such conditions prevail, we are blamed, but what can we do? Another said "what we use at Pelonomi Hospital is not used at Universitas and National Hospitals. In fact, we use the cheapest brand – no name – so we cannot understand why there are stock shortages. While air fresheners are available at Universitas Hospital, we had to battle for little things such as floor polish".

When asked why such a situation prevailed at Pelonomi Hospital and not at other hospitals in the Free State, one supervisor summarised the general feeling of the others: "The problem lies at the head, the head is where the problem is. If the head aches, the whole body becomes corrupt. In short, we blame management for all these".

For trade unions, the general lack of information and the handling of promotions, merit awards and performance appraisals, had been major concerns. Furthermore, nepotism, and the shortage and placement of staff were some of the complaints that trade unions often received from their members.

According to management at Pelonomi Hospital, some of the grievances mostly raised by workers related to the unfair placement of workers, racial conflict between doctors and nurses, heavy workload due to absenteeism and management not abiding to agreed procedures.

5.3.1.3 Way in which grievances are handled

In response to the question whether the grievances of all workers were treated in the same manner at Pelonomi Hospital, almost the same percentage of nurses (67.9%, n=53) and blue-collar workers (64.3%, n=27) indicated that the grievances of all the workers were not treated in the same manner.

The respondents were also granted the opportunity to share the reasons for their dissatisfaction. The following responses emanated:

	Nurses	Blue-collar workers
➢ It depends on who you are (favouritism)	(65.5%, n=19)	(86.6%, n=13)
➢ Supervisors are ill equipped to deal with workers' grievances	(6.9%, n=2)	(6.7%, n=1)
➢ Never receives feedback on their grievances	(29.6%,6)	(6.7%, n=1)
➢ Workers are rotated too much between wards (easy for them not to be charged)	(6.9%, n=2)	

5.3.1.4 Suggestions to improve the grievance procedure

When asked what could be done to improve on the grievance procedure at Pelonomi Hospital, respondents made a few suggestions. The largest

percentage of the respondents could not provide any suggestions (58.4% of nurses and 53.7% of blue-collar workers). Less than a quarter of nurses (23.4%) and somewhat more blue-collar workers (36.6%) suggested that the grievances of all workers should be treated in the same manner. Only a few respondents (18.2% of nurses and 9.4% of blue-collar workers) suggested that grievances should be recorded properly.

According to management, departments do not promptly address grievances. There also seemed to be impartiality in the handling of grievances. Both trade union representatives and management suggested that that all supervisors needed to be trained in order to obtain the necessary skills in handling grievances.

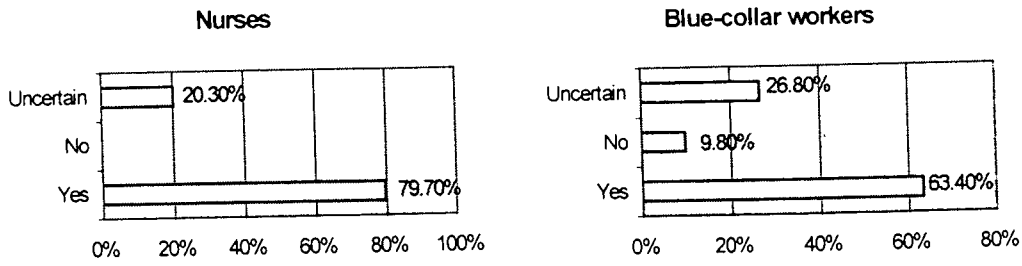
5.3.2 DISCIPLINARY PROCEDURES

As in the case of grievance procedures, respondents were also asked to indicate what steps were taken against workers involved in misconduct. A vast majority of the respondents (78.5% of nurses and 78.6% of blue-collar workers) indicated that incident forms were completed. Nine nurses (11.4%) and four blue-collar workers (9.5%) stated that nothing was done to offenders. A relatively low percentage of workers indicated that alleged offenders were warned verbally and did not know what happens to offenders (6.3% and 3.8% of nurses and 7.1% and 4.8% of blue-collar workers, respectively).

5.3.1.1 Presence of a known/official disciplinary procedure

Figure 5.7 illustrates that the vast majority of nurses (79.7%) and more than half of blue-collar workers (63.4%) knew of an official disciplinary procedure at Pelonomi Hospital.

Figure 5.7: Knowledge about the presence of a disciplinary procedure



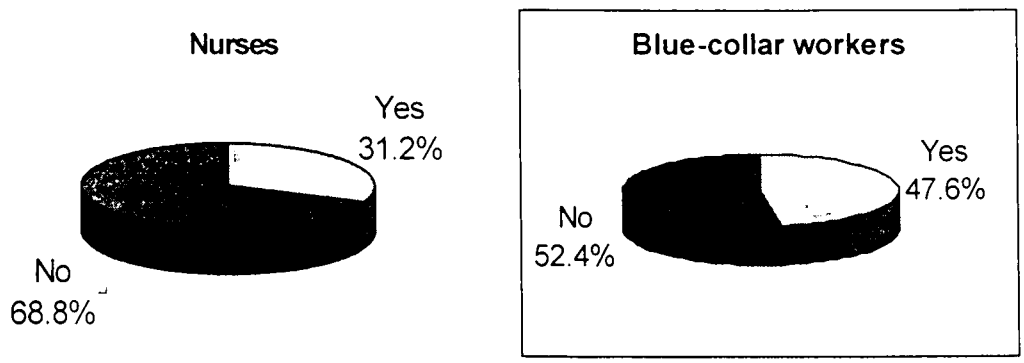
Respondents who indicated that they knew about the existence of a disciplinary procedure cited the following as their source of information:

	Nurses	Blue-collar workers
➢ Trade union officials and shop stewards	(45.7%, n=32)	(76.9%, n=20)
➢ Management/Labour Relations Officer	(38.5%, n=27)	(19.2%, n=5)
➢ Government Gazette and PAS document	(11.4%, n=8)	(3.8%, n=1)
➢ Supervisors and ward matrons	(4.3%, n=3)	

5.3.2.2 Work-related charges

It is interesting to note that the majority of the respondents (68.8% of nurses and 52.4% of blue-collar workers) never had any work-related charge filed against them. The remaining proportion of respondents (31.2% of nurses and 47.6% of blue-collar workers) indicated that they did once have work-related charge filed against them at Pelonomi Hospital.

Figure 5.8: Ever charged for an alleged offence



5.3.2.3 Nature of "most important" alleged offence

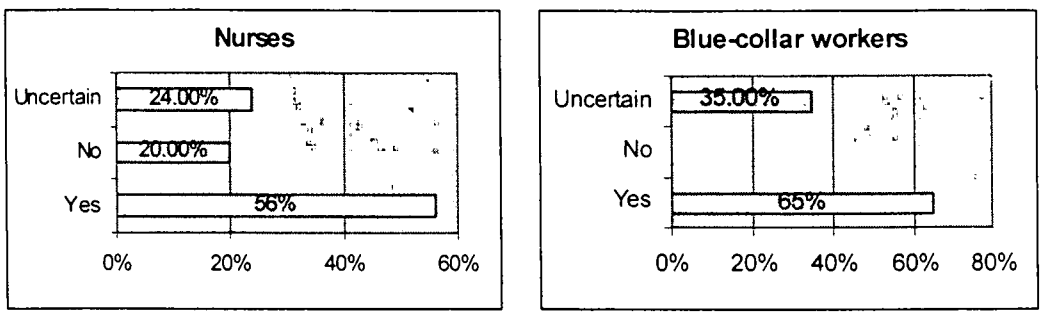
Table 5.8: Alleged offences committed by workers

	Nurses		Blue-collar workers	
Alleged offence	**N**	**%**	**N**	**%**
1. Absence without leave/playing sick	14	56	13	65
2. Alcohol abuse	2	8	4	20
3. Insubordination	7	28	1	5
4. Negligent patient care	2	8	-	-
5. Participation in illegal strike	-	-	2	10
Total	**25**	**100**	**20**	**100**

Question 71 of the questionnaire was designed to obtain information on the nature of the alleged offences committed by individual respondents at Pelonomi Hospital. Respondents were required to mention only one alleged offence that they regarded as "most important". Foremost among the alleged offences against respondents was absence without leave or 'playing sick' (see category 1). While theft and alcohol abuse are the second most common offence committed by blue-collar workers (category 2), and for nurses it was insubordination (category 3).

5.3.2.4 The manner in which the charge was handled

Figure 5.9: Fair treatment of alleged offenders



In response to how they were treated regarding their alleged misconduct, **figure 5.9** illustrates that more than half of the nurses (56%) and a large proportion of blue-collar workers (65%) indicated that they were treated fairly.

The following comments were made to qualify the various responses of whether respondents were treated fairly or not:

	Nurses	Blue-collar workers
➢ Was wrongly accused/my version was not considered	(30%, n=6)	(40%, n=10)
➢ I accepted that I was wrong/problem was resolved	(32%, n=8)	(65,%, n=13)
➢ Never received feedback	(20%, n=5)	(5%, n=1)
➢ Warned verbally	(8%, n=2)	

5.3.2.5 Offences commonly committed by health workers

Table 5.9: Offences commonly committed at Pelonomi Hospital

	Nurses		Blue-collar workers	
Offence	**N**	**%**	**N**	**%**
1. Absconding/leaving work without permission	101	45.1	36	37.5
2. Drunk on duty/alcohol related offences	45	20.1	42	43.7
3. Negligent patient care	39	17.4	-	-
4. Absenteeism	2	2.2	4	4.2
5. Theft/fraud	15	5.4	12	12.5
6. Insubordination	22	9.8	2	2.1
[4]**Total**	**224**	**100**	**96**	**100**

The respondents were asked to mention three offences that were commonly committed by their colleagues at Pelonomi Hospital. Slightly more nurses (at 45.1%) than blue-collar workers (at 37.5%) stated that absconding and/or leaving work without permission as one of the offences commonly committed by workers. Alcohol related offences seem to be the second most commonly offence. Of great concern was the fact that about 17.4% nurses indicated negligent patient care as an offence that was commonly committed. Media reports in late January and February 2001, also highlighted assaults by nurses on patients. According to the South African Nursing Council, such behaviour is unacceptable and brings the nursing profession into disrepute (Sowetan, 2001:1).

According to the supervisors of cleaners, of all the offences that were commonly committed by workers at Pelonomil Hospital, alcohol abuse during working hours, absence without leave, laziness and insubordination ranks

foremost. This situation is reflected in statements such as "they [workers] come and go as they please. Someone would arrive drunk on duty only to go and drink further at 9 O'Clock. In such situations, management insist that we such workers should be given a day off. Nurses also come drunk to work.... They even go to taverns wearing uniform. From sister to cleaner, it is all the same. How does an intoxicated nurse administer drugs, in fact, some of them drug themselves with the drugs".

There is also a perception among these supervisors that alcohol abusers receive preferential treatment. "Previously it was easy to just to dismiss workers who are drunk on duty, but now they have rights...If you find someone being drunk on duty and report it, the question that we as supervisors are asked, is what has the person done that is wrong. This give us the impression that it is OK to be drunk on duty if no mistake is done. Workers with serious alcohol problems are sent to AA [Alcohol Anonymous] and it is only after then that such a worker can be dismissed if found guilty again".

With regard to absence without leave, supervisors also appear to encounter problems of how to deal with such problems. The only thing that they can do is to write incidence forms against such offenders. According to them, this is also a futile exercise as nothing is done to the allege offenders. They also have to endure verbal abuse from their subordinates.

> "We encounter serious problems with regard to absence without leave. There is a tendency among workers not to report sick and present a medical certificate, even for up to 29 days. They only bring these medical certificates on the 30th day. According to our vague understanding of the rules and regulations of the hospital, a medical

[4] The total in this case does not indicate the number of respondents that answered the question, but rather the number of times respondents mentioned the specific offence. Respondents were asked to provide three offences that were

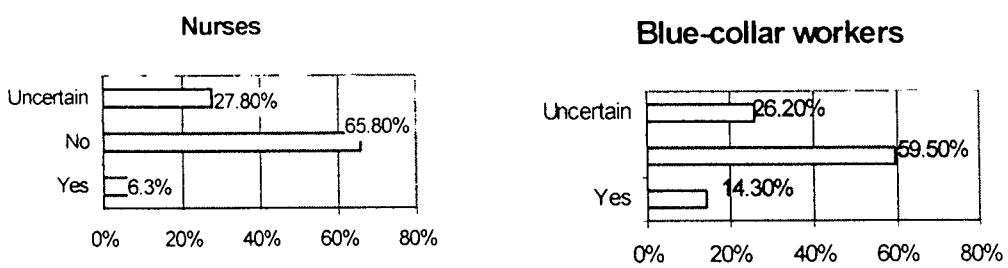
certificate had to be produced after four days of absence in the case of sick employees.... Management says there is nothing that we can do because the certificates are legitimate as competent doctors issue them. The issue is not about legitimate medical certificates, but how the system is been abused by workers and even incompetent managers..."

Another supervisor stated that "management policy for workers who are absent for about 29 days is to issue a letter that the supervisor has to take to the particular worker. This is dangerous because I go there with one security with the hospital's vehicle. The security remains in the vehicle while I take the letter. One is exposed to verbal abuse and at times even physical abuse by these workers".

According to management, absenteeism, alcohol-related offences, theft, fraud, negligence and abuse of sick leave are some of the major offences committed by workers at Pelonomi Hospital.

5.3.2.6 The manner in which disciplinary matters are handled

Figure 5.10: Whether disciplinary matters are handled consistently



commonly committed.

According to **figure 5.10** a relatively large proportion of respondents indicated that disciplinary matters were not handled consistently (65.8% of nurses and 59.5% of blue-collar workers). Only slightly more than a quarter of the respondents (both nurses and blue-collar workers) stated that matters relating to discipline were handled consistently.

The following comments were made to qualify the various responses of whether disciplinary matters were handled consistently or not:

	Nurses	Blue-collar workers
➢ It depends on who you are (favouritism)	(70.1%, n=47)	(72.7%, n=24)
➢ Workers are disciplined according to the offence that they have committed	(7.5%, n=5)	(18.2%, n=6)
➢ Never receive feedback about disciplinary procedures taken against allege offence	(19.4%, n=13)	(9.1%, n=3)
➢ Doubt the capacity of superiors to handle disciplinary matters	(3%, n=2)	

5.3.2.7 Suggestions to improve on the disciplinary procedure

The respondents suggested several ways in the disciplinary procedure could be improved (question 78). In answering this question it is evident that respondents made a distinction between the hospital management before 1994 and thereafter. These suggestions are presented in **table 5.10**.

It is evident from **table 5.10** that the suggested changes to the disciplinary procedure were closely linked to the problems respondents experience with the structures that were been pointed out earlier. Foremost among the

suggestions made was that discipline must be applied more consistently and without any favouritism (43.4% of nurses and 55.3% of blue-collar workers).

Table 5.10: Suggestions to improve on the disciplinary procedure

	Nurses		Blue-collar workers	
Suggestion	**N**	**%**	**N**	**%**
1. Discipline must be applied more consistently without any favouritism	33	43.4	21	55.3
2. Management should become more strict	11	14.5	4	10.5
3. Campaigns should be launched to inform and teach all workers about the disciplinary procedure	11	14.5	3	7.9
4. The whole disciplinary procedure should be overhauled	9	11.8	5	13.1
5. Offenders should have representation during disciplinary hearings	12	15.8	5	13.2
Total	**76**	**100**	**38**	**100**

For management at provincial level, the decentralisation of discipline to institutions would make great strides in improving the handling of disciplinary matters. This implies that management at institutional level need to be trained in the handling of discipline. In this regard, Van Rensburg & Van Rensburg (1999:221-224) indicated that various capacity-building initiatives had already been undertaken to capacitate institutional managers.

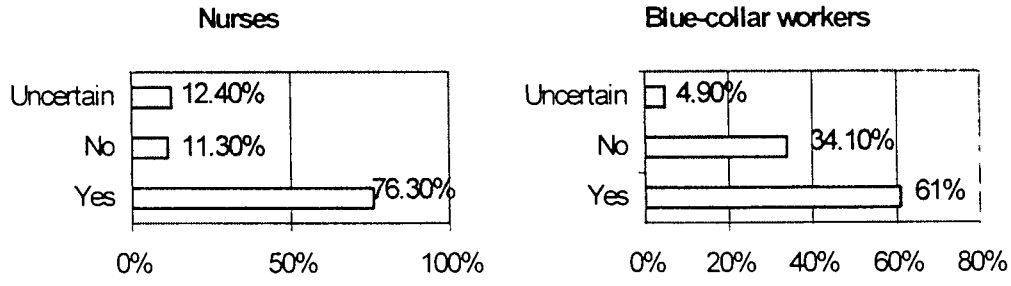
5.4 LABOUR RELATIONS PRACTICES

The general focus of this section is an evaluation of the performance of Pelonomi Hospital. This section also reports on findings relating to duties, employment contracts, and meetings between hospital management and workers and communication procedures.

5.4.1 An evaluation of the performance of Pelonomi Hospital

Hospitals are unique, complex, social institutions that have certain functions to perform. One of these functions is the delivery of critical health care to the community. Respondents were asked to state whether Pelonomi Hospital was succeeding in performing its functions. Regarding this question the majority of the respondents (76.3% of nurses and 61% of blue-collar workers) were of the opinion that the institution was succeeding. It is also evident from **figure 5.11** that more than double the percentage of blue-collar workers (34.1%) than nurses (11.3%) believed that the institution was succeeding. The focus group discussion with supervisors of cleaners also revealed that this group believed that Pelonomi Hospital was succeeding in performing its functions.

Figure 5.11: Whether Pelonomi Hospital is succeeding in performing its functions



Reasons for the respondents' **dissatisfaction** with the performance of Pelonomi Hospital (see **table 5.11**) mainly related to perceived bad treatment of patients and overcrowding (category 1). Respondents also mentioned the low moral workers experienced as a result of poor wages (11.1% of nurses and 33.3% of blue-collar workers). **Table 5.11** provides an account of other perceived hampering factors.

Table 5.11: Factors hampering the performance of Pelonomi Hospital

	Nurses		Blue-collar workers	
Hampering factor	**N**	**%**	**N**	**%**
1. Bad treatment of patients and overcrowding	3	33.3	3	20
2. Low morale among workers caused by low salaries	1	11.1	5	33.3
3. Restructuring without informing workers	2	22.2	3	20
4. Ineffective management (shortage of supplies)	2	22.2	2	13.3
5. General lack of discipline among workers	1	11.1	1	6.7
6. Apartheid legacy which provided less funds to previously disadvantaged hospitals	-	-	1	6.7
Total	**9**	**100**	**15**	**100**

Trade union representatives acknowledged that many improvements were made regarding the manner in which Pelonomi Hospital was managed. Nevertheless they highlighted that the safety and security of personnel, and low morale among workers as impediments to the institution's success. One representative regarded "the ratio imbalance in the staff intake which is 99% black despite being a regional hospital" as a hampering factor.

With regard to all the hampering factors identified by the respondents, the following suggestions were made:

	Nurses	**Blue-collar workers**
➢ Effective management and communication structures should be established	(65.2%, n=15)	(42.1%, n=16)
➢ Management should become more assertive, committed and reliable	(13%, n=3)	(21%, n=8)
➢ Train and increase the salaries of personnel	(8.7%, n=2)	(23.7% n=9)

➢ Patients should pay for services	(8.7%, n=2)	(2.6%, n=1)
➢ Involve workers in restructuring	(4.3%, n=1)	(10.5%, n=4)

5.4.2 Duties

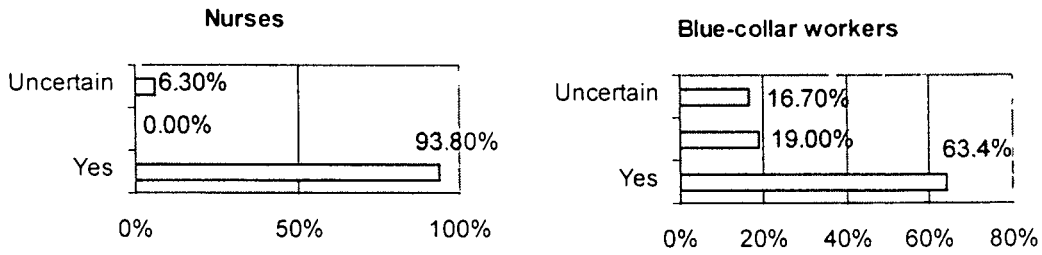
Of the 80 sampled nurses and 42 blue-collar workers, the vast majority (93.8% and 97.6% respectively) indicated that their duties were clear to them.

5.4.3 Employment contracts

The basis of any employment relationship is the contract of employment. A contract of employment comes into existence when both parties to the relationship agree that the employee will provide certain services to the employer, with the employer in turn remunerates the employee for these services (Grossett & Venter, 1998:185).

As depicted in **figure 5.12**, the majority of the respondents (93.8% of nurses and 63,4% of blue-collar workers) entered into an employment contract with management. Eight blue-collar workers (19%) indicated that they never entered into an employment contract with management. The remaining proportion of respondents was uncertain whether they had concluded any contract of employment (6.3% of nurses and 16.7% of blue-collar workers).

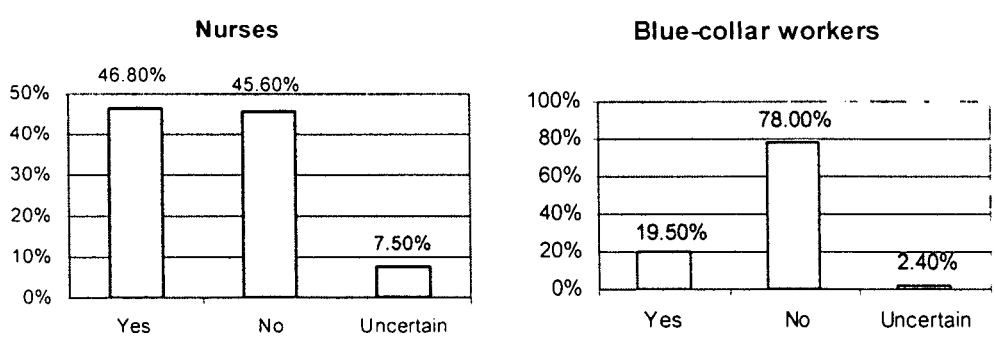
Figure 5.12: Application of employment contracts



When asked how the employment contract was applied, the vast majority of respondents (76% of nurses and 77.8% of blue-collar workers) indicated that their employment contracts were applied both verbally and in writing. There was only a slight difference between the responses of nurses and blue-collar workers regarding the application of employment contracts.

5.4.4 Meetings between management and workers

Figure 5.13: Knowledge of structures/arrangements where employees meet with management



From **figure 5.13** it can be concluded that slightly less than fifty percent (46.8%) of nurses and a relatively small proportion of blue-collar workers (19.5%) were familiar with the existence of structures/arrangements where employees met with management at Pelonomi Hospital. A closer analysis

shows that 45.6% of nurses and the majority of blue-vollar workers (78%) did not know about the existence of the mentioned structures/arrangements.

Figure 5.14: Regularity of general (worker) meetings with management

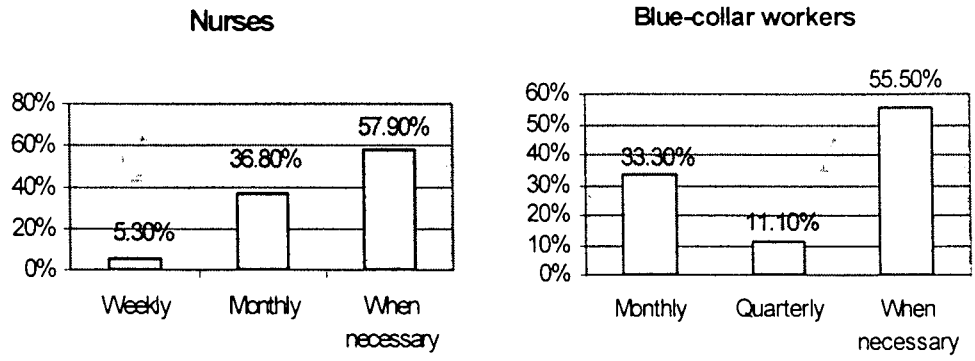


Figure 5.14 depicts the periods at which management at Pelonomi Hospital met with workers to discuss work-related issues. Almost the same proportion of nurses (57.9%) and blue-collar workers (55.5%) stated that management met with workers only when it was necessary.

Respondents were also asked to indicate whether the arrangement of meeting with management was worthwhile and to provide reasons to qualify their response. Almost 90% of nurses and 55% of blue-collar workers indicated that such meetings were worthwhile. The most common reason presented was that such meetings facilitated communication and joint decision-making. Furthermore, they also provided workers with a platform to raise their grievances. The remaining proportion of the respondents felt that the present arrangement of meeting with management was not worthwhile. One nurse (2.6%) indicated that only their supervisors were allowed to attend, and when allowed to attend their inputs were not taken seriously. Two blue-collar workers (22.2%) were against the current arrangement because not enough meetings were held.

5.4.5 Communication

As stated in Chapter One, proper communication channels ensure the effective and efficient management of an organisation. In fact, ineffective communication channels are regarded as the single "greatest" factor that contributed to worker dissatisfaction. According to **table 5.14** below, important notices, messages and work related issues were communicated through supervisors and ward matrons (53.8% in the case of nurses and 61.9% in the case of blue-collar workers). Circulars appeared to be the second most common way of communication for both nurses (41.3%) and blue-collar workers (14.2%).

Table 5.12: The way information is communicated

	Nurses		Blue-collar workers	
Means of communication	**N**	**%**	**N**	**%**
1. Supervisors and ward matron	43	53.7	26	61.9
2. Letters, circulars and notice-board	33	41.2	6	14.2
3. Meetings	1	1.3	4	9.5
4. Union officials	-	-	4	9.5
5. Do not know	3	3.8	2	4.8
Total	**80**	**100**	**42**	**100**

When asked whether they experience any problems with regard to the way in which management communicate notices and messages, slightly more than half of the respondents said no (54.4% of nurses and 61% of blue-collar workers). This suggests that respondents receive messages and notices in time. The remaining proportion of the respondents (45.6% of nurses and 39% of blue-collar workers) indicated that they did experience problems with the way in which messages and notices were communicated. Some of the reasons highlighted included that messages and notices usually reach

workers in the form of instructions, without considering the views of workers. In addition, messages and notices reached workers too late and there were doubts about the credibility of the messages that are transferred by supervisors.

Trade union representatives also confirmed that important messages were communicated through circulars and meetings with management. Problems that they encountered with the way in which information was communicated was that "circulars were not comprehensive enough at times" and "no feedback from HOD's after meetings with top management".

5.4.6 Workplace forums/joint decision-making committees

In any workplace there is conflict of interest in relationships (Bendix, 1996:6; Davey, Bognanno & Estenson, 1982:11; Sutton, 1986:14). For instance, in an institution such as a public hospital there are specialised organisational functions. These functions are performed in an environment in which certain practices such as labour relations have to be observed. As a result, there is a constant pressure to achieve effective organisational outcomes whilst adhering to inherent practices and procedures in the workplace. Thus, orderly arrangements have to be developed for conducting employer and employee relations.

According to managers interviewed, a shop steward committee and a joint worker-management decision-making committee exist at Pelonomi Hospital. At provincial level, the DoH Labour Relations Forum provides the means through which management and trade unions meet. Meetings of these structures are conducted on a monthly basis. These structures serve as mechanisms through which management consults and discusses issues affecting workers. They also provide labour organisations with the

opportunity to raise their concerns. The DoH Labour Relations Forum also serve as a bargaining forum.

5.4.7 Job satisfaction

Respondents were asked to react – either by agreeing or disagreeing – to a number of statements pertaining to job satisfaction. **Table 5.13** illustrated the responses. The extremes of the Lickert scale were incorporated in a three-point scale. "Strongly agree" was added with "agree" (also expressed as satisfied) and "strongly disagree" with "disagree" (also expressed as dissatisfied).

Table 5.13: Experience of work at Pelonomi Hospital

Statement	Agree		Uncertain		Disagree		Column total
	N	%	N	%	N	%	%
1. I can cope with my workload	95 *23	72.4 *57.5	- -	- -	21 *17	27.6 *42.5	**100**
2. I enjoy a good relationship with my supervisors	65 *32	85.5 *80	3 *1	3.9 *2.4	8 *7	10.5 *17.5	**100**
3. I am satisfied with the management of shifts	56 *26	73.7 *65	4 *7	5.2 *17.5	16 *7	21.1 *17.5	**100**
4. There is enough promotion opportunities	23 *8	30.3 *20	3 *6	3.9 *15	50 *26	65.8 *65	**100**
5. Employees at Pelonomi Hospital are fairly dismissed	42 *14	55.3 *35	22 *14	28.9 *35	12 *12	15.8 *30	**100**
6. The allocation of leave is satisfactory	72 *40	94.7 *100	1 -	1.3 -	3 -	3.9 -	**100**
7. I am satisfied with the physical conditions where I work	62 *25	81.6 *62.5	3 -	3.9 -	11 *15	14.5 *37.5	**100**

Table 5.13 continued

Statement	Agree		Uncertain		Disagree		Column total
	N	%	N	%	N	%	%
8. The recruitment and selection procedures at Pelonomi Hospital are fair	31 *7	40.8 *17.5	30 *12	39.5 *30	15 *21	19.7 *	100
9. Workers are rewarded for exceptional performance	28 *8	36.8 *20	5 *2	6.6 *5	43 *30	56.6 *75	100
10. There are effective and efficient structures to deal with the daily problems of workers	46 *14	60.5 *35.3	3 *4	3.9 *10	27 *22	35.5 *55	100

* These are responses of blue-collar workers. The other responses are of nurses.

The vast majority of respondents (94.7% of nurses and 100% of blue-collar workers) claimed that the allocation of annual leave days was satisfactory[5] (see category 6). Almost the same large percentage of nurses (85.5%) and blue-collar workers (80%) were inclined to agree that they enjoyed a good relationship with their supervisors (category 2). The majority of nurses (73.7%) and blue-collar workers (65.2%) indicated their satisfaction with the management of shifts (category 3). Respondents also indicated their satisfaction with the physical conditions where they worked (81.6% nurses and 62.5% blue-collar workers).

Respondents clearly expressed their dissatisfaction with the availability of promotion opportunities at Pelonomi Hospital (65.8% of nurses and 65% of blue-collar workers). Somewhat more blue-collar workers (75%) than nurses (56.6%) disagreed that workers were rewarded for exceptional performance (category 9). Nurses and blue-collar workers seem to differ largely over the

recruitment and selection procedures at Pelonomi Hospital (category 8). For example, while 52.5% blue-collar workers are dissatisfied with the recruitment and selection procedures only 19.7% nurses are. A closer analysis revealed that a significant proportion of respondents (28.9% of nurses and 35% of blue-collar workers) displayed a mixture of feelings of whether workers were fairly dismissed or not at Pelonomi Hospital.

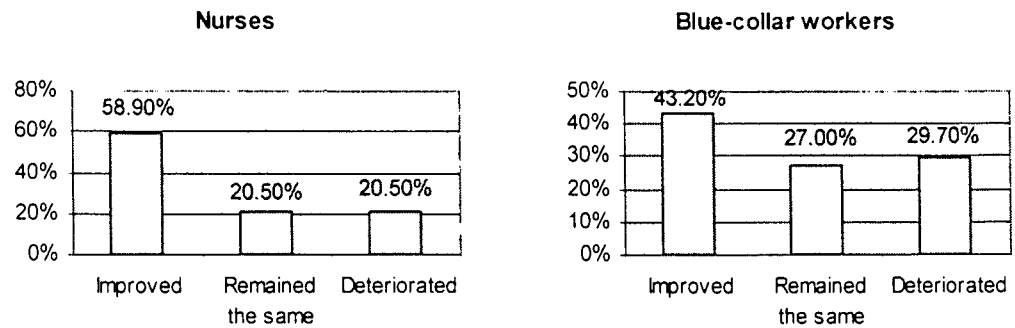
5.4.8 Management of Pelonomi Hospital

Since 1994, many changes have taken place in South Africa in almost every sphere of life. Consequently, the public sector and health services in particular were overhauled. New management structures came to replace old ones. Against this background, respondents were asked to compare the manner in which Pelonomi Hospital is presently managed to the previous dispensation.

According to **figure 5.15**, almost sixty percent of nurses and less than 45% of blue-collar workers indicated that the way Pelonomi Hospital is presently managed has **improved**. Slightly more than a quarter of blue-collar workers (27%) and twenty percent of the nurses felt that the present management of the hospital had **deteriorated**. A similar pattern of responses is evident regarding respondents who believe that the way in which Pelonomi Hospital is managed has **remained the same** (29.7% in the case of blue-collar workers and 20.5% in the case of nurses).

[5] See Table 7.1 in paragraph 8.3.4

Figure 5.15: Evaluation of the general management of Pelonomi Hospital



The illustration below provides the reasons for the respondents answers presented in figure 5.15:

	Nurses	Blue-collar workers
➢ Management is more transparent, accessible and sensitive to the needs of workers	(50.6%, n=37)	(45.9%,m n=17)
➢ There is still much racial discrimination	(12.3%, n=9)	(21.6%, n=8)
➢ There is a general lack of discipline	(16.4%, n=12)	(10.8%, n=4)
➢ Shortage of supplies is a common feature		(2.7%, n=1)
➢ Workers are not informed about changes/ restructuring	(9.6%, n=7)	(8.1%, n=3)
➢ There are rewards for exceptional performance	(1.4%, n=1)	
➢ Problems are now resolved faster	(6.9%, n=5)	(8.1%, n=3)
➢ Too early to detect changes	(2.7%, n=2)	(2.7%, n=1)

For supervisors of cleaners, the previous management of Pelonomi Hospital was better because the workforce was disciplined and motivated. According to these supervisors, the democratisation of the workplace has affected

public hospitals because workers are abusing their rights. The following quotations express the feelings of supervisors about the current management of Pelonomi Hospital:

> "We were disciplined previously but now everybody does as he/she pleases because our management are afraid to take firm action against workers who does not care about their work. The irony is that the very same workers will never act in the same way at Universitas and National...are there separate rules for these hospitals"?

> "Workers no longer wear uniform, because if they want to leave work at 9 O' Clock in the morning, no one would notice.... One supervisor was intimidated and verbally abused by one cleaner who came with her husband. She was scolded with that common vulgar word of Bloemfontein...in full view of the public...in the hospital. What if she was stabbed...and mind you, nothing was done".

According to one supervisor, the pathetic approach of management to problems is the main reason for all the underlying problems at Pelonomi Hospital. Supervisors stated that they do not call for the harassment of workers, but management should make it its prerogative to run the hospital as effectively as possible.

In reply to the question what do they (supervisors) intend to do with the problems that they encountered, the following responses emerged:

> "You can put us on video...we talk the truth. We are not given warnings when we have done mistakes, but rather final warnings...we are brave enough to tell them [management] that we are 'fed up'. We are tired of being scolded about our mothers..".

"We intend to speak to management again but if they still continue with the attitude they have, we would have no choice but to approach Head Office. We want them to take note of our problems. We know they will be quick to charge us, but we know we do it for the well being of our hospital...".

"In fact, we are sitting on a time bomb which would explode anytime... from outside everything looks OK...but this place is rotten, it is rotten...there is no discipline here".

From the above statements, it is clear that supervisors of cleaners are mainly concerned about the "lack" of discipline at Pelonomi Hospital. If this assertion by supervisors is true, the onus is on management to enforce disciplined behaviour among workers. This will ensure the continued existence and effective and efficient functioning of the institution.

5.5 IN CONCLUSION

This chapter dealt with the procedures of converting inputs into outputs. The findings presented can be summarised as follows:

Findings on **strikes** revealed that both nurses (32.9%) and blue-collar workers (45%) believed that strikes negatively affected the image of health care services. Despite this belief, slightly more than half of the nurses (53%) and 44% of blue-collar workers indicated that they would be willing to strike if necessary. In general, the results suggest that racial discrimination and low wages mainly cause strikes at Pelonomi Hospital.

There was almost a universal knowledge about the presence of a **grievance procedure** (79.7% of nurses and 63.4% of blue-collar workers) and a **disciplinary procedure** (90.9% of nurses and 63.4% and blue-collar workers). For 30% of nurses, the usual grievance was heavy workload while about 44% of blue-collar workers generally encountered problems with a shortage of supplies, treatment, equipment, linen and protective clothing. Absconding/leaving work without permission appears to be the usual offence committed by nurses, while and alcohol related offences are more common amongst blue-collar workers at Pelonomi Hospital. More disturbing is the fact that about 17.4% of nurses are allegedly involved in negligent patient care.

Survey results also indicate that the majority of the respondents (76.3% of nurses and 61% of blue-collar workers) regarded Pelonomi Hospital as succeeding in performing its functions. A third of nurses regarded the bad treatment of patients as hampering the progress of Pelonomi Hospital. The same percentage of blue-collar workers indicated that overcrowding of patients and low morale caused by low salaries that hampered the progress of the institution.

It is the responsibility of management to provide information to its workforce in the simplest and easiest to understand format. Of concern is that the study revealed that 45.6% of nurses and 39% of blue-collar workers experienced problems with the way important messages are communicated to them.

With regard to the work experience at Pelonomi Hospital, the vast majority of respondents (94.7% of nurses and 100% of blue-collar workers) were happy with their annual leave. A high percentage of respondents also felt that workers were not rewarded for exceptional performance (56.6% of nurses and blue-collar workers 75%). In the subsequent chapter, the focus is on the main conclusions and recommendations of the study.

CHAPTER 6

MAIN CONCLUSIONS AND RECOMMENDATIONS

CHAPTER 6: MAIN CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

Since 1994, there has been a commitment to fundamental reform of the public health system, including labour relations in the country. As stated earlier, transformation and restructuring have been accompanied by a profound and diversified impact on all stakeholders in the public hospital system. It is hoped that the precious gains that have been made in terms of progressive labour relations legislation and innovative structures and mechanisms, are not easily whittled away.

The previous three chapters presented the findings of the research. Collectively, these chapters provide some insights into the state, trends and constraints affecting the effectiveness and efficiency of labour relations management in the public hospital system. This chapter aims to draw conclusions from the findings. A number of common themes have emerged from this analysis, and have informed the recommendations. The aim of these recommendations is not to criticise. Instead, they intend to draw the attention of policy-makers in the public health sector (and the Sub-Directorate of Labour Relations of the Free State Department of Health in particular) to the complexities facing labour relations at institutional level. Wherever possible, the recommendations also highlight possible solutions to the observed constraints.

6.2 MAIN CONCLUSIONS

6.2.1 Working conditions and remuneration

Wages, working hours, fringe benefits and working conditions are some of the most important outputs of Graig's Open Systems (**see figure 2.2**). These rewards play an important role in raising the motivation and enhancing the commitment and loyalty of employees to the organisation. Results of the study indicate that all blue-collar workers earn less than R 3000. The researcher is not a position to declare whether this is acceptable or not. What is clear, however, is despite the important role that has been assigned to wages (as an output) in the open systems theory, results of the study suggest otherwise. Results in **paragraph 3.3.2** indicate that approximately 80% of nurses do not receive the night duty allowance that they are entitled to

With regard to working conditions and/or factors, it is clear that workers at Pelonomi Hospital are satisfied with their annual leave, the attitude of their immediate supervisors and their relationships with colleagues

6.2.2 Trade unionism

Throughout the decades unions have become important aspects of economic life. Millward & Stevens (1986:23) regard trade unions as constructive forces, embodying the conflict of interest between employer and worker, but also providing a means of resolution of this conflict.

As Dunlop and Craig's theories postulate, trade unions are regarded as important actors representing employees in the labour relationship. As discussed in Chapter One, trade unions in the public health sector had to fight a difficult battle

before they received recognition. From the data gathered in this study it appears that trade unions play an important role in harmonising relations between management and employees. They have also been hailed by almost half of the respondents (both nurses and blue-collar workers) as playing a significant role in maintaining workplace democracy and worker benefits. Indeed, the researcher could observe during his interaction with trade union representatives that they are not only involved in matters directly relating to workers, but also in a wide range of activities that would benefit their members.

Nonetheless, management at both institutional and provincial level highlighted that trade unions are often impatient. Supervisors of cleaners also revealed that shop stewards are fuelling discontent among workers (see **paragraph 3.4.10**). Above all, statements such "they [trade unions] abuse their powers and are often arrogant" connote negative interpretations about how trade unions act.

6.2.3 Strikes

According to Dunlop and Craig, inputs from the labour relations system itself and from the environment are transformed through various processes to form outputs of the system. These processes, amongst other, include collective bargaining, conciliation, arbitration of interest disputes and strikes (Bendix, 1991:13, Finnemore & Van der Merwe, 1996:16-17, Grossett & Venter, 1998). In this regard, strikes are often utilised by employees after of negotiations have3 failed.

The picture that develops from the results concerning strikes is an interesting one. Respondents were asked what would encourage them to participate in a strike (**question 49**) and what the main cause of the strike was, that they participated in (**question 53**). In both instances low wages/salaries was in the forefront. While wages in the public health sector are determined at national

before they received recognition. From the data gathered in this study it appears that trade unions play an important role in harmonising relations between management and employees. They have also been hailed by almost half of the respondents (both nurses and blue-collar workers) as playing a significant role in maintaining workplace democracy and worker benefits. Indeed, the researcher could observe during his interaction with trade union representatives that they are not only involved in matters directly relating to workers, but also in a wide range of activities that would benefit their members.

Nonetheless, management at both institutional and provincial level highlighted that trade unions are often impatient. Supervisors of cleaners also revealed that shop stewards are fuelling discontent among workers (see **paragraph 3.4.10**). Above all, statements such "they [trade unions] abuse their powers and are often arrogant" connote negative interpretations about how trade unions act.

6.2.3 Strikes

According to Dunlop and Craig, inputs from the labour relations system itself and from the environment are transformed through various processes to form outputs of the system. These processes, amongst other, include collective bargaining, conciliation, arbitration of interest disputes and strikes (Bendix, 1991:13, Finnemore & Van der Merwe, 1996:16-17, Grossett & Venter, 1998). In this regard, strikes are often utilised by employees after of negotiations have3 failed.

The picture that develops from the results concerning strikes is an interesting one. Respondents were asked what would encourage them to participate in a strike (**question 49**) and what the main cause of the strike was, that they participated in (**question 53**). In both instances low wages/salaries was in the forefront. While wages in the public health sector are determined at national

level, all role players at institutional level had a role to play in sharing information on this aspect since they are the ones affected.

On the basis of Dunlop and Craig's theoretical framework and discussions in Chapter Five, one can contend that salaries will continue to be a major trigger of strikes in the public health sector. The manner in which wage negotiations have been dealt with over the past three years has also contributed to the hard feelings among public servants. The negativity that surrounded these wage negotiations will continue to flow back each time new negotiations begin. It is only when this issue is addressed adequately, and all parties work in tandem, that a less confrontations may be observed in the public health service.

It cannot be over-emphasised that labour peace is needed for the effective delivery of services at public hospitals. Labour unrest is counterproductive and should be avoided where possible. All the input factors and throughput factors mentioned before should therefore be analysed and managed to obtain maximum labour peace at hospitals.

6.2.4 Grievance and disciplinary procedures

As stated in Chapter Two, labour relations cannot be seen to exist in isolation. Instead it should be seen as a substructure of the socio-economic environment, being impacted by environmental influences such as the economy, politics and various legislative factors. The grievance and disciplinary procedure of an organisation form part of the throughput factors according to Craig. The manner in which grievance and disciplinary procedures should be managed is guided by labour legislation, but it still remains the responsibility of parties at shopfloor level to implement them in a meaningful way.

The conclusion that can be drawn from the study is that a significant majority of the respondents know about the existence of grievance and disciplinary procedures at Pelonomi Hospital. Further analysis of the survey results suggests that some improvement is needed in how these procedures are managed.

6.2.5 Labour relations practices

The systems theory suggests that all factors in the industrial system are linked. This implies that any malfunction in one part may lead to a disorder in another. In this regard, Labour Relations Officers in public hospitals need to take into account the causal linkages between specialised organisational functions (i.e. nursing) and practice (such as industrial relations) and overall organisational effectiveness. Nurses, for example, have very delicate tasks to perform. In the performance of these tasks they continuously have to take into account whether they act within the legal parameters of their duties. Above all, they have to be sure whether they are promoting organisational effectiveness or working towards destroying the goals of the organisation.

The primary goal of any hospital is to render effective and efficient health care to the community it serves. It is encouraging to note that the majority of the respondents (76% of nurses and 61% of blue-collar workers) stated that Pelonomi Hospital is succeeding in performing its functions (see **paragraph 5.47.1**). This is an important starting point because the moment employees have the perception that they are working for an organisation bound for failure, they will be less motivated.

Paragraph 5.4.5 revealed the importance of communication in creating a workplace environment that ensures the sustainability of an organisation. Results from the study indicate that a significant proportion of the respondents (45.6% of

nurses and 39% of blue-collar workers) are experiencing problems with the way in which messages and notices are communicated.

Furthermore, it is clear that proper procedures are not always followed in drawing up employment contracts with new employees. **Figure 5.12** reveals that no employment contracts were concluded in the case of 19% of blue-collar workers. In addition, in the case of approximately 10% of nurses and blue-collar workers were employment contracts only concluded in writing, without any verbal explanations. This practice is in conflict with the stipulations of the LRA on the drawing up of employment contracts.

6.3 RECOMMENDATIONS

The survey was primarily undertaken to analyse and assess the effectiveness and efficiency of labour relations processes and practices in the public hospital system. The researcher wishes to stress that the following recommendations are not intended as criticism on those charged with labour relations at Pelonomi Hospital and at provincial level. It is hoped that the findings will make some contribution to the very difficult task of addressing the legitimate grievances of nurses and blue-collar workers at Pelonomi Hospital and improving labour relations in general.

In general terms, notable foundations have been laid for transformation of the labour relations environment by the creation of innovative structures for managing reform. However, changes in the labour relations scene over the past few years require significant changes in attitudes and approaches of all parties. These changes are difficult, and therefore require active processes involving all key stakeholders. There seems to be a need for management, unions and workers at institutional level to interact more often, and in a more constructive

and effective way. In this regard, the roles of joint-decision making structures and management-worker committees should be clearly defined. Such structures should not only be utilised when there are problems; they should serve the purpose of enhancing communication and information sharing at institutional level.

It is evident from the main conclusions that financial constraints (low salaries, lack of increment and the late and/or non-payment of allowances) are foremost in creating discontent among workers, and thereby leading to strikes. There is an urgent need for the national Government to address the immediate material and non-material needs of public health sector workers. While there might be reasons not to address all the needs satisfactorily, it is important that such reasons are conveyed to workers. This will go a long way in curbing strike incidents that became a common feature at public hospitals during the late 1980's and early 1990's.

No institution can function effectively and efficiently without the orderly execution of the tasks. The perception that unions are fuelling discontent and create ill-disciplined workers is disturbing. Clear guidelines are required with regard to the role and powers of trade unions at institutional level.

There seems to be a need to establish and communicate clear objectives for labour relations and work performance in an effort to eradicate uncertainty as far as possible. Complaints by workers over lack of training and promotions could be addressed in this way. In fact, the structuring of exemplary orientation and induction programmes to ensure the critical needs of new employees are met, need to be developed. The results suggest that management is not paying enough attention to this critical step.

Lack of effective communication channels, and the apparent slow-pace of handling grievances and misconduct, have been major sources of frustration and upset among workers at Pelonomi Hospital. A practical solution to this problem could be the compilation of an operating structure of the institution. Such an operating structure should include what, where, how, and who is responsible for whatever tasks. It is also suggested that workers' performance need to be evaluated over a reasonable period. To ensure fairness and enhancing performance in general, feedback should be provided to workers.

The researcher acknowledges (as the LRA stipulates) the importance of giving workers involved in misconduct a fair chance of rehabilitating. However, in the light of budgetary constraints that public hospitals face and the need to provide critical care, can it really be expected from such institutions to run rehabilitation programmes for workers who abuse alcohol? It should, as a matter of urgency, be determined whether the programme of rehabilitating workers at Pelonomi Hospital is worthwhile to undertake. Attempts should rather be made to improve the basic needs of workers and ensure the effective functioning of labour relations structures and procedures.

In conclusion, all organisations, such as hospitals, exist for a specific reason. In this regard the function of hospitals is the provision of effective and affordable care to the community. It remains a management prerogative, in consultation with all stakeholders, to maintain the coherence of structures and mechanism, and rules and regulations aimed at achieving organisational objectives.

BIBLIOGRAPHY

Adler, G. 1998. The public sector. Labour relations and transformation. *SA Labour Bulletin*, 20(6):40-45.

Albertyn, C. 1990. Freedom of association. In Robertson, M. (Ed.). 1990. *South African Human Rights and Labour Law Yearbook 1990.* Vol 1. (pp.-297-316).

Aldair, B. & Albertyn, S. 1998. New Management. *SA Labour Bulletin*, 22(3):39-45.

Allen, R. E. (Ed.) 1990. *The Concise Oxford Dictionary.* New York: Oxford University

Allen, R. E. & Keaveny, T. J. 1983. *Contemporary Labor Relations.* New York: Addison-Wesley.

Angus, B. & Humphrey. 1991, Friend or foe. *Productivity SA.* 16(2):10-13, 10-27.

Anstey, M. 1995. Can South African industrial relations move beyond adversarialism? Some comparative perspectives on the prospects of workplace forums in South Africa. *Industrial Relations Research and topics Series*, Issue no 20:1-5.

Apolis, P. 1997. In the public service. *SA Labour Bulletin*, 21(4(98-100.

Bailey, K.D. 1987. *Methods of social research* (Third edition). New York: Macmillan.

Baskin, J. 1991. "Cosatu": Challenge of the 1990's – extract from his book, "striking back". *South African Labour Bulletin*, 16(1):65-71.

Baskin, J. 1993. The trend towards bargained corporatism. *SA Labour Bulletin*, 17(3):64-69.

Baskin, J. 1995. The need for centralised (but flexible) bargaining. *SA Labour Bulletin*, 19(1):51.

Bendix, D.W.F. 1980. Industrial relations and social change. *Official Journal of the Institute of Labour Relations*. UNISA, 4(384):3-68.

Bendix, S. 1996. Industrial relations in the new South Africa. Kenwyn: Juta & Co.

Benjamin, P. 1995. The new Labour Relations Act. *SA Labour Bulletin*, 19(1):16-19.

Buhlungu, S. 1997. Constructing consensus. *SA Labour Bulletin*, 22(3):71-74.

Chaska, N.L. 1990. *The nursing profession: Turning point*. St Louis: CV Mosby.

City Press Business. 2000. Public servants decry offer. (6 June), p.1.

City Press, 1999. Hostage drama after money fails to arrive. (07 February), p.14.

City Press, 1999. Hospitals experiencing problems. (04 July), p.6.

City Press, 2000. Aluta Continua on the labour front in 2001, (31 December), p.13

Clegg, H. 1972. *The system of industrial relations in Britain*. Oxford: Blackwell.

Cloete, F. 1995. Summary and conclusions: Towards a strategic framework for public sector transformation. In Cloete, F., & Mokgoro, J (eds.). 1995. *Policies for public service transformation*. Juta: Kenwyn.

Cloete, J. J. N. 1993. *Administration and management of health services*. Pretoria: Van Schaik.

Community Resource and Information Centre (CRIC). 1990. Public sector strikes: an overview. *South African Labour Bulletin*, 14 (8):9-14.

Cooper, C.1996a. Strikes and lockouts in the LRA. *South African Labour Bulletin*, 20(1):81-85.

Cooper, C. 1996b. Recent case law on strikes and lockouts. In Cheadle, H. *et al.* 1996. *Current Labour Law 1996*. Johannesburg: Juta.

Craig, A. 1975. A framework for the analysis of industrial relations systems. In Barrett, B., Rhodes, E. & Collier B. J. (Eds.). *Industrial relations and the wider* society. London: Macmillan.

Critical Health. 1992. Struggles for better wages and working conditions in the public sector. Critical Health, no 39 (pp. 7-14).

Crouch, C. 1982. *Trade unions: The logic of collective action*. Glasgow: Fontana Paperbacks.

Davey, HW., Bognanno, MF. & Estenson, DL. 1982. *Contemporary collective bargaining* (fourth edition). New Jersey: Butterworth.

De Villiers, L. 1993. Kollektiewe Onderhandeling en Vakbonde. *Nursing RSA,* (3):22-23, 41.

Deale, P. 1988. Spotlight on Law. Labour law for personnel managers. *IPM*, 8(9):35.

Dekker, L.D. 1994. Labour market institutions and the definition of socio-economic goods. *Business Alert*, no 153, pp. 4-8.

Department of Labour. 1998. *Common Cause*. vol. 1. Pretoria: Department of Labour.

Die Volksblad, 1999b. Woede oor oortydbetaling (23 June), p. 3.

Douglas, D. 1995. Healing our hospitals. *South African Labour Bulletin*, 19(5):65-67.

Driel, M. 1998. Anti-privatisation for democratic public sector reform. *SA Labour Bulletin,* 22(1):59-62.

Du Toit, D. 1995. Corporatism and collective bargaining in a democratic South Africa. *South African Industrial Law Journal*, 16(4):785-805.

Dunlop, J. T. 1958. *Industrial relations systems*. New York: Henry Holt.

Finnemore, M & Van der Merwe, R. 1996 (fifth edition). *Introduction to Labour Relations in South Africa*. Butterworth: Durban.

Finnemore, M. 1996. *Introduction to Labour Relations in South Africa*. Buttherworth: Durban.

Flanders, A. 1975. *Management and unions*. London: Faber & Faber.

Focus on Nedlac. 1996. A user's guide to the new LRA. *SA Labour Bulletin*, 20(6):40-45.

Forrest, K. 1996. Mapping out the future: the public sector in the wake of the nurses' strike? *SA Labour Bulletin*, 20(1):59-68.

Government Gazette. 1997. White paper for transformation of the health system in South Africa. Pretoria: Department of Health.

Government Gazette. 1998. Employment Equity Act. Vol 400 (no 19370). Cape Town: Government.

Grobbelaar, N. J. & Prinsloo, J. J. 1998. Industrial relations: structures and procedures. In Slabbert, J. A. Prinsloo, J. J., Swanepoel, B. J., & Backer, W. (Eds.). 1998. *Managing employment relations in South Africa*. Johannesburg: Butterworths.

Grogan, J. 1998. *Workplace Law* (Third edition). Grahamstown: Juta.

Grossett, M & Venter, R. 1998. *Labour Relations in South Africa: A comprehensive guide for managers and practitioners*. Durban: International Thomson.

Habib, A. 1997. From pluralism to corporatism: South Africa's labour relations in transition, *Politikon*, 24(1):57-75.

Hardiman, T.P., & Mulreany, M. 1991. *Efficiency & Effectiveness in the public domain*. Dublin: Institute of Public Administration.

Heunis, J.C & Pelser, A.J. 1997. Down the needle! Should public sector nurses in South Africa have the right to strike? *Curationis*, 20(3):41-46.

Hindson, D. 1987. *Pass controls and the urban African proletariat*. Johannesburg: Ravan.

Hirson, B. 1989. *Yours for the union*. Johannesburg: Witswatersrand University press.

Hyman, R. 1975. *Industrial relations: a Marxist approach*. London: Macmillan

Hyman, R. 1989. *Strikes* (fourth edition). London: Macmillan.

Ingersoll, R.G. 1992. The South African labour market: Critical issues for transition. In Baker, F. 1992. *Unions, collective bargaining and wages*. Pretoria: Van Schaik.

Initiative for Sub-District Support. 1998. The health of Tshepo – A guide for managers and governors. Durban: Health Systems Trust

Innes, D. 1994. New realities: The changing face of labour relations, *The Innes Labour Brief*, 6(1):6-13.

Jacklin, N. & Machin, A. 1998. Grading and wages. *SA Labour Bulletin*, 22(3):32-38.

Jones, R.A. 1982. *Collective bargaining in South Africa*. Johannesburg: Macmillan.

Kaluzny, I. & Arnold. D. 1982. *Management of health services*. New Jersey: Prentice Hall.

Keamey, R.C. 1984. *Labor relations in the public sector*. New York: Marcel Dekker.

Kochan, T.A. 1980. *Collective bargaining and industrial relations*. Homewwood: Irwin.

Konivow, R. B., & McElroy, F. E. 1975. *Communication for the safety professional*. Chicago: National Safety Council.

Kotze, W. 1991. Labour relations not a fuction of SANC. *Nursing RSA*, 6(4)):7.

Kotze, W.J. 1995. The South African Nursing Council: 50 years of professional self-regulation. *Curationis,* 18 (3):16-26.

Landman, A. A. 1989. "A unitary theory of industrial discipline". *SA Mercantile Law Journal*, vol 1:67-86.

Landman, A. 1990. The new labour legislation: Balancing interests. *Human Resource Management*. (pp.4-6)

Levy, A. & Associates. 1995. *Annual report of Labour Relations in South Africa 1995-1996*. Johannesburg: Andrew Levy & Associates.

Levy, A. & Associates. 1998. *Annual report of Labour Relations in South Africa 1998-1999*. Johannesburg: Andrew Levy & Associates.

Logart, H. 1995. The year of public sector reform. *The Innes Labour Brief,* 6(4):7-20.

Macun, I. & Psoulis, C. 1998. Unionisation, *SA Labour Bulletin*, 22(3):25-31.

Marcus, M.H. 1991. The debate over levels of bargaining (A legal approach). *South African Journal of Labour Relations*, 15(4):31-43.

Maree, J & Godfrey, S. 1995. Trends towards corporatism in South Africa: Industrial relations and industrial strategy in the textile industry. In Van der Merwe, A (ed.). 1995. *Industrial Sociology: A South African perspective*. Isando: Lexicon (pp. 86-117)

Marelli, T. M. 1993. Nurse manager's survival guide. Practical answers to everyday problems. St Louis: Mosby.

Mgidlana, G. 1995. A special focus: Labour Relations in South Africa. *Newsletter of the Community Dispute Resolution Trust*, (7):1-5.

Miller, D.C. & Form, W.H. 1980 (Third edition). *Industrial Sociology: Work in organizational life.* New York: Harper & Row.

Millward, N. & Stevens, M. 1986. *British workplace Industrial relations 1980-1984: The DE/ESRC/PSI/ACAS surveys.* Aldershot: Gower.

Mischke, C. 1996. The new law of industrial action. *Jutas Business Law*, 4 (part 1):5-7.

Musapelo, M.C. (Deputy Director: Labour Relations Sub-Directorate in the Free State Deparment of Health) 1999. Personal interview (05 May 1999).

Myburgh, A & Wade, R. 1996. Meaning of strike: The new definition. *Employment Law*, 13(2):22-26.

National Assembly Portfolio Committtee on Health. 1995. Industrial action by nurses 1995. Report of the National Portfolio Committee on Health: Pretoria.

Nel, P.S. & Van Rooyen, P.H. 1993 (second revised edition). *South African Industrial Relations: Theory and Practice.* Pretoria: Van Schaik.

Neuman, W. L. 1997. *Social research methods: Qualitative and quantitative approaches*. Allynn & Bacons: Needham Heights.

Nieuwmeijer, L. J. 1998. Communication with employees and unions. In Slabbert, J. A. *et al.* (Eds.). 1998. *Managing employment relations in South Africa.* Johannesburg: Butterworths (Chapter 14).

Novitz, T. 1998. Freedom of association and 'Fairness at Work' – An assessment of the impact and relevance of ILO Convention no 87 on its Fifth Anniversary. *Industrial Law Journal*, 27(3):169-191.

Nyembe, L.1992. The public sector and the right to strike. *SA Labour Bulletin*, 16(7):41-47.

Olivier, M. 1993. The employment protection of public-sector employees: Recent developments. *De Rebus*, no 328 (pp. 1001-1003).

Olivier, M. 1995. A new Labour Relations Act: Essential characteristics and impacts for the profession. *De Rebus*, no 330. (pp. 357-361).

Olivier, M. P. 1998. Statutory employment relations in South Africa. In Slabbert, J. A. *et al.* (Eds.). 1998. *Managing employment relations in South Africa.* Johannesburg: Butterworths (Chapter 5)

Oranje Hospital. s.a. A guide to principles applied in misconduct and disciplinary action. (Unpublished guide). Bloemfontein: Oranje Hospital.

Osterhaus, L.B. s.a. *Labor relations in the hospital and their effect on management.* Michigan: Ann Arbor.

Palmer, G. 1983. *Industrial Relations – Great Britain.* London: George Allen & Unwin.

Pogenpoel, M. & Müller, M. 1996. Challenges facing the South African nursing profession. *Health SA*, 1(1):9-14.

Portfolio Committtee on Health. 1995. Industrial action by nurses 1995. Report of the National Portfolio Committee on Health: Pretoria.

Public Service Co-ordinating Bargaining Council. 1999. Constitution of the Public Service Co-ordinating Bargaining Counci: Pretoria.

Ray, M. 1997. Centre or sector? Collective bargaining in the public service. *SA Labour Bulletin*, 21(6):32-36.

Ray, M. & Aldair, B. 1998. NEHAWU: One public service, one union? *SA Labour Bulletin*, 22(3):52-57.

Singh, A. 1996. The new Labour Relations Act: What we've have got. *Productivity SA*, 22(1):4-6.

Singh, A. 1997. Privatisation: Unions finally buy in. *Productivity SA*, 23(1):12-13.

Singh, R. 1976. Systems theory in the study of labour relations: time for appraisal? *Industrial Relations Journal,* 7(3):59-71.

Slabbert, J.A. 1991. *Inleiding tot arbeidsverhoudingebestuur.* Roodepoort: Digma.

Slabbert, J.S. 1987. *Vakbondwese en arbeidsverhoudinge*, Roodepoort: Digma.

Sloane, A. A., & Witney, F. 1985. *Labor relations* (Fifth edition). London: Prentice-Hall.

Smith, S. K. 1993. Industrial relations in the Swedish Public Sector: Time for a different paradigm? *Journal of Collective Negotiations*, 22(1):55-67.

South African Labour Bulletin. 1985. Labour relations in the public sector. *SA Labour Bulletin*, 14(8):12-14.

Sowetan, 1999. War on lay-offs (20 October), p. 9.

Sowetan, 2001. Two nurses suspended. (1 February), p.1.

Stewart, A. 1995. The characteristics of the state as employer: Implications for labour law. *Industrial Law Journal*, 16(1):15-28.

Steyn, F.G. 1995. Aspects of wage bargaining structures and processes in South Africa. *South African Journal Economic Management Sciences*, 15(Fall):132-147.

Stuurman-Moleleki, J., Sait, L. & Long, P. 1997. Health legislation. *South African Health Review 1997*. Durban: Health Systems Trust.

Sullivan, E. J. & Dekker, P. J. 1985. *Effective management*. New York: Addison-Wesley.

Summers, C. 1995. Workplace forums from a comparative perspective. *Industrial Law Journal*, 16(4):806-813.

Swartz, D. 1998. Beyond policy. *Productivity SA*, 24(4):18-21.

Terreblanche, S & Nattrass, N. 1994. A periodisation of the political economy from 1910. In Webster, E. 1994. *Work and industrialisation in South Africa*. Randburg: Ravan, (pp. 190-204).

The Hospital Strategy Project. 1996. Achieving equity, efficiency and accountability: A vision and strategy for South Africa's public hospitals. Johannesburg: The Hospital Strategy Project.

The Institute of Health Service Management. 1994. Managing Health services. Bristol: The Open University.

The Star Workplace. 1999. Strikes: Prevention is better than cure. (10 February), p.10.

The Star Workplace. 1999. Unions exploiting employers - who allow it to happen. (24 March), p.6.

The Star Workplace. 1999. New employer and union IR plans emerging. (24 March), p.4.

The Star. 1999. Report on health-care crisis alarmist, says Gauteng official. (23 June), p.1.

The Sunday Independent. 1996. Business hit back at Cosatu over the lockout as a right. (21 April), p.6.

Thompson, C. 1996. Collective bargaining. In Cheadle, H. 1996 *Current Labour Law*. Johannesburg: Juta.

Tilley, S. 1998. Good policies need good practices. *Budget Watch*, 4(2):4.

Troskie, R. 1994. The need for management training by nurses registered for nursing administration. *Curationis,* 17(1):40-45.

Van der Merwe, T. & Muller, M. 1997. Guidelines for professional development in the formulation of nursing standards. *Curationis*, 20(3):4-8.

Van Rensburg, D. & Van Rensburg, N. 1999. Distribution of human resources. In *South African Health Review*. 1999. Chapter 16 (pp.201-232). Durban: Health Systems Trust.

Van Uytrecht, P. 1995. Conflict, Power, Labour relations and Labour law. *Industrial Law Joumal*, 16(1):29-40.

Verster, J.D. & Joubert, W. 1989. Render unto Caesar. *The Public Servant*, (August):14-16.

Von Holdt, K. 1995. The LRA agreement: "worker victory or miserable compromise". *SA Labour Bulletin,* 21(1):25.

Walizer, M.H. & Wienir, P. L. 1978. *Research methods and analysis: Searching for relationships*. New York: Harper & Row.

Wood, G. 1998. *Trade union recognition. Cornerstone of the new South African employment relations*. Thomson: Durban.

World Labour Report. 1989. Employment of labour incomes: Government and its employees, statistical appendix. Vol. 4. Geneva: International Labour Organisation.

APPENDIX A

INTRODUCTORY LETTER AND INTERVIEW SCHEDULE: NURSES AND BLUE-COLLAR WORKERS

Centre for Health Systems Research

3343

SZ MATEBESI

THE EFFECTIVENESS AND EFFICIENCY OF LABOUR RELATIONS PROCESSES AND PRACTICES IN THE PUBLIC HOSPITAL SYSTEM

Dear Respondent

I am currently a research intern at the CHSR&D. Part of my obligations as an intern is to conduct a research project of my own. I am interested in determining *the effectiveness and efficiency of labour relations processes and practices in the public hospital with special reference to Pelonomi Hospital.* This survey is conducted among randomly selected nurses and blue-collar workers. I therefore kindly request to interview you. Eventually the data of this survey will assist with the development of labour relations at your work place.

The bearer of this letter is a fieldworker who has been authorised and trained to conduct the interview.

I have the permission of the Department of Health to conduct this study. However, I am not connected in any way with the Department. All the information collected would be treated with the greatest confidentiality and your anonymity will be guaranteed.. You will thus not be harmed in any way whatsoever by taking part in the survey. Your co-operation is very important in order to ensure representativeness of the results. However, you are under no obligation to participate in the study.

I believe that the information yielded by this study will be of interest to all employees and management at Pelonomi Hospital. It may also prove of practical value to the health services and to labour organisations, and produce improvements in the facilities and services provided.

Should you need more information you are welcome to contact me at the address and numbers mentioned above.

I sincerely thank you for your collaboration and time.

SZ MATEBESI TEL 051-4013323
RESEARCHER

MR JC HEUNIS TEL 051-4012993
SUPERVISOR

CENTRE FOR HEALTH SYSTEMS RESEARCH & DEVELOPMENT

INTERVIEW SCHEDULE

NURSES & BLUE-COLLAR WORKERS

For office use

1- 3

SECTION A: WORK HISTORY

1 Gender

Male	1	Female	2

4

2 Highest academic qualification?

1. Degree	1	2. 1 Year diploma	2
3. 2 Year diploma	3	4. 3 Year diploma	4
5. Std 10	5	6. Std 9 and lower	6
7. No formal education	7	8. Other (*specify*)	8

5- 6

3 What is your occupation/rank?

1. Chief Professional nurse (Post)	1
2. Chief Professional nurse (Rank)	2
3. Senior Professional nurse	3
4. Professional nurse	4
5. Enrolled nurse	5
6. Enrolled Assistant nurse	6
7. Blue-collar worker	7

7

4 If blue-collar worker, what is your job description?

Cleaner	1	Porter	2	Driver	3
Messenger	4	General worker			5

8

5 Work place at the time of interview?

.....

9- 10

6 How many years have you been working at Pelonomi Hospital?

< 2 years	1	2 to 5 years	2
6 to 10 years	3	11 to 15 years	4
16 to 20 years	5	> 20 years	6

11

7 Have you attended any in-service training in the past two years?

Yes	1	No	2

12

8 If yes, what type of training did you attend?

.....

13- 14

9 If no, would you like to attend any kind of training?

Yes	1	No	2	Uncertain	3

15

10 What kind of training would you like to undergo?

.....

.....

16- 17

SECTION B: WORKING CONDITIONS & RENUMERATION

11 What type of appointment do you have?

..... [ ] 18

12 What is your bruto monthly salary before deductions?

< R1000	1	R1001-R2000	2
R2001-R3000	3	R3001-R4000	4
R4001-R5000	5	R5001-R6000	6
> R6000	7		

[ ] 19

13 Do you regularly receive any of the following extra income from your job at Pelonomi Hospital?

Reward	Yes	No	Not applicable	
1. Night duty allowance	1	2	3	[ ] 20
2. Overtime payments	1	2	3	[ ] 21
3. Bonus	1	2	3	[ ] 22

14 If you receive(d) a bonus, when last did you receive one?

..... [ ][ ]

23- 24

15 How much was the last bonus that you received?

1. Less than my monthly salary	1
2. The same as my monthly salary	2
3. More than my monthly salary	3
4. Uncertain	4

[ ] 25

16 Do you have knowledge about the types of leave that workers at Pelonomi normally receive?

Yes	1	No	2	Uncertain	3		26

17 How satisfied are you with each of the following aspects at Pelonomi Hospital?

1. Very satisfied
2. Reasonably satisfied
3. Uncertain
4. Reasonably dissatisfied
5. Very dissatisfied

Aspect	**Degree of satisfaction**					
1. Your salary	1	2	3	4	5	27
2. Your working hours	1	2	3	4	5	28
3. The number of days leave you receive	1	2	3	4	5	29
4. Annual increament	1	2	3	4	5	30
5. Housing allowance	1	2	3	4	5	31
6. Medical allowance	1	2	3	4	5	32
7. Relationship with colleagues	1	2	3	4	5	33
8. The attitude of your immediate supervisor	1	2	3	4	5	34
9. The condition of the equipment that you work with	1	2	3	4	5	35
10. Involvement in decisions that affect you	1	2	3	4	5	36

18 Have you ever seriously thought of leaving Pelonomi Hospital to work somewhere else?

Yes	1	No	2	→ Q. 20

37

19 If yes, why did/would you like to leave Pelonomi Hospital?

.....

.....

.....

38- 39

SECTION C: ATTITUDES & INVOLVEMENT IN TRADE UNIONS

20 Do you think it is a "good" or "bad" idea for workers at Pelonomi Hospital to belong to trade unions?

	Good idea	Bad idea	Uncertain	
1. Nurses	1	2	3	40
2. Blue-collar	1	2	3	41

→ Q. 23

21 In the case of nurses, why do you say so?

.....

.....

.....

42- 43

22 In the case of blue-collar workers, why do you say so?

.....

.....

23 Do you belong to any trade union? 44- 45

Yes	1	No	2

46

24 If no, why not?

.....

Go to question 37 47- 48

25 If yes, to which union do you belong?

.....

49- 50

26 How long have you been a member of this union?

< 2 years	1	2 to 5 years	2
6 to 10 years	3	11 to 15 years	4
16 to 20 years	5	> 20 years	6

51

27 If you had to decide, would you still remain a member of your present union, join another one or withdraw totally from being involved in any trade union?

1. Still remain member of present union	1
2. Join another union	2
3. Withdraw from trade union activities	3

52

28 Why do you say so?

.....

.....

53- 54

29 Generally speaking, do you think that your trade union see to your labour needs properly, or not?

Yes	1	No	2	Unceratin	3

55

30 Why do you say so?

.....

.....

56- 57

31 In your view, should your trade union become *more* or *less* demanding in its approach to negotiations, or is its present approach *satisfactory*?

1. More demanding	1	2. Less demanding	2
3. Approach is satisfactory			3

58

32 How often does your union hold general (worker) meetings at Pelonomi Hospital?

1 Weekly	1	4. Monthly	4
2. More than once a week	2	5. When necessary	5
		6. Other.....	6
3. Every two weeks	3	.....	

59- 60

33 Have you ever taken any work related complaint to your trade union representative?

Yes	1	No	2	→ Q. 37

61

34 What was the nature of the complaint that you regard as most important?

.....

.....

62- 63

35 How was your complaint handled by the union representative?

1. Very satisfactory	1	2. Satisfactory	2
3. Uncertain	3	4. Unsatisfactory	4
5. Very unsatisfactory		5	

64

36 Why do you say so?

.....

.....

65- 66

37 Are you aware of the Labour Relations Act (LRA) no. 66 of 1995?

Yes	1	No	2	→ Q. 39

67

38 Where did you receive information about the LRA?

.....

.....

68- 69

39 In your view, what is the attitude of both Pelonomi management and trade union representatives towards one another?

	Good	Bad	Uncertain	
1. Management towards trade union representatives	1	2	3	70
2. Trade union representatives towards management	1	2	3	71

40 What can be done to improve the working relations between trade union representatives and management at Pelonomi Hospital?

.....

.....

.....

72- 73

41 How influential do you think is your trade union in the following areas?

1. **Very influential**, 2. **Influential**,
3. **Uncertain**, 4. **Little influential**,
5. **Not influential at all**

Area	Degree of influence					
1. In securing higher pay	1	2	3	4	5	74
2. In securing satisfactory working conditions	1	2	3	4	5	75
3. In communicating a good image of health services	1	2	3	4	5	76
4. In securing benefits for its members	1	2	3	4	5	77
5. Creation of promotion opportunities	1	2	3	4	5	78
6. Influence on management practices	1	2	3	4	5	79
7. Handling of disciplinary cases against members	1	2	3	4	5	80
8. Protection from unfair labour practices	1	2	3	4	5	81
9. In educating members about their rights at the workplace	1	2	3	4	5	82
10. Promotion of good relations between workers	1	2	3	4	5	83

42 What is the most single important thing that you appreciate about your trade union?

.....

.....

.....

84- 85

43 What is the single most negative aspect about your trade union?

.....

.....

.....

86- 87

SECTION D: STRIKES

44 What purpose do you think strikes are playing in public hospitals?

.....

.....

.....

88- 89

45 Do you think it is good for workers at public hospitals to strike? 1. Yes, conditinally 2. Yes, unconditionally 3. No 4. Uncertain

1. Nurses	1	2	3	4	90
2. Blue-collar workers	1	2	3	4	91

46 In the case of nurses, why do you say so?

.....

.....

.....

92- 93

47 In the case of blue-collar workers, why do you say so?

.....

.....

.....

94- 95

48 Would you personally be willing to strike if necessary?

Yes	1	No	2	Uncertain	3	96

49 What is the most important reason that would encourage you to participate in a strike?

.....

97- 98

50 Have you ever personally participated in a strike while working at Pelonomi Hospital?

Yes	1	→ Q. 51	No	2	→ Q. 55	99

51 Which strike that you personally participated in was the most significant one?

.....

.....

52 How long (in terms of days) did the strike action take? 100- 101

..... days 102- 103

53 What was the main cause of the strike?

.....

.....

..... 104- 105

54 What was the outcome of the strike?

.....

.....

..... 106- 107

55 Many factors contribute to strike action. In your opinion, to what extent do you agree that the following items contribute to strike action at Pelonomi Hospital?

1. Large extent
2. Some extent
3. Uncertain
4. Small extent
5. Not at all

Factor	Extent of agreeing					
1. Ineffective grievance and disciplinary procedures	1	2	3	4	5	108
2. Low wages	1	2	3	4	5	109
3. Poor service conditions	1	2	3	4	5	110
4. Racially segregated work facilities	1	2	3	4	5	111
5. Heavy workload	1	2	3	4	5	112
6. Abnormal working hours	1	2	3	4	5	113
7. Discriminatory supervision	1	2	3	4	5	114
8. Racial discrimination	1	2	3	4	5	115
9. Lack of communicating information that affects workers	1	2	3	4	5	116
10. Dismissal of other workers	1	2	3	4	5	117

SECTION E: GRIEVANCE & DISCIPLINARY PROCEDURES

56 What do you normally do if you have a grievance about your working conditions?

.....

118- 119

57 Is there any grievance procedure at Pelonomi Hospital?

Q. 59

Yes	1	No	2	Uncertain	3

120

58 If yes, where did you obtain the information about the grievance procedure at Pelonomi hospital?

.....

121- 122

59 Did you ever have any grievance since working at Pelonomi Hospital?

Yes	1	No	2	Uncertain	3

123

60 If yes, what was the nature of the most important grievance that you ever had at Pelonomi Hospital?

.....

.....

.....

124-125

61 Were your grievance fairly treated?

Yes	1	No	2	Uncertain	3

126

62 Why do you say so?

.....

.....

127-128

63 What are the **three** most important work-related problems that you generally encounter at Pelonomi Hospital?

.....

.....

.....

129-134

64 In your opinion, are the grievances of all workers treated in the same manner at Pelonomi Hospital?

Yes	1	No	2	Uncertain	3

135

65 Why do you say so?

.....

.....

136-137

.....

66 In your opinion, what can be done to improve on the grievance procedure at Pelonomi Hospital?

.....

.....

.....

138-139

67 What steps are taken if you or your colleagues have committed or alledgely committed an offence?

.....

140-141

68 Is there a known/official disciplinary procedure at Pelonomi Hospital?

Yes	1	No	2	Uncertain	3

142

69 If yes, where did you obtain the information about the disciplinary procedure at Pelonomi Hospital?

.....

143-144

70 Have you ever had any work-related charge against you at Pelonomi Hospital?

Yes	1	No	2

→ Q. 74

145

71 If yes, what was your "most important" alleged offence?

.....

.....

146-147

72 Were you fairly treated for this offence?

Yes	1	No	2	Unceratin	3

148

73 Why do you say so?

.....

.....

149-150

74 Mention **three** offences that are usually committed by your colleagues at Pelonomi Hospital?

.....

.....

151-156

75 In your opinion are disciplinary matters handled consistently at Pelonomi?

Yes	1	No	2	Uncertain	3

157

76 Why do you say so?

.....

.....

.....

158-159

77 Disciplinary action must be applied progressively. For each of the following offences indicate what form of discipline you consider fair if a worker at Pelonomi is to be found guilty of it: **(Number of committing the same offence is within brackets)**

Forms of discipline: 1. *Verbal warning*
2. Written warning *3.Disciplinary hearing*
4. Suspension *5. Tranfer* *6. Demotion* *7. Dismissal*

OFFENCE								
1. Theft (2nd)	1	2	3	4	5	6	7	160
2. Absence without leave (8th)	1	2	3	4	5	6	7	161
3. Fraud (1st)	1	2	3	4	5	6	7	162
4. Late for work (6th)	1	2	3	4	5	6	7	163
5. Sleeping on duty (3rd)	1	2	3	4	5	6	7	164
6. Gross negligence (4th)	1	2	3	4	5	6	7	165
7. Intimidation (4th)	1	2	3	4	5	6	7	166
8. Under the influence of alcohol (3rd)	1	2	3	4	5	6	7	167
9. Assault (2nd)	1	2	3	4	5	6	7	168
10. Failure to book on duty (3rd)	1	2	3	4	5	6	7	169

78 In your opinion, what can be done to improve on the disciplinary procedure at Pelonomi Hospital?

.....

.....

.....

170-171

SECTION F: LABOUR RELATIONS PRACTICES & PROCEDURES

79 A hospital has certain functions to perform, one of which is the delivery of critical health care to the community. In your opinion, do you think that Pelonomi Hospital is succeeding in performing its functions?

Yes	1	No	2	Uncertain	3

172

80 If not, what hampers the progress of Pelonomi Hospital?

.....

.....

173-174

81 What can be done to improve the situation at Pelonomi Hospital?

.....

.....

175-176

82 For the eeficient and effective functioning of Pelonomi management expect every employee to perform his/her duties. Do you know what your duties are?

Yes	1	No	2		177

83 If yes, are your duties clear to you?

Yes	1	No	2		178

84 Have entered into an employment contract when you accepted employment at Pelonomi Hospital?

Yes	1	No	2	Uncertain	3		179

85 If yes, how was the employment contract applied?

Verbally	1	In writting	2	Both ways	3		180

86 Do you know of any structure(s)/arrangement(s) where employees meet with management at Pelonomi?

Yes	1	No	2	Uncertain	3		181

87 If yes, how often does management at Pelonomi meet with workers to discuss work-related issues?

1 Weekly	1	4. Monthly	4		
2. More than once a week	2	5. Only when necessary	5		
3. Every two weeks	3	6. Other.....	6		182-183

88 In your opinion, do you think that this arrangement of meeting management at Pelonomi is worthwhile? (*Please motivate your answer*)

.....

.....

184-185

89 How does management communicate important notices, messages, and work-related issues that affect workers?

.....

186-187

90 Do you experience any problems with regard to the way management communicate notices, messages and work-related issues that affect workers at Pelonomi Hospital? (Please motivate your answer)

.....

.....

.....

188-189

91 Please indicate to what extent do you agree with the following statements: 1. Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree

STATEMENT						
1. I can cope with my workload	1	2	3	4	5	190
2. I enjoy a good relation-ship with my supervisors	1	2	3	4	5	191
3. I am satisfied with the management of shifts	1	2	3	4	5	192
4. There is enough promotion opportunities	1	2	3	4	5	193
5. Employees at Pelonomi are fairly dismissed	1	2	3	4	5	194
6. The allocation of leave is satisfactory	1	2	3	4	5	195
7. I am satisfied with the physical conditions where I work	1	2	3	4	5	196
8. The recruitment and selection procedures at Pelonomi are fair	1	2	3	4	5	197
9. Workers are rewarded for exceptional performance	1	2	3	4	5	198
10. There are effective and efficient structures to deal with the daily problems of workers	1	2	3	4	5	199

ONLY FOR RESPONDENTS WHO HAVE BEEN WORKING FOR TEN YEARS OR MORE

92 **In conclusion:** Since 1994, many changes have taken place in South Africa. As a result, health services were also overhauled and new management took over. In your opinion, has the general management of Pelonomi..... (Tick one answer) when compared with the previous management?

1. Improved	1	2. Remained the same	2
3. Deteriorated	3		

200

93 Why do you say so?

.....

.....

.....

201-202

THANK YOU FOR YOUR TIME AND COLLABORATION!

APPENDIX B

FOCUS GROUP
DISCUSSION GUIDE

FOCUS GROUP DISCUSSION GUIDE

INTRODUCING THE DISCUSSION

Firstly, I would like to introduce myself once again. I am Zacheus Matebesi, a research intern at the Centre for Health Systems Research & Development (CHSR&D) at the University of the Free State. I would also like to thank you in advance for making available your precious time to participate in this study. As you would have realised by now, this study is about *the effectiveness and efficiency of labour relations in the public hospital system.*

The issues to be discussed affect us all as a hospital that does not function effectively and efficiently has a major impact on the lives of the community it serves. Some of you might be experiencing some doubts at the moment, but please be reassured that you will not be identified in any way. Any information given will be treated with the greatest confidentiality and your anonymity will be guaranteed.

This discussion session will be tape recorded to enable me to refer back when writing my report. If anyone is uncomfortable of being recorded, please notify me. Remember, while you work within the same institution, your experiences and observations with regard to certain aspects of your workplace may differ. It is for this reason that no one should feel afraid to raise his/her opinion, even if it differs with that of others.

Before we start with our discussion it would be helpful to get acquainted with one another. Lets start by introducing ourselves. X, can you start?

(Adapted and modified from Ackerman & Matebesi, 1996)

QUESTIONS

1. How did you become a supervisor?

2. Suppose I never worked at Pelonomi Hospital and is a new supervisor whom you have to orientate. What would you tell me about Pelonomi Hospital?

3. How do you feel about the presence of trade unions at Pelonomi Hospital?

4. What factors contribute to strike action at Pelonomi hospital?

5. Tell me about the problems you encounter with workers at Pelonomi Hospital?

6. Tell me about the problems you encounter with management?

7. What work-related offences do workers at Pelonomi Hospital usually commit?

8. How is discipline applied at Pelonomi Hospital?

9. Since 1994, many changes have taken place in South Africa. As a result, health services were also overhauled. Changes in management occurred at various health institutions. What can you tell me about the present management of Pelonomi Hospital when compared to the previous?

10. What would make your life easier as a supervisor at Pelonomi Hospital?

APPENDIX C

INTERVIEW SCHEDULE:
TRADE UNION REPRESENTATIVES

INTERVIEW SCHEDULE

TRADE UNION REPRESENTATIVES

FOR OFFICE USE

1- 3

SECTION A : BACKGROUND

1 Gender

Male	1	Female	2

4

2 Name of union.

.....

5- 6

3 Position at work

.....

7- 8

4 Position in trade union

.....

9- 10

5 How long have you been working in the above positions?

5.1 Position at work .....

11- 12

5.2 Position in trade union .....

13- 14

6 How long have you been a member of your union?

Less than 2 years	1	3 to 5 years	2
6 to 10 years	3	More than 10 years	4

15

7 What is your highest educational qualification?

.....

16- 17

SECTION B: TRADE UNION PROFILE

8 Is there any specific aspect of the Labour Relations Act of 1995 that your union is not happy with?

Yes	1	No	2

18

9 If yes, specify.

.....

.....

19- 20

10 How long has your union been representing workers at Pelonomi Hospital?

> 2 years	1	2-5 years	2	6-10 years	3
< 10 years	4				

21

11 Approximately, how many members do you have at Pelonomi Hospital?

> 1 000	1	1 000-2 000	2	2 001-3 000	3
3 001-4 000	4	4 001-5 000	5	< 5 000	6

22

12 How often does your union hold meetings with its members at Pelonomi Hospital?

Once a week	1	More than once a week	2
Once every two weeks	3	Once a month	4
		Other (*specify*).....	5

23- 24

13 What is the single most important feature of your trade union that makes it popular amongst workers at Pelonomi Hospital?

.....

.....

.....

25- 26

14 Please mention the **three** most important problems that you often encounter with management at Pelonomi Hospital?

.....

.....

.....

.....

27- 32

15 Please mention the **three** most important problems that you often encounter with management at Provincial Government level?

.....

.....

.....

.....

33- 38

16 How would you describe your relationship with the Pelonomi Hospital management?

Very satisfatory	1	Satisfatory	2	Uncertain	3
Unsatisfactory	4	Very unsatisfactory			5

39

17 Please motivate your answer.

.....

.....

.....

40- 41

18 What should be done to improve your union's relationship with management at Pelonomi Hospital?

.....

.....

42- 43

19 What is the single most important thing that you *appreciate* about management at Pelonomi Hospital?

.....

.....

.....

44- 45

20 What is the single most negative aspect about management at Pelonomi Hospital?

.....

.....

.....

46- 47

SECTION C: STRIKES

21 In your view, what role do strikes play at public hospitals such as Pelonomi Hospital?

.....

.....

.....

.....

48- 49

22 There are six broad causes of conflict in labour relations. Please indicate to what extent you agree that the following factors contribute to strike action at Pelonomi Hospital:

1. Strongly agree 2. Agree 3. Uncertain 4. Disagree
5. Strongly disagree

Factor	Extent of agreeing					
1. Renumeration matters (salaries and promotion etc.)	1	2	3	4	5	50
2. Management affairs (procedures, cohesion identity and human relations)	1	2	3	4	5	51
3. Employment relations (disciplinary and grievance systems, labour practices)	1	2	3	4	5	52
4. Communication (effectiveness and rumours)	1	2	3	4	5	53
5. Personnel affairs (working conditions, equipment, facilities, benefits)	1	2	3	4	5	54
6. Training (needs and opportunities)	1	2	3	4	5	55

23 Please mention three issues over which workers at Pelonomi Hopspital have striked in the past.

.....

.....

.....

56- 61

24 How often in the last three years has your union embarked on industrial action at Pelonomi Hospital?

.....

62- 63

25 What was the nature of the industrial action that you regard as most significant?

Work-to-rule	1	One day stoppage	2
Picketing	3	Prolonged strike action	4
Go slow	5	Sit-in	6
Secondary strike	7	Other (*specify*)	8

64- 65

26 How long (in terms of days) did the industrial action last in the most significant one?

..... days

66- 67

27 What was your union's main grievance with regard to the above industrial action?

.....

.....

.....

68- 69

28 What was the outcome of the industrial action?

.....

.....

.....

70- 71

29 What is the main course of action of the union when you have a serious dispute with management at Pelonomi Hospital?

.....

.....

72- 73

30 What is the main course of action of the union when you have a serious dispute with management at Provincial Government level?

.....

.....

74- 75

SECTION D: GRIEVANCE & DISCIPLINARY PROCEDURES

31 How do feel about the way worker grievances are handled at Pelonomi Hospital?

Very satisfied	1	Satisfied	2	Uncertain	3
Dissatisfied	4	Very dissatisfied			5

76

32 Please motivate your answer.

.....

.....

.....

77- 78

33 Mention **three** most important grievances of workers at Pelonomi Hospital?

.....

.....

.....

79- 84

34 In your opinion, what can be done to improve the grievance procedure at Pelonomi Hospital?

.....

.....

85- 86

35 How do you feel about the way discipline is handled at Pelonomi Hospital?

Very satisfied	1	Satisfied	2	Uncertain	3
Dissatisfied	4	Very dissatisfied			5

87

36 In your view, which offence(s) committed by workers at Pelonomi Hospital warrants immediate dismissal?

Nurses	....
Blue-collar workers	....

88- 89

90- 91

37 In your opinion, what can be done to improve on the disciplinary procedure at Pelonomi Hospital?

.....

.....

.....

92- 93

38 Please indicate what action would you consider fair in the following offences (**number of committing same offence is within brackets**)

Forms of discipline 1. Verbal warning 2. Written warning 3. Disciplinary hearing 4. Suspension 5. Transfer 6. Demotion 7.Transfer

Offence	Form of discipline							
1. Theft (2nd)	1	2	3	4	5	6	7	94
2. Absence without leave (8th)	1	2	3	4	5	6	7	95
3. Fraud (1st)	1	2	3	4	5	6	7	96
4. Late for work (6th)	1	2	3	4	5	6	7	97
5. Sleeping on duty (3rd)	1	2	3	4	5	6	7	98
6. Gross negligence (4th)	1	2	3	4	5	6	7	99
7. Intimidation(4th	1	2	3	4	5	6	7	100
8. Under the influence of alcohol (3rd)	1	2	3	4	5	6	7	101
9. Assault (2nd)	1	2	3	4	5	6	7	102
10. Failure to book on duty	1	2	3	4	5	6	7	103

SECTION F: LABOUR RELATIONS PRACTICES & PROCEDURES

39 Is there any structure(s)/arrangement(s) whereby trade unions meet management?

Yes	1	No	2	104

40 If yes, how often does your trade union meet with management?

1. More than once a week	1	2. Weekly	2
3. Every two weeks	3	4. Monthly	4
5. Other (*specify*)	5		

105- 106

41 In your opinion, how do you regard this arragement of meeting management?

Very satisfatory	1	Satisfatory	2	Uncertain	3
Unsatisfactory	4	Very unsatisfactory			5

107

42 Please motivate your answer.

.....

.....

.....

108- 109

43 How does management communicate important notices, messages, and work-related issues that affect workers to the union?

.....

.....

110- 111

44 Do you experience any problems with regard to the way management communicate notices, messages and work-related issues that affect workers at Pelonomi Hospital? *(Please motivate your answer)*

.....

.....

112- 113

45 A public hospital has certain functions to perform, one of which is the delivery of critrical health care to the community. From labour's point of view, do you think Pelonomi Hospital is succeeding in performing its functions?

Yes	1	No	2

114

46 If not, what hampers the service delivery of Pelonomi Hospital?

.....

.....

.....

115- 116

47 What can be done to improve the situation at Pelonomi Hospital?

.....

.....

.....

117- 118

48 Since 1994, many changes have taken place in South Africa. As a result, health services were overhauled and new management took over. In your opinion, has the general management of Pelonomi Hospital (**tick one answer**) when compared with the previous management?

1. Improved	1	2. Remained the same	2
3. Deteriorated	3		

[ ] 119

49 Why do you say so?

.....

.....

.....

[ ][ ]

120- 121

50 **In conclusion**, what do you think affect(s) the success of your union in its attempt to fight for worker rights?

.....

.....

.....

[ ][ ]
[ ][ ]

122- 125

51 What can/must be done to improve this situation?

.....

.....

.....

126- 127

THANK YOU FOR YOUR TIME AND COLLABORATION!

APPENDIX D

INTERVIEW SCHEDULE:

PROVINCIAL AND HOSPITAL MANAGERS

INTERVIEW SCHEDULE

PROVINCIAL & HOSPITAL MANAGEMENT

FOR OFFICE USE [ ][ ][ ] 1- 3

SECTION A: BACKGROUND

1 Gender

Male	1	Female	2

[ ] 4

2 Position

..... [ ][ ] 5- 6

3 How long have you been employed by the Provincial Department of Health or Pelonomi Hospital?

..... [ ][ ] 7- 8

4 What is your highest educational qualifications?

..... [ ][ ] 9- 10

5 Have you obtained any training on the following?

	Yes	No	
Human resource management	1	2	[ ] 11
Personnel management	1	2	[ ] 12
Labour/industrial relations	1	2	[ ] 13

6 How would you rate your knowledge of the new LRA?

Poor	Reasonable	Good	
1	2	3	[ ] 14

7 If reasonable or good, where did you gain this knowledge about the LRA?

.....

.....

15- 16

SECTION B: WORKING CONDITIONS & RENUMERATION

8 How many hours per week do workers work at Pelonomi Hospital?

	Hours per week
Nurses	.....hours
Blue collar workers	.....hours

17- 18

19- 20

9 Are there any in-service training opportunities for nurses and blue-collar workers at Pelonomi? (Please specify)

Nurses: .....

21- 22

Blue-collar workers: .....

23- 24

10 Do nurses/blue-collar workers sometimes receive the following extra income from their jobs at Pelonomi Hospital?

	Nurses		Blue-collar workers	
	Yes	No	Yes	No
1. Nightshift duty	1	2	1	2
2. Overtime	2	2	2	2
3. Annual bonus	1	2	1	2

25- 30

11 Please provide details about leave benefits for nurses/blue collar workers Pelonomi Hospital.

Type of leave	Days per year	
	Nurses	Blue-collar workers
Paid holiday leave		
Unpaid holiday leave		
Paid sick leave		
Unpaid sick leave		
Paid maternity leave		
Other, specify.....		

31- 40

SECTION C: TRADE UNIONISM

12 Mention the trade unions that represent workers at Pelonomi Hospital.

.....

.....

.....

41 42
43 44
45 46
47 48
49 50

13 Please mention the trade unions that you have recognition agreements with?

.....

.....

.....

51 52
53 54
55 56
57 58
59 60

FOR HOSPITAL MANAGEMENT ONLY

14 What type of joint-decision making committees/forums exist at Pelonomi Hospital?

.....

.....

.....

61- 66

15 What functions are performed by these structures?

.....

.....

.....

67- 72

16 Do shopstewards' committees exist at Pelonomi hospital?

Yes	1	No	2

73

17 How often does the Pelonomi Hospital management meet with trade union representatives?

Once a month	1
More than once a month	2
Once every two months	3
Quarterly	4
Other (*Specify*).....	5

74- 75

18 Do you think it is a good idea for workers at Pelonomi to belong to trade unions?

	Good idea	Bad idea	Uncertain
Nurses	1	2	3
Blue-collar worker	1	2	3

76
77

19 In the case of nurses, why do you say so?

.....

.....

.....

78- 79

20 In the case of blue-collar workers, why do you say so?

.....

.....

.....

80- 81

21 What are the three most important problems that you often encounter with trade unions at Pelonomi Hospital?

.....

.....

.....

.....

82- 87

22 What is the most single important thing that you *appreciate* about trade unions at Pelonomi Hospital?

.....

.....

.....

88- 89

23 What is the single most *negative* aspect about trade unions at Pelonomi Hospital?

.....

.....

.....

90- 91

PROVINCIAL GOVERNMENT MANAGERS ONLY

24 Which trade union operating at hospitals in the Free State is the majority trade union?

.....

92- 93

25 What is your opinion with regard to the presence of trade unions at hospitals in Free State?

.....

.....

.....

94- 95

26 Please mention all the labour relations structures/forums whereby the Department of Health (DOH) meet trade unions at provincial level?

.....

.....

.....

.....

.....

96- 103

27 What are the functions of each of the structures/forums mentioned above?

.....

.....

.....

.....

.....

.....

104- 111

28 Please mention **three** most important problems that you often encounter with unions at provincial government level.

.....

.....

.....

.....

.....

.....

.....

112- 117

29 Generally, how would you describe your relationship with trade unions?

Very satisfactory	1	Satisfactory	2
Unsatisfactory	3	Very unsatisfactory	4
Uncertain	5	Uncertain	5

118

30 Why do say so?

.....

.....

.....

119- 120

31 What can / must be done to improve on the relationship between the Department of Health and trade unions?

.....

.....

.....

121- 122

32 What is the most single important thing that you *appreciate* about trade unions at Pelonomi Hospital?

.....

.....

.....

123- 124

33 What is the single most *negative* aspect about trade unions at Pelonomi Hospital?

.....

.....

.....

125- 126

SECTION D: STRIKES : BOTH RESPONDENTS

34 Do you think it is acceptable for workers at Pelonomi Hospital to strike?

	Acceptable	Conditionally	Not at all	
Nurses	1	2	3	127
Blue-collar workers	1	2	3	128

35 In the case of nurses, why do you say so?

.....

.....

.....

.....

.....

129- 130

35 In the case of blue-collar workers, why do you say so?

.....

.....

.....

.....

.....

131- 132

36 There are six broad groupings of causes of conflict in labour relations. Please indicate to what extent do you agree that the following factors contribute to strike action at Pelonomi Hospital:

1. Strongly agree 2. Agree 3. Uncertain 4. Disagree
5. Strongly disagree

Factor	Extent of agreeing					
1. Renumeration matters (salaries and promotion etc.)	1	2	3	4	5	133
2. Management affairs (procedures, cohesion identity and human relations)	1	2	3	4	5	134
3. Employment relations (disciplinary and grievance systems, labour practices)	1	2	3	4	5	135
4. Communication (effectiveness and rumours)	1	2	3	4	5	136
5. Personnel affairs (working conditions, equipment, facilities, benefits)	1	2	3	4	5	137
6. Training (needs and opportunities)	1	2	3	4	5	138

40 If yes, how often does your trade union meet with management?

1. More than once a week	1	2. Weekly	2
3. Every two weeks	3	4. Monthly	4
5. Other (*specify*)	5		

105- 106

41 In your opinion, how do you regard this arragement of meeting management?

Very satisfatory	1	Satisfatory	2	Uncertain	3
Unsatisfactory	4	Very unsatisfactory			5

107

42 Please motivate your answer.

.....

.....

.....

108- 109

43 How does management communicate important notices, messages, and work-related issues that affect workers to the union?

.....

.....

110- 111

44 Do you experience any problems with regard to the way management communicate notices, messages and work-related issues that affect workers at Pelonomi Hospital? *(Please motivate your answer)*

.....

.....

112- 113

45 A public hospital has certain functions to perform, one of which is the delivery of critrical health care to the community. From labour's point of view, do you think Pelonomi Hospital is succeeding in performing its functions?

Yes	1	No	2

114

46 If not, what hampers the service delivery of Pelonomi Hospital?

.....

.....

.....

115- 116

47 What can be done to improve the situation at Pelonomi Hospital?

.....

.....

.....

117- 118

48 Since 1994, many changes have taken place in South Africa. As a result, health services were overhauled and new management took over. In your opinion, has the general management of Pelonomi Hospital (**tick one answer**) when compared with the previous management?

1. Improved	1	2. Remained the same	2
3. Deteriorated	3		

☐ 119

49 Why do you say so?

.....

.....

.....

☐☐
120- 121

50 **In conclusion**, what do you think affect(s) the success of your union in its attempt to fight for worker rights?

.....

.....

.....

☐☐
☐☐
122- 125

51 What can/must be done to improve this situation?

.....

.....

.....

126- 127

THANK YOU FOR YOUR TIME AND COLLABORATION!

APPENDIX D

INTERVIEW SCHEDULE:

PROVINCIAL AND HOSPITAL MANAGERS