Transferability of Policies and Organisational Practices across Public and Private Health Service Delivery Systems: A Case Study of Selected Hospitals in the Eastern Cape: Exploring Lessons, Ambiguities and Contradictions

By

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Declaration

I, Mziwonke Milton Mpofana declare that this thesis represents my own unaided work. It is submitted to the School of Government, University of the Western Cape.

I have not copied the whole or any part thereof and it has never been submitted to any other institution of higher learning for any other degree. I have acknowledged and fully referenced all the sources used.

All opinions expressed herein do not necessarily represent those of the university.

Name: Mziwonke Milton Mpofana

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Key Words

Public-private-partnerships; best practice, policy transfer, service delivery models, health services, governance, labour relations, Eastern Cape Province

List of acronyms

APP	Annual Performance Plan
BBBEE	Broadbased Black Economic Empowerment
BCMM	Buffalo City Metropolitan Municipality.
BRICS	Brazil-Russia-India-China-South Africa
CEE	Central and Eastern European countries
DENOSA	Democratic Nurses Organisation of South Africa
CMH	Cecilia Makiwane Hospital
EBPM	Evidence Based Policy Making
EC	Eastern Cape
JSE	Johannesburg Securities Exchange
HASA	Hospitals Associations of South Africa
HOSPERSA	Health and Other Services Personnel Trade Union of SA
HPCSA	Health Professionals Council of South Africa
IMF	Institutional Management Forum
NEDLAC	National Economic Development and Labour Council
NEHAWU	National Education, Health and Allied Workers Union
NHI	National Health Insurance

NPM	New Public Management
NT	National Treasury
OSD	Occupation Specific Dispensation
PACS	Picture Archive Communications System
PFMA	Public Finance Management Act
PHC	Primary Health Centre
PMDS	Performance Management and Development System
PPPs	Public- Private Partnerships
PPPFA	Preferential Procurement Policy Framework Act
PSC	Public Service Commission
PSR	Public Service Regulations
SA	South Africa
SDIP	Service Delivery Improvement Plan
UK	United Kingdom
USA	United States of America
USAID	United States Development Aid Agency
WPTHS	White Paper on the Transformation of the Health System
WPTSD	White Paper on the Transformation of Public Service Delivery

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Abstract

Since the advent of South Africa's democracy in 1994 there have been several changes in the policy and legislative arena specifically promoting public-private-partnerships in the health sector. These initiatives have given rise to opportunities for inter-sectoral policy transfer under the rubric of "best practices". This exploratory study examines the character, obstacles and contested nature of a selection of policy transfers between private and public health institutions in a single province of South Africa. The study looks at the dynamics at play around envisaged, current and past transfers of policies and organisational practices in relation to administrative systems and technologies used in four different hospital settings – two public and two private hospitals in the Eastern Cape Province of South Africa. This thesis explores the views of managers and labour organisations about policy transfer focusing on local contexts, and how various parties construct policy transfer, hence providing a perspective of policy at the "plant" level. In this research, special focus is placed on different agents' role and understandings of their contexts and how and why policies move and contradictions of these developments. In-depth interviews were conducted at four major Eastern Cape hospitals. The thesis argues that in practice, policy transfer is messy, politicized and traversed by power and vested interests and that organised labour plays a key role in policy transfer process. The thesis focuses on the different philosophical/ideological underpinnings, socio-political values and operational environments in each sector. This study is designed to contribute to existing knowledge on practices particularly *between the public and private sectors* in order to widen the understanding of the complexity of transferability.

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Chapter 1: Aims and rationale of the study

Background to the Problem

South African policy makers see long-term partnerships between the public and private sectors as a key policy objective in health, but the empirical understandings of this relatively new process is contested and its contestations poorly documented. The objectives of this Phd are to understand these processes and actors involved in public–private interactions in South African health sector. This study empirically interrogated the issues in transferability of policies and related organisational contexts and practices across the public-private divide. It was informed by a comparative analysis of policy and governance systems. The context for this study is the fact that we have two competing health systems or models in South Africa: one public and one private. The conventional tendency is to see the private sector as a success, which needs to be emulated by the public sector.

The majority of South Africans use public health care services (Peltzer 2009: 2). South Africa's health service delivery in public sector and its health outcomes have been and remain very poor if not critical. Not only are these highly skewed systems characterised by a large but underserviced public sector and an over-resourced and expensive private sector but they also serve very different segments of the population with the private profit-seeking system (dominated by three large listed firms) serving only about 15% of the population. According to Motsoaledi (2015) 80% of the medical specialists of the country being available to only 16% of the population and leaving the remaining 84% of the population to struggle in long queues with only 20% of the remaining specialists. Today, we have some life-saving health services being accessed by this 16% of the population only". Further, the idea and practices of privatisation are part of the state's "transformation" agenda (McDonald and Ruiters, 2005). Corruption and using the public sector for private purposes of accumulation of capital has become a major concern, and

has been getting worse but importantly involves both the private and public sector actors (Rispel et al., 2015).

But rapidly rising costs of private health care, on the other hand, have become major public issues. Mediclinic blames "The price increases are primarily driven by the above inflationary increases in nursing salaries (driven by the shortage of nurses and the nursing salaries in the public sector), as well as fluctuations in the exchange rate and increases in food and electricity charges," (Moneyweb 18th February 2015). Private health providers are said to be fleecing medial insurance and aid funders (Rispel et al 2015).

In South Africa, it is widely held that where a public institution "does not yet have the skills, the private sector can contribute to skills transfer and capacity building (Treasury, 2007; Broomberg, 2011; Van den Heever, 2012). The state, think-tanks, leading newspapers (*Financial Mail*, *Business Day*) and a number of policy entrepreneurs have advocated for "policy learning", emulation and "transfer" of ideas, knowledge and practices especially from the private to the public sector (Coovadia et al. 2009). In order to address this, Treasury has suggested and prioritized Public-Private Partnerships (PPPs) as a mechanism and opportunity for co-operation and learning from the private sector model. According to National Treasury (2007: 11) "part of the PPP contract should also involve the private party *transferring* appropriate skills to the procuring institution". By promoting efficient and competitive public service delivery, PPPs are viewed as the key to reaching disadvantaged populations while minimising costs to the government, transferring skills and best practices from private to public and enabling national, provincial, and municipal governments to concentrate on their "core" missions.

Public and scholarly debate about transferability (the appropriateness of, what and how the public sector should learn from the profit-driven private sector) has been pronounced (Bond, 2014; Harris, 2010; Steinberg 2011; Van den Heever, 2012). But there are few case studies of the contested dynamics of policy transfer, the influence of private sector

models and specifically the leading actors involved at the hospital level. This is thus the focus of this Phd. The contested politics of PPPs is evident in Nehawu's stance that there will be "blood on the floor" should the ANC government try and impose PPPs without proper consultation. Nehawu taking its cue from the Health Minister has also threatened mass strikes should the NHI not be implemented.

> How do we continue to justify that you and I here Honourable Members, who call ourselves the representatives and humble servants of our people, together with the judges of our courts who are defenders of the constitutional rights of our people, benefit from resources in a very expensive medical scheme of our own – for us and us only? We can no longer continue to defend these unsustainable positions with flimsy arguments like claiming that there are a few taxpayers in our country, conveniently and deliberately forgetting that the poor pay heavy tax through VAT on an everyday basis. We need to urgently change this state of affairs and hence we want Universal Health Coverage – we want NHI where we will be forced to pool together funds for all South Africans and "all" means "all" – not just a selected few (News24, 10 May 2016).[1]

The Democratic Alliance for its part,

> Strongly condemns the recent statement by the National Education, Health and Allied Workers' Union (Nehawu) opposing the introduction of public-private-partnerships (PPPs) in state hospitals. Nehawu is clearly living in the past and does not seem to realise that assistance from the private sector will greatly improve the health and wellbeing of South Africans, especially the poor, whilst also helping to promote sustainable economic

[1] www.news24.com/.../nhi-not-a-beauty-contest-between-private-and-public-sector-mot

> development. Public hospitals often do not have the staff, equipment and medicines to treat basic conditions and South Africa is one of only a few countries in the world where the number of children dying due to inadequate health care is growing (DA website 22 March 2010).

The ANC's view in 2005 was that in terms of health objectives and better outcomes,

> PPPs can play a significant role in providing health care services in a very poor province like the Eastern Cape. They bring in private sector capital and equalize the services that can be provided between those who can afford medical aid and those who cannot (MEC for Health, Goqwana in *PPP Quarterly*, 2005).

Since 1994 government initiatives have opened opportunities and in some cases pushed through policy transfer between public and private entities. These opportunities have been contested. In South Africa, there is an established tradition of organized labour's participation in policy transfer and change processes which includes active participation through shop floor, extra-parliamentary engagements and statutory institutionalisation of these stakeholders' participation through Nedlac (National Economic Development and Labour Council). Nedlac is a statutory body for representatives of government, organized business, organized labour and civil society organisations to meet to consider all socio-economic and labour policy, legislation for consensual adoption and implementation.

Against this background, this thesis is an attempt to explore the contested dynamics of policy transfer focusing on local managers and the labour representatives and hence providing a perspective of policy at the top and at the grassroots level. Four organisations: two public and two private hospitals in the Eastern Cape are analysed in as case studies in this Phd. These hospitals are: Cecilia Makiwane, Frere Hospital (public but with some activities privatised) and Port Alfred Hospital (part public and part private) and Netcare Greenacres Private Hospital (completely private). Port Alfred

Hospital as a whole is a public-private partnership (also called "co-location"). In 2014, at Cecilia Makiwane plans were started towards extensive privatisation that was to coincide with the physical relocation of the hospital. A number of public-private partnerships initiatives around specific services have been introduced at Frere Hospital. These public hospitals increasingly have adopted outsourcing practices and could be regarded as partly privatized. Since the mid-2000's the Eastern Cape has been targeted as an important site for Public-Private Partnerships (PPPs).

Aims and rationale

The rationales for this study were derived from five sources: first, the increasing interests within academic and government in the influence of private sector models over the public sector, and the increasing pressure on the public sector to "improve" by adopting private sector models; second debates about "best practice" and policy transfer between countries and between sectors; thirdly, the mechanical and unreflective way (emulation) in which this happens; fourth, the neglected and often negative role ascribed to trade unions and frontline workers in delivering health. And, finally, the dearth of South African scholarship in this important area of policy analysis.

Although there is a growing body of knowledge in the policy transfer field (see Fawcett and Marsh 2012) research themes tend to be narrow and quantitative often driven by the need to justify the use of private sector methods in public services. It does not assign a significant role to labour-management conflicts emerging interest in transferability at international level (between countries). Sturdy (2004: 171) has argued that "more research is needed on the construction and appropriation of ideas and associated multiple and multidirectional interactions" such as labour and management. Existing literature in South Africa reveals little evidence of research on contestations in health policy transfer. It also seems that South African debates have also largely neglected the international research on policy transfer (See Steinberg 2011).

The broad aim of this study is to understand the influence of ideas and practices of privatisation and new public management in health in South Africa. The central aim of this study is to contribute to knowledge about the processes in the transferability of private sector models and practices between public and private health systems. The thesis explored issues around: who transfers, the forms and channels of transfer, and the impediments facing transfer. Further, the study examined what kind of judgments go into notions of "efficient" and "better"; how these notions are contested in workplaces, and what lessons and/or best practices can be drawn and implemented in both sectors' health service delivery systems to transform and improve them. Policy transfer between public hospitals is often excluded and needs to be included in the analysis.

The study is based on in-depth interview research comparing managers and labour representatives at four major hospitals in the Eastern Cape Province (two public and two private), to establish how policy transfer is understood adapted and contested and the extent to which private sector practices have been transferred. This study explores the following particular sub-questions across the two hospital sectors:

> What are the challenges facing hospitals and in which services and functions are there policy transfers (past, present and planned)?
>
> Where do these policy ideas come from; are they coerced or voluntary, who are agents and how is change resisted by organized labour?
>
> What are the different philosophical/ideological underpinnings, socio-political values and operational environments in each sector.
>
> How do key actors in the receiving environment understand policy transfers and what needs to be done to make these transfers function?
>
> In which ways do policies and practices converge across the two sectors and how do they fit in with the concept of policy transfer and its

application?

How are the transformative aspects of health policies being implemented in both health systems?

Viewed from worker and management observations, how are the transferred policies/practices contested in the receiving environment?

What is the view of labour and management about the future of policy transfer?

The study explored the above listed sub-questions and does not seek to examine health outcomes of specific cross sectoral policy transfers (since this would require extensive data over a long period) but has a narrower focus. The hypothesis drawn from the review of literature was that policy analysts and policy makers have an oversimplified rational narrative on the policy transfer issue. In reality, policy transfer is contested: it is driven by vested interests; occurs through many channels, across sectors, and across multiple organisational settings. Some public hospitals seem to work well and others not.

The wider import of my work is to add to knowledge and practices *between the public and private sectors* in order to contribute to understanding of transferability that may take place across both sectors. I am also interested in how some public sector facilities are able to improve and how perhaps public-to-public policy and learning exchanges might occur.

Taking the above considerations as a point of departure, this thesis therefore wanted to explore the contested views of frontline actors in both sectors on this issue, using a semi-structured approach with in-depth interviews. The study looks at the key actors, their differing contexts and conflicts in the policy transfer adoption and implementation process. I explored the transfers of policies and organisational practices in relation to administrative systems used in four different hospital settings – two public and two

private hospitals in the Eastern Cape Province of South Africa. The scope of study on policy transfer was designed to be open-ended but as the study unfolded the focus narrowed to the issues raised by interviewees. This is not unusual, since research by its nature cannot assume the answers beforehand. The focus of the research therefore became a specific look at policy transfers with an understanding the concept "policy" includes both the content and ways in which things are done in organisations (Levine, 1997). While the researcher recognises the importance of health outcomes, this PhD does not consider or measure health or other outcomes of these processes since this is beyond the scope of this Phd. In addition, given that this is not a medical study *per se* but more about perceptions and conflicts in policy transfer practices, the researcher did not the outcomes of policy transfer for patients. This is a one of the several limitations of the scope of study.

This study investigated organized labour's responses to specific kinds of policy transfers that these actors saw as important, and how these responses have eased and/or hindered policy transfer process. Although not originally seen as a fundamental aspect of the thesis, it became clear as this Phd research unfolded, that organised labour's role in "producing health" was critical but underemphasised in the secondary and grey literature. The focus on organised labour emerged more powerfully during fieldwork interviews with managers who made it clear that their staff are highly unionised and that there is nothing new that can be implemented without the explicit involvement of trade unions. The four Eastern Cape hospitals are heavily unionised and this is not unique to the province.

A labour perspective might be especially pertinent at a very general level: frontline workers (nurses, cleaners and managers) after all, collectively produce the services that are "produced" in organisations such as hospitals. The perspectives of labour studies in the first instance bifurcate into conflict (Marxist and pluralists) and co-operation (Kelly 2012). Burawoy (1979) has, however, pointed out that both elements (conflict and co-operation) are at play.

A key concept also explored further in chapter 2 is "policy transfer" which has been defined as intentional action and has become associated with ideas such as "best practice" and "evidence-based" policymaking (Hudson and Lowe 2004: 195). I argue that there is considerable oversimplification of "best practice" and policy transfer ideas among policy makers. My research is based on the comparative policy analysis literature on the concept of transferability as developed by scholars such as Dolowitz and Marsh (1998), Peck et al (2010), Evans (2009), Hudson and Lowe (2004) among others.

Research Methodology

This research was based in the Eastern Cape, a province known for poor public health services, where four major hospitals (two public and two private) were studied where extensive public-private partnerships and outsourcing have been adopted. The choice of interviews as the main tool for collecting evidence in four case studies in two different sectors allowed for understanding the socially constructed perceptions and the nature of evidence, understandings of reality and of policy change. Furthermore, the choice of two different sectors --- one widely associated with a poor service delivery record and the other known for or perceived as having a good service delivery record --- provided a compelling context for transfer. Using only four cases of key informants allowed the researcher to get a view of how a limited number of key actors understand the possibly multi-dimensional complexities of the transferability issue. Comparing responses allowed us to get a wider perspective on an issue. This choice also enabled an understanding of the complexities of Public-Private Partnerships in a South African context with its tradition of heavily unionised workplaces.

The qualitative research methodology chosen for this study is a case study, with a variety of qualitative methods such as in depth interviews, direct observations, a scan of local newspapers and document analysis. Four different organisations in two different sectors were examined to generate data about each of them in specific areas to understand relationships between their characteristics, configuration, organisational practices and

modus operandi and how each organisation can draw lessons from others to enhance their own operations. Also, this examination was conducted to gain insight into the actors' perceptions, networks and experiences and undertakings of policies.

The research sites were compared in detail in upcoming chapters to establish local organisational and social asymmetries. The research sites chosen reflect the respective organisational settings wherein the service delivery systems exist and operate. Each hospital has different aspects and features. Greenacres is a fully private Netcare entity; Port Alfred is a hybrid PPP hospital, Frere is public hospital with some outsourced functions but recently has been hailed as a significant example of successful turnaround and as a model of public service to be emulated, whereas Cecilia Makiwane Hospital is struggling to find its feet. These organisational settings are characterized by particular ethos, structural configuration and modus operandi which include hierarchical arrangement of organisational units with attendant authority structures. These organisational settings are themselves located within ideological, socio-political, cultural, economic, labour and technological contexts which influence, inform and shape what happens inside them (Brubaker (1984; Beetham 1987). The two different kinds of organisations and sectors (public and private) then have different purposes and values guiding their governance.

This primary research involved interviews mainly with the CEOs and senior managers and with front-line staff (who are members of organized labour and reflected organized labour's views during the interviews). The CEOs are central actors in policy transfers since in many ways they are gatekeepers who must accept, reject or modify new policies. Newspapers complemented the analysis of key informant information. I chose newspapers to provide an outsider view and at some level and objective check on what insider actors say. This was an attempt to see issues from at least three sides. A limitation of the study is that nurses and general workers and middle management was left out of the study. One motivation for not doing extensive interviews was that the researcher was trying to explore polarities in viewpoints and extensive interviews would

have required sampling. The interviews with managers and shopsteward chairpersons were purposive.

Among the key trade unions in the South African health sector are the National Education, Health and Allied Workers' Union (Nehawu), the Democratic Nurses Organisation of South Africa, the Public Servants Association of South Africa and the Health and Other Service Personnel Union of South Africa. Most of the trade union interviews for this thesis were with Nehawu shop stewards, the dominant majority union that has fiercely contested aspects of policy change. The exclusive focus on Nehawu was driven by the Phd's concern to excavate the conflicted dynamics of policy transfer and this is perhaps an element of bias in the research, but one that nevertheless concurs with the aims and scope of the research. Nehawu has been the main force resisting market-based policy change and has taken policy positions to back this.

The shopstewards were interviewed in person (face-to-face in three cases and one telephonically). They were at the time, senior local leaders of Nehawu since they were all "branch" chairpersons with knowledge of the entire hospital. It is understood that each hospital which I researched had at least 100 members making a branch. In some cases membership ran into hundreds.

Interviews in three hospitals took place on site in a private setting and lasted two hours a session. Shopstewards had no strong preferences about anonymity indicating that they were not feeling afraid that the substance of interview could lead harassment by management. Nehawu has operated in these sites for more than two decades.

Extended interviews were conducted with health management professionals to solicit their reflections on the strategic issues and policy transfer areas in their facilities and how these might improve the quality of the services they were rendering. Except for Greenacres interviews happened over *two* days (in 2013 and 2014). These reflections were compared and analysed so as to get a balanced view of what may be happening in instances of policy transfer in the service delivery model in these facilities. The

"evidence" however can be seen as "acecdotal" yet it is crucial for inner meanings to be surfaced that such "anecdotal" narratives be included. This conforms with a social constructionist approach.

In the secondary research surveys of existing policy regimes and legislative prescripts, government policy documents, publications such as strategic documents and annual reports were studied to probe the policy milieu and networks which provide the opportunity structure for policy transfers.

However, it must be noted that despite numerous attempts through numerous contacts I was exceptionally frustrated in trying to get copies of strategic planning, reporting and budgeting for the public hospital. While EC government departments have APPs, Departmental Budgets and so on, these are extremely hard to access for individual public hospitals. The chief directorate strategic planning for EC health department also could nt assist despite written emails and telephonic request. This has major implications for how academics do research in this area.

Ethics

The study was considered feasible and ethical since it was geographically clearly delimited, it did not seek to enter into sensitive business, medical or financial or performance issues at the four hospitals. It was intended to add to the debate on how to improve the architecture and design of public-private intersectoral relations in health or at least uncover areas for further research.

Although the research was conducted in a hospital setting it was not itself a medical research *per se*. The focus was largely on organisational matters relating policy transfer and their application as organisational practices. The Management of the selected Eastern Cape hospitals (public and private) were consulted about this study granted the researcher permission to conduct it.

The researcher took note of and observed all the rules and requirements imposed on him by conventional ethics and those required by the hospital management. The researcher made all questions for interviews available to senior managers, professional staff as well as ordinary workers at the hospitals. The results of the research will be presented to relevant staff at the hospitals.

Chapter Outline

Chapter 1: This chapter presents the aims of the research and its rationale. Second, it sketches the background to the problem to be investigated. Third, it presents the research problem, hypothesis and propositions examined and explored. Fourth, it provides the research methods used in conducting this study. Fifth and lastly, it provides an ethical statement that explains possible ethical issues anticipated and confronted as well as the manner in which they were dealt with.

Chapter 2: This chapter reviews three broad approaches to policy transfer: the standard or rational view, the cultural view and the conflict/political view. This review provides a basis and a theoretical framework for the rest of the dissertation. It also presents different kinds of policy transfers; the subtle issues and undercurrents inherent in these kinds of policy transfers. It further identifies involved actors in policy transfers; policy agents and networks, risks involved, organized labour's responses to the policy transfers. It locates the policy transfer within the rise of the NPM and state versus markets debates.

Chapter 3: This chapter provides an outline of policy transfer debates in SA with a focus on the public health sector. It briefly looks at policy transfer in sectors other the health, since all sectoral government policies are drawn from a common ideological and policy disposition. The chapter also introduces policy change and implementation issues in the Eastern Cape.

Chapter 4: This chapter examines the features of the for-profit private health sector's and how it can be viewed as a model and inspiration for policy transfer. Given its historic

exclusiveness and capital intensiveness in South Africa, the geography of private sector shows that it only provides services where there is "effective" demand and not according to social needs. This chapter focusses on hospital services because the essence of this thesis is a comparative analysis of public and private hospital organisational settings. It also outlines the private sector health sector in the Eastern Cape and its successes. Within this context, this chapter sketches the kind of relationship the private sector has tried to carve with the public sector and related issues.

Chapter 5 and 6 describe and analyse the operational and organisational environment in which service is delivered at Netcare Greenacres Hospital and Port Alfred private hospitals The focus of the examination is on governance structures and their role in ensuring effective service delivery; current service delivery model; business processes; staff capacity, deployment, performance management and its development; the procurement regime; utilisation of technology to enhance service delivery management and operational staff's perceptions of the service they render. These chapters also explores what policy transfers may have taken place in the past, present and those that might be envisaged for the future and how these fit within the environment.

Chapter 7 and 8 describe and analyse the operational and organisational environments in which service is delivered at Cecilia Makiwane and Frere Hospitals, focusing on governance structures and their role in ensuring effective service delivery; the current service delivery model; business processes; staff capacity, deployment, performance management and its development; procurement regime; utilisation of technology to enhance service delivery management and operational staff's perceptions of the service they render. These chapters also explores what policy transfers may have taken place in the past, present and those that might be envisaged for the future and how fit within the environment.

Chapter 9 presents an analyses of policy transfers that have happened at both hospitals locating them within the theory of bureaucracy, considering bureaucracy as an

administrative system and operational context within which service delivery systems are located. Special focus is placed on the agents in transfers, forms of transfers, immediate results and impediments, lessons, ambiguities and contradictions between the systems applied at these hospitals.

Chapter 2: International literature and theoretical framework

Introduction

In this chapter we review three broad approaches to policy transfer. The standard or rational view, the cultural view and the conflict/political view. I suggest a synthesis of these views as a framework for the rest of the dissertation. The standard view of the policy transfer process is that of a one-way and top-down, rational process. But it is generally agreed among critical policy scholars (Newman and Clarke 1994; Wright 2010; Peck 2010; 2011) that policy is based on power, values and interests and policy-makers "are not impartial actors, but moral agents with personal preferences, whose decision-making is influenced by 'selective response to interests' and 'the power structure" (Wright, 2010: 310). Policy processes in private and public organisations are different in many respects, while both sectors affect each other.

Policies are usually written down as official statements with a set of objectives tied to activities (Weiss, 1998). It is also important to stress that policies broadly defined include organisational rules and practices, operational policies and procedures or forms of activities and interventions that are aimed at promoting change (Levine, 1997). Policy transfer has become a new area of academic study within the field of comparative policy, policy change and policy analysis (Peck 2010; Legrand 2012). Individual policies are often tied to other policies and can be seen as making up a model. The new public management model for example proposed a major shift from traditional Weberian bureaucracies to business models.

A key point made in this thesis is that policy transfers are often "messy" because private and public health can be seen as different subsystems systems within market societies

(see Block 2008). A "system" can be defined as an arrangement of parts and their interconnections that come together for a definite purpose (von Bertalanffy, 1968). Roemer defined a health system as "the combination of resources, organisation, financing and management that culminate in the delivery of health services to the population." (cited in Ebrahim and Bowling 2005: 14). According to the World Health Organisation (2000: 1) a health system is "all activities whose primary purpose is to promote, restore, and maintain health." In recent years, the definition of "purpose" has been further extended to include the prevention of household poverty due to illness (*siteresources.worldbank.org/**HEALTH**NUTRITIONANDPO*). A health system has many parts and is clearly more than the sum of its parts. One of the arguments explored in this thesis is that we have to be sensitive to how dis-embedded parts of systems are transferred between organisational settings.

What sets an ideal *public* health system apart from a private one are a number of fundamental differences among these being that public sector is concerned with activities to promote people's health whereas a private system of health care is geared to the interests of shareholders. Although the activities of producing health in the private and public sectors look similar externally, the inner meanings and purposes and objectives might differ. This is an insight (same phenomenon, different meaning) that most comparative approaches are keenly aware of (Hague and Harrop, 1987). But these typologies of systems arguably invite caricature since no pure public or private systems exist (see chapters 6-9 of this thesis). Private sector health, for example, might be heavily regulated by the state and might also perform public functions. The extent of "hybridisation" (through public-private-partnerships for example) is also a matter of empirical research for each country and a question that is addressed in this thesis.

Policy transfer

Dolowitz and Marsh, provide a widely accepted standard definition of policy transfer: as "a process in which knowledge about policies, administrative arrangements, and

institutions in one time and/or place *is used* in the development of policies, administrative arrangements, and institutions in another time and/or place" (1996: 344). The existing literature on policy transfer covers a range of issues from the content of policy transferred, degrees of transfer, the different actors involved in promoting and recipients of transfers, geographies and sectors in transfers, whether policy transfer is coerced as well as issues of power, institutional cultures and translation. Policy transfer may also involve a number of mechanisms, channels and scales. The substance of transfer can include (i) policies (ii) institutional practices (iii) ideologies or justifications, (iv) attitudes and ideas, and (v) learning from negative lessons (Dolowitz, 1997). Moreover, transfers can also take place across policy fields (transport and housing). Likewise, transfers take place between the private and public sectors and are implied in neoliberalising practices such as privatisation, PPP's and corporatisation (McDonald and Ruiters, 2012). In this thesis, the latter is the focus and the ways actors make sense of policy transfer is central. I also question the simplistic idea of "transfer" to show that an understanding of the translation of policy ideas and practices across different contexts, governance regimes and power relations is a contested terrain with contradictory effects.

"Policy transfer" as a field of enquiry, has become a somewhat nebulous field of scholarship shading into issues such as "best" practice, evidence-based policy making and touching on issues such as globalisation, policy convergence, path dependency and new public management. While the standard literature generates many directions (and fashions) for research, it is sometimes hard to track the exact path and process of transfer and to demonstrate that it happened especially when a broad definition such as that used by Dolowitz and Marsh (1996) is used.

The standard reasoning behind intersectoral transfers of private sector expertise is that the public sector does not have capacity and "expertise for innovative and higher quality" infrastructure development projects (Greve and Hodge 2010:153). This standard definition of policy transfer sees it as rational action and change based on evidence of success in one place.

Most obviously, countries and firms seek to adopt new ideas, emulate policies and import technologies to grow their economies and businesses on a wider scale. Some marxists would argue that the growth of productive forces requires increasing scale and interconnectedness in a converging world. It is argued that the compression of nation states around the world into a "global village" through information, communication and technological advances and compelling economic considerations has precipitated the growth of policy transfer. Corroborating this point Dolowitz and Marsh (2000) argued that as technological advances have made it easier and faster for policymakers to communicate with each other, so the occurrences of policy transfer have increased. Legrand (2012:330) has also noted that "globalisation has *compelled* nations to emulate the economic policies of countries that have been successful in navigating the neoliberal environment". Expressing a similar sentiment, Evans (2009) argued that the world of public policy is becoming increasingly small due to dramatic changes in global communications, political and economic institutional structures, and in nation states themselves. In addition, the boundary between what was traditionally called public and private is increasingly blurred (Newman and Clarke, 1996).

This purported speed up in policy transfer has been reinforced by the expansion of international institutions capable of orchestrating common regional policies. For instance, globalisation and regionalisation in the form of G8 countries, European Union (EU), BRICS with their attendant multi-level cooperative agreements has increased the need for and tendency to embark on policy and "best practices" exchanges and interfusion has become more pronounced.

Voluntary or imposed Policy Transfer

The policy transfer literature notes that policy transfer can be located within a continuum ranging from voluntary through to negotiated to coercive. Dolowitz and Marsh (1996) Evans (2009) and Legrand (2012) described a "voluntary" transfer as arising from some form of dissatisfaction with the status quo as a consequence of poor performance (much

like the way privatisation of public hospitals is presented by the Goqwana see earlier ref in chapter 1). There is also what Dolowitz and Marsh (1998:41) termed the "middle ground" and involves a transfer experiment originating from "the actors' perception that their country is falling behind their competitors and therefore need to catch up". Lending credence to this "envy" of other governments' policy transfer experiments is the observation that between 2008 and 2010 the UK was approached for information and advice by over thirty countries on how they had managed to improve their procurement processes and the impact that this improvement had on the public expenditure (Fawcett and Marsh, 2012).

Coercive transfer clearly describes an asymmetrical power relationship where one agency/institution/country has the ability and resources to compel another country to adopt a particular policy (Dolowitz and Marsh, 1996; Fawcett et al, 2012; Legrand, 2012). Structural adjustment and austerity budgets imposed by the IMF come to mind.

However useful, the distinction between voluntary and coerced policy transfer can be questioned. Peck et al (2010: 169) criticise the standard view arguing that "conventional political-science understandings of

> 'policy transfer' (sic) typically posit the existence of a relatively unstructured policy market …. in which emulators engage in freely chosen transactions, adopting policy products that maximize reform goals. In this rational-actor environment, policy transfers are stylized as a distinctively conspicuous category of boundary-crossing practice, the occurrence of which is (implicitly or explicitly) traced to superior performance in exporting jurisdictions.

A national ruling elite who might be seen as having been captured by external forces might appear to voluntarily adopt SAPs (Mkandawire, 2001). Inasmuch as the interaction appears as a "voluntary" interchange process, there might be however a subtle coercive activity "because the recipient country is denied freedom of choice"

(Evans 2009: 245). Policy, as critical analysts argue, has much to do with values, political manifestos than with scientific evidence of what is good for society as a whole. The issue of power become whose values dominate.

In political analysis, "policy convergence" refers to the growing similarity in public policy, structures, practices, approaches and processes among nations or other governments (Bennett, 1991b). This encompasses convergence in policy goals, content, instruments, outcomes, organisational forms, language and style. The concepts (convergence, isomorphism, change and transfer) are related but not the same. And, using similar (neoliberal) language/ideas across private and public sectors, while significant, might not be sufficient evidence of an actual "policy transfer". In this thesis, we will see both examples of convergence (growing similarities) and transfer. Isomorphism is the

In addition, a conception about policy that has been heavily debated is whether policy making (and by implication policy transfer) is a step-by-step rational process (as depicted in the policy cycle) or a "messy" process (Hudson and Lowe, 2004: 7) in which previous policies, resistance and political ideologies play a major role. Hudson and Lowe (2004) drawing on Lindblom (1988) and the incrementalists have argued that policy and by extension, policy transfer are far from rational and reflect uneasy truces, compromises, power and belief systems. This is the line of approach that will inform this thesis.

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Given concerns about the "thin" evidence sometimes invoked to "prove transfer" (also see Hudson and Low (2004: 212-214) a more rigorous approach to policy transfer is needed. Some kinds of transfer, however, are perhaps easier to pinpoint that "ideas". This is so when there are identifiable agents promoting models/tools/innovations (see Harris 2006; Steinberg 2011). Public-private-partnerships (PPP) for example are a specific kind of institutionally arranged policy transfer package widely advocated by the British government in the 1980s and adopted in SA.

In the context of a policy being transferred from one management regime to another, an analysis of similarities and differences of governance contexts is crucial. A standpoint that this Phd adopts is that the rational aspect has been overstated and the contextual factors of different governance regimes understated. As Evans and Davies (2009) have highlighted, the role of policy networks and epistemic communities is crucial in power relations behind transfers. Policy transfer places limited emphasis on how "evidence is construed and constructed by policy officials … the more empirical question of why and when certain types of transfer appear in particular settings and not others, has still not been fully addressed" (Legrand 2012:330). The "best practice" paradigm has been questioned by leading critical scholars in the policy field, Peck et al (2010):

> The ideological emphasis on "what works," which has been a feature both of Third Way discourse and post-financial crisis pragmatism, can be seen as another way in which practical experience is symbolically privileged over more theoretical knowledge. … a deepening reliance on technocratic forms of policy development and delivery is a widely observed feature of late-neoliberalism.

Because the reasons for policy transfer might not always be rational, it is worth looking at some "non-rational" reasons identified in the literature on policy change. These range

from “bandwagoning, convergence, emulation, policy learning, social learning to lesson-drawing” (Ikenburry, 1990; Rose, 1991; Evans and Davies, 1999). The table below lists reasons with “bandwagoning” as one of the least reflective of all types.

Table 1: Motivations for Transfers

Type	Definition
Bandwagoning	Embarking on policy transfer experiments out of perceptions on how other governments have been able to address their problems.
Convergence	Unintentional harmonisation of macroeconomic forces or common processes.
Copying	Direct and complete adoption of a policy
Emulation	Adoption of only the implicit idea embedded in the transferred policy idea rather than the actual and entire idea
Inspiration	Embracing of the spirit behind the idea and this degree of transfer and outcome bears no relationship or resemblance to the original idea.
Lesson drawing	An action-oriented intentional activity involving research”

Source: Ikenburry 1990

Less enthusiastically, Pollit (2004) asserts that countries have set ways of doing things and that post-war welfare states have not been dismantled. The globalisation thesis has been overstated as the path-dependency school has argued (Pierson 2001).

Policy Agents and Networks

Which actors are involved in policy transfers? It is worth noting that the policy transfer phenomenon is unlike a pollen grain which is just carried randomly by the wind but policy transfer is consciously and intentionally peddled by an "extensive array of actors" (Legrand 2012:332). To this end, several categories of agents of transfer have been identified in the literature on policy transfer, namely: politicians; bureaucrats; policy entrepreneurs including think-tanks; academics, policy networks or epistemic communities; pressure groups; global financial institutions; international organisations; and supra-national institutions (Dolowitz and Marsh, 1996; Evans, 2009; Legrand, 2012).

Hudson and Lowe (2004) grouped policy transfer agents into three categories: Insiders, Outsiders and Global Players. Insiders are politicians, civil servants and party officials. Outsiders include NGOs, think tanks, pressure groups and corporations. The global players include international NGOs, supranational governmental organisations such as World Bank, WHO, international experts and consultants. Dolowitz and Marsh (1996); Evans (2009); Legrand (2012) identified agents of change as politicians; bureaucrats; policy entrepreneurs including think-tanks; academics, policy networks or epistemic communities; pressure groups; global financial institutions; international organisations; and supra-national institutions. Steinberg (2011) identified National Treasury and the Policy Unit and Monitoring and Evaluation to have been in the forefront of policy thinking and promoting policy transfers and change processes.

Several of factors enable policy transfer among actors including a common discourse, similar ideologies, professional, shared networks among personnel, and the presence of think-tanks and policy entrepreneurs (Dolowitz, 1998). Not included in Dolowitz and Marsh's lists of role players is the army of consultants that typically drives the formulation and implementation of policy transfer (I will focus on consultants in SA in Chapter 3).

In this view the persuasive power of management gurus and knowledge agents is stressed. The global players include international NGO's, supranational governmental organisations such as World Bank, WHO, international experts and consultants. These global players advise, influence and persuade prospective recipient countries on the advisability, soundness and benefits of adopting their policy ideas and how evidence-based and credible those ideas are. International regimes play a key role in processing policy ideas through epistemic communities which attempt to use their knowledge resources to promote global awareness of certain policy problems and policy options (Evans and Davies, 1999). Stone (2001: 4) pointed out "The World Bank has adopted the discourse of knowledge and learning in its development programmes. As one Bank Director noted, "the world's nations can learn a great deal from each other's experience" and "... we will continue to facilitate this learning" (cited in Stone 2001).

Pertaining to bureaucrats, Pollitt and Bouckaert (2011:66) noted that the quest for new ideas led to proliferation of "politically flavoured senior civil appointments" during the 1990s, alongside "management consultants" increasingly playing a prominent role in advising executive ministers in Australia, Belgium, Canada, Germany, UK and the USA.

Key policy actors who are often involved behind the scenes of policy transfer processes are consultants (or policy entrepreneurs). They are not merely a predictable response to the political economy in which they thrive. Consultants have been involved in policymaking in a variety of countries, particularly since the 1980s often usurping the role of politicians.

The UK, France, Australia, Canada and New Zealand have used policy consultants (Hudson and Lowe 2004). Complex privatisation deals have attracted massive consultancy fees. As Prince (2012: 194) argued it "is necessary to consider in greater depth the actors involved. Getting to grips with their situation ... within policy processes is necessary to understand their form, their actions, and the discourses they mobilize". In the UK the Margaret Thatcher administration relied heavily on consultants' services in a

wide range of areas of governance (BBC Report quoted in Prince 2012: 194).

conditions do the effective transfer of institutional reforms occur between different administrative and political systems? The key theoretical question then becomes whether practices in different unique contexts and spaces are directly and easily transferable? In their examination of the NPM movement Marsh and Dolowitz (1998) unearthed several factors that negatively impact on and explain policy and institutional transfer failures. Essentially Marsh and Dolowitz highlighted the complexities involved in policy or institutional transfer processes in the face of an assumed simple and mechanistic view as presented by early NPM proponents.

Dolowitz and Marsh (1998) argued that the impact of programmatic complexity was mediated through other factors. These included:

- path dependency arising from past decisions;
- institutional and structural impediments;
- a lack of ideological compatibility between transferring countries;
  and insufficient technological, economic, bureaucratic and political resources on the part of the receiving country/partner to implement transferred policies.

Dolowitz and Marsh (1996: 353) also argued that "the transfer of policies cannot be regarded as a mere technical exercise as it also takes into account political values and ideologies. Randma-Liiv (2008: 3) also argued against "the uncritical transfer of a mixture of public administration tools from various countries, which different resources as well as institutional framework may easily lead to substantial problems". Rose (1993) argued that the realisation of policy transfer is contingent on the substitutability of institutions and symmetry and equivalence of assets of the receiving country. Dolowitz and Marsh (2000) identified three kinds of reasons for failure in policy: uninformed transfer, incomplete and inappropriate transfer. The first type happens when a policy is adopted with either limited information about the policy; the second when only some parts of programme are transferred, and the third, when too little consideration is paid to

the differing context and situation. All three errors arguably are at play in South African policy transfer from private to public sectors.

Fine (2014: 7) refers to

> conceptual imperialism as far as social policy is concerned, with the analysis and policies for developing countries following … whether it be in erstwhile goals of modernisation or the more recent turn to market mechanisms. This raises the issue of how to learn from the literature without becoming its slave.

Noting the speed with which the post-communist Central and Eastern European (CEE) countries embraced Western policies and technical expertise in the aftermath of the fall of communist regimes Randma-Liiv (2005) cautioned that politicians and managers with too little experience may easily fall into the trap of fashionable approaches while overestimating the positive outcomes of the new ideas and underestimating the negative drawbacks of such one-size-fits-all models.

It is thus debatable whether the advanced techniques and "best practices" of privileged sectors or nations of the world provide the most useful and realistic lessons for developing countries. Reiterating the importance of the latter point Common (1996) argued that it needs to be considered that policy transfer is also dependent on the political system possessing the political, bureaucratic and economic resources to implement it. Acknowledging the dangers of direct and coercive transfers Evans (2009) argue that it should be a question of *learning* rather than direct transplanting, seeing that differences in political culture, levels of economic development, country size and bureaucratic capabilities will determine which reforms are feasible.

As Holden (2009: 313) notes, "the literature on policy transfer has paid insufficient attention to the role of commercial interests in the transfer of policy. Fawcett and Marsh (2012: 182) provided a useful summary of

warnings about policy transfers.

> The major thing to avoid at all cost is seeing policy transfer as a quick fix. This case indicates that successful transfer is dependent on considerable prior investigation about how the policy which a jurisdiction is considering transferring operates in the original jurisdiction. … the process requires significant commitment by politicians and, especially, public servants to investigating its operation in detail and is considerably helped if strong interpersonal relations develop between individuals in the two jurisdictions. Of course [transfer is helped by] a shared common language and few cultural and political differences between the two jurisdictions (Fawcett and Marsh 2012:182).

The political perspectives tend to focus on structured interests and outcomes (see Giroux and Taylor, 2002) rather than context—historical and social, time and place—or 'relevance'. They do not address why and when some ideas spread while others do not or do so in a different time and sequence? Such questions are the focus of cultural and, in particular, institutional perspectives. Lam (cited in Sturdy 20014, 164) for example argues that 'many of the problems lie not in structural barriers', but in the 'socially embedded nature' of the knowledge transferred.

Peck et al (2010:170) suggested key caveats for policy transfer researchers. First, "policies rarely travel as complete "packages," they move in bits and pieces—as selective discourses, inchoate ideas, and synthesized models—and they therefore "arrive" not as replicas but as policies already-in-transformation. Also, the policy transfer process "is not one of simple emulation and linear *replication* across policymaking sites, but a more complex process". Policy transfers carry risks of inappropriate implementation and "structural incompatibilities" between the transferred policy content and the receiving environment. Countries or institutions at different points in their development emulate, borrow, are encouraged to copy from each other. But

copying or mimicking a new technique may be successful or it may be a caricature. However, few scholars in the policy transfer field look at the role of organised labour and unions (an aspect I shall explore in the chapter).

Policy transfers across market and state and back again

The shift from states to markets has been a notable feature of late 2oth century political economy and there has been considerable blurring of the boundaries of state and market given the marketisation of the public sector. In the 1980s the debate about efficiency and the boundaries of state and market continued with new intensity. Public services (health, water education) have been marketized, broken up and outsourced and in some cases fully privatized. The dispersal of activities across various providers sets up new dynamics and oscillations of centralisation and decentralisation – concerns for tight control versus getting close to "customer" (Clarke 2008).

The specific kind of policy transfer that is researched here is involves processes by which "*knowledg*e of ideas, institutions, policies and programmes (Dolowitz and Marsh 2000) processes are moved across the private and public sectors. It includes the public-private partnerships (PPP), outsourcing and associated forms of privatisation of public sector services. As mentioned in chapter One, PPPs are seen by the South African state and major political parties as fundamental to skills and knowledge transfer from the private to the public sector in order to improve services.

Exploring comparative methods, and similarities and dissimilarities in characteristics of public and private sector organisational environments, Schiflett et al (1990) argued that there are major differences between the two sectors and their respective applicability and operability cannot be uncritically considered transplantable. It is more "fruitful to distinguish between private products producing organisations (PPOs) and public service organisations (PSOs) as distinct types when theorizing and applying findings" (Schiflett

et al., 1990: 580).

Following Weber, Simon et al. (1950:16) argued that public administration is a *planned* system of cooperative effort in which each participant has a recognized role to play and duties and tasks to perform … to achieve the organisation's purpose. Mouzelis (1967) defined bureaucratic administration as the exercise of control on the *basis of knowledge* and that it is this element of knowledge that makes administration rational. Rationality in this context is considered to be the logical arrangement of units of organisational structures and attendant authority structures, people and efficient execution of activities to achieve organisational goals that satisfy *public* needs. Professionals such as teachers and nurses are employed as permanent career staff based on their skills and they enjoy a high degree of autonomy. The difference is that better examples of good public systems draw on and are nourished by altruistic public ethics and public spiritedness (knightly behaviour) – values systemically undermined by NPM (Le Grand 2003). Le Grand argued that in the immediate post-war decades in the UK, the knightly assumption triumphed, while during the Thatcher era, the knavish assumption prevailed. Much of the NPM-like, Smithian market behaviour is driven by a set of assumptions about how humans behave and these assumptions are naturalised in the competitive free market (2003). The "commodification of inter-agency good will" and erosion of public spiritedness and cooperation means more conflict in work places (Clarke and Newman 1997: 80)

Crewson's (1997: 515) concluded that,

> A delicate balance must be achieved between providing adequate economic rewards and taking care not to destroy or ignore the intrinsic or service needs of public employees. The balancing of rewards in the public sector cannot rely solely on private-sector assumptions and techniques.

Janet Newman (2008) noted that performance monitoring often undermines workplace trust and promotes gaming. Pollitt (2000) draws similar conclusions (also see Hudson

and Low 2004).

The literature I draw from in policy analysis critically interrogates the multiplicity of agents who collaborate to produce transfers between different systems, their ideologies, political culture and forms of bureaucratic organisation. Unequal *power relations* at various scales including workplaces need to be more central to explaining policy transfer. This critical approach will constitute the framework for this research which focuses on labour and management at the facilities.

The divide between market and state is fundamental when considering the nature of policy between private and public sectors. Karl Polanyi argued in *The Great Transformation* (1944) that the evolution of market societies has been characterized by a double movement. On one hand, we have the movement of *laissez faire*--the efforts by a variety of interests to extend the scope and domain of self-regulating markets. On the other hand, we have the counter-movement: which protects to "insulate the fabric of social life from the destructive impact of market pressures… What we think of as market societies or "capitalism" are the product of *both* of these movements; forming an uneasy and fluid hybrid that reflects the shifting balance of power between these contending forces." (Block 2008).

For Polanyi in market societies, it is not about seeing the state or market as insulated sectors but about a shifting balance of power. Polanyi (1944) argued that the market is "embedded" within a society, in that social norms and morality determine *the scope* of the market. Polanyi asserted that free-market liberals seek to reduce society's rules over the market, wanting to subject society to the rules of the market. This stance when extended to labour and land (we can include health) reduces these basic social rights such as health care to things bought and sold in the market just like any other commodity.

On the other hand, Block (2008) noted, "Polanyi's double movement formulation has been criticized for being functionalist or for reifying an abstract entity called "society"

that somehow knows how and when to protect itself" against the market. Polanyi did however reconceptualise the field in which social struggles against commodification take place providing a "less class-deterministic account of who the relevant actors in these struggles are". Block (2008) argued that Polanyi sought a more holistic account of social conflicts in which the specific historical context helped shape how social groups mobilized. Along these lines. this study identified considerable resistance to neoliberal style policy transfer (ala Polanyi) by workers and sometimes managers in the health sector (see Chapter 5, 6, 7 and 8).

The idea of organisational culture is of course very relevant for policy transfers as public and private organisations may have very different ways of recruiting staff and may also draw from different political and cultural networks. For Blau (1956:119) "many official rules are honoured in breach". Furthermore, there is a difference between the intended effects of a formally designed institution and its actual effects (Blau and Meyer 1956). Blau and Meyer (1956) argued that the members of the organisation act as subjective and emotional beings. This is relevant for policy transfers.

Before looking at workers' resistance we examine the New Public Management argument.

New Public Management (NPM) ideology and managers: Learning from and bringing back the market to meet public needs

The New Public Management (NPM) describes a profound change or paradigm shift in a fundamental model and an institutional and cultural shift from mixed systems towards "free markets". The ideals of NPM are to transform public sector workplaces, workers and the public sector as a whole and turn citizens into customers. This includes a large-scale project of policy transfers and blurring the boundaries of the public and the private sectors. The ideal public service should not be delivered by the state (which should steer not row). As far as possible, the state should enable private enterprise and stick to its

"core" functions. "Core" as Clarke and Newman (1997) explain means that public organisations should only do what is essential, remain focused and shed additional functions contracting them on to the private sector. The net result is the creation of a nexus of contracts for non-core services. For example, schools may outsource after-care; hospitals security and universities, food, residences and library services. But drawing the line between core and non-core is "not a simple matter" for managers argue Clarke and Newman (1997: 79) and may have perverse effects leading to a decline in "public legitimacy". In addition, those who work in "core" functions may find themselves interacting with "non-core" workers creating inevitable disputes about who is doing what on whose turf. These boundary and blame shifting disputes may be lethal (see babies dying in Frere and CMH). As Newman (2004:17) puts it, "the cultural values that were embodied in notions of public service were undermined by the valorisation of the business world coupled with the emphasis on managerial and entrepreneurial criteria of success".

The key idea of the neoliberal/managerial approach to social citizenship is the defence of the individual's right to choose, and his/her freedom from oppressive interference by either governments or other individuals (Barbelet, 1988). In this regulatory framework, government is not obliged to secure the social needs of individuals beyond the protection of individual civil and political rights and should "leave it to the market" to provide services such as health. Neoliberals warn against moral decay of the dependent poor. According to Milton Friedman, the top advocate of the neoliberal approach to social rights:

> "The heart of the liberal philosophy is a belief in the dignity of the individual, in his freedom to make the most of his capacities and opportunities ... subject only to the proviso that he not interfere with other individual's right to do the same. This implies a belief in the equality of men in one sense; in their inequality in another" (2002:195).

Championed by Osborne and Gaebler (1992), the NPM movement also rejected the neo-Weberian bureaucratic model as well as the idea that public and private were strongly differentiated. Osborne and Gaebler (1992: 344-45) argued that reinventing the government would have to involve disrupting traditional public organisations and values and transferring private sector techniques such as: outsourcing of services; public-private partnerships; empowerment of clients to participate in management through governing councils and management teams; minimisation of rules; adoption of customer concept and steering rather than delivering service; introduction of user fees; proactive management rather than reactive response to social needs; introduction of decentralisation and restructuring of the market. Public services should be a network of contracts with private providers and private sector values.

Ferlie et al (1996) described NPM, an offshoot of neoliberalism, as a body of managerial thought based on ideas generated in the private sector and ideally *transferred* to the public sector. Thus the idea of policy transfer from the private to the public was a fundamental tenet of NPM.

NPM ideas emerged during the 1980's in countries like England, Australia and New Zealand. Commenting on the rise of the NPM, Goodsell (1993) argued that the current reinvention of government constituted a rejection of Progressive and New Deal Era models of government which involved *in*-house programme implementation and service delivery by hierarchically organized departments run by professional managers in accord with operational rules and fiscal checks.

"Partnerships" is a key word in NPM and the later "third-way" perspective. PPPs have been seen as a centrepiece of an "alternative/innovative," modernised marketized service delivery model and have also informed and shaped public debate in the healthcare system and service delivery more generally. Governments claim to use outsourcing and PPP's to build good relationships with the private sector to achieve public goals through private means. The outsourcing of delivery is meant to reflect a purchaser/provider split

between policy making (steering/purchasing) and actual delivery (rowing/providing). Alongside this, there is the growth of auditing and performance evaluation (Hudson and Low 2004).

PPPs are systems of formalized cooperation grounded in legally binding arrangements or informal understandings, cooperative working relationships and mutually adopted plans…involving agreements on policy and program objectives and sharing of responsibility, resources, risks and benefits over a period of time (McQuaid et al, 2010). Outsourcing can also be included under the rubric of "partnership". PPPs have also been defined as longer term "arrangements where the public and private sectors both bring their complementary skills to a project, with varying levels of involvement and responsibility, for the purpose of providing public services or projects" (Tang 2009: 684).

Criticism of and Resistance by labour to NPM

The third-way state since the 1980's has portrayed public sector workers and professionals as an obstacle to NPM modernisation (see Tony Blair's speeches attacking cited in Mooney and Law, 2007: 11-12). But local managers are faced with the need to secure consent at the point of production and this is well covered in the literature (Thompson 1989 and Burawoy, 1979). However, new ideas and practices and the agents who market them can become a source of undermining manager's power and identity As Sturdy (1997) comments "this threat is well illustrated in a quote from a manager about consultants cited by Sturdy (1997: 403)—'I like working with consultants (provided that they report to me and not my boss!!)'. As policy analysts Pressman and Wildavsky (1984) noted the role of discretion introduces for variability in how ideas and practices are received, resisted and adopted. Moreover, radical labour scholarship starts with the structural reality of tensions in capitalist employment relations (Thompson 1989). As Sturdy (2004: 163) argues, "resistance does not simply reflect a barrier to the adoption of ideas, but serves as a stimulus to it as well". His dialectical view suggests

that,

> at times when management control is challenged by labour. For some, such patterns are inevitable since management ideas/practices aimed at securing the control of employees are likely to fail or create new difficulties as they treat the symptoms not the cause of problems (2004: 163).

In the policy literature, the power is commonly seen as resource-based. However, such 'resource-based power' is largely observable and visible (Hartsock 1985) but less visible forms of power relate to agenda setting and non-decisions as well as discourses of "transformation and modernisation" in which workers are seen as an obstacle to progress. Expertise and evidence are used as a screen for objectivity to legitimate top-down changes and policies. Sturdy (2015) points out that,

> another form of power is evinced where groups seek to emasculate others, often prior to the implementation of new management practices, so to minimise resistance. This is witnessed in studies of organisational change where de-unionisation and casualisation are not only implemented as management ideas in themselves, but are also strategies which facilitate the implementation of other ideas by weakening oppositional groups. Resistance in this process domain is deemed more difficult because it focuses on altering forms of governance, for example, by excluding spokespeople and redefining which actors can contribute to decision-making.

This "processual forms of power" are harder to spot and to resist than resource power. In the arena managerialism, Sturdy (2015) notes terms such as " 'thought leadership' (e.g. research published by consultancies), training, lobbying and advertising" are pronounced. Heroic "turnaround managers are hailed as models to be emulated. The process of policy transfer might also be seen as a mechanism of globalising ideological class power production of meanings, signs and values in social life as often happens

through the World Bank and Washington "Consensus" (Hudson and Lowe 2004).

"Organised labour was the subject of an elaborate battery of attacks: new industrial relations legislation variously spoke in the names of the market, and the customer (Newman and Clarke 1996). Scholars have interpreted NPM as a direct attack on the power of organised labour (Wainwright 2012). Argyriades (2010:283) argued that the rise of the NPM and related policy transfer has been characterized by "renewed attacks on trade unions and attempts to curb their influence".

Resistance to NPM by trade unions (specifically social movement unions) is partly based on the normative idea that public service is not a "product" that can be simply be measured in only monetary terms. For example, good public health services are preventative whereas private health care is largely curative. Decisions about how much services to provide are political and the major distinguishing feature of public services is its political nature (Beetham, 1987). The table below provides further insight into the ideal type differences with respect to labour practices and governance even if these differences might be too sharply delineated (Dunsire, 1991).

Table 2: Comparing public versus private services (ideal types)

Public (old)	Private (new public management)
Equitable and democratic	Service according to ability to pay
Service with in-house staff public ethos	Subcontracts and outsourced workers
Uniform in its jurisdiction	Differentiated by economic service areas
Hierarchy of unbroken supervision	Intermediaries and nexus of monitored contracts
Standardised employment practices	Flexible packages

Cross-subsidised departments	Ring-fenced
Non-profit, no shareholders to pay out	Profit imperative
Long time horizon	Contract set time horizon for recouping profit
Accountability via elected representatives	Accountability through consumer research, use of advertising

Source: Dunsire (1991

The use if in-house staff and standardised employment and long term employment is characteristic of traditional public sector. The public service ethos of fairness, equity, impartiality, building solidarity, citizenship and professional has been under attack from new forms of business accountability and uncertainty for managers and public sector workers. (see column 2 of the table above). NPM critic (Argyriades, 2010:283) argued that an emerging trend related to the above phenomenon is that "a powerful combination of economic, social and political factors is gradually bringing about a substantial depersonalisation and de-professionalisation … in the new managerial culture". At the same time many critics have noted the high monitoring costs and extended transactions between principal and agents in outsourcing governance arrangements (Donahue, 1989; McDonald and Ruiters 2005).

Pollitt and Bouckaert (2011:72) identified three flaws in NPM which they considered fundamental. They argued that firstly: the "NPM story is misleadingly neat and over-simple" as bureaucracy has never been a singular and monolithic system - but consisted of different formations, sets and subsets that are not necessarily all rigid and rule-bound and were based on lateral and collegial rather than hierarchical relations.

Secondly, and in addition to the latter argument, they asserted that there has never been single hierarchical administrative systems even though there might be some that fit that hierarchical definition. Examples of hierarchical relations are found in "most expensive,

labour intensive sectors of administration such as education and healthcare which were never legalistic bureaucracies" (ibid.).

Thirdly, NPM has been "one-sided" in its critique of bureaucracy, which has focused only on the negativities and thus has overlooked the values of "honesty", "continuity", equity (equitable treatment of citizens in terms of impartial servicing of citizens) which could have been significant contributors to their own notion of efficiency. Pollitt and Bouckaert (2011) did not dismiss entirely the negativities of traditional bureaucracy but cautioned against the overly optimistic and unreflective jump to the new models of public organisations and regarding these as a panacea to all the ills of traditional bureaucracy (this is an insight the Phd develops in subsequent chapters).

Hudson and Lowe (2004) also noted that the proliferation of the use of performance measurement and evaluation processes in public services around the globe. The premise here is that public services are "product" and workers a resource. The use of performance measurement however tends to lower staff morale, encourage gaming (external compliance and tunnel vision), change staff attitudes to work and reduce trust in the workplace (Newman 2008)

Efficiency and adopting new ideas

The 1970's neo-classical distinction between public and private goods has been well documented and part of the reasoning for the distinction was the idea of economies of scale achieved and public efficiency through natural monopoly. Public goods supplied out of state funds were regarded as goods produced more efficiently by a natural monopoly organisations rather than by dispersed competitive organisations. The analytical failure of these distinctions became apparent in the 1980s when almost all previously recognised "public goods" -- even water -- were considered potentially open to privatisation and commodification (also see Simon's 1950 observations above) in the name of efficiency. Even in the residual state sector, market-like mechanisms were put

in place. Evidently, the debate about what is or should be public and private sectors cannot be divorced from politics and new arenas of capital accumulation.

Efficiency is among the most used words in motivating taking lessons from the private sector. Therefore, I will look at it briefly. It may be considered as features associated with "speed, simplicity, precision, reliability and vigour". Miruc (2008:115) argued that the idea of efficiency can be technically defined. It can be seen as the skillful and intellectual utilisation of "own organs and tools" to achieve objectives. The universal level conceives efficiency as one of the three values: effectiveness, advantageousness and economic efficiency. But, the synthetic level we consider the "*totality* of practical values of an action which are considered positive such as the good quality of the output or outcome" (ibid).

Beetham (1987) also argued that efficiency itself is a multi-layered concept whose different elements are not mutually consistent. The notions of rationality and efficiency are *socially* defined and since much of the debate about policy transfer and new public management rests on the apparent efficiency of the private sector, but the values aspect of a service needs to be stressed. Waldo (1948 cited in Denhardt, 2011) argued that efficiency on its own cannot be a value and it must always be defined in terms of a *particular social purpose being served*. A private hospital serving a minority population might be efficient in a narrow sense only and only so for elites. The evaluation of an administrative decision and choice is always value-laden and is dependent on "agreement or disagreement with values that a particular plan seeks to achieve on one hand and on judgement on the potential efficacy of the plan in attaining those values" (Dimock and Dimock 1964: 517). Efficiency is relational and therefore it cannot be de-contextualized.

An exclusionary private hospital that serves a small segment of the population "efficiently" (a form of health apartheid) but at very high exclusionary social costs and at high prices might be hard to defend as socially efficient. The legacy of racial

capitalism and inclusion of a black elite in sharing the profits of private health industry provides legitimacy for this form of inefficiency at the cost of the majority of black lives. A grizzly case of rationalisation and efficiency was the death camps of Nazi Germany. The goal was to kill as many people as possible in the most efficient manner (Shirer 1960).

Pollitt (2000) has extensively problematized the notion that efficiency can be easily measured and its successes and practices transferred. Efficiency of a service cannot be assumed to be value-free, and thus objective and measurable (Pollitt, 2000). Good education might mean different things to different people. It might therefor be undesirable to transfer policies wholesale from the private domain to the public domain. The meaning of efficiency can thus be stretched to mean: activity whose sum total should lead to the achievement of a public administration's objectives with minimal or no wastage. Therefore, efficient actions of public administration are those that lead to the achievement of intended social objectives in a positive and cost-effective manner. Here the means-ends relationship are socially and politically defined.

Denhardt and Denhardt (2009:406) believe that modern government is about much more than narrowly defined efficiency. It is also about the relationship of accountability between the state and its people, responsiveness, transparency and participation. Participation by citizens in governance process and the notion of civil society …. means more decisions are being made through meaningful interaction with citizens and that citizens are playing an important role not as recipients of government services but as contributors to the policies and programs that affect their lives (Denhardt and Denhardt, 2009:409).

Adding their voice on the critique of NPM and in the search for an alternative, Denhardt and Denhardt (2011) argued that government shouldn't be run like business; it should be run like democracy… whereby citizens and public officials are working to define and to address common problems in a cooperative and beneficial way. Denhardt and Denhardt

(2009:409) further argued that the better contrast is between NPM and what we call the "New Public Service," i.e. -a movement built on work in democratic citizenship, community and civil society, and organisational humanism and discourse theory.

They further outlined six general principles of the New Public Service, most notably that the primary role of the public servant is to help citizens articulate and meet their shared interests rather than to attempt to control or steer society; informing and educating the public on important policy issues; improving government decisions by supplying better information upwards from citizens to decision makers; creating opportunities for citizens to shape and in some cases to determine policy and so on. All these considerations would not apply in the profit-seeking private sector. Summing up these stark differences for health sectors, Ruiters and Van Nierkerk (2012) argued that government and private sector policy approaches are informed by very different values and principles with the former's objective being to expand public healthcare as a social citizenship entitlement which is provided equitably to all citizens regardless of their financial position, while the latter is driven by a profit-driven model aimed at cost containment and recovery. Not much however is said by these authors about public sector workers.

Denhardt R (2011:1) argued against the stereotypical view of the state as an inefficient, slow, rigid and unresponsive behemoth, pointing out that "although public bureaucracy is often thought of as an impersonal mechanism", in practice the contrary obtains as "behind every official's encounter with public organisations lies a lengthy and complex chain of events, understandings and behaviours". Therefore, "social processes in bureaucracies modify their structures and operations…. Making the organisation more flexible and responsive to changing conditions" (Denhardt 2011:1).

Finally, we consider the issue of innovation and the role of the state. Fred Block and his colleagues have argued that contrary to the commonly held idea that private companies are responsible for the world's big discoveries and innovations, that the state is the central actor in overcoming market failures. Block et al (2009) suggest two points:

> The diminishing role of the largest corporations as sources of innovation. (And) the expanded role of public institutions and public funding in the innovation process. This leads us to the surprising conclusion that the USA increasingly resembles a Developmental Network State in which government initiatives are critical in overcoming network failures and in providing critical funding for the innovation process.

Recent research on historical trends in drug innovations showed that state research institutions including universities have produced most of the basic knowledge which the private sector adapted for its advantage. The private sector is unable to match the public sector's role but has appropriated its work.[2]

> Historically, there has been a clear distinction between the roles of public-sector research and corporate research in the discovery of new drugs and vaccines to solve unmet medical needs. Public-sector research institutions (PSRIs) have performed the upstream, basic research to elucidate the underlying mechanisms and pathways of disease and identify promising

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[2] An excellent example of this traditional approach (as explained by Stevens et al, 2011) was Julius Axelrod's research at the National Institutes of Health (NIH) regarding the basic mechanisms of neurotransmitters, for which he received the Nobel Prize in 1970. This research provided the foundation for the pharmaceutical industry's discovery of an entirely new class of drugs, the selective serotonin-reuptake inhibitors (SSRIs), which have been important in the treatment of depression. All the major SSRIs were discovered by pharmaceutical companies with the use of Axelrod's basic discoveries and are therefore not included in our study (e.g., Eli Lilly's discovery of fluoxetine [Prozac], which received approval from the Food and Drug Administration [FDA] in 1987).

> points of intervention, whereas corporate researchers have performed the downstream, applied research to discover drugs that can be used to treat diseases and have then carried out the development activities to bring the drugs to market. The intellectual property that protects the investment in developing these drugs is created in the applied-research phase. (Stevens et al., 2011).

Conclusions

This chapter has extensively reviewed linked international literatures covering the underlying and immediate issues in policy transfer and policy change (the more appropriate designation of the field of study as argued by Hudson and Lowe 2004). The framing of policy transfer needs to take account of contexts, power relations and dominant shifting ideologies (Keynesian versus managerialism for example) and institutional settings, values, as well as historical patterns of policy making in various settings.

The extent of policy transfer from the private to the public has been much exaggerated, argues Pollitt (2011). Countries have retained their established ways of functioning and the 'revolutionary" aims of NPM are far from achieved. Peck et al (2010: 173) suggest that "in contrast to the policy transfer tradition, which invokes notions of rational diffusion and best-practice replication, critical approaches to *policy mobility* tend to explore open-ended and politicized processes of networking and mutation across shifting social landscapes".

Transfer of policy ideas and eventual implementation of a policy is heavily dependent on the relationship between the originating context and the destination for transfer. The views and role of organised labour has been the great silence in much of the policy transfer literature because workers are said to focus on bread and butter issues (see Buhlungu 2006). Along with Pollitt (2011), Peck (2010: 172) observes,

> In contrast to the policy transfer tradition, which invokes notions of rational diffusion and best-practice replication, critical approaches to policy mobility tend to explore open ended and politicised processes of networking and mutation across shifting social landscapes. The analytical pursuit of mutating policies, in this context, need not be a fatalistic affirmation of hegemony; it can reveal the limits of neoliberalisation as well as its logics. There is also a politics, then, to following mobile policies, to tracing their twists, turns, and localised effects.

Thus, particular processes of policy transfer, for example in a public hospital, can reveal much about conflicts and about the vested interests and political-economic contexts in which the transfers are occurring and also much about the ideological context.

It can be concluded from this literature review that policy transfer from the private to public sector is fraught with underlying assumptions, values, interests and philosophical underpinnings on one level and institutional arrangements, business processes and organisational culture and its dynamics on another.

The debate on sectoral private-public transfer is also about understanding the theories of state and market in capitalism and how these domains have interacted and intersected and mutually defined each other rather to consider them as stark dualities.

Chapter 3: South Africa's public health sector governance issues and the Eastern Cape

The purpose of this chapter is to outline policy transfer debates in SA with a focus on the public health sector. I start with a brief look at policy transfer in sectors other the health, since all sectoral government policies are drawn from a common ideological and policy disposition. The chapter also introduces policy change and implementation issues in the Eastern Cape.

Introduction: Debates on policy transfers and best practice in SA

Jeff Radebe, the former Minister of Public Enterprises, asserted that

> public policy needs to be designed around a mix of options that will attract strategic equity partnerships; redesign business management principles; introduce various immediate turnaround initiatives that seek to improve the efficiency and effectiveness of the entity; access globally competitive technologies where appropriate; mobilise private sector capital and expertise and develop new skills (www.polity.org.za/govdocs/policy).

The "policy transfer" literature (if that is an appropriate term) in South Africa is limited to a few key authors such as Harrison (2006), Cameron (2009), Steinberg on community policing (2011) and (Bond 2014) focusing on the World Bank and privatised municipal services (also see McDonald and Pape, 2002; McDonald and Ruiters, 2011). NPM is the neoliberal creed for the public service espoused by US and UK state ideologies. Cameron (2009) questioned the extent to which the South African public service has imported policy from the outside and the outcomes of these. Cameron (2009: 912) argued that the vocabulary of the post-Apartheid state administration transformation project included, "decentralisation; corporatisation; rationalisation (of personnel);

privatisation (of public entities), performance based contracts (for senior management), staff performance management [as]…key elements of NPM reforms".

From the quotation above and numerous other sources, many believe that the powerful influence of new public management (NPM) on the shaping of South Africa's system of government, administrative policies and labour relations is a now widely recognised fact (Bond 2014; Harrison 2001; Cameron 2009; Steinberg 2011). A number of scholars have pointed to the dominance of external advisors in the early years after Mandela came into office (Bond 2014; Harrison, 2006).

Harrison writes;

> the accepted international discourse on governance and development forcefully constrained the horizon of possibilities for policy innovation after apartheid… the powerful influence of New Public Management (NPM) on shaping of South Africa's systems of local government are now widely recognised (2006, p. 188).

In 1995, as Steinberg (2011) shows, after a year in power, South Africa's new democratic parliament, for example, it enacted laws that introduced a version of community policing and crime prevention into the country's policing system and an outcomes based education system. Both these statutes were simply "transferred indiscriminately from Anglo-American ideas that nonetheless became the bedrocks of the South African policing and education systems". South Africa in the 1990s, he argues, was a prime candidate for becoming "the most desirable destination on the planet where agents of 'policy transfer' might ply their trade at the time. …A host of foreign governments and think tanks descended on South African shores to offer advice" (Steinberg 2011: 349).

I will argue along with others, that it is apparent that policy makers have either succumbed to allure of "best practice" and the influence and fashions of external policy

or uncritically adopted models from abroad especially in respect of new public management and public services (Harrison, 2006; Steinberg, 2011) while the elite are mired in allegations of corruption (Southall 2012). The idea that there is a single way "best way" to do things (isomorphism) is a factor driving policy transfer. Everybody ends up chasing the magic bullet only to realise that a new one is already being invented.

The "rationalisation" of the workforce, Cameron (2009: 917) notes had unintended consequences which included the exodus of skilled staff from public service. He noted that the creation of Senior Management Service and the associated contract appointments had produced mixed results in the sense that as much as good managers could be found among the newly appointed senior management cadre, bad managers could also be found. Also, the contractual nature of their appointments meant a "premature departure of skilled staff" and in any event external policy ideas have been "erratically and inconsistently applied" (2009: 915).

Cameron (2009) argued that despite the fact that a number of measures were put in place to improve service delivery, available evidence suggested that there had been mixed results. These results indicate a lack of a systematic service culture in the public service. Cameron concluded by arguing that while there were *elements* of the NPM in the reform programme, it had not taken off in the way that had commonly been presumed.

Steinberg (2011: 350), noted that 'best practice' was being defined and generated by a burgeoning international industry of police reform." But, argued Steinberg, "it was not simply a matter of transferring a few good practices from one part of the world to another". Policy transferred from the UK and USA to South Africa post-1994 "always travel with *cultural* specific baggage" and never adapt easily to a new environment (Steinberg, 2011: 351). Offering a cautionary note, Steinberg (2011: 352) further argued that

> slicing off a set of policy transfers and transplanting them in foreign soil is an uncertain business … as the destination countries themselves consist of

> slow evolving structures and mentalities and what will precisely grow in their soil is hard to predict.

More so that "the destination countries are themselves in a state of profound and far-reaching transition". Illustrating the fluidity of the policy transfer process itself, the dynamic nature of the recipient environment and unpredictability of the kind of envisaged outcomes that may arise therefrom Steinberg argues that

> political cultures in transition are famously opaque; the question of how public institutions will 'behave' is somewhat unknowable, even to those who are designing them. All new regimes inherit deep structures of thinking and acting from the old; precisely what will be inherited or cast off is something that can be guessed at, but only really known ex post facto and the transfer of ideas and institutions from other political cultures is an especially uncertain venture (Steinberg 2011: 353).

Steinberg's (2011: 352) caution above about the uncertainty that "slicing off a set of policy transfers and transplanting them in foreign soil" being an uncertain business, resonated with the situation at the dawn of democratic dispensation in South Africa in 1994. However, few if any policy transfer commentators listed above emphasised the role of the labour movement in SA.

Public health crisis and policy transfer in SA

The health system in SA as noted before is fragmented. Fundamentally, there are two perspectives on the transformation of South Africa's health system: the rights based perspective and liberal, free market perspective that vigorously promotes policy "transfer" in one direction. The former perspective argues that access to health is a human rights and social justice issue which requires equitable distribution of resources (funding, physical and human resources) and ensuring universal access to health in a single health system (Ruiters, 2011; Van Niekerk, 2012).

The ANC's health plan, published in 1994, was the post-apartheid model for health system change. The legislative and policy frameworks that were introduced were based on Sections 10 and 27 of the Constitution of the RSA. These sections provide every citizen the right to have access to health care services including reproductive healthcare and all these to be provided within a context of the basic values and principles that govern the public service which include high standard of professional ethics; effective, economic and effective use of resources; a development-oriented, responsive, accountable and transparent administration (RSA, 1996). It social democratic ambitions were evident.

> It had its antecedents in the concept of primary health care as promoted at Alma Ata and envisioned a system based on community health centres, in which children younger than 6 years and pregnant mothers would receive free treatment, reflecting the recommendations of the Gluckman Commission 50 years earlier (Coovadia et al. 2009: 827).

In reorganizing, configuring and transforming the South Africa healthcare system official policy has been to unify the fragmented health services at all levels into a comprehensive and integrated National Health System. This is the context for what some deem appropriate policy transfer, based on the progressive World Health Organisation principles.

The liberal market perspective (Broomberg, 2011, Van Den Heever, 2009) which defends separate health systems and “choice”, argues that healthcare transformation challenge in South Africa is about more than funding. The challenge lies in healthcare management and that needs a technical rather than emotive and politically charged approach to ensure access and achieve good quality and adequately funded universal access to health-care services. The latter perspective further calls for a robust policy debate which should include making the real causes of our current failures clear and developing a policy that points to practical and concrete steps to overcome these failures.

The White Paper for the Transformation of Health System (WPTHS) emphasizes that efforts should be made to ensure the improvement in the quality of services at all levels (RSA, 1997). Gesturing to international "best practice" and benchmarking, it further directs that clear outputs, targets and performance indicators benchmarked against comparable international standards be put in place; service standards, monitoring and evaluation mechanisms and structures designed to measure progress be developed; plans for staffing, human resource development and organisational capacity building tailored to service delivery needs among other.

The public service code of conduct (1997)

> An employee -
>
> promotes the unity and well-being of the South African nation in performing his or her official duties;
>
> will serve the public in an unbiased and impartial manner in order to create confidence in the Public Service;
>
> is polite, helpful and reasonably accessible in his or her dealings with the public, at all times treating members of the *public as customers* who are entitled to receive high standards of service;
>
> has regard for the circumstances and concerns of the public in performing his or her official duties and in the making of decisions affecting them;
>
> is committed through timely service to the development and upliftment of all South Africans;
>
> does not unfairly discriminate against any member of the public on account of race, gender, ethnic or social origin, colour, sexual orientation, age, disability, religion, political persuasion, conscience, belief, culture or

language;

does not abuse his or her position in the Public Service to promote or prejudice the interest of any political party or interest group;

respects and protects every person's dignity and his or her rights as contained in the constitution; and recognises the public's right of access to information, excluding information that is specifically protected by law. (http://www.psc.gov.za/documents/code.asp)

The new government defined the roles of the various public hospitals in the referral chain and clear differentiation between the primary, secondary and tertiary levels of care as well as the establishment of appropriate referral mechanisms to facilitate interaction between community, clinic and hospital-based care. It also required the development of appropriate clinical referral guidelines to improve the equity, efficiency and quality of care; and reorientation of existing hospital-based staff towards the Primary Healthcare (PHC) approach (RSA, 1997).

The provincial health departments' role was to promote and monitor the health of the people in the province, and develop and support a caring and effective provincial health system through the establishment of the district health system based on the principles of PHC. The district health facility would assume responsibility for planning, management, and evaluation of health services for a defined population in a given district locality. Due to the nature of some South African provinces being largely rural, peri-urban, farm, and rural areas fell within the same health district as the nearest town. It was further proposed that, for the effective implementation of the PHC approach, a rationalisation and redirecting of existing allocations to primary health care facilities would be implemented (RSA, 1997).

It was envisaged that the new service delivery approach would be underpinned by eight *Batho Pele* principles namely consultation, service standards, access, courtesy,

information, openness and transparency, redress and value for money. A new Code of Conduct for Public Service (1999) also required the public servant to treat the members of the public in a polite, helpful and reasonably accessible manner. It further required a public servant to provide a high standard of service; treat each citizen with respect and protect every citizen's dignity (PSR, 2001).

In a review of the healthcare policy framework Buch (1999) and Coovadia et al (2009) noted changes such as the removal of structural and institutionalised racism**,** upgrading of many clinics and the building of new healthcare facilities in underdeveloped and hitherto under-serviced communities; introduction of free primary health care that also removed the affordability barrier that many citizens had been facing over the years.

But the public system has been in crisis. Schneider et al (2007) identified four critical areas where new policies have failed: weak governance and management; dysfunctional PHC; emergency medical service and hospital service delivery characterised by substandard quality of care; weak human resource planning, development and management; ineffective planning, budgeting, monitoring and dysfunctional evaluation. Schneider et al. (2007) attributed the decline of the health sector human resources to various factors including growth of the population dependent on the public sector. Population growth between 2004 - 2009 appears to have outstripped the availability of health facilities (RSA, 2010). The decline in the production of nurses as well as the exodus of healthcare professionals to UK and Middle East, low morale and demotivation, poor pay and promotion prospects, lack of management support to staff, weak and poorly conceptualised management development programmes, training programmes that have little or relevance to practical reality have also been identified as key human resource problem areas (RSA, 2010). Furthermore, piecemeal responses to health human resource development have been noted, focusing on recruiting Cuban doctors, compulsory community service and scarce skills recruitment and rural allowances. Despite HRD transformative policies and programmes having been introduced between 1994 and 2010 they seem to have yielded limited results.

According to Schneider et al (2007) the health management information system is characterised by slow progress in implementation, poor data quality and lack of feedback mechanism across national, provincial and local. It is also characterised by weak data collating and interpretive capacity for policy development and decision-making.

Public Service Regulations (PSR) (2001) elaborated on the improvement of public services via a service delivery improvement programme. Schneider et al (2007) noted that despite the introduction of a range of NPM inspired imported policies such as the Patient's Charter and customer satisfaction surveys, there is evidence that little has changed in the culture of service provision.

Furthermore, many questions the South African healthcare system as a whole which is seen as profoundly irrational (Bond 2014). It has an under-resourced public sector that caters for about 70% of the population and an over-resourced private sector that caters for 20%. The latter has used the bulk of financial and human resources". This raises questions of equity in service and equitable access and the extent of racial and income discrimination being embedded in the provision of healthcare, as will be explored later in this chapter.

The South African health sector has been beset by persistent challenges (RSA, 2014). This finding was corroborated by the findings of the National Health Facility Audit commissioned by the National Department of Health in 2011. This audit found that quality problems in the public sector includes inefficient administrative and clinical processes, lack of essential equipment, unclean health facilities, long waiting times and patient dissatisfaction. At the level of dispensing medicines there is a still a lack of public confidence in community health centres and clinics which dispense medicines to needy members of the public (Ward et al., 2014).

In order to improve the quality of healthcare services at all levels, government set up the Office of Health Standards Compliance (OHSC), an independent authority with legislative powers tasked to inspect health facilities and issue directives for service

improvement. Department of Health has recently put in place minimum competency requirements for hospital managers and established an Office for Health Standards Compliance, which now monitors indicators such as the availability of medicines and supplies, cleanliness, patient safety and waiting times (RSA, 2014)

Fostering of policy transfer from private health sector, and public-private partnerships in health

Despite all official pronouncements in the belief in single health system and a strong public health system, the ANC appeared to lack confidence in the ability of the state to transform the public health sector to deliver what they considered to be "effective" service. Government envisaged policy exchange and cooperation between public and private health sectors in several areas leading to knowledge transfer. It further proposed that communities, government departments, the NGO/CBO sector, the business community, the education sector, trade unions and mass media will all be mobilised to work in partnership to resolve major health problems (Dambsiya et al., 2011). Leading elements in the state strongly preferred to look to public-private partnerships – which are long term contractual arrangements of considerable complexity compared with once off private-public exchanges (Shuping and Kabaneii 2007).

The health policy framework proposed the introduction of various policies and regulations to encourage long term closer collaboration with the private hospital sector. These areas of cooperation and policy exchange with the private sector included delivery and management of services, provision of information and audit systems, development of standardised clinical management protocols, coordination of expensive equipment in geographic areas, service provision to district health authorities by accredited providers, sessional work by private providers in public facilities and referrals contracts with private practitioners (Dambsiya et al., 2011).

One of the key institutional sites for continued policy innovation, learning and transfer is

the National Treasury. The PPP Unit, overseen by National Treasury essentializes much of the debate on policy transfer (RSA 2007). Upon attainment of freedom and democracy and as part of transformation initiatives in South Africa the government adopted PPP's as part of its transformation tools and alternative service delivery models just as it has happened in the developed countries during the late 1980's and early 1990's (Harrison 2006; Cameron 2009).

In 2009-2010 tertiary hospitals registered with the National Treasury as potential PPPs by the provincial departments of health were the Polokwane academic hospital, the Chris Hani Baragwanath hospital and the Tygerberg hospital complex. Treasury spokesperson noted that additional projects mooted are the Nelson Mandela hospital, in Mthatha, and the King Edward VIII hospital, in Durban.[3]

Upon assumption of political leadership of the national Department of Health in 2009, Dr Aaron Motsoaledi who is a key proponent of progressive NHI policy, declared that the health sector must return to its *original* strategic vision. The questions that arise from the Minister's assertions are whether there was a digression from the objectives of this vision or non-implementation or inappropriate implementation and if the objectives were implemented and implemented appropriately, why have they not yielded the desired results?

The Twenty Year Review (RSA, 2014) also noted that over the past twenty years, South Africa has experienced high levels of instability in the top levels of administrative leadership due to the disruptions experienced during transition from one administration to another. This has been evidenced by the sudden changes at senior administrative leadership level where incoming ministers and Members of Executive Council (MECs)

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[3] http://www.engineeringnews.co.za/article/are-partnerships-the-answer-to-south-africas-ailing-public-hospitals-2010-06-04/rep_id:4136

often appoint their own administrative leadership in their departments.

Government by the early 2000's started to appoint CEO's with business background to head up public hospitals. These appointees were meant to be the conveyer belts for NPM and policy transfers. Dr Bevan Goqwana's (former Eastern Cape Health MEC) promoted the business-isation of the Eastern Cape public service. "for more than a year I have been looking for hospital Superintendent-Generals with private sector experience to replace the current SGs. Medical SGs are doctors and not trained to manage" (Allan et al. 2004: 19).

On assessing the reasons for the deterioration of public healthcare service it appears that since 1994, the management of public hospitals progressively weakened with the switch from medically trained superintendents as hospital managers to hospital chief executive officers (CEOs) who might not have any medical qualifications (RSA, 2014). Consequently, in September 2011, the Health Department issued a *new* policy directive that required a hospital CEO to have qualifications and experience in a health related profession. This is a good example of policy changes and reversals that have been labeled.

Labour responses in policy transfers in the public sector

Schneider et al (2007) argued that public health workers in SA were still described as harsh, unsympathetic and breaching patient confidentiality --- treatment rarely found in private hospitals, but hardly expected in decent public institutions. In most leading public hospitals staffs were struggling. Von Holdt and Murphy (2007:330) offer three sympathetic quotes from professional nurses to show why this is so:

> "We are trying our best, but it is so difficult. Records are not up to date! We do not have time to take vital data, change dressings, keep records of incidents and mortality and morbidity conferences. We know what's not written is not done"

> "We always have to rush: we wash, we medicate, we move on. You miss some things. You cannot listen to the patient. You cannot be broad and implement things that would improve health care and staff morale. You cannot apply your knowledge and improve the unit."

> "When we go to meetings with supervisors we complain about the shortage of staff, the linen, the cleaners. They tell us, 'Try your best!' They come with no solutions. It is a waste of time, problems remain unresolved. Who do we cry to? We never see the managers."

In South Africa, policy transfer of the neoliberal variety faces formidable obstacles such as cited above by Von Holdt but the power of trade unions is also a factor. The resistance history of trade unions (and unions in the health sector) has been extensively documented (Buhlungu, Von Holdt 2007). Buhlungu (2006:13) has noted that "the consensus among scholars in the field of labour studies is that labour movement has played a pivotal role in the struggles for economic and social change in the contemporary period". Moreover, Adler and Webster (1995) cited in Buhlungu (2006:13) argued that the role played by Cosatu in South Africa's democratic transition requires alternative approaches to problematizing and conceptualizing transitions and attendant processes of policy making and policy transfer. To avoid pitfalls, they argue that we should not presuppose that transitions are merely processes and outcomes characterised by "elite pacting" whereby civil society organisations such as the labour movement have no role.

Walker and Gilson (2004), argue that, the success of policy change may be limited, depending on the ways in which discretion is exercised by key workers and unions at the point of implementation and "translation" (Sturdy 2004). Getting employees to agree on a policy is also daunting for managers. In an organisational setup people have their own views, which, most of the time are conflicting views and opinions to the change process (Hudson and Lowe, 2004). Given these considerations, a labour perspective seems

critical in understanding policy change in sectors such as health where very strong unions prevail. However, simplistic views underestimate the crucial role of implementers/workers in both hindering and facilitating policy. An effective state bureaucracy is the key to a successful developmental state (Von Holdt, 2010; Sandbrook et al, 2007; Southall, 2007).

Von Holdt and his colleague showed that public hospitals in South Africa seem to have a high level of adversarial unionisation and institutional stress (Von Holdt and Maserumule 2005; Von Holdt and Murphy 2007). In 1991 Nehawu had only 18 000 members, in 1994 the union had 64 000 members, in 1997 membership leaped to 163000 members. In 2013 membership stood at 260 738 (Nehawu 10th National Congress, 2013).

In this adversarial context, Nehawu felt that,

> Most public institutions, hospitals in particular have suffered from years of under-budgeting and have chronic staff shortages resulting in excessive workload and public servants working in dilapidated, cold and unsafe buildings, many of them work without essential equipment and supplies. We demand that all vacant posts be filled immediately (Press Statement 12 January 2011)

Cosatu noted the,

> collusion between capital and the state is being consciously facilitated by the National Treasury which advocates the neoliberal philosophy based on the principle that growth must occur first, and then employment will follow.
> The National Treasury, in alliance with capital, argues that economic policy must first promote economic growth, which in turn will generate demand for labour and therefore increase employment; employment will

> increase people's incomes and thereby lead to an improvement in the distribution of income. (Address by the COSATU 2nd Deputy President comrade Zingiswa Losi at the NEHAWU 10th National Congress – held from 26th 29th June 2013, Birchwood Hotel, Boksburg, Gauteng)

A study by Honda et al (2015) blamed poor staff attitudes and lack of direct access to doctors and not receiving medicines. Among other factors, over-centralisation, fragmentation, low management capacity and understaffing were seen as causes of institutional stress in public hospitals, which ultimately produce such dysfunctionality in the hospitals.

But abuse of patients, corruption, maladministration, wastage and nepotism may have become so widespread and even ingrained in the South African public service and in the upper political echelons under the guise of Black Economic Empowerment (BEE). Southall (2014) recently came the conclusion that accumulation and clientelism are the very essence of the state. Party loyalty trumps loyalty to the national interests. Karl von Holdt (an ANC stalwart) argued that, "the ANC has degenerated into various factions fighting over the vast rents of the state" (cited in *Daily Maverick*, 11 July 2013).

Nehawu in 2014 noted that,

> The contracted staff hardly possess institutional knowledge or loyalty. This trend applies to all outsourced services. Outsourced cleaning, outsourced porter services, outsourced maintenance, outsourced pharmaceutical dispensing etc., all lead to less efficient and effective services and these provide for inadequate working conditions. NEHAWU is committed to working with the government in providing positive solutions to the current health crisis and we will continue to demand that we be heard. In our 2007 and 2010 strikes, we fought not only for improved wages and working conditions of public health workers, but called for the implementation of the adopted progressive policies, passed in our congresses, summits and

> forums. This is the role that NEHAWU and its members are determined to play in reversing this crisis. ..We believe that all South Africans should receive the same services regardless of how much money they earn, whether or not they are employed and irrespective of where they live. We believe that the way to do this is to pool all the money, raised through taxation and mandatory contributions, for purchasing services through a publicly administered fund.

Among other demands, Nehawu has called for:

- tighter regulation of medical aid schemes and private hospitals.
- Curb rising medical aid premiums.
- Dismantling the unholy alliance of the big private hospitals (Life Healthcare, Medi-Clinic and Netcare) that feasts off the sick.
- End outsourcing, private-public-partnerships and labour-broking.

(Nehawu marching for improved service delivery and better working conditions in the Health Sector, 1 October 2014 http://www.cosatu.org.za/show.php?ID=9561)

Are there inherent problems in public health services internationally? Empirical evidence (Hacker, 2007; McIntyre, 2012; Coovadia, 2009) indicated that throughout the world public sector health service delivery is generally good with the notable exceptions of South Africa and the United States of America (also the only countries globally with large private health systems). Health service delivery in these two countries is generally characterised by challenges of access and quality. Hacker J (Economic Policy Institute Briefing Paper, 2007) revealed that America's $2.2-trillion-a-year medical complex is enormously wasteful, ill-targeted, inefficient, and unfair. The United States spends much more as a share of its economy on health care than any other nation, and yet all this spending has failed to buy Americans the one thing that health insurance is supposed to provide which is health security (WWW.EPI.ORG). Similarly, South Africa already

spends 8,5% of its GDP on health in excess of the 5% recommendation of World Health Organisation (WHO) and yet its healthcare service remains poor compared to similar middle income countries (NHI, 2012). Studies conducted on the performance of the South African health system bears evidence of its ineffectiveness and inefficiency.

Eastern Cape Public Health Sector issues

In 1993 the Eastern Cape Province was created from the amalgamation of the Transkei, Ciskei bantustans and areas that fell within the Cape Provincial Administration (CPA) and at the time it was clear that it was going to struggle (Ruiters 2011). When the provinces were divided up, most of the Cape healthcare administration (the experience and infrastructure) were incorporated into the new Western Cape. The Eastern Cape is mostly rural with three major urban centres (Port Elizabeth, East London and Umtata) and the wealthy tend to live in PE and the coastal resort towns such as Port Alfred, which is also where the private hospitals are to be found.

The Eastern Cape health profile was as follows: life expectancy was 47,6, whereas the WC it was 60 and infant mortality in EC 89 per 1000 and 39 per 1000 in the WC (Kelly, 2011). The Eastern Cape receives the least funding from national government for health. Furthermore, the Eastern Cape Province has fewer doctors working in the public health sector, relative to its population and burden of disease. Moreover, 61 percent of its 6 million people live in rural areas and the former bantustans (Ruiters 2011). Women make up 52.9% of the provincial population but 33.7% of the population are younger than 15 years (ibid.).

The infant mortality rate (IMR) and under-5 mortality rate (U5MR) increased between 2000 and 2005, peaking in 2005 at 59.6 per 1,000 live births and 96.7per 1,000 live births, declining later (MRC, 2010). The Medical Research Council (MRC) (2010) study showed a significant social gradient in which patients living in the poor rural areas had higher rates of mortality than patients from urban areas

(http://www.ncbi.nlm.nih.gov/pmc/article/pmc3640777//#b34-ijph-41-19).

In a case study of the crisis of public healthcare in the Eastern Cape, Allan et al. (2004:14) found that doctors were unwilling to live and work in rural areas and were also increasingly reluctant to work under the pressured conditions they experienced in state hospitals. Dr Bevan Goqwana's (former Eastern Cape Health MEC) promoted the business-isation of the Eastern Cape public service. Allan et al. (2004:19) quoted him in their case study of the crisis of public healthcare in the Eastern Cape as saying, "Hospitals have to be run like businesses".

The former Premier of the Eastern Cape Reverend Stofile also expressed a similar sentiment when he remarked that "civil service was unable to master the art of managing hospitals" (cited in Allan 2004:29). This subsequently led to the contracting of private management companies for two years to manage hospitals whilst government retained responsibility for personnel, budget and provision of care with the expectation that there will be skills transfer (Allan, 2004).

By 2009 the key issue for the ECDoH was getting a clean audit. Research done by a special support team (IST, 2009: 5) noted, respondents alluded to the fear that permeates the ECDOH and the efforts that have ensued to ensure a clean audit bill. This has included the creation of a duplicate financial structure (the Audit Intervention Programme), and the general beefing up of managerial and corporate service structures often at the expense of clinical services".

In 2014, the MEC for the ECDoH identified several as policy priorities for the province in 2013/14:

to combat HIV/AIDS and TB,

- to decrease maternal and child mortality rates,

- to revitalise primary health care,

to build and upgrade public health facilities (paying special attention to more rural settings), - to phase in the NHI,

- to develop and produce a new cadre of health professionals (Eastern Cape Department of Health Policy and Budget Speech 2013/14: 1).

The biggest budget slice of the province in 2015 went into education: R29.4-billion; health was second with R18.4-billion (DD 7-3-2015). In 2012/13 a major investigation into corruption in the EC health Department showed that there were 540 ghost workers and "8 034 Eastern Cape health department employees were listed as directors of active companies, while 929 are listed as suppliers to government departments," (http://www.corruptionwatch.org.za/the-sickness-in-e-cape-health-department). As Psam (2014) noted,

> The ECDoH MEC has stated that the strengthening of the health system's effectiveness is a priority for the Department in the 2013 financial year. In order to achieve this, he has identified the "fight against fraud and corruption, strengthening financial management, supply chain management and human resources management"20 as being key to attaining this standard. Highlighting the progress made through interventions used, including the SIU formula agreed with the Auditor General, the MEC has pointed out that the Department is projected to save an amount of approximately R264 million because of these efforts.21 The National Treasury is also giving investigative assistance to the ECDoH. Furthermore, a hotline number has been created that will allow for people to call in and report incidences of fraud.

As Rispel et al (2015) noted Eastern Cape is the most mentioned province (56% following by Gautneg, 16%) in newspapers when it comes to public health sector corruption. Respectively, external service providers, funders and suppliers were most

implicated in corruption.

The questionable rise of consultants (and bee procurement)

The post-1994 public administration, be it at national, provincial or municipal level, has seen a shift towards and heavy reliance on consultants. In the 2008-09 to 2010-11 financial years, the Eastern Cape provincial government spent a total of R8,8 billion on consultants for all departments. Of this R3,5 billion was spent on consulting/professional services, R3,1 billion on contractors, and R2,2 billion on agency/outsourced services. About one third or R2, 9 billion was spent on consultants in the Health Department between 2008-2011. (AG June 2015) Despite the utilisation of consultants to advise government and to improve service delivery there has been a rise in litigation cases against the provincial government of the Eastern Cape particularly against the Health Department. This raises a question of whether there is any relationship between the hiring of consultants and improved service delivery or to put it differently, whether there is value in the use of consultants.

Commenting on the extent of costs involved in the use of consultants by government and whether these costs were commensurate with the value derived from their use the Daily Dispatch (30/10/2012) reported:

> The auditor-general (AG) revealed during the 2010-11 financial year consultants were appointed to perform core departmental functions. They are not adequately monitored even though staff are paid to monitor them. Furthermore, reliance on consultants is not accompanied by an appropriate level of skills transfer. The then Finance MEC Phumulo Masualle revealed that a total of R2.9-billion was spent in 2009-10, R3-billion in 2010-11 and R2.7-billion in the 2011-12 financial years. Masualle also revealed an amount of R1.2-billion has been budgeted for the 2012-13 financial year. The health department was the biggest spender on consultants at R1.151-

billion in 2011-12.

The Daily Dispatch reported that:

> Figures released by the department show medical negligence claims went up from R4.5-million in 2005 to R166-million in 2009 to R4.8-billion last year. Senior manager of legal services Mlungisi Mlambo estimated that the final settlement was roughly half of the claimed amount. Claims in the first three months of this financial year stood at R1.1-billion, although in the same period the department paid out R154-million in settled claims from previous years. This payment was more than half of the R254-million it paid out to settle cases from 2010 to last year. Obstetrics and gynaecology cases feature high on the list of problematic clinical areas in the Eastern Cape. The department is the most sued government department in the country, with up to 96% of claims emanating from the Mthatha region. (Daily Dispatch, 16/10/2015)

In a telephonic interview (30/06/2015) the Chief Financial Officer (CFO) of the Eastern Cape Department of Health noted that they are using consultants at administrative level (Head Office and District Offices) as well as at health facilities level.

> At Head Office level these consultants are used in a wide range of purposes such as preparation of financial statements, supply chain management as well as human resources management. At health facility level they are used for services such as specialist surgeons, specialised medical services as well as for billing systems.

The CFO further remarked:

> The reason for using consultants was the inadequate human resource capacity and the scarcity of critical skills such as financial management, auditing and Information technology and the attendant long and arduous recruitment processes. We are convinced that the services and time we buy from them is value for money as we monitor, evaluate their work and deliverables. Thus they close the gaps we have in terms of capacity and they produce what we would have otherwise not been able to do. It is also worth noting that the Office of the Premier and Provincial Treasury are moving towards downscaling the use of consultants but you know how government works it might take some time. And I think this should be accompanied by sharpening of recruitment processes.

Interviewed by the Daily Dispatch (30/10/2012) on the use of consultants by the Eastern Cape provincial government departments, spokesperson Manelisi Wolela confirmed that:

> Consultants were used for a variety of purposes. It is a reality that the Eastern Cape provincial administration, including municipalities, utilises consultants to beef up areas where there are capacity constraints, especially in infrastructure development, financial management, auditing and asset management, as well as ICT. But it was a fundamental principle that all consultants contracted by government had to mentor staff and transfer their skills.

In an interview with the Daily Dispatch (25/01/2013) on the 2012/13 national and provincial audit outcomes the then Deputy Auditor-General observed that:

> Provincially health, education, public works and rural development and agrarian reform were the main users of consultants. Consultants have been employed to provide services such as the preparation of financial statements, for which departments should have internal staff. However, since these skills were not available internally or departments were not

> successful in recruiting suitable staff, they relied on consultants to perform these function. Vacancy rates caused some departments to use consultants in areas where permanent capacity was required, such as in information technology, financial management and project management. Tedious appointment processes also contributed to the vacancy levels. At some departments, positions were frozen due to budget constraints or moratoriums were placed on filling positions. The transfer of skills was not included specifically in the contract, while in other instances the transfer of skills was included but was not effective.

The AG further noted the opportunities for corruption:

> Awards were also made to consultants who did not have proper terms of reference. Awards were deliberately split into smaller units to avoid procurement requirements. Most of the senior management positions had been vacant for more than 12 months. (DD 06/09/2012)

Bateman (2011) noted that basic changes and corruption in the EC health sector was being tackled in the late 2000's under Pillay's (short-lived) leadership. This included,

> clean-up measures such as cancelling and re-advertising tenders for the Cecilia Makiwane Hospital revamp (the ones now accepted are R120 million cheaper than previously… increasing support services (ambulance fleet increased from 58 to 460 vehicles and 25 more patient transport and nine more mortuary vehicles bought in over the last 12 months, plus speeding up blood and pathology services. Skills upgrading programmes meant that, for example, in emergency medical services, 312 ambulance staff who were not 'fully compliant' for their jobs were now properly trained, another 200 had been employed while posts for another 150 were being advertised. This means that where we had only one driver per vehicle

> (meaning patients lay unattended in the speeding ambulance), every vehicle now has two people.

The Daily Dispatch (25/01/2013) reported that the Eastern Cape provincial treasury late last year (2012) showed that provincial government departments spent R8.5-billion on consultants, contractors, agencies and outsourced services fees in three years. The auditor-general (AG) also revealed during the 2010-11 financial year consultants in the Eastern Cape were often appointed to perform core department functions.

The CFO's response to the issue of use of consultants by the government departments generally and hospitals in particular is confirmed by key government figures (CFO, former MEC, former Provincial government spokesperson and AG, and shop stewards). Consultants are used for variety of purposes. It is also evident that consultants are largely used to augment the inadequate capacity and unavailability of the critical skills. This finding resonates with Greve and Hodge's (2010:153) assertion that private sector expertise can be used where the public sector does not have capacity and "expertise for innovative and higher quality" infrastructure development projects. The rise and prevalent use of consultants is also noted in a BBC report quoted in Prince's study (2012:194). In this study he observed that in the UK the Margaret Thatcher administration relied heavily on consultants' services in a wide range of areas of governance.

As the international literature (Evans and Davies 1999; Randma-Liv, 2008; Peck 2010; Legrand 2012; Prince 2012) presents consultants or policy entrepreneur's' role as being advisory, advocacy and policy development, in the Eastern Cape government generally, health department and hospitals in particular their role is that of augmenting inadequate human resource capacity. The reasons advanced for contracting consultants is the inadequate capacity and the scarcity of critical skills which emanates from the less interest or reluctance of personnel with critical skills to come and work for government due to the perceived low remuneration compared to the private sector on one hand and

the slow and tedious recruitment processes on the other.

It is also evident that there is over-reliance on consultants even where there is requisite personnel which can be regarded as “double parking” (a finding which was also identified by AG). It seems a lot of funds are used on the hiring of consultants but with less or no requisite value in terms of skills transfer and sustainability. It is evident that there is incompetency and maladministration in the development of clear terms of reference and contracts in relation to the work the consultants are supposed to do; mismanagement of contracts and failure to monitor the work in terms of time, quality, costs as well as skills transfer.

The procurement processes and procedures relating to the hiring of consultants seem to be irregular in some instances as the market seems not to be tested adequately to ensure cost effectiveness and efficiency in procurement. This practice often results into unnecessary siphoning of funds by the same or other consultancy firms through charging of exorbitant funds. This finding seem to be flying against the CFO’s view that the consultants are effective and they address the capacity gaps they have in the organisation. The consultants also seem to violate the principle of skills transfer that was suggested by the government spokesperson as the primary consideration for hiring consultants. It can be deduced from these findings that the consultants find consulting for the government a lucrative business and by not transferring skills they are deliberately ensuring perpetual dependence of government on them and the sustainability of their business.

The procurement of consultants seem to be characterised by a veil of secrecy. As organised labour argues there is a lack transparency and accountability with regards to the decision-making on the use of consultants. There is also no feedback and information sharing on the outcomes of the work of consultants.

Labour in the Eastern Cape

Labour organisations in the Eastern Cape are centred in concentrated urban geographical sites such as the motor companies, public hospitals, and schools. Public sector unions are strong in the EC (Klerk, and Desai 2011).

In the Eastern Cape, there are 7 major public hospitals (CHM, Frere, Livingstone, Dora Nginza, Victoria, Umtata General, Nelson Mandela Academic Hospital). These are supported by specialist facilities, day hospitals and clinics. In the Eastern Cape, it is estimated that about 13,600 nurses are employed in the public sector by the Department of Health (Denosa website,http://www.denosa.org.za/Provinces.php?id=318, accessed 13 October 2015). Nurses belong to either Nehawu and Denosa.

Interviewed telephonically by this researcher (31/09/2015) Nehawu shop stewards expressed doubts about the use of consultants in the Eastern Cape public health sector. Their view (CMH and FH Shop stewards) was that they are aware that the hospitals do use consultants. The shop stewards also observed that in some instances consultants are used even where there is personnel employed to perform the related functions. In some instances, consultants are used for instance (in strategic planning sessions and assessment of organisational culture or teambuilding sessions for instance) and produce reports with recommendations but these will not be shared with labour and there will be no visible change in the institution as a result of the use of consultants. In some instances, they are appointed alongside the existing personnel but there will be no skills transfer so that the personnel are fully capacitated to perform and ensure there is no further need for contracting them again and this saves government funds.

Conclusions

Key government policy makers had a strong preference for adopting private sector techniques and systems for managing public hospitals. In South Africa the National Treasury and the Policy Unit and Monitoring and Evaluation have been in the forefront

of policy thinking and promoting policy transfers often in inappropriate ways as described by Steinberg (2011). The ambit of public services has been narrowed so that their public/political features have receded in favour of seeing them as business processes. Unions especially have resisted this vision. It also appears that there been enough understanding of the originating environment and the commensurability of the transfer with the recipient environment.

The public sector requires sufficient political capacity not only to manage relationships with the private sector but also to enable innovation and experimentation. The conclusions of the chapter show that the Eastern Cape health system emblematised the social contradictions and geographical/spatial problems in the distribution of health resources.

Chapter 4: South Africa's private health sector: effectiveness and contested issues in policy transfer

The private sector broadly defined consists of non-governmental organisations (NGOs); philanthropic organisations, faith-based hospitals and voluntary support organisations and a for-profit sector (Dambsiya et al, 2011). The latter is generally a large, corporate hospital sector, while the not-for-profit sector is a smaller, rather heterogeneous sector consisting of workplace health services and charities (http://www.healthlink.org.za/uploads/files/private_98.pdf).

This chapter examines the for-profit private health sector's features and how it can be seen to provide inspiration and models for policy transfer. Given its historic exclusiveness and capital intensiveness in South Africa, the geography of private sector shows that it only provides services where there is "effective" demand and not according to social needs. The focus of this chapter is on hospital services because the essence of this thesis is a comparative analysis of public and private hospital organisational settings. I will also outline the private sector health sector in the Eastern Cape and its successes. Against this backdrop, the issues about the kind of relationship the private sector has tried to carve with the public sector are highlighted.

The private for-profit healthcare sector has various role-players concerned with financing, administration and managed care services (medical aid schemes, administrators and brokers); healthcare providers (primary care providers or general practitioners, specialists, emergency, hospital services) services and pharmaceuticals and other consumables (Van den Heever, 2012; Hodge et al, 2012).

The major players in the formal private-for-profit healthcare service are: Netcare, Life Healthcare and Medi-Clinic, in order of size of assets (Dambsiya et al, 2011; Van Den

Heever, 2012). These private healthcare service providers are largely servicing patients on medical aid schemes. But they compete for scarce skills and patients (which may have implications for policy transfer between them given business secrecy). Out of pocket payments as well as direct-payments by specific industries also contribute to the revenue of the sector (McIntyre, 2010). We also find a wide range of health professionals and service providers who either operate solo or in groups. These professionals include "general medical practitioners, dentists, therapists, psychologists, dieticians, optometrists, diviners, faith healers and herbalists. These groups control more than three quarters of all private sector beds and more than 80% of all private sector theatre facilities" (Matsebula and Willie 2007: 159). Netcare improved its operating profit by 7.9 percent, Life Healthcare's went up by 12 percent and Mediclinic's by 15 percent. The past five years (since 2015) have seen substantial gains in shares upon the three large healthcare groups. Life Healthcare Group Holdings shares have increased by 158 percent since its listing in June 2010, while Mediclinic International shares saw value increase by 275 percent, and Netcare by 203 percent. (http://www.africa.com/top-investment-opportunities-south-africa/).

South Africa has a regulated private health sector. The White Paper included requirements for the granting of new private hospital licenses and extensions to current ones; revision of the legal definition of private hospital facilities to eliminate loopholes. Significantly, it included the investigation of mechanisms for collaboration between the public and private sectors in the use of public hospital facilities, as part of a process to develop creative solutions, which will benefit both sectors (RSA, 1997). Before opening or operating a private hospital or a pharmacy in South Africa, authorisation must be obtained from the national Department of Health (Schneider, et al., 2007) (Ward et al., 2014). The establishment of private health facilities by individuals or/and group of individuals has also been brought under regulation with the introduction of the Certificate of Need (CON) through the National Health Act of 2003. The CON could be seen as part of human resource planning and provisioning, seeking a rational spread of

resources (Dambsiya et al, 2011).

There are also laws governing specific aspects in the private healthcare sector policies such as the Medical Aid Schemes Act of 1998, Medicines and Related Substances Control Amendment Act, Pharmacy Amendment Act of 1997, National Health Act of 2003, and other Regulations.

There is a standard narrative from the private health companies that SA's has a very successful and profitable private health system, the envy of foreign and local competition and even the public health sector. For Bloomberg, the major public health challenges in SA are largely "self-inflicted". Broomberg (COO of Discovery, 2011:2) argued that private sector success can be emulated by the public sector and that

> …there is no reason [why] these or similar tools and approaches cannot be effectively deployed throughout South Africa's public healthcare system, with effective adaptation strategies.

Highlighting the rise of private healthcare Ruiters (2011:32) noted that the "extent of this commercialisation in health can be gauged by the establishment and promotion of private hospitals, medical aid schemes and a proliferation of pharmaceutical retail chains and public-private partnerships (PPPs)". Further demonstration of the growth of private health sector is that "in addition to approximately 3,500 privately run clinics, at present there are more than 300 private hospitals and day clinics with a total of more than 34,000 beds; 7,529 general practitioners, 6,726 specialists and 77,569 nurses actively working in this sector. Individuals and companies provide associated services. These include more than 3,500 dentists and 3,000 pharmacists; companies providing funding and administration services which includes 25 open and 67 restricted medical schemes, approximately 30 medical scheme administrators as well as other health insurers; and other upstream and downstream industries" that assist in the supply and distribution of the related goods and services to and for the sector (Econex 2013:6).

The private health sector is serviced by several thousands of professionals. Entry to these professions is regulated by related legislation and professional bodies. There is also an overlap between public and private sectors in South Africa as some of the staff employed in the public sector are also working in the private sector and some public hospitals operate private wards and public facilities rely on the private sector for their facilities (Dambsiya et al 2011:90). This reflects a weak and inconsistent policy and regulatory regime of the government and an investment with little or no substantial returns and recapitalisation on the public sector facilities.

The table below shows the number per category of healthcare professionals in the private sector. These figures do not include the entire spectrum of healthcare professionals in South Africa such as other supportive and complementary healthcare providers like physiotherapists etc. Nor does it include the public sector professionals.

Table 3: Private health sector professionals

Category	Number
Specialists	5 177
General Practitioners	7 298
Dentists	2 524
Optometrists	2 249
Pharmacists	3 197

Source: Genesis healthcare market background paper, 2012 cited from Van den Heever, A. (2009). Strategic health systems reforms: Some issues for discussion: slide 9.

The period 2000 – 2012 saw a notable growth of medical scheme membership by 24%. This membership amounts to 15 – 18% of the population (Econex, 2012). That leaves out in the cold the unemployed and those whose employment does not provide medical

aid cover. Matsebula and Willie (2007) argued that private hospital services are therefore mainly accessible to middle class and wealthy households and those with private health insurance.

Broadbased Black Economic Empowerment (BBBEE) profile

The private healthcare industry started mainly as a white dominated sector due to the exclusionary policies of the Apartheid regime but the introduction of Black Economic Empowerment legislation and attendant policies paved the way for a wide-ranging and inclusive participation by black and other previously disadvantaged individuals. The proposals in the Health Charter include substantial changes in the levels of ownership, concentration and representation of black persons across the value chain within the health sector. The private hospital industry has moved rapidly to implement Black Economic Empowerment (BEE) strategies and all stakeholders in the sector have demonstrated commitment to supporting the imperatives of the Broad-Based Black Economic Empowerment Act (Act 53 of 2003). A number of BEE initiatives took place, especially among the three major hospital groups in 2005 (Matsebula and Willie 2007:171).

In terms of the size and black economic empowerment profile of these major players Netcare is the biggest in South Africa with 55 hospitals located all around the country and accounting for 30% of all hospital beds. This hospital group has been listed in the Johannesburg Stock Exchange (JSE) since 1996 (Hodge et al, 2012). Netcare is vertically integrated with providers of primary health. According to its BBBEE compliance certificate it has 35.43% black ownership and 14.78% women ownership. http://www.netcare.co.za/content/BBBEECertificate2011~1.pdf.

Perversely, as long as the state fails to deliver reliable public services Netcare will thrive. Netcare is seen as a "defensive" stock for investors because demand for health is less volatile and is underwritten by Medical Aid. "Netcare also has first-mover

advantage over its competitors, in the PPP market" with the Lesotho and four other South African PPPs including Port Alfred. "Its entrenched relationship with government is likely to see it continue to earn benefits from these opportunities". (Moneyweb 16 November 2011).

Analysts suggest, "Local growth for Netcare is likely to come through greater demand from the emerging middle class and partnerships with government. Netcare is also able to leverage on surging demand from lower-income groups." Its involvement in four clinics and a 455-bed hospital in Lesotho is an example of how Netcare intends approaching this market, *offering management capabilities* rather than capital support. This is a low-risk approach in a region desperate for quality healthcare. (Moneyweb 16 November 2011). http://www.moneyweb.co.za/archive/the-investment-case-netcare-ltd-2/

Life Healthcare is the second largest hospital services provider accounting for 25% of the market. Following the investment by Brimstone and Mvelaphanda in 2005, Life Healthcare became one of the largest black-empowered companies in South Africa and the only major black-empowered private hospitals group. As at 31 March 2010, black equity ownership in the Company was 43%, reflecting the aggregate ownership interests of Mvelaphanda and Brimstone, each a black-controlled company as defined in the BBBEE Act and the Codes (Life Health Integrated Annual Report 2014, p.).

In 2010, historically disadvantaged South Africans represented 64% of Life's workforce. Life is also committed to progressive procurement policies, where possible, which provide for participation of black small and micro and medium enterprises through provision of garden services and nursing agencies in the industry. Group and pharmaceutical procurement has ensured that 80% of spend has been provided by B-BBEE accredited vendors (Life Health Integrated Annual Report 2014).

Mediclinic is the third largest of the 3 largest hospitals in South Africa with 52 hospitals located largely in the metropolitan areas of Gauteng and Western Cape. It has a national

medical emergency service. It has been listed on the JSE since 1986. Mediclinic Southern Africa (Pty) Ltd, a company registered in South Africa, is the holding company of the Company's operating platform in Southern Africa. It is 100% owned through a wholly owned subsidiary (with most group operating companies partly owned and doctor shareholding in hospital investment companies) Mediclinic Southern Africa maintained its level 4 contributor status on the generic BBBEE scorecard, as externally verified. The company vaunts 47.17% in black ownership and 10.12% in black women ownership. Black management representation increased from 11% in 2006 to25.8% at year end. http://www.annualreport2015.mediclinic.com.

Barriers to entry in the private health market are high and only two independent private hospitals have been able to access the industry in the last 5 years. The 3 existing large hospital groups continue to expand their existing fortunes with construction projects currently underway and planned (Hodge et al. 2012:45). Despite the private health sector's notable growth over the last twenty years, in the last five years it seems to have reached a ceiling. It has begun to search for growth prospects outside South Africa (McIntyre, 2011). Private hospitals group, Life Healthcare, is looking to grow more aggressively abroad and may enter another country in the near future, having already firmly established itself in SA, India and Poland. There had been fewer growth opportunities in SA in the past few months and it was trying to diversify outside the country. About 95% of Life's revenue came from SA. (*Business Day*, 16/11/2015).

As CEO Andre Meyer argued "Life's investments abroad would pay off in the future" (Business Day, 16/11/2015). Advocates of profit-oriented health care assert that "the private sector is not only flourishing but is cost-effective, provides quality care and is able to complement government in expanding coverage while relieving pressure on public funding" (Ruiters and Van Niekerk, 2012: 10).

Interestingly, these groups continue to invest in physical infrastructure and technology in South Africa although they have reached the ceiling in terms of their customer pool. This

is evident in the current and planned physical and technological infrastructure projects of Life Healthcare in Beacon Bay East London (Life Healthcare Integrated Annual Report, 2012).

Financing and revenue generation

The private hospitals revenue generation and sustainability is derived primarily from patient inflows and hiring out of its facilities to other healthcare professionals. Hodge et al (2012) McIntyre (2011). Hodge (2012) noted that private hospitals derive their funding from government- subsidised medical aid schemes and self-financed payments from those few wealthy individuals who can afford their own medical insurance. Customers are received through "GP recommendations, self-referrals, emergency admissions and funder-directed patients" (Hodge 2012:47). Such a growing, over-resourced and expensive private sector seems irrational in the face of ordinary people who are needy and yet are unable to access care but it reflects the skewed and inequitable nature of South Africa's health system.

It is axiomatic that the private sector is only open to those who can pay. The "afforders" are those that are in formal employment, retired and those from wealthy families that can afford to buy medical insurance. An important development in the history of South Africa's heathcare policy environment has been the introduction of the Government Employees Medical Aid Scheme (GEMS). The advent of this scheme introduced participation and incentivisation of existing and new government employees who choose to enrol in it. According to Van den Heever (2012:45) GEMS has grown from two sources: "new low-income members who were never on a scheme before and existing open medical schemes" (those that predominantly target individual members). He noted that GEMS has consequently caused a general consolidation of medical schemes, with only two (Discovery and GEMS) now covering just more than 50% of all beneficiaries.

Although the emergence of GEMS has been a positive development in terms of

expanding access to quality health it has also come with contradictions. A major contradiction has been that the public sector is underwriting an increased revenue base for private healthcare profits. It seems that government is providing the private health sector with a "blank cheque" to do whatever it wishes without committing the private health sector to or holding it accountable for the realisation of the national development outcome of a long and healthy life for all South Africans. The impact and customer satisfaction levels of GEMS are worth investigating.

Investment in technology

Strategic documents of the private Hospital Groups indicate that investment in technology is one of their priority considerations. Life Healthcare has a project to upgrade and replace its hospital information system to improve financial and risk management, data management, operational performance and patient satisfaction. Its strategic decision support department is responsible for the storage and analysis of data pertaining to hospital visits and provides significant strategic information to the business enabling improved management of key business areas.(http://www.lifehealthcare.co.za/ir/Financial_Info/Life%20Healthcare%20Prelisting%20Statement%2018%20May%202010.pdf).

Mediclinic has indicated that they are focusing on providing the best possible facilities, with technology of an international standard. Facilities upgrade, state-of-the-art equipment, expansions and maintenance (http://www.annualreport2015.mediclinic.com).

Netcare (like Life Healthcare) is largely investing in information technology equipment to enhance their operational efficiency. They spent R383 million on capital investments in 2010 (http://www.netcareinvestor.co.za/reports/ar_2010/an_strategy.php).

According to their Integrated Annual Report they have implemented a SAP system which focuses on embedding the financial and central procurement processes at the corporate office. They have further implemented a Kronos Personnel Management

Software which is designed to improve employee time-and-attendance and scheduling processes (http://www.netcare.co.za.). The fact that labour costs are cited as a major factor makes it unsurprising that private health companies have looked to squeeze labour.

Thus, it is evident that the hospital groups continue to invest in information technology systems. At one level the development of these technologies seem to be aimed at operational efficiency and customer satisfaction. It can be argued that underlying these two goals is keeping shareholders happy, optimisation of human resources, identifying and capitalizing on potential efficiencies for profit maximisation rather than the realisation of the national outcome of promoting a healthy population. This sustained investment on technology whilst the public system is stressed and the private system serves an ageing population raises questions of future sustainability of the industry and its social rationality. Coye and Kell (2006) argue in a US context, that the competition between medical firms, investment in new technology tends to resemble an "arms race" with lack of reliable information and bias from the sellers of new technology all impeding rational decisions. This points to another example of the "anarchy" of the market and "market failure" in private health systems.

The relationship between the operations and continued investment in technology of the private hospital industry and its feeder market also raises ethical and justice questions. According to Life Healthcare report ageing patterns is one of the important demand drivers for healthcare services. Since elderly people on average require more medical care, the average number of bed days per 1,000 of medical scheme population rises with the age group. This is a reflected in both an increase in hospital admissions and an increase in intensity. Ageing populations not only increase hospital admissions but also increase revenue per patient day (http://www.lifehealthcare.co.za/ir/Financial_Info/Life%20Healthcare%20Prelisting%20Statement%2018%20May%202010.pdf). This view indicates how the private hospital industry is not geared to needs of the overall population's healthy life. This poses an

ethical question on the operations and practices of private hospitals.

Major issues and policy problems

Although South Africa's health system has an overarching government health policy and framework that governs and supports both public and private sectors, this policy and framework is still skewed in favour of the private sector in terms of funding and human resourcing and it lacks a consistent and decisive regulatory framework and financing model. The government has a weak or non-existent regulatory framework and policies for the private health sector. This weakness is evident in various components within the private healthcare value chain that do as they wish.

The private health system in South Africa has raised concerns for showing dramatic increases, which cannot be justified on economic grounds (Van den Heever 2012: 6). Healthcare costs increases in the private sector are transferred to the patients but in the public sector, innovative ways have to be found to provide healthcare services without transferring the costs to patients (CEO, Frere Hospital). Matsebula and Willie (2007, p. 159 & 160) noted that sharp escalations in costs of private hospitals and the number of medical specialists in the private hospital industry constantly draws the attention of health care funders and regulatory authorities in respect of its cost structures and pricing practices. The fee-for-service repayment mechanism applied by medical schemes encourages over-servicing thus precipitating cost-escalation in the environment and making private hospital services exorbitant and inaccessible for the majority of South Africans. Hospital costs, specialists' charges, administration charges and medicines have been up to recently the key cost drivers in the private health sector. Medicines have been removed from the top four cost drivers due to government's intercession in setting pricing parameter (Hodge et al 2012:22). This price escalation can be attributed to gaps in the regulatory structure, as well as certain problematic behaviour by funders and providers, leading to high costs of services and related supplementary products (Econex, 2013).

The private hospitals recently complained that they have to increase nurse salaries each year at levels well above CPI in order to catch up to the salaries offered by the State. "In order to retain more experienced and qualified nursing staff, the private sector is constantly trying to catch up to the current salaries offered by the public sector," (Mediclinic cited in Moneyweb 18th February 2015).

Hodge et al (2012) argued that there is a lack of constraints on pricing on the part of healthcare practitioners as well as hospitals. Moreover, there is a perception that they are not obligated to compete and the presence of associations and reference price lists are not conducive to competition either.

Lack of transparency, information sharing and collusion within the healthcare industry and among the role-players also appears to be a problematic area that hampers affordability. Healthcare markets are well known to suffer from failures on both the demand and supply side that can both harm access to coverage and drive up costs beyond what a properly functioning market would permit (Van den Heever 2012:8). He argued that from the demand side these failures are a result of information asymmetries and moral hazards between an insurer and the insured. Explaining these asymmetries, he noted that the insurance applicant is often unable to understand the quality of the insurance sold to them; and an insurer does not know the health status of the insurance applicant. Moral hazards relate to applications for insurance only upon illness and lack of limits on consumption of healthcare goods.

Patients cannot shop around for services and compare prices and service quality; lack knowledge of the healthcare product and its value in relation to the costs. The private health sector is also characterised by secrecy within its supply value chain, expressed mainly in lack of transparency on issues relating to "information, price and quality" among and within the role-players. Information on price and quality is not available to key decision makers, healthcare practitioners and consumers themselves. (Hodge 2012:9). On the latter point, he argued that treatment patterns for specialists are suspect

as it is impossible to discern whether there is over-application of hospital procedures and technology in the administering of treatment with the aim to maximize profit.

The rationalisation and amalgamation of individual private hospitals into major national hospital groups have enabled these groups to adopt a centralised approach to purchasing for medicines, consumables, and equipment. But this centralised approach has endowed them with "significant market power over medical product companies, allowed for the easy implementation of the kick-back (or rebate) mechanism, whereby product suppliers needed to comply with the rebate system to access the hospital platform" and this has been a pervasive practice "within the three major hospital groups" placing the suppliers at the mercy of these conglomerates in terms of access to business opportunities (Van den Heever 2012:41).

Van den Heever (2012:59) also noted "vertical collusion" and perverse incentivisation practices "between specific intermediaries contracted to medical schemes and a healthcare service or product providers which may have the purpose of driving up the costs of medical schemes". He identified several areas which these practices occur.

For example, deliberately increasing theatre times on invoices to medical schemes; loading year-on-year facility fee increases on those areas where medical; schemes are least able to manage unitisation (theatre fees, which are charged by the minute; and ICU and High Care); deliberate over-investment by hospitals in specific equipment which are predisposed to high utilisation by specialists (Van den Heever 2012: 69).

The collusive practices demonstrate the underworld of market forces and private health sector in particular which has little appreciation of health as a human rights and social justice issue. These manipulative practices render the medical aid contributors susceptible to exploitation and helpless as they have no say or choice in how their healthcare and purchasing of associated products should be administered. The much trumped efficiency of the private health sector is in question.

This calls for decisive government intervention which currently seems not to be forthcoming "as government has to-date focused its attention largely on public delivery, the private provider system has emerged largely without any government stewardship" (Van den Heever 2012:61).

As the OECD (2015) noted, in SA, private specialists encourage unnecessary medical procedures. Over 70% of private births in 2014 were C-sections although the WHO recommends a rate of 15%. The massive surge in the number of knee and hip replacements was "supplied-induced demand" since between 2011 and 2013. There had been an inexplicable 53% increase in knee replacements and a 31% increase in hip replacements.

Pervasive problems occur within the private health sector because of perverse incentives to overprescribe. Existing comparative studies of public and private sectors in South Africa has showed that

> In South Africa, where 62% of women delivering in the private sector had C-sections, compared with 18% in the public sector. … It was estimated that in Mexico, Brazil, and South Africa, unnecessary C-sections increased delivery-related health costs in the private sector by at least 10-fold… Two studies in South Africa found that the majority of private general practitioners were not aware of the recommended medications, doses, or durations for treatment of sexually transmitted infections (Baso et al. 2012: 8-9).

Labour Issues

Netcare …employed 20 000 nurses and administrative staff in 2015. It is not allowed to employ doctors/specialists but they paly a dominant role visa vis other staff. xxxx. Doctors are fundamental to profiteering arrangements to drive up patient fees and company profits. As Van den Heever (2012) shows there are implicit arrangements with

doctors that they will admit patients to ICU and High Care in circumstances even where that is not clinically necessary; collusion with doctors to ensure that they keep patients in hospital for unnecessary extended periods; admitting patients for repetitive tests which could be conducted on an outpatient; deliberate arranging of specialist consultation and procedure codes to encourage hospital referrals; placing pressure on specialists to increase their use of hospital resources in exchange for hospital privileges; Rewarding specialists directly or indirectly and offering them shares for increased hospital referrals (Van den Heever 2012: 69).

Netcare has been subject to unionisation with Hospersa having about 25% of members. Hospersa represented the majority of nurses and administration staff within the Netcare Group. (Fin24 10 May 2010).

Nehawu also has members and a forum on Netcare. Strikes in 2010 and 2013.

"It is ironic that Netcare, a company rated as one of the top five companies, that recently announced a 30 percent increase in earnings in the first quarter and a R1bn profit in the last financial year has the audacity to offer its workers an inflation-linked 8.5% increase," he said.

Nehawu "The forum noted the painful lesson learnt from the Section 197 Transfer of Catering Staff to Compass Group in 2014. The transition happened after the 2013 National Strike and we believe it was a direct response by Netcare to reduce the union bargaining power and strength within the group." http://nehawu.org.za/files/NETCARENATIONALBARGAININGFORUM)

In 2015 Netcare announced plans to centralise its financial administration so that all hospitals in a region such as Gauteng would be served by one centre.

Eastern Cape Private private healthcare

There are two major hospital groups operating in the Eastern Cape Province: Netcare, and Life Healthcare. Netcare has 4 hospital facilities and 2 providers of primary health in the Eastern Cape: Medicross, Prime Care and 1 emergency medical service (Netcare 911). Netcare Healthcare facilities are located in Port Alfred (Port Alfred Private Hospital), Grahamstown (Settlers Private Hospital), Port Elizabeth (Netcare Greenacres Private Hospital) and Uitenhage (Netcare Cuyler Private Hospital). Together they have more than 2500 beds, close to 7% of the national number (HASA, 2012).

Netcare's annual report for 2012 noted that out of 9262 beds nationally, it had 527 in the EC. The table below indicates the provincial geographical spread of Netcare hospital beds in 2012. (http://www.netcareinvestor.co.za/reports/ar_2012/sao-hospital-division-review.php)

Table XX Netcare: Eastern Cape Footprint

Eastern Cape	527
Cuyler Hospital	124
Greenacres Hospital	340
Port Alfred Hospital[3, 4]	31
Settlers Hospital[3, 4]	32

Source: http://www.netcare.co.za.

Life Healthcare has 9 facilities in the province operating in Mthatha, Queenstown (Queenstown Life Healthcare), East London (St Dominics and various small hospitals) and Port Elizabeth (Life Mercantile and Life St Georges) http://www.lifehealthcare.co.za). Most of these date from the mid-1990s.

Most whites in the Eastern Cape were served by racially exclusive sections and wards in public hospitals. There were very few private facilities in the early 1980s. In August 1985 a private Poli-Clinic in PE had only 10 beds, a casualty unit with three resuscitation bays and a two-bed treatment room, a pharmacy and two theatres. It was bought by Netcare in 1997. The next chapter provides a detailed look at Greenacres hospital owned by Netcare.

Private care has also been extended through PPPs which collocated inside public hospitals. A co-location arrangement in Port Alfred and Grahamstown's Settlers Hospital has various black shareholders with diverse technical and medical expertise including *Qaphela* women's empowerment group which is responsible for the delivery of "non-core services such as provision of laundry and catering services." (*Daily Dispatch* DD, 8/05/2007). This is the subject of chapter 6.

Conclusion

Having examined the private health sector in terms of its purpose, configuration, role players, financing, issues and policy problems in the operational practices and environment, it evident that the current health sector configuration and two-tiered health citizenship reflects South Africa's ongoing social fragmentation, lack of national cohesion and residual apartheid mentality (Ruiters and van Niekerk, 2012). While it is no longer officially race-based, it is still divided along class lines, reflected in stark and ever-more obvious distinctions between the public and private health sectors in terms of access and quality. Transformation efforts in the health sector have spanned more than a decade but the problems of inequity remain acute between the public and private sectors (Rispel and Setswe, 2007).

The glaring difference in services between the public and the private health sectors mirrors the growing inequality evident in almost every aspect of South African life

(Broomberg et al, 2011) rather than any inherent superiority of the market driven private health sector.

The complex scenario sketched above defies simplistic comparison between the public and private hospitals. A serious comparison may not only reveal differences and similarities that favour one hospital over the other but might also expose deep lessons, underlying contradictions and ambiguities within and between them and these can unearth further areas of research. It appears that the key determining issues in the public-private health service delivery are the level of rigidity in the regulatory regime, level of inappropriateness and level of inefficiency in the business models and associated process models.

Perceptions of inefficiency, ineffectiveness and poor service can also be found in some areas and instances of private sector. Highlighting the service delivery record of private health sector Ruiters stated that the private sector has "a mixed record in health systems and this is evidenced by poor quality care, over-prescribing, limited reach beyond higher income groups and barriers to access due to user charges" (2011:4). Confirming Ruiters' assertion the NHI also stated that like the public health system, the private sector has its own problems albeit these are of a different nature and mainly relate to costs of service which include pricing and utilisation of services (RSA, 2012:7).

Comparison between public and private health institutions, some scholars argue, are invidious (McInytre et al, 2012). Supporting this, Du Toit (2002) argued that public service delivery is a comprehensive concept that does not only refer to the end-product or result but is more of an umbrella term referring to the results of intentions, decisions and actions undertaken by institutions and people. Du Toit further argued that

> service delivery is not something that merely happens but it requires among other things an infrastructure with adequately qualified people to support the general welfare of the people and therefore a systematic approach is needed to understand what happens from the point of decision-

> making about what the citizenry need and how that need has to be met through to the point where that service is delivered (2002:56).

It is widely accepted that the South African healthcare system is dualistic (public and private) with the private supported largely by government. From a moral viewpoint the dualistic nature of the South African healthcare system should have been complementary and mutually enhancing for the benefit of the entire population. Due to the historical roots of racial inequality, the capitalist nature of the system compounded by policy and regulatory indecisiveness of the government, the private sector has not substantially impacted on the lives of the majority of citizens even though it is partly sustained by the public revenue through taxes. This scenario raises questions of whether the relationship between the two sectors is symbiotic or parasitic and whether the public sector can draw any moral and ethical lessons from the private sector given the two sectors' different values and meanings ascribed to the notions of efficiency, effectiveness and rationality which are the centrepiece of any organisation serving or interacting with the people for mutual benefit.

There have been calls for the adoption of private sector principles to improve public health sector service delivery system and there have been practical cases of adoption of these practices through PPPs and full scale privatisation initiatives. The results have not been entirely impressive because marketisation of public goods has led to unscrupulous practices (as demonstrated in collusion) within the healthcare value chain, rise in costs and unaffordability; all to the benefit of the private sector. Therefore, the transfer of private sector practices to public sector should consider the content of the transfer and its informants (in terms of philosophy and values) the expected outcomes and whether these will serve the general social good of the population rather than serve the few.

Chapter 5: Case Study of Greenacres Netcare Private Hospital

The next several chapters considers the contested nature of policy transfers empirically in four hospital settings. Following Marsh and Dolowitz (1998: 38) the thesis sees policy transfer in broad terms to mean the "process by which knowledge of ideas, institutions, policies and programmes in one time and or place is fed into policy making arena in the development of policies and programmes in another time and or place". The chapter focuses in on specific types of transfer that key informants chose to highlight and that they were prompted to respond to in follow up questions. Informants, for example, were not specifically asked about outsourcing at first but rather a general question was posed about how ideas form "outside" i.e. form another sector have been "imported" into the hospital.

The point of view of the actor, their position as intermediaries between head office and the local hospital staff and their ideological orientation is central in this chapter and the next three. This chapter explores the envisaged, current and past transfers of policy and organisational practices in Greenacres Netcare Hospital (hereafter GA). Interviewees provided lots of detailed information although they were selective about what they revealed. I have tried to use much of the interview material hence the frequent long quotes.

The chapter focuses, among others, on the following particular areas highlighted in my original statement of the aims of the Phd research:

(i) In which services and functions have there been policy transfers (past present and planned)?

(ii) Where did these policy ideas come from; are they coerced or voluntary, who are agents and how might agents be linked in epistemic networks?

(iii) What do the key actors in the receiving environment think need to be done

given challenges to make such transfers to function?

(iv) In which ways do policies and practices converge and how do they fit in within the concept of policy transfer and its application?

(v) What are perceived cause/s of poor public health service delivery or substandard private sector delivery?

(vi) How are the transformative health policies being implemented in both health systems?

(vii) Are the transferred policies/practices functioning in the receiving environment? (Viewed from recipients' observations). If yes, what make them to function? If not, what causes them not to function?

(viii) What is the view of labour at the hospital about policy change and transfer?

Context

As noted in introductory chapters context and the ways parts and systems work together are vital to understanding transferability. Netcare owns the Greenacres private hospital in Port Elizabeth (it also has stakes in the Port Alfred PPP) and it is the largest private health company in South Africa. Netcare Greenacres Hospital is situated in Port Elizabeth in the Nelson Mandela Bay Metropolitan Municipality in the Eastern Cape Province of South Africa. According to the 2011 Census the Nelson Mandela Bay Metropolitan Municipality has an estimated population of 1.1 million. Of these 60% are African, 24% Coloured, 1% Indian, 14% White and a little less than 1% unclassified. It has an unemployment rate of 36,6% (Nelson Mandela Bay Municipality IDP -2011 – 2016).

When the hospital opened its doors on 1 August 1985 as a Poli-Clinic it had only 10 beds, a casualty unit with three resuscitation bays and a two-bed treatment room, a pharmacy and two theatres. The hospital was taken over by Netcare in 1997. "We now

have 340 beds in the hospital, including 223 medical and surgical general adult beds. We also have 35 adult intensive care bed, seven neonatal intensive care beds, 18 adult high care beds, as well as an emergency department with eight examination and four resuscitation bays." (General Manager / GM, Interview News 24, 2/09/2015). According to the company website, this facility services the communities of Port Elizabeth and the surrounding district suburbs (www.netcare.co.za/98/netcare-greenacre-hospital). It is however a profit-driven firm and hence most of the population cannot utilize its services. The Netcare group private hospitals revenue generation (R24 billion in 2009) and sustainability is derived primarily from patient inflows and hiring out of its facilities to other healthcare professionals (see chapter 4).

The GM of GA confirmed (2016, personal email communication) that 372 nurses are employed alongside 211 admin staff (close to 600). GA cannot "employ doctors" who are medical professionals since the HPCSA rules do not allow private hospitals to employ and there are no "auxiliary" staff.

> "Our core staffing is nursing and all other staff fall under admin in a support role to our nurses. We do not make use of consultants at Netcare Greenacres Hospital. Our staff are either employed on a full time basis or on a fixed contract" (my emphasis).

The GM (Interview after her resignation, http://www.thenational.ae/uae/health/uae-nursing-staff-levels-fall-behind-region-and-world) held that "Nurses also feel that they are not remunerated sufficiently for the amount of effort they put into their work, especially since they sometimes work in very high-risk conditions." She went on to argue that, "People should be educated that nursing is still a scarce skill that is in great demand worldwide, which gives those who choose it job security as well as great opportunities to travel around the world to fill vacancies. Nurses no longer want to be at the bedside, either, because they aspire to be in managerial positions where they don't have to work such long hours and do night shifts."

The GM position of GA changed during the course of this study in 2015. The first GM was a white female (the person I interviewed) who had considerable experience with the company as an area manager and later GM since 2006. Her view on nurses is that they aspire to be managers because they feel they are not appreciated (http://www.thenational.ae/uae/health/uae-nursing-staff-levels-fall-behind-region-and-world).

The new 2016 GM is a white male, who was also manager at Life health (Netcare's competitor in PE). As mentioned in the methodology section of chapter 1, the following sections discuss responses to particular issues put to key players in the hospital, with some corroboration from newspaper sources. The reason I chose newspapers is to provide another view, possibly an outsider view and at some level and objective check on what insider actors say. This is an attempt to see issues from at least three sides. A limitation of the study is that nurses and general workers and middle management was left out of the study. One reason for not going into extensive interviews was that the researcher was trying to explore polarities in viewpoints and extensive interviews would have required sampling. The interviews with managers and shopstewards were purposive.

Planning structures and process for policy changes

According to the General Manager, the organisational structure is aligned to the service delivery plan. She further noted that everyone in his or her sphere of operation is responsible and accountable.

> Our facility's organisational structure consists of the Hospital Manager with six managers responsible for marketing, finance, human resource, nursing, pharmacy and facility management. Our structure does not only ensure responsibility to an official but also authority to innovate and take decisions in his/her area of operation and be accountable. (Greenacres GM,

interview, 20/11/2014).

The General Manager indicated that planning for service delivery and the outcomes of planning are communicated to all in the facility so that everyone is aware of what will be implemented in the ensuing year.

> Planning for policy changes takes place through management and division meetings. Some changes are introduced and communicated through an alert system. If a change is division specific it is communicated directly to that particular division. (Greenacres, GM, Interview, 20/11/ 2014)

According to the shop steward staff is not involved in planning for policy changes and improved service delivery. Elaborating further and indicating how the staff is excluded from planning he said:

> The Executive Management and middle management consisting of unit managers sit and conduct their planning. Unit managers then report to their staff. The executive management then meets organised labour to share what has been planned in respect of the strategic direction and operational plans. (Greenacres Shop steward, interview, 20/06/2015)

The shop steward indicated that innovation is risky.

The General Manager noted that the hospital implements government's transformative policies. She also indicated that they also have their own equity policies on human resources and financial management but these are aligned to government's policies.

> We are implementing Employment Equity Act, Broad-based Black Economic Empowerment Act among other legislations. We also have our own financial management policies, auditing principles and King Codes of Good Practice. As much as we are not governed by the Public Servants Act, our human resources policies are aligned to government's policies and

> legislation that relate to human resources. We have found these policies to be working effectively and they protect the organisation as well as our client. (Greenacres, GM, Interview, 20/11/2014).

According to the shop steward *Batho Pele* posters are posted in the canteen. He also noted that he was not certain about the extent to which management and staff know the practical implications of the *Batho Pele* policy. The responses to this question revealed two different views. One view was that planning does take place at Executive Management level and gets cascaded down through Heads of units. The other view focused on workers not being involved in planning for service delivery improvements except through being informed of the outcomes of planning. There seems to be differences in understanding of workers involvement in organisational planning for service delivery. Organised labour want their representatives to sit in the Executive Management strategic planning meetings and fully participate instead of merely being informed of the outcomes. Management regards members of organised labour as being first and foremost members of staff belonging to various units and sections wherein they participate in planning or deliberating on the outcomes of planning

Perceived causes of poor quality service

The General Manager noted that they are still receiving positive comments on their service although there may be isolated cases of complaints of negative staff attitudes.

> We have not received any negative comments about the quality of our service but there may be some pockets of poor service from time to time as in any environment there will always be those who will let us down. These surely relate to individual staff attitudes and management issues. (General Manager, interview, 20/11/2014).

The General Manager indicated as per the literature review in this Phd and chapter 4 that "private hospitals operate in a competitive environment and therefore competition calls

for a high level of professionalism, positive attitude and quality care and therefore it is important for them to always want to stay ahead".

> There is a complaint management system and our performance in terms of quality is assessed against it. We are now also providing more admission terminals to alleviate congestion and recruiting more staff. We also have ongoing assessment of our quality assurance. (Greenacres, GM, interview, 20/11/2014).

According to the shop steward perceived poor service delivery stems from various sources. Some of these sources are internal and some brought in by new employees' brought in by agencies who bring deliberate and non-deliberate negative behaviours:

> Perceived causes of poor quality originate from different angles. Lack of communication by the facility itself of procedures and processes to the public; lack of appreciation because management sometimes do not appreciate the good work done by the staff and this leads to demotivation and low morale; also, differences in staff's understanding of the facility's procedures and processes because some personnel particularly nurses are employed through employment agencies and are not inducted when they arrive and because of not knowing Netcare protocols they end up behaving inappropriately or administering procedures incorrectly. (Greenacres, Shop steward, interview, 20/06/2015

This very perceptive comment speaks to the problem of outsourcing and of monitoring agents by principals. Permanent workers have to pick up when agency workers mess up. It was also reported that negative perceptions may stem from low staff morale. The shop steward noted that marketing strategies of private hospitals are always positive. The positive feedbacks that the facility is receiving also confirm the perceived good quality service it renders to its clients.

Innovations in organisation models in the last decade

The Netcare national CEO stated that they operate in a manner that provides a balance between risk and reward across a gamut of arrangements, from leasing, management and construction of facilities to the provision of clinical services and care. In addition, to what the Netcare outsourcing partnerships and their PPPs with the government health sector offers, he argued that the most critical factor in ensuring long term sustainability was ongoing training and skills transfer to local staff and external monitoring and technical support and this has provided ongoing accountability and credibility (Hasa 2012, http://www.hasa.co.za/conference-2012/new-public-private-partnerships-models-ideally-suited-for-south-africa/).

The General Manager of Green Acres (Interview, 2014) noted key changes in the last decade that have taken place in the PE facility are hospital occupancy rates increases, introduction of new specialist medical fields and the introduction of new technology. *The Herald* newspaper also reported technological innovation at Greenacres Hospital (GA) related to the simplification of radiology using Picture Archive Communications Systems (PACS). Describing the new technology, how it works and how it will be utilised the General Manager said:

> This is similar to a digital camera, where digital images are downloaded and stored on a computer. All patient X-rays and other diagnostic studies will be stored on a central computer. Authorised family physicians and specialists will be able to access diagnostic images online at any time. *This is a major project for healthcare in the Eastern Cape*. It is a continuation of the unwavering commitment to provide both patients and referring doctors with a world-class imaging service of excellence (Interview in Daily Dispatch, 23/09/2010, my emphasis).

Significantly, the Manager emphasised that the Province as a whole will benefit. The

newspaper reports (see *The Herald*) played up technological innovations as part of local boosterism for the city. It is important to also note that medical tourism is also part of how cities sell themselves (Ruiters and Van Niekerk 2012). But the increase in patients' intake, may be mainly due the introduction of the government medical scheme (GEMS) which allows he lower ranks of government employees to have access to medical aid benefits.

On the other hand, the shop steward (also the chairperson of Greenacres Nehawu branch) indicated intense time management as one of the key changes that he has observed in the facility. Unlike the GM of GA, he stressed changes related to the management's approach and service delivery improvements.

> We have seen the introduction of time management policy which is a clock out and clock-in system. This is intended to tightly manage the time used by staff on lunch to minimise costs on the company. The system shows a ''RED'' so that the time is deducted . You are given choices to be deducted from your leave or pay in cash. Ironically, this policy does not apply to the senior management (Greenacres Shop steward, 20/06/2015).

The intensive time management at GA reveals a disciplinary technique of giving people choices. He went further noting that,

> We have also seen the introduction of Ward administrators and touch down teams whose responsibility is to go around listening to the staff soliciting their ideas on what they think can be introduced to further improve service. There are also suggestion boxes that are also intended to solicit clients' ideas on improving service. These ideas are discussed by management and labour to see if they do not have labour relations implications, if they were to be introduced (Greenacres Shop steward, 20/06/2015).

Policy transfers and outsourcing practices

The General Manager of GA when specifically asked, indicated that *all* their services, except nursing services, are outsourced.

> Security, facility management, cleaning, catering and laundry services are outsourced. We are leasing our security system and we outsource the security personnel to a private company. As part of the Service Level Agreement the company is responsible for training and retraining the security personnel and also upgrading the system when the time for that has arrived.
>
> The GM went on to explain using the ubiquitous "core-non-core language that,
>
> The most recent outsourcing that has been implemented was the catering service. It has always been done in-house but now we have decided to outsource it so that we can focus on our *core function* and also to manage costs. Private companies are able to negotiate prices which the health facility is unable to nor does it have adequate personnel and time to do that.
>
> In her opinion,
>
> There is not much difference between the in-house and outsourced service particularly with the recently outsourced catering service. The quality of service is still the same. We have also entered into a Service Level Agreement with the new company to ensure that they maintain good quality service. On the other hand, it is advantageous in the sense that it has reduced our costs (Greenacres, GM, Interview, 20/11/2014).

It is also understood, that head office does the outsourcing contracts. CEO Richard

Friedland in the Face-to-Face newsletter announced "Netcare has made the decision to outsource its retail pharmacy operations to the Clicks Group Limited, "Clicks", on a long-term basis". Clicks will be taking over 37 Medicross pharmacies. It furthermore mentions the take-over of front-shop pharmacy operations in 51 Netcare hospitals. The Health & Other Service Personnel Trade Union of South Africa (Hospersa) "is truly astounded by this," General Secretary Noel Desfontaines. "In terms of the LRA [Labour Relations Act] employers have to consult with employees when it is considering transfers, and here we see Netcare merely announcing it in a newsletter. It is simply unheard of," (HR Pulse June 2016).

However, according to the GA shop steward chairperson, outsourcing is relatively new and has become more prevalent in the last few years.

> For the past ten years that I have been around this facility, cleaning and security have been outsourced. Netcare has recently outsourced catering and hostesses to Prestige Catering company. There was a consultation with labour organisation to see if this was really the last resort. Hostesses were absorbed but some caterers were encouraged to apply anywhere in Netcare facilities.

The shopsteward provided more detail on extensive outsourcing plans

> There is also an impending outsourcing of auxiliary or non-nursing services such as care workers and porters. Care workers could not be absorbed to nursing because they still needed further intensive training. Organised labour is negotiating for their retraining and career pathing. The administrative function will also be outsourced as a new IT programme called SEP software will be introduced. Staff is encouraged to go to training so that they can get first preference when the new company takes over administrative functions (Greenacres Shop steward, 20/06/ 2015).

It is clear that a comprehensive hallowing out of the hospital has occurred through eroding the inhouse workforce. The shopsteward revealed that in his view, "Workers felt betrayed by the labour organisation". So from the point of view of the shopsteward, there has been intense job-cutting occurring at GA as well as demoralised trade union members. His own view was of company's change ideas, policy and organisational practices are driven by profit maximisation and they as labour organisation try to ensure that the workers are not negatively affected by the implementation of those ideas and practices.

What becomes apparent is that the GA hospital as a place of insecurity for workers and policy "innovation" and workplace conflict are viewed differently by different actors.

Origins of policy ideas/organisational practices and the "package" of changes and innovations

One of the important themes of chapter two was where ideas get "cooked up" and how they get transported through policy networks, epistemic communities and ideas peddlars (Peck et al., 2010). According to the GA General Manager, policy ideas and new organisational practices are derived from various sources including company head office and existing and new national government policies and regulations.

> We are governed by and operate within national government policies and regulations as well as from our Head Office. The regulations that originate from government relate to licensing of operating private healthcare facilities and the associated service and quality improvement standards as well as outsourcing of services (Greenacres, GM, 20/11/2014).

The General Manager, when asked about a package of change and innovations replied: they always come in "total packages" that cannot be broken down into segments from which selections can be made (see Peck et al 2010 and see chapter two of this Phd).

> The changes that we have to adopt either come from the national Head Office of Netcare or national or provincial government and we have to implement them. Unfortunately, changes and innovations come in total packages that cannot be segmented for us to choose or discard. For instance the National Core Standards even though they have budgetary implications in some instances in the form of having to effect alterations in our physical space, we cannot discard but we must find ways to comply. (Greenacres, GM, 20/11/2014)**.**

The shop steward indicated that in his understanding the change ideas, policy and organisational practices ideas came from government and from the Company head office (Netcare).

> Change ideas come from internally (within the facility), some come from the Company (Netcare) and some come from government. The main consideration in introducing these changes for the Company is to maximize profit and savings. These ideas are a law so we have to work around them or if not favourable we negotiate with the company (Greenacres Shop Steward, 20/ 06/2015).

The shop steward indicated that selection from the package of change and innovations is dependent on what would contribute to cutting costs and maximizing profit. He further indicated that in his observation the Company feels that there are non- core services they can do without and it is these services they prefer to outsource.

In summary, policies and organisational practices reportedly came from sources internal to the facility as well from Netcare, national government and some other stakeholders the facility is affiliated to. The government policies implemented relate to operating licenses and attendant "service and quality improvement standards" they have to adhere to. There was also some disagreement between the interviewees on the rationale and driving forces behind these ideas. The General Manager saw them as compliance and

service delivery improvement driven whilst the representative of organised labour saw them as being driven by profit maximisation.

Innovation comes from above, usually in a total package and it is not possible to segment the package of changes and innovations. However, the shopsteward argued that the union is forced to resist and modify any proposed policy transfer or change if members interests are compromised. Therefore new ways of complying with the entire package have to be found.

Agents of change and innovations and networks for emulation and sharing of changes and innovations

As reflected in chapter two (the literature review) a central issue in policy transfer is the agents who bring about policy transfer/learning. The General Manager indicated that there are factors that precipitate change and agents that drive change. These factors include the economic situation, deterioration of the public health sector which leads people to go to private hospitals as well as the fact that more people now are covered by medical aids for instance since the establishment of GEMS among others. The GM also mentioned that there internal as well as external agents of change. Agents of change are Netcare Head Office officials, health organisations and hospital groups such as Hospitals Association of South Africa (Greenacres, GM, Interview, 20/11/2014).

The General Manager said there are various networks for emulating, advocating change and sharing ideas and challenges. There are also *project teams* in place to manage the implementation of quality improvement and changes.

> There are a number of networks for sharing these changes and innovations and these include Hospitals Associations of South Africa (HASA) conferences, seminars, quality assurance forums and sages or study groups (Greenacres, GM, Interview, 20/11/2014).

The networking through Hospitals Associations of South Africa (HASA) conferencing appears to play a role in policy exchange. As noted earlier, the work of Evans and Davies (2009) on the role of policy networks, epistemic communities and the dynamics of human cognitive reactions in the policy transfer process links up with the concept of "bandwagoning," (Ikenburry, 1990) where one company tries to keep up with another. As the GM noted, "There are various networks for sharing of changes and innovations such HASA conferences, seminars, quality assurance forums and sages or study groups as well as the Institutional Transformation Forum (ITF)" (Interviews 2015). It appears that the ITF is a consultative structure between management and employees rather than a classic "think tank" for initiating innovations.

The shop steward noted, there are networks for sharing changes and innovations. This sharing takes place at the company/plant level at institutional transformation forum monthly meetings. This is a forum comprising representatives of organised labour and management.

Ways in which policies converge

The General Manager indicated that there is always a gap between the policy and implementation and this causes problems.

> You sometimes find that the environment is not geared for a particular policy or regulation hence you will recall that I said we bring in HPCSA (Health Professionals Council of South Africa) to assist and give guidance on implementation or engage with the authorities on our behalf to change or modify the regulation to fit the environment. (Greenacres, GM, Interview, 20/11/2014)

According to the shop steward there is always a conflict between policy ideals and its application. He cited an example of a longstanding policy that was working well for the facility and staff which was replaced by a new policy. This ended up affecting the staff,

organisational stability in terms of staff retention and morale.

> There was a policy that was called ‘gold care’. Staff was remunerated according to patient survey points that were generated from patients’ feedbacks. Accumulation of these points afforded one worker or group of workers a voucher with which they can buy anything for themselves and that was called a net-reward. The new management abolished this policy. This led to decrease in staff motivation levels and resignations. (Greenacres Shopsteward, interview, 20/06/2015)

There is always a tension or potential conflict between the policy as an idea and its application and recipient environment. This tension inevitably produces unintended consequences and failure as the dynamics of the environment have not been considered. It has also emerged that because the staff are compelled to implement they seek assistance to implement or negotiate its implementation.

Space for innovation and experimentation

The General Manager noted that there are limited opportunities for trying out new ideas internally and this occurs only at operational level. Staff members make suggestions in respect of service delivery through quality improvements programs and if such suggestions have been found useful they are recommended to Head Office and if they are accepted at Head Office level they are standardised and introduced to all area facilities.

> There is space for innovation internally insofar as operational and quality improvement issues but not in terms of policy. Insofar far as introduction and implementation of new policies and practices, we have no space to manoeuvre we just have to implement government policies and regulations as well as those of Netcare Group. If we can’t implement them or operate outside those policies and regulations we may not be allowed to operate

(Greenacres, GM, Interview, 20/11/2014).

According to the shop steward approval for innovation is dependent on whether the Company thinks it is not going to lose.

> For instance, the facility has what is called Acquit which is an IT tool. This tool serves to determine how many patients are mobile and how many may need comprehensive care. All that will determine the number of staff the company needs. This negatively affects the quality of care because this is a non-thinking tool. The application of this tool puts a strain on the nursing staff (Greenacres Shop steward, interview, 20/06/2015).

The General Manager stressed that there is little space for discretion and localisation in the delivery of services more especially at the operational level and on issues relating to service delivery improvement. The idea that the private is innovative and less encumbered with red tape and top-down centralised leaders is also shown to be somewhat fallacious. She also indicated that at policy level, the environment is *fixed and rigid*.

> We have no choice in terms of implementing new policies and practices or otherwise we are not allowed to operate. In instances where these regulations are not applicable due to the uniqueness of organisational context and technological advancement the HPCSA is brought in to assist to give guidance on implementation or they engage with the authorities on our behalf to change or modify the regulation to fit the environment. (Greenacres GM, Interview, 20/11/2014)

The shopsteward held a contrary view. There *is* space for discretion and localisation more especially if it favours and increases the company's profits although it is limited for personally initiated innovations. He also indicated that discretion also carries a risk if something goes wrong.

> There is discretion but also has limitations but if it affects company negatively the person that used that discretion will be liable for any damage to the company. For instance if you (nursing staff) are allocated for resuscitation and you choose to administer a drug to a patient in the absence of a nurse and a patient dies you liable, unequal treatment between nursing staff and medical staff. So, inasmuch as there is limited space for discretion there is also fear to use it.

The idea that staff in private hospitals are innovative and more so than in public hospitals is also rejected by the shopsteward who noted that being innovative can cost you your job.

> …staff are reluctant to use discretion in the delivery of service because of the fear of the reprisals should something go wrong. Staff are keen to improvise and innovate by suggesting changes but are simultaneously cautious because of the risks involved. (Greenacres shop steward, interview, 20/06/2015)

It is clear that while there is a limited space for discretion and localisation, in practice fear in the workplace drives workers to resist innovation. Moreover, this space exists only on operational matters. On strategic and policy matters they are compelled to confirm even where the policy does not fit the environment. Where the policy does not fir the environment they invite the health professional body to assist and give guidance in the implementation or intercede with the government on behalf of the facility. It appears that policy transfer does not necessarily become a "shoe-fit" and has to be customised. Secondly, it appears that there is a subtle form of coercion or a threat of coercion as one interviewee said that if they do not oblige they may not be able to operate. It also emerged that even the available limited space for use of discretion carries risk of disciplinary action if things go wrong.

Recruitment

As noted by General Manager, the hospital has its own recruitment policies, processes and procedures but they are implemented within national government policies such as targeted appointments. The Regional Office is responsible for approval of appointments.

> The recruitment process is simple and quick. New appointments and replacement positions get approved first. They are advertised internally in our intranet for two weeks. We focus on empowerment and affirmation internal candidates that might have been on contract or on lower positions and designated groups. If there are no internal candidates that responded within two weeks we advertise in the external mainstream media and also through recruitment agency. It takes us two months to fill a position and this applies to nurses, administrative and finance personnel. In terms of recruitment of scarce skills we talk about highly specialised nursing staff and this category we cast the net wide. We do not recruit doctors. The doctors we have here are part of Netcare and have their own consulting rooms in the facility. (Greenacres, GM, Interview, 20/11/2014).

The shop steward remarked that recruitment process in the facility is not as good as it is purported to be. He indicated that it is filled with contradictions because what is on paper and what is reported is not what obtains practically.

> Recruitment process have become questionable. On paper they look good. They also talk about employment equity and representativity. The management will come and present the Employment Equity Plan to the Institutional Transformation Forum and is endorsed but when you look at management and supervisory posts they are not EE compliant. Even people of colour that are appointed soon leave because they are no chances of upward mobility. Some posts take a long time to fill. For instance there

> is a post that has been vacant since November 2014 (now it's June 2015) and has not yet been filled until now but there are rumours that it will be filled in September. The reason for this might be the fact it is earmarked for a certain individual. IT supervisory 3-4 will be filled in September (2015). Nursing – labour is part of the selection and interview panel. (Greenacres Shop steward, Interview, 20/06/2015)

In summary these responses show that the facility recruits only nursing, administrative and auxiliary staff. Medical staff, such as doctors, are not employed by Netcare but they just have consulting rooms. Posts are advertised internally in the intranet for two weeks. The facility management focuses on empowerment and affirmation internal candidates that might have been on contract or on lower positions and designated groups. It takes two months to fill a position. Recruitment processes are seen by a labour representative as questionable and not in line with the facility's EE Plan and that some posts take long to be filled. It also emerged that "workers of Colour" meaning Black/African have a high turnover in the facility because they are denied upward mobility opportunities.

Training and retraining of human resources

The General Manager remarked that there are three categories of health professionals. There are enrolled nurses, registered nurses and highly specialised nurses.

> Netcare has its own training college which trains nurses called Netcare Education. Nurses receive theoretical training in the college and come to receive practical training in the facility and that training is conducted by clinical facilitators. (Greenacres GM, Interview, 20/11/2014).

Besides professional training it appears that the facility does conduct on-going training and development of the staff. According to a Daily Dispatch newspaper training and development programmes are conducted at the facility. In an interview with the said newspaper the Ward unit manager was quoted saying:

> Nurses attended self-development workshops, conferences and lectures at least twice a week as well as team-building exercises three times a year to help them improve their service. (The Herald, 12/05/2005)

The facility has its own training facility as well as professional training programs which are sponsored by Netcare. A Daily Dispatch (12/05/2005) newspaper report also revealed that there are also other ongoing staff development programs in the facility and professional training.

Procurement processes and staff performance management

The General Manager indicated their procurement processes are not as cumbersome as the government's. They are able to procure items, goods and services in as short as possible time.

> Our procurement processes are much simpler and quicker than the government's ones. You order today and get it today. There is also flexibility in the sense that we are able to source other stock from a nearby Netcare facility and reimburse them later. Insofar as capital assets are concerned it takes a bit longer than is the case with general goods. We also have to get three quotations, submit a request and get approval which must go through three signatories. The procurement of capital assets is planned and prepared for a year before. (Greenacres, GM, Interview, 20/11/2014).

In relation to staff performance management and development system the General Manager remarked that they have their own employee performance management and development (PMDS) tool. She also indicated that performance assessment is done bi-annually and is developmental as much as it is performance focused.

> We have an employee performance and development tool. The employee and supervisor negotiate and enter into work plan and performance

> agreement which sets performance levels and standards. There are two review sessions that are conducted to review employee performance. These review sessions serve to monitor performance and identify underperformance. The Netcare Group has been contemplating introducing a performance-related pay system however, labour organisations have not agreed on this. There are no performance bonuses for employees and employees are comfortable with that. (Greenacres, GM, Interview, 20/11/2014).

According to the shop steward there is a performance management system in place in the facility but it has its challenges.

> There is a performance management tool in this facility. Performance assessment is done four times a year. It is based on a rating system that include B-E meaning below expectation, M-E meeting expectation, E-E exceeded expectation. It also requires an employee to submit a portfolio of evidence to prove his or her performance. The challenge with this system is that it is not developmental it is just an evaluation tool to determine the worthiness of the employee to the Company. There are instances where there are tensions between supervisors and employees because employees feel that supervisors are not implementing this system properly. It is just used as a personal tool by supervisors to hit a people they don't like. – supervisor and personal max system has been favouring management. (Greenacres, Shop steward, Interview, 20/06/2015)

But as reflected by the shopsteward, pay for performance may undermine efforts, as rewards crowd out intrinsic motivation. The use of performance measurement can lower staff morale, encourage external compliance, change staff attitudes to work and reduce trust in the workplace (Newman 2008). Performance measurement if it is to bemeaningful is expensive and takes away resources from actual service to patients.

The performance management system includes contracting between supervisor and supervisee and setting of performance and service levels that are monitored twice or four times in a year and rated. It also emerged that there is a contemplated move towards performance related pay system which organised labour rejects. The Shop steward indicated that the performance management used in the facility is not developmental but serves to determine an "employee's worthiness to the company" and as a victimisation tool.

Installation, maintenance, functionality and effectiveness of IT in enhancing service delivery

The General Manager explained that the Head Office is responsible for the provision of their IT needs and IT support is regionalised and localised (on-site). "We have got a good IT system. It stores our data and speeds up service delivery". Elaborating further on their IT system she said.

> We have an integrated Hospital Information System which keeps patients information. Even you Mzi if you had been in one of Netcare facilities you will also appear here (in our facility) (Greenacres, GM, Interview, 20/11/2014).

The shop steward remarked that there is a person from National Head Office who is employed for installing and maintaining. He also indicated that he was not sure whether this service was outsourced. He reported that he only knows of the SEP IT system that was still partially being introduced and would be fully rolled out later when administration is outsourced. There is also a biometrics IT system that is used for staff attendance monitoring as well as a complaints management system. The facility's system is functional and effective.

In summary, a functional and effective IT system exists at the facility. This system is managed by the Netcare Head Office but is also regionalised. It also integrates patients'

information. It is evident that there is a new IT system for managing administrative processes that is in the process of being rolled out as well as an attendance monitoring system.

Lessons from inter-sectoral policy/organisational transfer

The General Manager remarked that there are lessons that can be learnt from the public sector. These lessons relate to the quality of care that is rendered in some public hospitals.

> Provision of healthcare in public sector is driven by service ethos and humaneness whereas the private sector is driven by profit generation. Also government has hi-tech equipment which it can afford to purchase. Equally so the private sector is ahead in terms of technological inventions which the public sector can learn from the private sector. (Greenacres, GM, Interview, 20/11/2014).

According to the shop steward there are lessons that private sector can learn from public sector. He also mentioned that just as not all public sector healthcare facilities are bad, similarly not all private sector healthcare facilities are good as they are purported to be.

> Nurses are leaving private sector for public sector and the question is why if the private sector is that good. Public sector is investing in its staff with benefits like housing subsidy, medical aid to motivate their staff. Although one of their values is to care but they are not practicing this. Also, not all public hospitals are bad just as not all private hospitals are good. In private sector too you do find instances of negligence and bad staff attitude. In private sector the issue or skills development is not prioritised and as a result we have to fight for these things although in the public sector is part of their human resource development priorities. (Greenacres, Shop steward, Interview, 20/06/2015).

Further highlighting other key areas that the private sector can learn from the public sector the shop steward said:

> Consultation, communication and participation in recruitment and other important organisational processes are just some of the practices that private healthcare sector can learn and adopt from public healthcare sector. In the private sector management is not allowed social responsibility.

Like the GM, the shopsteward noted, "Public healthcare sector has good equipment and has highly trained nursing and medical specialists." He went to suggest,

> Private healthcare sector can learn and adopt inter-generational mix in the appointment of senior management cadre to grow future managers. Senior managers in the private healthcare sector are too old compared to the public sector senior managers. Private sector can also adopt the introduction of flexi- time and arrangement of re-imbursement of the time missed. (Greenacres, Shop steward, Interview, 20/06/2015)

The shop steward noted that the public sector healthcare can also learn from the private sector. The lessons he mentioned relate to professional values and work ethic:

> Healthcare in the private sector is viewed very seriously unlike in the public sector. For instance, the issue of punctuality is a norm and is not negotiable. Everyone in the organisation from the Superintendent-General to a cleaner has a responsibility towards the success of the organisation. The public sector healthcare can also introduce the carer of the month awards as one way of recognition for a job well done and a non-monetary rewards and which can also serve as a staff motivation tool. (Greenacres, Shop steward, Interview, 20/06/ 2015)

Conclusion

It is clear that constant changes that have taken place in the facility over the last decade. The General Manager focused on an increase in patients' intake, technological advancements and advancement and introduction of specialist's medical fields. Netcare is a business and needs to show expansion and profit to keep shareholders satisfied. It needs to find ways to keep costs down. It is also evident that these policy changes have been internally initiated and others have been externally induced. These transfers have been driven largely by Netcare officials, health organisations and hospital groups associations. There has also been various networks and platforms where change ideas have been shared and emulated.

Management viewed these changes as part of quality of service improvement whereas labour viewed these changes as having been coercively introduced as they have not been consulted on them.

On the other hand, the shop steward reported extensive outsourcing, an electronic time management system, quality of service assessment approach and new information technology mechanisms for soliciting clients' feedback on their experiences of the facility. The introduction of time management policy, which is a clock out and clock-in system to tightly manage the time used by staff on lunch to minimise costs on the company was seen as an unwelcomed management innovation. The shopsteward also made an interesting observation that nurses are leaving private sector for public sector, which has started to provide better job security and benefits.

The dissonance in the issues identified or considered as vital might seem obvious but is not to be dismissed lightly. It reflects that "reality" can be construed differently by different actors depending on their positionalities.

Lessons that could be learnt by the private sector from public sector include service ethos and humaneness in the delivery of service rather than being simply profit driven.

Private sector can learn the prioritisation of development of its workforce, meaningful consultation and communication with labour organisations in decision-making affecting the organisation.

Chapter 6: Case Study of Port Alfred Hospital (a Private-Public Partnership)

Port Alfred hospital is rather different from Greenacres. In this chapter, Port Alfred Private Hospital's background is sketched including organisational and operational environment. It explores the envisaged, current and past transfers of organisational practices in relation to administrative systems and technologies used are explored. This exploration uses the same themes as chapter 5 but given the uniqueness of Port Alfred as a hybrid or a co-location of private and public sectors, a PPP with Netcare (see picture below), additional areas are explored. The theory of PPP and the policy transfers and best practices implicated are covered in chapter 2 of this thesis. Port Alfred Hospital is a key sites for "policy innovation". In South Africa the government adopted PPP's as part of its transformation tools and alternative service delivery models adapting models in the developed countries (Harrison 2006; Cameron 2009).

As already noted in Chapter 1 and 2 of this thesis the National Education, Health and Allied Workers Union (Nehawu) has opposed PPPs in State hospitals, partly because they included outsourcing of staff and facilities. It believed that it was the State's responsibility to deliver services to poor working class communities. The proponents of PPPs (government, private health industry and accounting firms like PWC, KPMG and World Bank) freely admit there is a lot of criticism of PPPs yet thye suggest PPPs create jobs, generate growth, and benefit society and the economy (see Chapter 2).[4]

[4] http://www.engineeringnews.co.za/article/are-partnerships-the-answer-to-south-africas-ailing-public-hospitals-2010-06-04/rep_id:4136.

Source: Netcare website

Contextual background

The Port Alfred Hospital is situated in a small coastal town of Port Alfred (previously white) in the Eastern Cape province, about 150km from the larger coastal cities of Port Elizabeth and East London. As part of the Ndlambe municipality the Port Alfred Hospital services the areas of Port Alfred, Alexandria, Bathurst, Boknes, Bushmans River, Kenton-on-sea as well as their surrounding black townships and farms. It is a predominantly upper class coastal holiday area with an economy largely devoted to agriculture, eco-tourism, hospitality, retail government, personal and company services sectors. As noted in the 2011 Census, Ndlambe municipality population is about 61 000 broken down into 77% African, 7,3% Coloured, 0,2 Indian and 14% White. Most major business premises in Port Alfred are concentrated in the CBD which also has the hospital

close to historically white areas. The CBD is the commercial and retail node of the town consisting national chain stores, local shops, offices, hotels, bed and breakfast, banks and owner operated businesses, government services. Demand for business premises is evident through the conversion of residential buildings east of the CBD to offices. Business uses within the townships are mostly corner/spaza shops and neighbourhood convenient stores. Mixed use development such as home businesses, offices and residential development is slowly emerging at the entrance to the town from Port Elizabeth (Ndlambe Municipality Draft IDP, 2014-2015).

Unlike the long established Greenacres, the hospital in its current form was established in 2009 as a result of a public-private partnership between the Eastern Cape Department of Health and Nalithemba (a consortium made up of general practitioners and other medical experts who saw a market for such a service). The new PPP hospital was opened in August 2009 with 90 public beds, and 31 private beds. Netcare provides facility management and 'soft services' (Netcare 2010).

Previously the premises belonged to a public hospital (Nursing Manager, Interview 2013). "With 75 full-time positions within the hospital, contracted external providers have created many more opportunities," Friedland noted that a minimum of 50% of the shareholding in the consortium was held by local black shareholders during the 15-year lifespan of the project. (http://www.southafrica.info/about/health/health-230209.htm#.V6nZbY9OLIU#ixzz4GqDkLaut). The PPP also allowed for the development of black capital in commercialised health under the wing of the state and Netcare.

In the course of my research it was unclear how the PPP was awarded (if competitive bids were entertained) if the union agreed and how public participation was conducted. The details of the PPP are unclear (what payment Netcare would receive, how risks were distributed etc)

As the former MEC for Health of the Eastern Cape Province, Ms Nomsa Jajula observed

that the importation of private sector service delivery mechanisms will assist in the socio-economic development of the province. In an interview with the Daily Dispatch she said:

> With the new hospital comes many opportunities for new and current business in a large number of different economic sectors. The hospital will most definitely draw new inhabitants who will need any number of goods and services, thereby stimulating economic growth. The department wants the projects to benefit the local community through not only providing healthcare beyond the bare minimum, but also through the provision of job and the purchasing of construction materials. In the interest of the long term development of the region, will be the ongoing expenditure on procuring 'soft services', which is expected to exceed R600-million over the operational period of the project (Daily Dispatch, 30/06/2008)

But the public and private hospitals in a co-location arrangement but with separate entrances is somewhat reminiscent of apartheid. The *Daily Dispatch* (08/05/2007) reported a R600 million deal between the Eastern Cape government and a private hospital group to build and equip a hospital in Port Alfred (and to upgrade Grahamstown's Settlers Hospital). At the opening of the Grahamstown PPP hospital, Vilikazi, the Netcare chairperson said

> Neither the private nor the public sectors had the means to tackle the healthcare challenges that South Africa faced on their own. Together however the two could make really meaningful strides in developing an infrastructure that provided healthcare that was more equitable for all. The private consortium will also be responsible for managing both public and private facilities for the next 15 years. This facilities management service

> includes the provision of all soft services such as catering, cleaning, linen and laundry, maintenance and replacement of facilities and equipment.[5]

The Port Alfred public-private partnership a similar initiative is a

> 15-year public - private partnership deal, signed in Bhisho by the Department of Health and a Netcare/black empowerment grouping called Nalithemba Hospitals. The project entailed the building of a new 90-bed hospital in Port Alfred in the vicinity of the town's decaying Kowie Hospital (DD, 08/05/2007).

Nalithemba has various black shareholders with diverse technical and medical expertise including *Qaphela* women's empowerment group which is responsible for the delivery of "non-core" services such as provision of laundry and catering services. Outsourcing and the attendant diminishing of trade union power and the development of black capital were thus synchronised.

Pro-Health is responsible for provision of HIV-Risk Management and related clinical services; Vestline is responsible for health trauma, occupational health and HIV-related matters. These separate business entities constitute the executive board governing the operations of Port Alfred hospital (*Daily Dispatch* DD, 8/05/2007). The complexity of the business side of the hospital (PPP contracts and SLA) is an interesting example of how the state, lawyers, accountants and white and black capital are partnering. Motivating for the PPPs particularly in the health sector, Reich (2002) argued that they offer the potential to combine the different strengths of public and private organisations,

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5 http://www.travelclinic.co.za/live/content.php?Session_ID=c905695238ab13c3858bdbd062051148&Item_ID=5892.

which include the private sector's creative influence, entrepreneurial spirit or organisational capacity, along with civil society groups, in addressing health problems in poor countries. Reflecting on the PPP champions' belief in the importance and usefulness of such arrangement Roehrich (2014: 111) asserted that PPP advocates believe that "promoting increased diversity of provision and contestability such partnerships secure better quality infrastructure and services at optimal cost and risk allocation. From his assessment of performance of PPPs in Africa Farlam (2005) concluded that over the previous 15 years the record of PPPs was mixed, the process was complex, and governments should not expect PPPs to be a 'magic bullet'.

According to the Nursing Manager there are instances where policy and practices do not converge or are incompatible between public and private settings.

> For example a national policy was introduced and it allowed a nurse to obtain consent from a patient for administering a surgical procedure or a particular treatment that might have risks. In private hospitals consent has always been obtained *only* by a doctor from a patient whereas in the public sector it has always been obtained by a nurse in the absence of a doctor. For us in a private hospital this was an ethical dilemma (Port Alfred, Nursing Manager, Interview, 9/12/2014).

Approach to Planning for improved service delivery

The Nursing Manager explained that planning for policy and improved service delivery does take place and it is done *systematically*. It is led by the Hospital CEO and his management team. It is informed by the hospital's mandate and the issues that emanate from the operational and organisational environment. She insisted that evidence was used to formulate policy:

> The Management of the hospital consisting of Chief Executive Officer, Nursing Manager, Technical Manager, Catering Manager and Heads of

> other business units such as Dispensary convenes a strategic meeting at the beginning of the financial year. They consider the hospital's service delivery plan of the past year, the balanced scorecards, staff and patients' satisfaction surveys. These are factual documents that reflect the hospital's state of service delivery. They identify successes, failures, challenges and develop a new service delivery plan and improvement plan. This strategic meeting is preceded by budget submissions of the individual sections and business units that are done in the month of June. In that budget submission there is a list of items and associated costs that would be required for operations in the following year. These can be regarded as a wish list as the strategic meeting with the attendant review will determine and confirm what can be considered a necessity and what is merely a nice to have. The outcomes of the management planning session are shared and cascaded down to general staff in business units meetings (Port Alfred, Nursing Manager, Interview, 21/10/2013).

Here we see an example of a "scientific" approach to policy based on evidence of success and "what works". The Manager indicated that these reports and documents are highly sensitive commercial secrets especially given the competitive environments of private hospital groups. However, as explained in Chapter two there is considerable debate about rational policy making and "depoliticised value-free" planning. For example, when the maternity ward was not "making money" the managers decided to open it to the public (it has little to do with community needs).

The shop steward concurred with the Nursing Manager that workers are involved in the facility's planning processes but only at the lower level (business unit level). He also indicated that staff members are called to respective section meetings whereby they are invited to make inputs on the facility's planning process.

There is a thus comprehensive and detailed planning process that takes place at the

hospital which include the involvement of section heads and an expectation that the outcomes of such planning processes are communicated downwards to the staff. The organised labour representative agreed with the Nursing Manager that staff is afforded an opportunity to give inputs to the facility's planning process. There appears an issue of a planning approach dichotomy between "bottom up" or "top down" approaches. This is evident in the Nursing Manager's comments on how the staff is involved in the planning process - "planning outcomes are cascaded down by section heads".

Regarding the performance management system, the Nursing Manager remarked that each individual manager contracts with the Chief Executive Officer (CEO). The CEO in turn has a contract with the Area Manager. Each employee has a clear job description and performance plan, which is linked to the strategic pillars of the hospital and Netcare starting from the manager. The hospital's performance management system is based on the following elements: contributing to the achievement of national targets, enhancing performance development, and providing the best and safest patient care and operational excellence. The performance plan is designed in a manner that links performance objectives upward to the values of the hospital and to the Strategic Pillars of the hospital and Netcare.

Key changes and innovations in organisation models

The Nursing Manager (I interviewed for almost an entire day in 2013 except for lunch break and then again in 2014 for a shorter period) identified key changes that have happened in the facility. The CEO, a black male who was about to resign was not able to meet for interviews. Hence, the nursing manager was my key source. She is a middle-aged white female. Unlike Greenacres manager, the nurse manager was closer to the ground-level workforce and offered additional insights. Some of these key changes she observed relate to policies and some to organisational practices and procedures:

> Indeed, there have been new policies, procedures and practices that have

> been introduced. At policy level, these are National Core Standards, Netcare Core Standards, a policy on access to surgery for all patients regardless of affordability and the PPP arrangement. (Port Alfred, Nursing Manager, Interview, 21/10/2013).

According to the shopsteward, there have been changes that have taken place at Port Alfred Hospital since its rebirth. This includes its transformation into a public-private hospital and the manner in which the delivery of services has changed.

> As you will remember Port Alfred Hospital was a public hospital but because of its bad condition and was even condemned by the Provincial Department of Public Works. Instead of upgrading it, the government decided to make it a public-private partnership (Port Alfred, Shop steward, interview, 12/06/2015).

This is exceptionally important observation by the Nehawu shopsteward since it indicates a major policy shift in the original ANC vision to rebuild public sector health.

The Nursing Manager said *most* of hospital functions are outsourced to private companies. The facility management ensures that they render the services they are contracted for according to the standards set by the facility.

> All our services are outsourced except the nursing and related staff. Security, laundry, cleaning, catering and waste removal. Contracts for outsourcing are done *nationally*. Performance or non-performance of service providers depends largely on how they are managed by the client. There are service level agreements that regulate the contractual arrangements and the penalty clauses for non or under-performance. Records of performance are kept. The service level agreements are reviewed on a regular basis. Issues of non or under-performance are discussed to find remedial actions. If they are persistent they are escalated

to their management. If still they persist, contracts are cancelled.

It is unclear if indeed any contracts were cancelled and at what costs and through which legal processes.

My informant explained that there are also other services that are shared with the public hospital to optimize the utilisation of those facilities.

> There are also services that are shared between us the (private hospital) and the Eastern Cape Department of Health and these are Emergency Services and Theatre. A shared service is a service that is utilised by both private and public patients. We are also intending to share the maternity ward as it is under-utilised as it currently stands (Port Alfred, Nursing Manager, Interview, 21/10/2013).

The decisions around which facilities to share are negotiated and strategic although it might have been written into the original PPP contract. "X-ray, casualty and theatre are shared areas. Shared areas are managed by the private partner. The partnership arrangement is supposed to be 50/50 but the private partner is more dominant and weighs heavily on government resources" according to the shop steward (Interview, 12/06/2015).

The shop steward felt that concurred that the private sector was parasitical on public taxpayers resources.

He noted that several services of the hospital are outsourced. This is similar to Greenacres. "Clinical and medical services are provided in-house. Catering, maintenance, cleaning, switchboard are outsourced".

In summary, most of the services are rendered through external mechanisms. Some services are shared between public and private. Although the partnership arrangement is supposed to be equal the private sector is dominant. Also, there are arguments and

perceptions that the private sector is using public sector resources with little returns for the public sector which makes the relationship to appear parasitic.

Quality of service delivery

The Nursing Manager indicated satisfaction with the level and quality of service rendered at the facility, which is such that they that they not received any negative comments on the quality of their service.

> Our patients' satisfaction surveys are positive about the service of the hospital and patients are encouraged to make suggestions for further improvement of service (Port Alfred, Nursing Manager, Interview, 21/10/2013).

According to the shop steward, they have not received any serious complaints about their service to an extent that they can be published in newspapers. The facility is known for good quality service.

> In response to this issue it emerged that there is no bad perception on the quality of service rendered at the facility. This was attributed to not remaining complacent with positive comments but to involving citizens in the measuring and commenting of their performance and service – "patients are encouraged to make suggestions for further improvement.

The Nursing Manager argued the hospital environment and ambiance is welcoming from the entrance right to the wards. There is also a free flow of patient queues and patients know where they should go to as there is signage. Describing the facility environment, the Nursing Manager said:

> From the reception area to the wards and ablution facilities are clean. There is clear signage in all sections and staff attitude is positive, welcoming and

> helpful. The waiting area is not congested. Required medical stock is always available. There is a clear business process and workflow that is followed when patients are attended.
>
> Interestingly she noted that although they have two facilities the reception area is shared,
>
> Although this hospital is a public-private partnership with both hospitals located in the same premises, public and private patients are received in the same reception area. No emergency patient is ever turned away because of unaffordability. There is less mortality rates.

Regarding labour discipline the Manger noted that,

> There is also incidents management system. This system looks at the regularity of occurrence of serious incidents such as absconding and what steps have been taken up to the finalisation of a case. This management system is also electronic.
>
> The Manager said,
>
> There are also regular meetings with the surrounding community members to assess the hospital's performance in serving their needs and identification of areas of improvement. There is a complaints management system that includes the encouragement of patients to forward their complaints and suggestions for improvement through the use of e-mails, letters, suggestion boxes as well as call-ins. The staff have a positive attitude and have passion about their work and they want to be seen to be among the best (Port Alfred, Nursing Manager, Interview, 21/10/2013).

According to the shop steward the hospital is known for good quality service. There is also a service quality assurance officer who is responsible for monitoring and assessing

service levels. This officer receives, analyses and act upon the complaints received, provides feedback and ensures the redress of submitted complaints.

The Nursing Manager noted that they have their own IT system and that Netcare provides the IT needs of the hospital from installation to maintenance. Commenting on the functionality of their IT system the Nursing Manager said:

> Our IT system is very functional, real time and effective. Almost all the work of the hospital is done electronically and web-based e.g., recruitment of staff, procurement, administrative processes relating to patients' information and admissions are directly and immediately [available] to Head Office, quality improvement reports. The IT system we have can link a patient that had once attended Port Alfred with other Netcare hospitals elsewhere. It facilitates and enables access to financial information. It has replaced manual administration and reduces chances of errors (Port Alfred, Nursing Manager Interview, 21/10/2013).

According to the shop steward, the IT system is provided internally and is functioning properly and effectively.

In summary, I found that there is an IT system in the facility, provided by Netcare. This IT system was deemed functional and effective. Furthermore, almost all the administrative work of the facility is done electronically and it assists in facilitating administrative processes associated with patient information. The IT system links Port Alfred hospital with other Netcare facilities elsewhere and "it reduces the administrative burden and errors".

Origins of policy ideas/organisational practices and types of sources of policy changes

According to the Nursing Manager some policy ideas/procedures or organisational practices emanate from within the private sector environment and some emanate from outside (government). The hospital embraces new policies and practices and views them as part of Netcare's way of ensuring improved service in all facilities that are associated with it and standardisation of practices.

> Some changes and innovations are introduced from Netcare Head Office, by the National Department of Health and in some instances internally by our own staff. The Head Office assesses the environment and introduce the necessary changes and enhancement programmes. They have been centralised but not coercively introduced. (Port Alfred, Nursing Manager, 21/10/2013).

According to her,

> Some changes have been introduced internally by management after assessing their own operational environment's demands and challenges and some are introduced by Netcare and have used their own discretion. It is also worth mentioning that it also depend on whether these changes are operational or strategic in which case, if they are strategic they will have to be vetted by the Board. (Port Alfred, Nursing Manager, 21/10/2013).

> Management suggests,

> There has been a high level of cooperation in terms of implemented as they are regarded as assisting to improve the performance of employees quality of service (Port Alfred, Nursing Manager, 21/10/2013).

But, the shop steward remarked that workers cannot authoritatively say where the sources of policy ideas and organisational practices come from because they are not consulted on these.

> I cannot say for sure where these ideas are coming from but I can only surmise that since the hospital is not an island but exist within the republic therefore these ideas could be coming from government and Netcare Head Office which is also supposed to adhere to government directives (Port Alfred, Shopsteward, interview, 12/06/2015).

In summary, policy ideas and practices are introduced from both outside, namely from national, provincial government, Netcare Head Office as well as internally.

According to the Nursing Manager, proposed changes are evaluated depending on the impact they will make in terms of enhancing the service as well cost-effectiveness.

> Any impending introduction of change or innovation will be assessed in terms of its suitability and benefit to the hospital as well as its budgetary implications. Any changes that are related to the core business and will enhance quality of service, effectiveness and efficiency and customer care are prioritised (Port Alfred, Nursing Manager, Interview, 21/10/2013).

The shop steward was of the opinion that decisions relating to what to choose to implement or not to implement from the package of changes rests with the management.

> Such decisions are management decisions and they do not even consult us on such decisions. However I am sure that they will not choose changes that will not favour the facility or threaten the profits of the company (Port Alfred, Shop steward, interview, 12/06/2015).

The Nursing Manager made a clear distinction between operational and strategic policy. "There is space for innovation and experimentation. However, it depends on its strategic

or operational nature. At operational level there is space more especially if the proposed innovation will help in improving service".

> In most cases innovations that are introduced are always aimed at ensuring operational efficiency and effectiveness and therefore it is easy to implement them, the Board is only informed for noting and are welcome by the Board (Port Alfred, Nursing Manager, Interview, 21/10/2013).

According to the shop steward there is no space for experimentation because the operational environment is prescribed and regulated and that is the nature of the health sector environment more particularly in the private sector.

> The health sector environment is highly regulated and the private health sector in particular is driven by business interests. Therefore I cannot think of *any instance* where a progressive idea from a staff member to improve service delivery can be accepted by management. Management is representing the interests of the capitalists that are running these hospitals so they will always be suspicious of ideas that may threaten their existence and profits (Port Alfred, Shop steward, interview, 12/06/2015).

In summary, it seems important to distinguish operational and strategic aspects of policy although as my literature review (see Pressman and Wildavsky 1986) pointed out even strategic policy has to be implemented and operationalised and "street level bureaucrats" have enormous power in bending and changing policy on the ground. To paraphrase Wildavsky, policies designed by a Sandton head office might look very different in Port Alfred.

Agents of change and innovations sharing of ideas and innovations

The Nursing Manager confirmed that the Head Office assigns certain managers internally to take note of impending innovations so that they can start preparing for their

implementation. In some instances, the Head Office bring in service providers.

> The innovations are introduced and facilitated by Netcare themselves or service providers contracted by them. There is also a Quality Leadership Team from Head Office that drive these changes. Impending changes are also brought or communicated electronically through a system called Alert. A manager responsible for that particular area will be responsible for ensuring the implementation of that particular change directive or what is considered an innovation (Port Alfred, Nursing Manager, interview, 9/12/2014).

It also appears that there is a "think tank" of change management specialists resident at Head Office (but I was not able to interview Head Office personnel). The Nursing Manager noted that there are platforms for sharing knowledge and innovations. Sometimes these platforms assist in learning from others how to deal with certain situations or how participants can enhance their own practices.

> Innovations are shared through internal training sessions, conferences and quality improvement workshops that are hosted by Netcare or their preferred service providers. Other sharing platforms are monitoring and evaluations reports of other sister facilities whereby the implementation and the effectiveness or ineffectiveness and the revision or adaptations of these innovations are reported and posted *on the intranet* for everyone and particularly managers to access (Port Alfred, Nursing Manager, Interview, 21/10/2013).

The shop steward said that he does not know whether there are platforms of sharing changes and innovations because they are neither consulted nor involved in change processes taking place at the hospital.

> Workers in this hospital do not know what is happening in this hospital

> because there is no consultative engagements with the management. What we see is only the implementation of new things without having been consulted (Port Alfred, Shop steward, Interview, 12/06/2015).

The response to this question revealed that for and among the management layer changes are shared through training sessions, conferences and workshops but that unionised staff did not interpret these sessions as opportunities for sharing knowledge and innovations.

In general the worker leader at the PPP hospital seemed less in the loop that at Green Acres but quite militant/adversarial and suggesting there was tensions. The shop steward remarked that "there will always be tension between the policy implementation and the environment in which it is implemented more especially if there is no consultation between the management and workers", elaborating as follows:

> Policies and practices that are just introduced without consulting them with the people involved will not work. There will be tension and resistance which will affect service delivery. This refers to both policies and practices that are introduced from government or internally. You must remember people are not robots they have their own ideas and therefore it is important that their ideas are considered or else there will be chaos and those policies and practices will not succeed. It may be the reason why we have dissatisfaction among employees (Port Alfred, Shop steward, Interview, 12/06/2015)

The Nursing Manager returned to the operational/strategic divide when talking about discretion and localisation in the delivery of service.

> There are strategic and operational issues that are dealt with in the execution of the mandate of the hospital. On operational issues the

> management does use own discretion in matters such as facility management and visiting times. However on strategic issues such as recruitment, training and procurement policies, management can only make recommendations to the Board and it makes decisions (Port Alfred, Nursing Manager, Interview, 21/10/2013).

As the shop steward observed no discretion or localisation in the delivery of services because they are prescribed by law and regulations.

The responses to this issue again revealed disagreement between the respondents. Local management indicated that there is space for discretion and localisation in the delivery of services but also that discretion depended on the level and space at which it will be exercised. According to the shop steward the bureaucratic nature of the work environment does not allow flexibility. It appears that strict adherence to rules and regulations is also applicable in the private sector. Where there is space for discretion and localisation that still needs to be vetted by the Board.

Alignment of organisational structure to the service delivery plan and Business process model

The Nursing Manager indicated that management is satisfied with the level of organisational structure's alignment to the service delivery plan. There is also adequate personnel with the requisite expertise to manage the business units.

> It is aligned as it relates directly to the business of the hospital. Each section is headed by someone who has the requisite expertise e.g. The medical section is headed by a qualified professional nurse called Nursing Manager. The technical section and catering section as well as the associated specific units are headed by personnel with requisite expertise. As the hospital is operating 24 hours there is a shift leader for the after-hours time who is responsible for responding to any emergency. This

> person is provided with cellular phone so that even if he is at home he can be called anytime for emergency situations. This is applicable to all the sections (Port Alfred, Nursing Manager, Interview, 21/10/2013).

The shop steward remarked that the staff are invited to meetings to give their inputs to the planning process.

Explaining the hospital's business processes the Nursing Manager indicated that there different kinds of visits by patients which are dealt with differently. Among these visits there are planned and emergency visits. Each visit has its own business process as she explained:

> Since most of private hospital's patients are on medical aid the online administrative processes include seeking authorisation from the medical aid provider. Then the patient is admitted and referred to examination either by a professional nurse or doctor who will determine whether the patient should be hospitalised or receive home treatment. On either of these opinions the patient will be provided with prescription. On admission, a patient is assigned a nurse who is called a Case Manager who monitors the condition and recuperative progress of a patient and updates the doctor on progress. The Doctor also monitors progress and he/she directs that the patient be discharged (Port Alfred, Nursing Manager, Interview, 21/10/2013).

Describing the business process pertaining to dealing with emergency cases the Nursing Manager continued:

> In an emergency, a patient is assessed to determine the seriousness of a patient and to prioritize his/her attention. If the patient is less serious he/she is referred to the reception to go through the administrative processes of admission and then come back to see a professional nurse or a doctor for

> examination, diagnosis, prescription and discharge or hospitalisation. If the patient is serious, he/she is immediately examined by a doctor. Thereafter he/she is stabilised by medical staff. On determination of his/her seriousness the patient is hospitalised or transferred to another hospital. In terms of time taken to attend a patient, it depends on the seriousness of the case of the patient. However seriousness of patients' cases are ranked in terms of priority eg. Priority One (1) – must see the doctor in 10 minutes, Priority Two (2), must see the doctor in 60 minutes, Priority Three (3) non-urgent must see the doctor in 4 hours. The hospital business process is clear, simple and less time-consuming. The screening and prioritisation of patient's cases reduces unnecessary congestion in waiting areas (Port Alfred, Nursing Manager, Interview, 21/10/2013).

According to the shop steward the business processes at the facility are satisfactory. Explaining the process from reporting to admission or release of a patient he said:

> The administrative staff receive patients, take their medical aid details and liaise with medical aid offices to get authorisations. There are also service standards that talk to waiting times among other things. If the promised waiting time is exceeded because of some delays the patients are informed (Port Alfred, Shop steward, Interview, 12/06/2015).

The response to this question has revealed that there are standard business processes in the facility which are different depending on the nature of the patients' visit. It also appeared that the time taken to attend to patients ranges from 1 to 4 hours depending on the nature of the case. The processes are clear, simple and effective. It was also indicated that there are service standards associated with attending to a patient and if for any reason these have not been adhered to explanations are provided and apologies extended to the patients.

Transformative health and related policies implemented

The Nursing Manager insisted they do implement government's transformative health policies. Their operating licence is dependent largely on compliance with several government policies. She also indicated that it is sometimes difficult to implement some policies or procedures that are introduced from outside. Elaborating on the difficulty of implementing some of these policies she mentioned that:

> It has been difficult to implement some of these policies because some of them had budgetary implications which were not planned for such as the need for change of specifications of the design layouts of the physical infrastructure as required by the health new norms and standard. (Port Alfred, Nursing Manager, Interview, 21/10/2013).

According to the shop steward the facility implements government policies such as Labour Relations, Basic Conditions Employment Acts and other related legislation. He also found these to be easily implementable but management manipulates and distorts this customisation to serve their interests. "They do not follow the Labour Relations Act properly because there are instances where they just dismiss workers instantly without following the steps outlined in the Act" (Port Alfred, Shop steward, Interview, 12/06/2015).

It appears to be difficult to implement government transformative legislations and policies in some instances due to their financial implications which have not been considered or expected. It also appeared that the government's transformative policies and legislations are implemented and they are customised and adapted where necessary. It further emerged that in the course of their customisation practices may not be aligned to the original policy or legislation and the management use may them to get rid of some workers without following the proper procedures.

Recruitment processes and procedures

The Nursing Manager remarked that the hospital has its own human resource, training, financial management and related policies. These policies are drawn from Netcare but they are aligned to the national government policy frameworks. She further noted that although aligned to national government policies, they are customised to the hospital's operational environment and therefore the hospital finds them easy to implement. Furthermore, policies are found to be effective because they produce the intended and desired results. In instances where they do not work well they are revised. Detailing the recruitment process the Nursing Manager had this to say:

> Netcare Head Office formulate recruitment policy framework and all associated hospitals utilize those. … It takes two weeks to a month to recruit and fill a vacant position. The process that is followed involves placing the advertisement on the intranet for two weeks and encouraging staff to recommend people they know that are looking for related jobs. If there is no positive response or no response at all, an advertisement is placed on the local newspaper for a week. After a week subsequent to the closure of the advertisement, sifting and shortlisting is done, an interview panel including labour representatives is constituted, interviews are organised and prospective candidates are invited for an interview. The panel makes a recommendation after the interview and a motivation is written for that particular candidate, scanned and emailed to the Area Manager within a day. It is received back the next day and the successful candidate is informed same day or the next one.|

Further making distinctions between the recruitment process of lower levels and senior management staff and the time it takes to finalize an appointment the Nursing Manager said "With the appointment senior management, a position is advertised for two weeks and the next two weeks is spent on arranging interviews and all the necessary

administrative process up to the final appointment. In essence, it also takes a month to fill a vacant position" (Port Alfred, Nursing Manager, Interview, 21/10/2013).

The shop steward observed recruitment policies seem to be easily implementable. Unlike in the public sector it is not very time-consuming to recruit and fill a vacant position. He estimated that it can take one to three months to appoint a worker.

In summary, the findings were that recruitment processes and procedures are quick. Furthermore the Netcare Head Office formulate recruitment policy framework is utilised by this associated hospital. Various recruiting methods are used including verbal messages, intranet adverts and local newspaper for lower levels of staff. Senior management and specific critical skills are recruited through head-hunting, advertisement on national newspapers and recruiting companies. It takes about one to three months to recruit and fill a vacant position.

Training of human resources

According to the Nursing Manager, the hospital has its training management system. A training needs assessment is done every year to compile a register of training needs. The Area Office of Netcare is responsible for organizing and coordinating training. The training investment in one staff member is harvested by ensuring that trained staff come back to share and train others:

> We conduct training needs assessment and compile a register thereof. We submit our training needs to Netcare area office which in turn organizes transversal training and call for nomination of candidates for training. Every year different categories of employees are sent for training. One employee is sent to training and he/she is given a responsibility to ensure that he/she trains other employees on his/her return. There is in-service training provided by external service providers as well in-house training provided by senior staff. There is training on Customer Care Ethos which

> was designed by Netcare and is meant for everyone associated, working or trading in the name of Netcare. 'Doing it the Netcare Way' which has been aimed at instilling humane and compassionate values and customer-friendly behaviour to employees. Also, the hospital has a Transformation Committee which considers applications for training. Funding for training is provided in the Skills Levy stipulated by the national Skills Development Levies Act (Port Alfred, Nursing Manager, Interview, 21/10/2013).

Highlighting the diverse training programs offered, the cost effective in which training is provided and managed as well as the wider impact of this training the Nursing Manager said:

> There is ongoing training for lower levels of staff which is aimed at up-skilling them from care-workers to enrolled nursing auxiliaries up to registered or professional nurses. There has also been an Infection Control Course for all staff members which is aimed at empowering nursing staff to train patients to control contracting infections even when they are discharged. This training will help patients and also their families if they also take it to their homes and families. This training has a ripple effect in a sense that health-conscious and healthy families make healthy communities and reduce the likelihood of individual family community members to unnecessarily contract diseases. This can be viewed as part of community health education reach.

The shop steward agreed that there is a training programme for staff although he could not provide detailed information on it. He also indicated that there is a structure that considers staff training needs.

> There are training programs for the staff in the facility. …there is a training coordinating structure. …training is preceded by training needs assessment

> to ensure that training is needs based and targeted, …trained personnel has a responsibility to come and plough back to other personnel what they have gained in the training program. It appears that training is considered an investment that must have returns. The training returns are aimed at enhancing staff capacity, to improve service and also impact on the community they are serving through community health education (Port Alfred, Shopsteward, Interview, 12/06/2015).

Procurement processes and procedures

According to the Nursing Manager, the facility procures many kinds of essential consumables and medicines such as syringes, needles, sterilisation alcohol, dressing trays, gauze, gloves, cotton wool, scalper blades, scissors, masks, and medicines. All these are purchased according to needs and having considered the frequency at which these items have been required per month. The facility procurement has proven to be satisfactory to date.

> Procurement is done on a needs basis having deduced from needs and requisition trends. Netcare Head Office has a database of providers and negotiates purchasing prices with providers every year and gives its associated hospitals a list of preferred providers. The hospital pharmacists makes procurement of all the required stock online from the preferred providers after the nursing department has provided the pharmacist with its needs. The receipt, reconciliation and dispensing and overall control of this stock is done electronically to ensure that it reaches its destination and the patient as it is charged against the patient's medical bill in any case hence it is procured on a needs basis.

The Nursing Manager explained,

> The hospital has a system application process which is a comprehensive

> database to manage and control stock and a centralised stock management to ensure there is no wastage and unaccountability. Online procurement, delivery and receipt of stock is done and completed in one day. In terms of the time in which the stock is delivered and efficiency in which it is dispensed it can be safely said the hospital's procurement regime is satisfactory. It is unique to private hospitals in the sense that the public sector healthcare is still using the cumbersome and time-consuming manual procurement system which is still based on adhering to the tender regulations (Port Alfred, Nursing Manager, Interview, 21/10/2013).

The shop steward noted that procurement processes at the facility are not complicated or time-consuming. Depending on the type of goods or services that are procured it can take up to a week to receive the goods. (Port Alfred, Shop steward, Interview, 12/06/2015).

Netcare, however as a large company is able to negotiate good prices from suppliers. Prices are negotiated centrally by Netcare. Suppliers and service providers are drawn from the existing database. However, this should also apply to the state (see example of ARVs and Aspen cited by Minister Motsoaledi). The findings have showed that the procurement processes are quick and simple compared to the public sector procurement. It was also noted that procurement is done on-line and on a needs basis deduced of course from the trends. A digital system reconciles what has been ordered and utilised and what has not been utilised to ensure efficiency. In terms of time taken to procure the shop steward indicated that procurement can take between 3 to 7 days depending on the nature of the goods.

Labour relations

The Nursing Manager noted that the hospital workforce work for 42 hours in a week. Every second week, the personnel gets a weekend offduty opportunity. Personnel

management and deployment is done through analysis of demand based on trends shown by previous days and peak days in particular. Elaborating on how personnel is deployed, managed and rewarded the nursing manager said:

> The hospital has a daily personnel deployment system which is electronically operated (clinical staff). It involves a capacity assessment of today's personnel against the bookings scheduled for the following day and personnel scheduled for that day and a calculation of number of hours spent on attending to a patient. Information about the certain categories of staff and number of hours spent by those personnel on their work, scheduled bookings are loaded on an Excel spreadsheet template and it calculates and projects the volume of capacity of staff needed for the following day. It also indicates if there is a need for additional capacity of one or two persons. Those additional two are also scheduled for the following day's shift. But their hours will be banked to be given to them when they need additional leave days or special leave (Port Alfred, Nursing Manager, Interview, 21/10/ 2013).

Describing how each employee is held accountable for performance and how that performance contributes to the realisation of organisational goals, the Nursing Manager said:

> Each personnel is held accountable for measurable results or key performance indicators which include maintaining the patients' blood pressure and temperature to acceptable levels, ordering of correct medical stock and the associated quantity and dispensing of that stock without any wastage, the level of satisfaction of patients which is done through patient satisfaction survey (personnel attitude, helpfulness, courtesy), audit reports (regular and acceptable disposal of the used medical material).

She went on to outline that,

> These are measurable results/key performance indicators that are rated in percentages. These measurable results and their ratings are cascaded from CEO, Nursing Manager down to the nursing staff. Performance assessment is done twice a year. There is an interim assessment which is aimed at tracking progress on the implementation of performance plan and achievement of targets and identifying impediments and possible impediments to realisation of targets. There is a final assessment to check and confirm the realisation of targets. There is also an electronic attendance monitoring system called a hand reader device which is used alongside a manual duty register which serves as a back-up, verification and reconciliation of days an employee has come to report for work (Port Alfred, Nursing Manager, Interview, 21/10/2013).

Elaborating on the actual assessment process, allocation of sources and performance rewards, the Nursing Manager said:

> A manager sits with his direct report to conduct performance assessment. Performance is assessed and ratings awarded. The ratings range from 0 to 5. 0 is for too early to assess; 1 is for not meeting the performance standard expected; 3 for good performance; 4 for high performance; 5 for top performance. The manager and the direct report must reach consensus on the scores. There are no individual performance bonuses awarded to employees. Employees are rewarded with the normal remuneration and a thirteenth cheque and an inflation-related pay increase. A nominal performance bonus is awarded only when Netcare nationally has performed well in terms of profit. In the hospital are also non-monetary rewards for best performance like certificates of excellence, care-worker of the month awards as well as staff parties (Port Alfred, Nursing Manager, Interview, 21/10/2013).

The shop steward concurred with the Nursing Manager that the PMDS is in place and that it is managed by the Human Resource Development (HRD) section. He also indicated that there is a committee that oversees implementation. The shop steward also indicated that there tends to be misunderstandings between some supervisors and employees:

> In some instances, there are disagreements over the key performance areas because some employees are just deployed to any section. This deployment causes misalignment between their job descriptions, work plan agreements and performance assessment reports. There is no policy on deployment and redeployment of staff. Another challenge that is being experienced is that other employees are allowed to submit performance assessments reports although they have been on study leave. The question on this practice is that on what basis is a person who had not worked be assessed. PMDS is about performance (Port Alfred, Shop steward, Interview, 12/06/2015).

A PMDS is in place and that performance assessment is done twice annually. The performance assessment include a systematic and detailed implementation plan which includes a one-on-one meetings wherein "measurable results or key performance indicators for managing performance are set and in turn are cascaded down to the lower levels of staff". It appears that performance assessment and measurement of performance is objective in the sense that it is based on measurable indicators that have been set beforehand and is rated. It has also emerged that there is no individual performance bonus.

Challenges pertaining to the implementation of PMDS were raised. These challenges relate to misunderstandings between some managers and employees during the assessment sessions. These misunderstandings emanate from staff deployments and redeployments which result in misalignments between job descriptions, work plan agreement and performance assessments reports as well as assessments of the workforce

that are “on study leave”.

The labour organisation does not agree with these arrangements and considers that they do not make logical sense. In addition to the performance management system there is also a scientific staff deployment and daily attendance monitoring system. There is also a non-monetary performance reward system to acknowledge, recognize, reward and motivate staff. It appears that the standards for performance are measured scientifically and employees are held accountable for performance and productivity and profitability of the organisation. The deployment of staff and monitoring of daily attendance are done electronically and can be determined scientifically to ensure that the investment made in the workforce can be measured against the outputs.

The Nursing Manager indicated there are organisational practices which she thinks the hospital can learn from the public sector. These include the management of labour relations, human resource development, employment equity and psychiatric nursing.

> We have a bit of a hostile and confrontational relationship with organised labour. The hospital management needs to learn how to engage with labour organisations on these areas. We can also learn multi-skilling through rotation of staff to other areas of nursing care because in private hospitals nurses are not exposed to other areas of nursing as is the case in public hospitals. The hospital also wishes to learn psychiatric observation from public sector because that expertise is not available and yet some people are brought in for that and are transferred to Port Elizabeth (Port Alfred, Nursing Manager, Interview, 21/10/2013).

A nurse employed at Netcare in 2013 earned approximately R8 000 per month with a R1 400 deduction for medical aid. "We cannot qualify for an RDP house but also earn too little to be granted a bond by banks," said a striking nurse. Netcare offered an 8%

wage increase while the workers want an 11% increase (HR Pulse 13 April 2013). [6] The shop steward indicated that he is not certain whether private sector hospitals can learn anything from public sector because the private hospitals' goal is to generate profit through curing the sick whilst the public sector hospitals' goal is to render a service therefore their goals are different. This is also a key argument of this thesis. Highlighting what he thought was the strength of the public sector hospital he said:

> There is however one thing that I think private sector hospital management can learn is constant interaction and engagement with organised labour and sharing their resources with public sector. The management is too distant from their personnel and this is the reason why the relations between the two are not good. As things are now private sector is weighing in heavily on public sector resources (Port Alfred, Shopsteward, Interview, 12/06/2015).

The Nursing Manager noted that with regard to the policies and practices implemented from outside the private sector they have not experienced serious challenges except with those that related to new Norms and Standards which had budgetary implications. Elaborating on the functioning or non-functioning of policy/organisational practices transfers the Nursing Manager said:

> Inasmuch as we have experienced some challenges with the implementation of exported practices and policies we have nonetheless tried to customize them to suit our environment so that we can make them work. Entering into partnership with government departments such as Justice on abused women and involving the community in assessing and setting service standards has only served to enhance the image of the

[6] http://www.hrpulse.co.za/news/229514-netcare-nurses-go-on-strike

> hospital in terms of caring attitude and the quality of our service (Port Alfred, Nursing Manager, Interview, 21/10/2013).

The shopsteward importantly remarked that "outsourced services are no better" because the outsourced companies do not interact well with the staff to get to know what they are doing and how they are doing it. This kind of "adversarial relation can affect service delivery because one can end up trying to undermine and sabotage each other". This illustrates the problematic of core/non-core and the problems that emerge in managing the boundaries and shunting issues between them (see Clarke and Newman 1997, also discussed in chapter 2 of this thesis). The "ownership" and boundary issue is compounded by perverse incentive set up by performance management and target setting whereby staff avoid taking on risk and responsibility for risky work. They similarly avoid innovation and team work (a familiar gaming problem, see Pollitt 2000) where rewards are not easily obtained. These motivational distortions can seriously hamper providing real services.

Transferred policies and organisational practices have not been difficult to implement and where there have been challenges, practices have been customised and have worked effectively. It also emerged that the transferred policies and practices are not necessarily better instead outsourcing can cause instability and adversarial relations.

Conclusions

What major insights can be drawn from the Port Alfred PPP case study? It is of course early days of the 15 year PPP contract. Reijniers (1994:138) argued that there are classic difficulties and complications that may arise in PPP's as "the common goal is not as common as it seems to be at first". Outsourcing of services was the norm at PA PPP. The in-house workers were outsourcing as a major problem because the outsourced companies do not interact well with the staff. The "adversarial relation can affect service delivery because one can end up trying to undermine each other". Worker representative

felt that the public sector was being used by the private sector (Netcare). The worker saw inconsistencies and gaps in the performance management system.

The Netcare Nurse Manager explained that the hospital is run like a branch or outlet of Netcare and is closely managed by the head-office and regional office. Strategic policy issues are dealt with centrally but there is room for discretion in operational matters.

Failures of Public-Private Partnerships

This juxtaposition of PPP operational model on one hand and interests and organisational culture on the other reveals stark differences which raises a serious question about the compatibility and reconcilability of the organisational cultures of these two sectors and consequently the transferability and workability of attendant practices which is the key issue in this thesis.

Holden (2009: 313) cautions that PPPs have been oversold and "the drawbacks of the model may be even more problematic for public health service organisations in developing and eastern European countries, where the expertise to negotiate, monitor and enforce robust contracts with the private sector may be more limited". Further highlighting these complexities and providing a critique of PPPs, Greve and Hodge (2010) and Buse and Waxman (2000) cited several challenges pertinent in PPPs namely long term and complex nature of the deals; their elitist and inaccessible nature (to ordinary citizens); lack of public participation and transparency; abdication of the lead role by government to private partners and thus enabling nation states to abdicate their responsibilities for the promotion and protection of their citizens'; government's lack of capacity to manage and scrutinize the activities in the partnership leading to private partners manipulating the partnership for their own selfish ends. A further complication and contradiction is the involvement and advocacy role of Treasury which is supposed to keep its distance so as to be able to objectively evaluate the PPP projects.

Greve and Hodge (2010) noted that many countries and international organisations have

been cautious about PPP's long term perspectives and economic promises albeit the fact that reviews conducted to date had acknowledged the economic and financial results accrued from them in particular countries. They further asserted that the key to sustainable partnerships includes "organisational complementarity, co-location and coterminosity and symbiotic interdependency" (Greve and Hodge 2010:150). Another example of mixed record of PPPs was noted by Buso (2004) when he argued that as much as documents on the effectiveness of implementation of PPPs indicate positive gains derived therefrom, there are also counter arguments. Using the example of privatisation of some health services to such institutions as Life Care and SANTA he argued that the gains purported to be achieved around issues of efficiency and quality; additional resources being freed up of from government fiscal responsibility as a result of privatisation; equity through redistribution of resources and consumer choices were all equally questionable in view of the inconclusiveness of documented outcomes. No benefit to the poor had been demonstrated.

There was consensus between nursing manager and shop steward that the private sector can learn from the public sector in relation to managing positive relations with organised labour. Also multi-skilling of nursing staff in public hospitals by rotating them was seen as superior to the private healthcare facility where nurses are exposed only to the sections they have been employed in.

Chapter 7: Case Study - Cecilia Makiwane (Public) Hospital

This chapter describes the context of this public hospital and explores its key policies and organisational practices. The envisaged, current and past transfers of organisational practices in administrative systems and technologies are analysed. In exploring transfers of organisational practices the same sub-questions are used as listed at the start of chapter 6. The problems of the Eastern Cape such as pervasive corruption, maladministration and low moral and low trust among staff affect CMH but I did not directly go into these highly sensitive matters in the interviews.

I interviewed the CEO and senior professional nurse and Nehawu shop steward at length.

Context

Geographically, the Cecilia Makiwane Hospital (CMH) unlike the city-based Greenacres, is situated in the Mdantsane black township outside East London in the Buffalo City Metropolitan Municipality (BCMM). Geographically, this township lies along the N2 national road between King Williamstown and East London. Mdantsane was established as part of the apartheid scheme of separate development and granting of nominal independence to the then Bantustan homelands such as Transkei, Bophuthatswana, Venda and Ciskei. The CMH was established between 1976 and 1979 and was named after Cecilia Makiwane who was the first registered professional black nurse in South Africa and a women activist who participated in the first anti-women's pass campaign in 1912 (http://www.buffalocity.gov.za); (htttp://www.sahistory.org.za). Built in 1972, the original design of the hospital is reminiscent of army barracks, with sprawling rows of wards that branch off from the main hospital spine.

CMH was a tertiary hospital for the then nominally independent Ciskei government and it also served to divert Black patients from Frere Hospital which was meant to be serve Whites only (Cecilia Makiwane, CEO, Interview, 15/11/2013). The recent massive R18 billion rebuilding on the new complex was overseen by the Coega Dev Corporation.

According to the CEO, the hospital is a Regional specialist hospital is a 1724 bed, five times more than the number at Greenacres. It is multi-disciplinary hospital, which is graded level 2 and providing all specialist services. As a huge hospital complex CMH offers the following medical services: Trauma and Emergency department, Paediatrics, Obstetrics/Gynaecology, Surgery, Internal Medicine, ARV clinic for HIV/AIDS in adults and children, Anaesthetics, Paediatric Surgery, Family Medicine, Psychiatry, Dermatology, Otolaryngology (ENT), Ophthalmology and burns unit. It also offers allied health services such as Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology, Social worker, Dentistry and Dietetics. The Orthopaedic department runs a weekly clinic. Other services that are offered include CSSD Services, Pharmacy, Post Trauma Counselling Services, Occupational Services, X-Ray Services with Computed Tomography (CT) facility, NHLS Laboratory, Blood Bank, Laundry Services, Kitchen Services and Mortuary. Other facilities include Operating Theatre, Intensive Care Unit (ICU) for adult, paediatric and neonatal patients and high care wards for general and obstetric patients (Cecilia Makiwane, CEO, Interview, 20/06/2014).

The total population of Buffalo City Municipal jurisdictional areas is about 724 000 but the CMH services a population of about 1,3million spread over a vast area consisting of Amathole, Buffalo City, Chris Hani and Joe Gqabi district municipalities. It services twenty thousand (20 000) emergency outpatients and has an in-patient intake volume of 1400 per 700 beds per month. Compared to Greenacres, it thus has an enormous load with only half the required number of staff posts filled and major issues with consumables running out (Oversight parliamentary visit report, 2011, https://pmg.org.za/tabled-committee-report/1478). The hospital is experiencing operational

pressures due to the large volume of patients who would have otherwise been screened and treated in primary health centres (PHCs) in area where there are no district hospitals and this affects the efficiency of the hospital. (Cecilia Makiwane, CEO, 15 November 2013). Staff shortages, congestion in long queues, shortages of supplies and medication, labour problems, perceptions of corruption and nepotism, and policy churning are among major problems reported in my interviews.

The hospital is governed by a Hospital Board which oversees the strategic plan as well as providing strategic guidance. At an administrative level, the hospital is led by a Chief Executive Officer with seven managers who are responsible for the day-to-day running of the hospital. Other non-clinical units include human resource, human resource development, financial management, facility management which all report directly to the CEO (Cecilia Makiwane, CEO Interview, 20/06/2014). The CEO is a trained medical doctor who at one point had a small practice in the former Transkei (Interview 2014). He is also a prominent ANC member in the local branch.

Planning for policy changes and improved delivery of services

The CEO's view on planning for policy changes and improvement of service delivery was that all this begins from the election manifesto of the ruling party which has to find expression in the government policies, strategies, programmes and priorities. These are led by political heads, administrative heads and implemented by line functionaries. Elaborating on the planning and implementation and service delivery improvement processes the CEO said:

> The institution receives directives from the Provincial Department of Health which emanate from national, provincial and MEC policy speech priorities through the Head of Department (HoD). All policy priorities are derived from the ruling party election manifesto. These directives are discussed by the executive management to determine their suitability and

> applicability to the institution's operational environment. They are then taken to the institution's planning session for discussion; adjustments where necessary and incorporation into the institutions five year strategic plan, annual performance plan and operational plan (Cecilia Makiwane, CEO, Interview, 20/06/2014).

Elaborating on the nature of the plans and commitments attached to them, levels of performance expected in the execution of those plans as well as monitoring mechanisms the CEO said:

> The strategic plan and the annual performance plan respectively are aligned to the five-year term of government and the three year Mid-term Expenditure Framework (MTEF) cycle. The institution also develops and publish Service Delivery Improvement Plan (SDIP) which is a mandatory document committing the Department of Health and the institutions in particular to service delivery standards that should be expected by the citizens and means of redressing and improving on the current levels of service. Progress on the implementation is monitored with scientific performance monitoring and assessment tools and reported on a monthly and quarterly basis. The institution uses an objective assessment indicator system which includes clients' perceptions surveys among other tools on their experiences of our services. This helps in terms of getting public perception on our services even negative feedbacks. The results of these surveys are used to improve our services (Cecilia Makiwane, CEO, Interview, 20/06/2014).

The Senior Professional Nurse indicated that the operational staff are not involved in planning. Sometimes the allocated budget is not spent but taken back to Treasury because of lack of proper planning and non-involvement of operational staff in planning for spending and delivery.

According to the shop steward, they are not involved in planning although there is an Institutional Transformation Forum at CMH consisting of labour and management. Managers do not recognise staff views in planning although they are involved in operations and understand better what is needed at operational level. He further stated that in organised labour's view, strategy is informed by what happens at operational level.

I found that planning for improved service delivery does take place at CMH. However, the respondents differed in terms of how inclusive and consultative the planning is. A detailed planning process was outlined starting from planning through implementation up to a monitoring process. It also emerged that there is a service delivery improvement plan that is developed as part of the planning process. It was also reported that the staff is not included or consulted in the planning process although there is a structure for ensuring that they are consulted. This non-involvement of employees in planning indicated was considered to have negative implications on the type, quality of the tools of trade purchased, service delivery and budget expenditure. It appears that management plan on their own, excluding the staff which results in staff not knowing what has been planned and budgeted for and not owning what has been planned. This may partly explain poor quality of service delivery.

Alignment of organisational structure to service delivery plan

The CEO believed that the management structure of the hospital is organised in such a manner that it talks directly to the business of the hospital and how the services are delivered.

> Our service delivery plan is informed by the needs of the community and patients and we organize ourselves and respond accordingly. It consists of the following business units: clinical services; nursing services; human

> resources management; human resource development; quality control which includes infection and prevention control, OHS; patient administration; pharmacy; clinical support which include radiology, social work, dieticians, physiotherapists, speech therapy. We then have soft services which include security services, grounds maintenance, housekeeping, laundry, food and cleaning services and general assistants; clinical engineering facility management which include plumbers, electricians and painters as well as IT and management information (Cecilia Makiwane, CEO, Interview (telephonic), 13/10/2014).

However according to the Senior Professional Nurse the organisational structure is not aligned to the business of the facility because the personnel employed at management level do not have the requisite competencies and there is no fair competition in the recruitment process.

The shop steward noted that the organisational structure is still being developed. He instanced that there were twenty contract workers for laundry whose posts had been advertised but never filled. The reason that was given was laundry workers were not shown in the structure. Organised labour found this abnormal and wasteful and asked how posts could be advertised if they are not in the structure.

The findings show that the organisational structure is not aligned to the service delivery plan. There is no completed or permanent organisational structure. Recruitment is done within an organisational structure vacuum and recruited personnel sometimes cannot be placed. This practice has cost implications because placing an advert and inviting candidates to interviews and then arbitrarily cancelling them all involves wasteful and fruitless expenditure which is incidentally against the government financial management prescripts.

Major Changes

Key changes and innovations in organisational models have happened in the last decade that can be linked to developments that have been learnt or adapted from the outside. According to the hospital CEO, major changes have taken place over the last two decades at CMH relating to the transformation policies and legislation of the post-apartheid government.

> The introduction of Performance Management Development System (PMDS), Preferential Procurement Policy Framework Act (PPPFA) and the establishment of consultative forums for management and staff as well as for the hospital and the community are just some of the changes that have been introduce*d* here at CMH. These developments are linked to the transformation process and attendant policies that have been taking place in South Africa. For small entrepreneurs had no opportunities to benefit from the business of the hospital. Organised labour as well the community had no engagement platform with the hospital management. Before 1995 service delivery was not developmental and labour-management relations were adversarial (Cecilia Makiwane, CEO, Interview, CEO, 15/11/2013).

It seems that the CEO has a clear notion that small businesses should also benefit from restructuring of the hospital. This is a BBBEE dimension for small-scale capital accumulation built into the public service. The Senior Professional Nurse concurred with the CEO on changes that have been introduced during the past decade.

The policy changes that have been introduced relate to broadening of access to services and use of technology.

> Some of the changes ... have been the admissions policies which are the no user fee; the introduction of information management system and a complaints management system. These are all new inventions introduced

> by government. The only challenge though has been lack of consultation and workshopping of the policies so that the staff can know why and how must they be implemented (Cecilia Makiwane, Senior Professional Nurse, Interview, 02/08/2014).

The shop steward confirmed that changes have taken place over the past few years. According to him, these changes related to service delivery mechanisms and complexing (merging various hospitals under one roof and centralising functions).

> Here we have moved from complexing to decomplexing. This system was about sharing of services. New office complex was built far from the facility and staff had to shuttle between the two complexes administrative buildings which meant waste of time. This complexing was reversed because of the "save Makiwane Campaign'' project commissioning team. We have also seen the emergence of PPP as a service delivery mechanism (Cecilia Makiwane, Shopsteward, Interview, 07/05/2015).

Politicians have announced more changes and NPM style innovations for public hospitals that include leveraging on the private sector resources and expertise whilst also optimizing public health resources, ensuring cost effectiveness and access. In an interview with the *Daily Dispatch,* the Eastern Cape Province MEC for Health Phumulo Masualle in 2009 set the tone for policy transfer when he said:

> Raising funds was a top priority and the department would now be offering public health space and equipment *for private sector use*. The equipment and infrastructure is the best, so we can have private doctors utilizing this (facility for a fee). We are in the process of revising the tariff structure to make it both attractive and affordable to patients from the private sector.

The department *will offer space for private patient use, which would keep private doctors in public health facilities for longer*. But we would have to put strict measures in

place, to make sure that we recouped whatever costs were incurred. This would be cost effective for all concerned. Giving the example of breast cancer surgery, which could cost about R30 000 in a private facility, and no more than R2 000 in a public one (*Daily Dispatch*, 26/03/2010).

Many transfers and learnings have taken place at CMH during the last decade. The CEO's conception of these changes was that they were about efficiency, such as business operational procedures and technological innovations and service delivery mechanisms. Most of these changes may be linked to the post-apartheid transformation expressed through legislation, policy frameworks, institutional configuration and service delivery mechanisms.

The CEO understood these changes as emanating from and being driven by government. On the surface that perception would appear to conform to the pronouncement by the former MEC for Health in the Eastern Cape that the Eastern Cape government will embark on a fund-raising offering private hospitals space to operate in public hospitals. But I would argue on the contrary that what government is doing is influenced by the NPM theory. The vocabulary the politician used in embracing, driving and justifying these changes revealingly include "cost effectiveness", effectiveness and "leveraging on private sector resources" It is not the government that is stretching a hand of cooperation to the private sector but it is the government that is being enticed to adopt private sector practices through the pervasive NPM theory.

Services and functions in which policy transfers/practices have been implemented

The CEO responded cautiously that although there is "no policy transfer or organisational practices imported from elsewhere" and that most of their services are provided through in-house mechanisms "there are some services that are outsourced". Services such as cleaning, (routine) maintenance, information technology, security, and

catering are provided in-house. In terms of service delivery mechanisms, the CEO highlighted two ways in which support services are provided.

> We are outsourcing some services because they are not the *core* function of CMH and neither the provincial department nor CMH itself has the capability to manufacture them. For example, the maintenance of specialised equipment is outsourced. The hospital has no technical capacity to maintain such high-tech equipment and to employ such capacity on a permanent basis may either be difficult to recruit because government may not afford to pay it or such capacity is not interested in working in the public sector due to low remuneration. We are also trying to explore public and private partnerships that can assist to develop internal capacity through skills transfer (Cecilia Makiwane, CEO, Interview, 15/11/2013).

The use of the term "core" indicated an unreflexive absorption of managerialism by public leaders. The term is used as if there is no alternative or that the distinction was always there. The naturalisation of new public management speak was a hallmark of the interviews with public managers.

The Senior Professional Nurse noted that some services at CMH are outsourced although she was not certain which ones, how were they contracted and whether they are still operating.

> There is one private catering service that I know of that has been operating which was bringing in pre-packed food. But of course staff are not consulted here on new developments. There is a communication challenge I would say (Cecilia Makiwane, Professional Nurse, Interview, 26/05/2015).

The shop steward noted that there is implementation of new service delivery mechanisms that were adopted from *outside* public sector. In his observation the manner

in which these mechanisms are structured, their performance and the value which they bring into improving service delivery are not necessarily positive.

> Another change we have experienced here has been the introduction of a PPP. This PPP is 80% private and 20% public ownership. Security is already outsourced. There is also the imminent outsourcing kitchen, grounds workshop and cleaning. Under the arrangement the personnel has been increased from six to twenty six per shift but there has been no improvement in service. This company brings qualified securities and they know that the more securities have a higher grading in terms of qualification the more the facility will have to pay. There is no monitoring of performance of this security company and there is high rate of absenteeism by the security personnel because there is no monitoring. Their service provider does not adhere at all to the service level agreement. The management is giving no reasons for this outsourcing and from organised labour point of view we fear that this outsourcing will lead to retrenchment (Cecilia Makiwane, Shop steward, interview, 27/05/ 2015).

In summary, there is outsourcing of services and functions at CMH similar to Green Acres Netcare hospital. According to the CEO *most* of their services except the clinical goods are still provided in-house including security and catering whereas the shopsteward said security is outsourced and catering/kitchen services are to be outsourced as well. The Senior Professional Nurse also mentioned the outsourcing of upgrading and development infrastructure and the establishment of a PPP as already taking place. This seems to support the view of the shopsteward that management is not communicating adequately with staff because labour is critical of PPPs.

On a personal observation in 27 May 2015 the author noticed by their uniforms, several private security firms hired by the hospital to provide security services. One such company was Eastern Guard.

Quality of service and perceived outcomes

For the CEO's view poor service delivery can be attributed to two issues; public health facilities themselves and secondly the public health system. He explained that within the public health system the perceived causes relate to the lack of primary health care and this in turn includes ignorance of the general public about their own health which leads them to go to hospitals for ailments that they could have prevented through primary health.

> In the health facilities, the perceived causes of this poor public health service delivery relate to negative staff attitude, overcrowding and corruption. These issues drive negative perception about public health facilities. In some instances they go to hospital for some minor ailments that could have been treated at a primary health centre; their limited understanding of the workings of the health system, poor responsiveness of the health system itself and generally the lack of promotion of primary health. The public has a responsibility for taking care of their health. Due to issues of poverty and other impairments the public end up coming to hospitals and hospitals become a social response to those challenges. The latter issue requires public education (Cecilia Makiwane, CEO, Interview, 15/11/2013).

The CEO tended to see external forces as a major impediment.

> On the issue of infant mortality the sad irony of this is that infant mortalities were *not* a result of poor nursing care but a result of poor facility management which led to failure of an electricity generator which in turn led to infant mortalities. However, the public views this as a poor quality of care and negligence. This caused the hospital a bad publicity image as its mortality rates are one of the hospital's important key

> performance indicators. However, the public perception was that infant mortality was caused by poor nursing. That challenge has since been addressed (Cecilia Makiwane, CEO, Interview, 15/11/2013).

The CEO took a fragmented view blaming the electricity failure and not a team failure.

According to the Senior Professional Nurse what makes CMH service to be perceived as poor is the inadequacy of working tools which leads to delays in serving patients, the working environment which is not conducive to high performance and low staff morale. Elaborating on the inadequate working tools and medical supplies he said:

> Shortage of medicine is one other indicator of poor service delivery. This comes from our procurement processes. For instance if we are changing suppliers it takes time to appoint another one leading to the depletion of existing stock. We do not have an e-procurement system and if we did maybe things could be different (Cecilia Makiwane, Professional Nurse, interview, 27/08/2014).

It also appeared that the cause of shortage of medicine is not only a result of tedious procurement process but is multi-dimensional and has political undercurrents which result from political rivalry and power play and anticipation of the introduction of NHI. The Daily Dispatch newspaper reported that:

> A tender worth R1billion for the distribution of medicines in the Eastern Cape has been put on hold after initial approval by Finance MEC Mcebisi Jonas. The man who has blocked the lucrative tender is Jonas's political rival, Health MEC Phumulo Masualle. Masualle's department wrote to national Treasury on August 27 asking them to hold off on final approval of the Public-Private Partnership (PPP) contract with Pharmaniaga Eastern Cape (Pty) Ltd. Masualle refused to sign the deal ... the Dispatch understands there may be a conflict of interest between Jonas and some

members of the consortium (Daily Dispatch, 08/10/2009).

Conceding the shortage of medicine and proposing remedial steps to address this challenge the former MEC for Health Phumulo Masualle was quoted by the same newspaper as saying:

> There were too many instances of drug shortages in the provincial clinics and hospitals, hence the need to facilitate the efficient distribution of drugs through a private-public partnership (PPP). We are exploring options to ensure that shelves are always well stocked, that drugs are available at all times, and the private-public partnership could do just that (Daily Dispatch, 26/03/2010).

The shop steward indicated another factor giving CMH bad reputation as the transfer of Frere's dying patients and bed-sores riddled patients to CMH which make the facility appear as not caring and having high incidents of mortality.

Whilst there was unanimity on the negative perception of health services at CMH, different examples and areas were identified from which this negative perception arose. These areas ranged from staff attitudes, delays in procurement processes which led to shortage of medicines, infant mortalities and overcrowding as transfer of almost dying patients from Frere Hospital. In an interview with the Daily Dispatch newspaper the former MEC for Health confirmed the shortage of medicines as one of the things that gave CMH a bad reputation while he simultaneously suggested an imminent establishment of a PPP to address the matter.

According to the CEO the quality of service has improved quite remarkably except in the areas of staff attitude. A lot still needs to be done though to fully turnaround the service in the hospital and how it is perceived by the public. Elaborating on the quality of service he had this to say:

> In terms of perceptions of specific patients or family or relatives of patients CMH is perceived as a good hospital by the public particularly the curative and nursing side. In addition the hospital ambiance, cleanliness gives a good and welcoming atmosphere. However a turnaround plan and a culture change program going beyond policy to institutional culture to change people – provide customer care training, re-engineer business processes, educating the public about how our services are accessed will be introduced shortly (Cecilia Makiwane, CEO, Interview, 20/06/ 2014).

The CEO believed that strong leadership, cohesive and dedicated team makes a difference in how a hospital delivers its service and how it is perceived. It should also be remembered that CMH is still suffering from the stigma of being known for delivering poor service. The issue is partly the human element and partly the environment. Human nature is not changed by policy frameworks and the institutional environment in some instances is not compatible with the imposed framework.

According to the Senior Professional nurse the Intensive Care Unit is known for its good quality of care. This is evident in the passion and commitment shown by the staff to the patients. There is also less absenteeism. Patients and relatives express satisfaction with the quality of service and care of the ICU section despite the fact that it is operating with half its staff complement.

The shop steward indicated that CMH service is considered good and this is evidenced by compliments that are given to staff by patients and their relatives. Also the patients leave CMH happy. Dedication of staff despite the dire shortage of staff is also one other indicator that is noted by patients.

Response to this question indicated that despite the negative public image of CMH in terms of the quality of its service, citizens also have a good perception of it. This good perception expressed in patients' compliments, arises from among other things ambiance, cleanliness giving a good and welcoming atmosphere and staff commitment.

Origins of policy ideas/organisational practices and types of sources of changes

The CEO commented that most of the changes introduced in the hospital organisational setting come from the provincial and national government and that these are centralised but negotiated with the staff. Overall, these changes become part of the operational framework of the establishment:

> These changes have been brought from the political level. These sources of change cannot be regarded as coercive; they are just part of the operational framework of government operational environment. If you like they can be categorised in terms of legislative, strategic and efficiency type of changes. Strategic sources are those that emanate from and seek to respond to community or patients' needs. Efficiency changes are those that seek to respond to fiscal constraints posed by national and international economic downturns and are driven by National or/and Provincial Treasury. Some of these changes do not just become mirror image of their sources but become local adaptations as they are amended according to local circumstances. (Cecilia Makiwane, CEO, Interview, 15/11/2013).

The Senior Professional Nurse also indicated that changes implemented at CMH are coming from government. For the shop steward changes come from the "politicians and legislature". He added that these are implemented by functionaries and consultants.

> Some of these changes are not forced on us but some are. In some instances we are not even consulted and when we try to express contrary views they press ahead with them anyway. For example we were against this complexing policy because we felt it was nothing else but an attempt to downgrade CMH and we fought it. We have also noted that in government lately there is a prominence of the use of consultants and yet

> there are officials that are employed to do that work. At the same time you will find that the management will talk about insufficient budget when workers demand certain things such as employment of more staff, improved benefits and service delivery related matters (Cecilia Makiwane, Shop steward, interview, 27/05/2015).

Responses to this issue show that the changes are largely centralised. In some instances changes were introduced coercively and workers resist them. It also appears that consultants are employed in contentious ways that workers see as wasteful. Furthermore the use of consultants as change agents is regarded as an abdication of responsibility on the part of those that are employed to do such work. It was also noted that the use of consultants is a waste of financial resources which could be utilised elsewhere. It could be argued that the use of consultants is necessary at times because some aspects of work need specially dedicated workforce with time to focus only on such a project and specialised knowledge which government officials do not always have seeing that their job descriptions require them to deal with a broad range of things.

Issues of innovation and the "package" of changes

According to the CEO the nature of government operational environment and the attendant changes is such that there is "limited or no choice" for selection on a package of changes, yet there are many ways in which local discretion is practiced. In the Senior Professional Nurse's view the choice of changes to be introduced depend on their budgetary and human resource implications. Acceptance and implementation also depends on how influential the person suggesting those changes is.

Response to this issue revealed that selection from a package of changes and innovations depends on the commensurability, conduciveness and amenability of the recipient environment. It also depends on the adequacy of financial and human resource capacity of "influential" individuals in the organisation. The issue of "influential persons may be

linked to corruption as the criteria used for and process of choosing to adopt a particular change initiative, associated implementing agents, workforce and financial resources is not transparent. Rightly or wrongly, there will be suspicions that certain individuals in the executive management or line functionary level might have connection with the proposed and adopted change which place them in position to favour particular individuals or companies. It should also be noted that certain decisions are the prerogative of the executive management. The issue then could be how to balance the need for transparency and executive management prerogative.

The CEO observed that there is a space for innovation and experimentation although it is limited due to the specialised and standardised nature of the sector. The Senior Professional Nurse indicated there is little space for experimenting because some people's ideas are accepted while others are not.

To summarise, there is space for innovation and policy experimentation although it is limited. However, there seem to be difference between the interviewees on the reasons why there is limited space. The CEO saw the reason being the nature of the sector whilst the Senior Professional Nurse saw mainly institutional capacity, power and influence or lack thereof on the part of the person proposing innovation or experimentation. This raises the issue of the "influential individual" who might benefit and thus the potential for corruption, discussed earlier.

Agents of change and networks

The CEO remarked that agents of change in the public sector context are mainly politicians, senior administrative officials and consultants. According to the Professional Nurse, the agents of change are the Top Management team. These two respondents thus agreed on the that administrative officials are the agents of change although the CEO probably because of his position knows that there are other agents than hospital officials only hence his inclusion of politicians and consultants.

As the CEO noted, some of these changes are conceived from the legislature and political forums where ministers and MECs meet to review policy implementation and need for new policies. These changes are discussed at national policy conferences, seminars and workshops.

> In these platforms the officials from respective provinces share ideas and experiences on how policies are implemented and what challenges are being encountered. There is also a programme called KHAEDU where officials learn from each other on how to improve service. At the same time there are challenges when it comes to the local level and by that I mean in the facility there is no proper induction of these policies and legislations to the operational staff before they are implemented and there is not even an opportunity to review them and advise the authorities on whether they are working or not under the circumstances of delivery (Cecilia Makiwane, CEO, Interview, 15/112013).

The Senior Professional Nurse professional agreed with the CEO that the staff are not taken to induction programs when new policies and changes are introduced.

> There is inadequate induction of staff to these changes to familiarize them with the policy changes. Inasmuch as there are various platforms for induction they do not relate to induction of new policies and change management (Cecilia Makiwane, Professional Nurse, Interview, 27/05/2015).

Ways in which policies and practices converge and fit within the concept of policy transfer and its application

According to the CEO, it is often difficult to find change being implemented smoothly. This is often due to human, physical, and financial resources constraints as well as organisational culture issues.

> In any change situation, one is always confronted with people who have different kinds of attitudes; there are issues of institutional compatibility and readiness, availability of adequate human and financial resources and so on and so on. In most instances in government, these issues seem not to be given serious consideration when new policies or norms and standards are introduced. So there is bound to be tensions and contradictions and therefore it depends on how these issues are negotiated and managed (Cecilia Makiwane, CEO, Interview, 15/11/2013).

According to the Senior Professional Nurse, change is a difficult process as it involves dealing with people who have different attitudes and it also depends on the availability of resources to implement the change process. So change is not easily transferable and implementable.

The shop steward noted that the introduction of policy changes is not as easy as it is often thought to be.

> In a work environment you have people who think differently, see things differently and having different attitudes towards change. The environment itself has various factors such as the culture of the organisation, the organisational structure which may or may not enable policy changes. This situation leads to resistance, confrontation and demotivation of workers (Cecilia Makiwane, Shop steward, interview, 22/05/2015).

Evidently, difficulties arise in reconciling policy/practices with the application of the policy transfer concept. Issues of human attitudes, institutional compatibility and readiness of the organisational environment and workforce, availability of adequate human and financial resources have been cited as reasons for this difficulty. It has also been indicated that resistance, confrontation and demotivation reactions arise in the recipient environment from policy transfer applications.

Discretion or localisation in the delivery of services

According to the CEO there is discretion and localisation in the delivery of services although it is limited. Any localisation and discretion happens within the confines of the prescripts.

> For instance the establishment of the institutional transformation forum which is a structured engagement forum with the organised labour. This structure serves to involve workers through their representatives in policy issues and decision-making. There is a platform for structured engagement with the community. This structure assists in terms of involving the community in the delivery of services. With the introduction of the new Framework for Norms and Standards for service delivery improvement there is some flexibility in terms of implementation as they are customised and localised taking into consideration the local circumstances (Cecilia Makiwane, CEO, Interview, 15/11/2013).

According to the Senior Professional Nurse the nursing environment is "specialised, prescriptive and standardised" and nurses do things by the "text book" and therefore there is little space for discretion

The shop steward indicated that there is no discretion or localisation in the delivery. Everything is done in terms of policy.

The findings have revealed little space for localisation and discretion. However there were some differences between the respondents on how far they can push the boundaries within those limitations. Another view was that because of the rigid specialised nature of the sector and the policy compliance driven environment, there was no scope at all for discretion. This difference between these views can be attributed to the different levels respondents operate at, namely the operational and strategic levels; in the former one narrowly focuses on implementation of nursing practices, standards and prescriptions

whilst at the strategic level one looks broadly at service delivery matters, the utilisation of the workforce, how to maximize their participation to achieve the desired results and how all that impacts on the lives of citizens.

Citizens processes and poor services

According to the CEO, the CMH "business" processes are standard just as in any other hospital. The reason why they might be perceived as poor can be considered as multifaceted ranging from an "appearance" of overcrowding to limited knowledge of the inner workings of government healthcare system and processes by patients. Elaborating on the reasons for this overcrowding and what can be done to ameliorate the situation he said:

> In some instances, citizens go to hospital for some minor ailments that could have been treatment at a primary health centre. Their limited understanding of the workings of the health system, poor responsiveness of the health system itself and generally the lack of promotion of primary health. Besides the citizens' lack of knowledge of the healthcare system the question is what do we do? I think there is a need for overhauling the business processes of CMH to deal with the overcrowding and long queues as we see that they are not responsive and convenient.
>
> He indicated that government wants to outsource and privatize the dispensary function (much like Netcare-Clicks link up).
>
> There are plans for a new system in collaboration with private pharmacies in the near future to help take the burden off the hospital dispensaries. Patients would soon be able to collect their prescription from certain pharmacies instead of the hospital. Also, we may have to introduce a pre-booking system and make sure our services run seven days a week (Cecilia Makiwane, CEO, Interview, 15/11/2013).

The Senior Professional Nurse remarked that the processes at CMH are standard just as in other hospitals. However, their effectiveness is hampered by overcrowding. This affects the nursing staff and results from the lack of citizens understanding of the manner in which the health system operate on one hand and the lack of an appropriate referral system. Elaborating further on the business processes she said:

> There are various business processes as there are different units doing different things and I will talk about the nursing side. When a patient arrives he/she reports to the administration side where his/her details are recorded. From there he/she is referred to the examination section where he/she will be seen by the professional nurse who will tell the patient which doctor he/she will see. From the nurse the patient will go and see the doctor. If there is a need for extra examination such as x-rays the patient will be referred to radiology section for example then back to the doctor for analysis of results and confirmation. The patient will get prescription from the doctor to go to the pharmacy and after getting medication he/she will be released (Cecilia Makiwane, Professional Nurse, interview, 27/08/2014).

Also commenting on the time their processes take from examination to admission or release the Senior Professional Nurse said:

> The whole admission and examination process it can take up to three or four hours which include one hour in administration, another hour waiting to see the doctor, another hour waiting for extra examination and back to the doctor, another hour for admission medication or referral to the ward. I also want you to know that Cecilia Makiwane is a referral hospital and is not supposed to be taking walk-ins but you find that everyone and anyone just comes straight to the hospital without having been referred by the PHCs or a doctor and this is why we experience overcrowding. This is

> caused by the citizens' lack of knowledge of the role of PHCs. The challenge involves the unacceptably high shortage of staff which is evidenced by the low staff to patient ratio and sometimes shortage of medication. In the Outpatients Department (OPD) for instance the norms and standard are supposed to be 1: 5 for a nurse (1 nurse for every 5 patients) but it is 1: 15. With the doctors it is supposed to be 1:15 but it is 1:20 (1 doctor for every 20 patients). This is overload and its implications is that examinations that are conducted on patients are not necessarily thorough which compromises the quality of care. In the trauma it is the same (Cecilia Makiwane, Professional Nurse, interview, 27/08/2014).

According to a newspaper report, an Eastern Cape Department of Health spokesperson disputed the problem of overcrowding as the result of the staff shortage ascribing it to the citizens' lack of understanding of the referral system or reluctance to accept it:

> The staff shortage was not the real reason that people were kept waiting, sometimes for longer than a day, for their prescriptions to be filled at Frere and Cecilia Makiwane [CMH] hospitals. The delays were caused by patients who ignored the rules of the referral system and waited at hospitals for their medication instead of going to fetch it from their nearest clinic. Patients who are meant to be getting their medication from the clinic must go to the clinic. The problem is not the number of pharmacists. Even if you were to get 80 pharmacists here, the waiting area would still be congested. The fundamental problem is the referral system. The way the system should work is that once a patient has been seen by a specialist in either CMH or Frere they should take their prescription back to the clinic or to the hospital that referred them (Daily Dispatch, 23/07/2013).

For the shop steward the business processes at CMH are still very poor. He attributed this situation to several causes having to do with staff ineffectiveness:

> Here, you will find that patients have to suffer long waiting times, staff ineffective and factional favouritism. Sometimes staff arrived at their own time and have negative attitude towards patients (Cecilia Makiwane, Shop steward, interview, 27/05/2015).

One Daily Dispatch report noted, one pharmacist contextualised the issue of citizens running to the hospital rather than going to clinics:

> We used to be busy because people who are supposed to go to the clinics used to come here.... I have taken it upon myself to make sure the medication is available at the clinics. I have even asked them to call me should they run out of something. The load has decreased by 45%. It's much better now – we even finish dealing with our patients early now (Daily Dispatch, 23/07/2013).

In response to this issue it is evident that the hospital does have standard business processes to attend to patients. It was also acknowledged that despite these standard business processes there were still challenges of overcrowding which meant that their processes were ineffective. The issue of overcrowding was attributed to the citizens' poor understanding of the healthcare system. In an interview with the Daily Dispatch one anonymous respondent revealed that the reason why patients flocked to the hospital was the absence of medication stock in the clinics. Inasmuch as the lack of understanding of primary healthcare affects the business processes it also appears that the primary healthcare centres themselves are not effective hence the citizens turn to the hospital.

Implementation of transformative policies

Commenting on the transformative health and related policies implemented to date and their performance the CEO noted that as a public institution the CMH is bound to operate within government's transformative policies and therefore all government

policies are implemented. These policies are working but have constraints in certain instances. Some policies are easy to implement and some are difficult. Where there are constraints there are unintended consequences. These constraints are due to the organisational environment, organisational culture, institutional arrangements, community demands as well as human and financial capacity and this gives rise to a need for customisation and adaptation of policies.

Regarding the implementation of the PMDS the CEO had this to say:

> PMDS implementation in public sector has complexities because there is no objective assessment of measuring of performance. Some key performance areas and outputs are unquantifiable and unmeasurable of to determine the expected performance levels in some categories of employment. In some instances these policies have to be adapted and customised to the organisational environment. Some of these policies bring unintended consequences.

Also highlighting the implications of the introduction of the no user-fee policy without the requisite resources and infrastructure the CEO said:

> The hospitals were flooded with patients leading to overcrowding in hospitals, shortage of staff and medicines, the overstretching of existing staff resulting into demotivation and burn-outs on some of the staff members; rise in sick leave taken and the rate of absenteeism; exodus of health professional to private hospitals as well as a further decline in the quality of service.

The CEO also remarked on the facility's responsibility to implement procurement related legislation and its implications.

> The facility also has a responsibility of implementing the Preferential Procurement Policy Framework Act. This Act relates among other things to the development and empowerment of local small enterprises and cooperatives in the health sector. For instance this constraint relate to the sophisticated and expensive nature of the equipment and goods required in this sector as well as the regulatory nature of the health sector procurement regime. Furthermore, even in the manufacturing of the linen still the small entrepreneurs are unable to provide risk assurances and indemnity because of lack of support. Also at a sophisticated goods level the health sector procurement regime requires risk assurances and indemnity which the small entrepreneurs are unable to provide in most instances. One such example is the manufacturing of prosthetics. Small entrepreneurs are unable to access this industry due to its specialised nature (Cecilia Makiwane, CEO, Interview, 15/11/2013).

The CEO concluded by noting that there is a need for synergizing the different pieces of legislations so that they do not contradict each other. Also there is a need for exceptions, flexibility and support in certain cases more especially with the development of small entrepreneurs that are finding difficult to benefit from the health sector.

According to the Senior Professional Nurse the PMDS is not properly understood and implemented or that management themselves understand it. She thought that it may just be a compliance matter. For the shop steward the existing legislation such as Labour Relations, Public Servants Act and Employment Equity Act are not implemented properly.

> The transformation legislations always appear ineffective but the fact is that they are not implemented effectively. Managers flout HR policies. There is indeed a challenge with the implementation of PMDS and this challenge arise from the negligence and lack of cooperation from the

> managers. The staff do comply but managers do not co-operate due to tensions between employee and manager. I believe supervisors know how to implement but it is just a matter attitudes. Human Resource also has workshopped staff on PMDS, so it cannot be a matter of not knowing how to implement. (Cecilia Makiwane, Shop steward, interview, 27/05/2015)

The Daily Dispatch newspaper noted that there is also a challenge relating to mismanagement of the system by the management staff themselves such as non-payment of some benefits to employees and this could be one of the reason employees take advantage of the PMDS system:

> For the past five years, the [provincial] department of health has not provided any career paths for doctors, despite this being the purpose of introducing Occupational Specific Dispensation & PMDS. Doctors have not received the 1% performance-related notch increases that characterizes their career path for satisfactory or above-average performance. (Bonuses for doctors with exemplary service performance have been refused.) The department of health has acknowledged that millions of rands are now collectively owed to doctors, yet no plan to repay the debt is forthcoming" SAMA [South African Medical Association] has resorted to the courts. In a test case in February 2013, a labour court decision recognised that the EC Department of Health was in breach of contract to a sessional doctor and ordered payment to him. To date he has not received a cent. Doctors are disillusioned and angry; morale is at an all-time low. All they ask is that they are paid their due, that the contracts they signed are honoured. (Daily Dispatch, 06/09/2013).

According to the shop steward the procurement policies are complicated and not implemented properly and involve corrupt practices:

> Procurement policies are not developmental and transformative. The

> business registration and qualification requirements for even tendering let alone getting a tender are complicated and I think they need to be overhauled. Another challenge is that procurement has got a lot of interference at political level. Politicians and officials alike benefit from these tenders and there is a lot of corruption. For instance you will find that some officials are double placing of some order within 5 days meaning one item is ordered twice within a space of five days. (Cecilia Makiwane, Shop steward, interview, 27/05/2015).

In summary, I found that there are difficulties associated with implementing this legislation effectively because of constraints created by stringent requirements of other legislations and policies like the PFMA and Treasury Regulations on the Preferential Procurement Policy Framework Act (PPPFA). There are also contradictions between these legislations. The difficulties and complexities in PPP FA implementation were attributed to the complicated nature and expensiveness of healthcare equipment which small entrepreneurs are not able to manufacture or buy. Also the disenabling environment with involves complicated and stringent tender and qualification requirements which small entrepreneurs have to adhere to. Some challenges were attributed to the long-winded bureaucratic processes.

The complicatedness of tendering and qualification requirements were also cited. Also, the officials' ineffectiveness, improprieties, favouritism and nepotism reportedly prevalent in government procurement processes of government were cited. It is evident that the public sector organisational environment which involves bureaucratic red tape and rigidity of organisational processes and procedures is not conducive to the effective implementation of some legislation. It also appears that government legislations and policies are contradictory in that one piece of legislation defeats the objectives of another. For example PFMA and PPPFA requirements contradict the objectives of Broad-based Black Economic Empowerment Act particularly the empowerment of small, micro and medium enterprises. This contradictory and complex environment

opens up opportunities for malpractices such as corruption.

Recruitment processes and procedures

According to the CEO the hospital has recruitment procedures as outlined by the Public Servants Act, Public Service Regulations and Employment Equity Act. There are also institutional arrangements that facilitate the implementation of the whole gamut of HR policy. The Human Resource section manages workforce needs of the institution. It assesses the institution's personnel capacity against the volume of patients requiring service and identifies capacity gaps through its work study processes and reports to the executive management. Where there are critical gaps which impact negatively on service delivery the management takes a decision to fill those particular positions. Elaborating further on the recruitment process and associated challenges the CEO noted:

> The identified posts are advertised for a given period of time, shortlisting of suitable candidates is conducted; the suitable candidate/s is/are invited for interview; successful candidate is appointed. Head-hunting for critical and scares skill is also conducted. Other implementation challenges are the time-consuming, long-winded processes and complexities involved in the filling of even junior and menial level posts. For instance, Public Servants Act does not specify or make it mandatory that posts must be filled within a certain period of time. In addition, the institutional arrangements, cumbersome and long-winded business processes, lack of appropriate delegations prolong the process of filling of posts to such an extent that it takes up to six months to fill a post even a cleaner post which affect service delivery. This cumbersome-ness can be attributed to the bureaucratic nature of the public sector organisational environment, policy implementation processes, the lack of delegation and the manner in which all these stifles and retards service delivery. In terms of the policy recruitment is supposed to take 60 days. However due to long-winded

> bureaucratic processes and a lack of appropriate delegations it ends up taking up to 6 months". This arrangement has adverse impact on the operational environment and in terms of human resource capacity and quality of service rendered (Cecilia Makiwane, CEO, Interview, 15/11/2013).

For the shop steward the recruitment process is poor on its own as well as in the manner in which it is managed at higher management level. He further indicated that there is no forward planning for replacing retired and resigned staff. Commenting on the selection and appointment process he argued:

> Shortlisting and interviews can proceed quickly after receipt of applications. The critical issue is the time taken to approve filling of vacant posts and actual appointment. Shortlisting and interviews can take seven days but it can take up to six months to fill the post due to delays. We are told that CEO now has HR delegations since October 2014 (Cecilia Makiwane, Shop steward, interview, 27/05/2015).

Responses to this showed that the recruitment processes and procedures are poor, which was attributed to cumbersome, long-winded and bureaucratic processes of the Head Office. It was also suggested that if these processes can be decentralised and much shorter, pointing to the short time that is taken by HR officials in the hospital to complete shortlisting, interviews and making recommendations to appoint.

Training and retraining of human resources

For the CEO, the hospital provides an integrated training platform. In explaining this training platform he mentioned that:

> For scarce skills we partner with training institutions of higher learning. Nurses are trained by universities and nursing colleges such as Lilitha

> College. They also use CMH as training platforms. These trainees are referred to as registrars. CMH provides an integrated training platform. Where specialisation is not offered locally these trainees are sent to hospitals in other provinces just as those provinces do send their trainees to us where they do not have such training. To avoid disruption when staff are sent to training we use national DPSA norm that not more than 10% should go to training at a given point in time (Cecilia Makiwane, CEO, Interview, 20/062014).

According to the Senior Professional Nurse staff members are given training opportunities but these are limited to management. Training has been opened up by management to every nursing staff member because the Nursing Council has introduced a system that generates points for individual staff members who attend training.

The shop steward indicated that training at CMH is given significant attention. He also indicated that there is a training committee which advises on training needs:

> I cannot fault CMH on training. Training is taking place and through training career pathing is facilitated. For instance there are cleaners who ended up going to the nursing career. However there is no career pathing for administrative staff yet. Staff sometimes recommend to management some other training courses and opportunities but management will not approve. Such example was the catering training from private company which would have afforded catering staff career pathing opportunities as well (Cecilia Makiwane, Shop steward, Interview, 27/05/2015).

The staff are getting training opportunities although these opportunities are limited and are not offered fairly but preferentially. It was also reported that this opening up of training opportunities is not due to the management's initiative but to the Nursing Council requirements and the associated points that are offered to an individual staff member who attends training which contribute to achieving a particular qualification.

There was also a view that the training that is received by staff contributes to further qualification and professional upward mobility. It also emerged that management sometimes turn down training requests which staff believe is important.

Procurement processes and procedures

According to the CEO the procurement procedures and processes are slow and cumbersome. Equally, he expressed some understanding why in some instances these processes need to be slow, due to the specialised nature of the clinical goods and human lives involved in procuring and utilisation them:

> Hospitals would appreciate a much faster system however that appreciation has its own risks. Hospitals are dealing with specialised clinical goods as well as general goods and the procurement procedures and time taken will obviously differ. The goods we procure impact on the lives of the patient and therefore time is taken to specify, check and recheck to ensure they are appropriate and safe for application and consumption by human beings (Cecilia Makiwane, CEO, Interview, 15/11/2013).

The CEO elaborated on the need for understanding the caution exercised in the procurement processes and appreciation of the lengthy process of procuring clinical goods. He equally indicated that it is possible to improve the turnaround times for procurement:

> Procurement, particularly clinical goods is driven by samples and demonstrations to make sure they are safe for human beings. Procurement for specialised goods takes anything from 30 to 45 days before an order is generated. The hospital is moving towards five day turnaround time for procuring general goods. Procurement of general goods such as grocery is a bit faster and this is largely due to familiarity and repetitive nature of their procurement and can take up to 5 days due to the use of LOGIS.

> "Procurement processes and procedures are guided by the PFMA, PPPFA, BBBEEA and Treasury Regulations and thus are unique to the public sector. A procurement process can take anytime from twenty to thirty to forty five days. The swiftness and timeliness of the procurement process depends on the delegations that a CEO has. If the CEO can be given all the procurement delegations the processes can be much quicker but because of the fact that most delegations reside with Head Office procurement processes take a long time (Cecilia Makiwane, CEO, Interview, 15/11/2013).

Highlighting the underlying values underpinning the procurement processes in the public sector the CEO noted that:

> Having said all that there are developmental and empowerment aspects that the private sector does not take into consideration when procuring goods or services which the public sector does. The private sector might find it difficult to countenance with the administrative burden and time taken to procure goods and services. Second, the private sector can learn from the public sector how to consciously integrate development and empowerment principles in their procurement processes and thus empower the emerging business enterprises and cooperatives to participate in the mainstream economy and create jobs opportunities. The public sector (national government) needs to fast track the introduction and implementation of the nationwide online procurement system which has been in the pipeline for a long time. The procurement system needs to be tailor-made for the public sector environment and include "a ready-to-respond system" that can respond to the need for acquisition of essential goods needed for daily operations and a "pre-approval system" that will respond to emergency situations (Cecilia Makiwane, CEO, Interview, 15/11/2013).

According to the Senior Professional Nurse the procurement processes are not convenient and are not responsive to the changing times. Nursing staff are still stuck with the old equipment and are not consulted when procurement is going to be done so that they can have input on specifications of consumables that will be purchased as it is they who use these consumables in their daily operations. There is a need for introducing demonstration sessions for these consumables and equipment before they are purchased so that the staff can input on specifications and choices to be made.

The shop steward saw the challenges of procurement as emanating from the tender system. For to him, labour's view on this system is that it is fraught with corruption:

> The challenges you experience in procurement arise from the complicated tender system. Also, it has got a lot of interference at political level. Politicians benefit from these tenders and there is a lot of corruption. For instance you will find double placing of some order within 5 days meaning one item is ordered twice within a space of five days. The question that arise is that has that item been delivered and utilised already? Workshop staff sometimes have no protective clothing for three months and the reason is that the internal supply chain staff want to award the supply contract to their own favoured companies. In terms of the time taken to procure is long. The process involves administrative staff identifying the need, writing a memo to manager and circulating it to all relevant operational managers and then to senior managers and up to CEO. Approval can take 3 days but placing order delivery can take up to 3 weeks (Cecilia Makiwane, Shopsteward, Interview, 27/05/2015).

It appears that the complex, tediousness and slow-moving procurement processes are not limited to the purchase of consumables but also apply to procurement of services for mega-project such as construction or upgrading on the hospital to improve service. The Daily Dispatch newspaper (19/07/2010).revealed that a construction tender that was to

provide critical facilities for the hospital was cancelled due to non-compliance in the tender process which led to a court case that halted the whole tender process:

In summary, I found that procurement processes are cumbersome, long-winded and unresponsive. The complicated nature of procurement procedures and processes, fraud, corruption and improper tendencies of supply chain management officials who deliberately stall procurement process and manipulate procedures so that they benefit their own preferred service providers were some of the complexities involved in the procurement processes. Cancellation of tenders due to legal contestations in the context of already long and tedious processes impacts on service delivery. The CEO explained one reason why procurement processes were so long, citing *the clinical goods and human lives involved in procuring and utilisation of these goods"* "notwithstanding the fact that delays have a negative effect on service delivery. A notable issue was excluding operational staff such as nurses from procurement, the drafting of specifications for consumables, and from giving input on the quality of those consumables and how they may affect the life of the patients.

Labour relations, performance management and development system (PMDS)

The CEO conceded that although there is a clear policy and standard tools for managing the utilisation and management of human resources and performance across the whole sector, performance management and development system (PMDS) remains a daunting challenge in the public sector. He attributed this challenge to a limited understanding of HR policy by managers and staff as well as opportunism that creeps in in the course of its implementation. He also mentioned that there are already initiatives to institutionalize, induct staff on PMDS and holding staff accountable for their performance:

> There are various indicators that are used to measure performance of

different categories of employees. These include clinical indicators such as bed utilisation, time spent on the patient and death rate; finance indicators such as time taken to pay suppliers (20-day turnaround time) as well as budgeting and expenditure patterns. For engineers the indicators include number of power outages and these are significant in a sense that they are 'indicative of how many people we heal or kill'. Indicators for frontline administrative staff and health professionals include number of complaints about the level of service. PMDS implementation is now enforced and those who refuse to contract will not be paid and will be charged for misconduct. PMDS is not yet fully functional and the reason is that the whole policy was not properly inducted. In my experience PMDS is associated with monetary rewards only. Compliance has up until recently been driven by motivation to get monetary reward.

He was skeptical of the value of PMDS

Most employee's orientation and understanding of PMDS is problematic in a sense that it is focused on performance bonus and pay progression regardless of the expected performance disregarding achievement of organisational goals and personal development. There is politicisation of PMDS and a culture of entitlement among employees which render the implementation of the system and disciplinary procedures ineffective. A contradiction in the implementation of the PMDS and the perception among most employees is that when a manager is implementing it to the letter he is regarded as 'putting the organisation into disrepute' instead of it being the underperforming employee who is supposed to be seen as putting the organisation into disrepute. Misconduct (Cecilia Makiwane, CEO, Interview, 15/11/2013).

He went on to note that,

> There is a need for PMDS orientation training for managers and employees so that it is properly understood what the CMH has begun doing. We have started with reviewing job descriptions; aligned them to the work plan agreement or performance contract and personal development. According to the PMDS policy, the employee and the employer/manager are enjoined to enter a performance agreement or work plan agreement based on the job description depending on the level of position based on clear understanding of the key performance areas (KPA's), expected outputs, targets and outcomes which are aligned to the organisation's SP and APP and OP. This agreement is reviewed quarterly and annually. This agreement also highlights the required resources and availability thereof to ensure that the employee execute his/her work plan successfully.(Cecilia Makiwane, CEO, Interview, 15/11/2013).

> Regarding workforce controls,

> A biometrics system can also assist in monitoring worker attendance or how many workers have turned up for work something which I cannot be able to tell you right now as we do not have that kind of system (Cecilia Makiwane, CEO, interview, 15/11/2013).

For the Professional Nurse the PMDS is not properly understood and implemented. She further stated that it appears as if Management themselves do not understand it properly, it is just a compliance matter.

However, the shop steward indicated that staff do understand what is expected of them when it comes to implementing PMDS and they comply. It is the managers who do not co-operate. Managers know how to implement it but just have negative attitudes. He also mentioned that Human Resource section has even workshopped staff on PMDS.

It seems that there is a challenge with the implementation of PMDS, partly attributed to

the employees and management's different understandings of the objectives and implementation procedures of the system. One view was that the system is being opportunistically abused by the staff to get maximum financial benefits which some of the employees do not deserve and that the system has been politicised. The employees' work plans are not linked to the institution's strategic goals and objectives. Also, job descriptions and the performance indicators are not quantified so that an objective assessment on performance can be done. Some argued that the PMDS was regarded as merely a compliance issue rather than a performance management and development tool. Another view was that supervisors are familiar with PMDS seeing that the HR section has even inducted management on it but they are just not taking it seriously.

On the issue of deployment and utilisation of the workforce the CEO noted that it depends on volumes of patients reporting to the hospital on a particular day:

> Deployment and utilisation of human resources is determined by assessing workload and volumes of patients needing attention on certain periods of time against available personnel and using trends from other days and their volumes as benchmarks to deploy required personnel (Interview, Cecilia Makiwane, CEO, Interview, 15/11/2013).

According to the Senior Professional Nurse the deployment and utilisation of human resources is done arbitrarily. There is also no training provided to those personnel who are deployed into new areas and when one person challenges his/her deployment she/he is told "to just do the work and complain later". This would show limited understanding of Labour Relations policy and employee's rights. Staff are rotated without any policy directive. At times some staff members are deployed to certain areas of work without any training.

The shop steward remarked that they do receive complaints from their members that relate to how they are deployed to work areas and the fact that they not consulted or given choices on which sections they would like to be deployed to.

There were sharp disagreements between the views of interviewees on this issue. One view was that staff are deployed on the basis of scientific assessment of volumes of expected patients on a particular, based on visits trends. Another view was that deployment is done arbitrarily and is not even informed by policy. That view was also strongly supported by the shop steward who indicated that as Nehawu they do receive complaints about deployments from their members.

Installation, maintenance, functionality and effectiveness of IT in enhancing service delivery

For the CEO, IT installation, maintenance and ensuring the functionality thereof is done by SITA (State Information Technology Agency) which is a government agency responsible for all government institution IT needs. He classified SITA as an in-house service in the sense that SITA provides the hospital with resident IT technicians. He highlighted SITA's advantages as being in-house, readily available, knowing government systems and IT compliance requirements He also listed IT systems used at CMH namely Personnel Administration PERSAL for human resource management; LOGIS, Budget Administration System (BAS), Asset Management IT system etc. He also noted that these systems are not integrated and, "their fragmented-ness is confusing, making it difficult to make business decisions, to ensure integration and to manage procurement risks such as fly-by night service providers": Enumerating on and describing these IT systems he said:

> The IT systems we currently have are: Personnel Salary System (PERSAL) for human resource management; Logistical Information System (LOGIS) for generating procurement orders and recording of procured goods; Budget Administration System (BAS) for budget and financial management; asset management system for recording and monitoring movement of assets; patients record system, pharmaceutical information managements system for recording incoming and dispensed medicines;

> tele-health system for tracking the health records of a patient who was seen in another public hospital and a mortuary information management system. These systems are enhancing our operations. Another system that can be used as a hospital visits pre- booking system whereby the hospital and the outpatients' visits are scheduled and communicated to the patients through sms messages indicating date and time for the following visit. This system can assist with resource planning so that the number of patients that will turn up on a particular day are known in advance and resources can be mobilised and deployed accordingly. This system can assist to communicate with patients to prepare for their visits and this can reduce queues, waiting times and turnaround times. "This system can also assist to monitor the work environment and be able to see how many patients have visited the hospital. (Cecilia Makiwane, CEO, interview, 15/11/2013).

According to the Senior Professional Nurse there is a resident IT specialist working with administrators. There are also other IT systems that relate to filing of blood results and radiology.

The shop steward remarked that IT is a shared service between Frere and CMH. He also highlighted an issue of what he termed racism whereby White IT technicians do not want to come to CMH. He also said that the reason could be that employees at Frere are able to procure equipment for themselves or take things that are meant for repairs to their homes. This suspicion has not been substantiated though.

In summary the existence of different IT systems was confirmed by all the respondents. Different examples of the different uses of these IT systems were given and elaborated upon. A desire to have other types IT systems and a comprehensive integration thereof to enhance the facility's operations and management was expressed. There were other systems that were shared between CMH and Frere Hospitals such as a radiology IT system.

Effectiveness of policy/practices transfers

According to the senior professional nurse, private hospitals are better in many respects than public hospitals. She enumerated an explained several aspects which make them different and better.

> Private hospitals are ahead in many respects. For example, they have funding, training is encouraged, there are performance rewards that contribute towards staff motivation, staff feel empowered and valued. Staff are also empowered with life skills such as budgeting and financial management to make sure that they do not necessarily enter into debt and ending up having their work performance affected. Here at CMH we do not even have an Employee Assistance Program to assist staff members who have emotional challenges (Cecilia Makiwane, Professional Nurse, Interview, 26/05/2015).

The shop steward was not too sure whether there is anything that public sector can learn from private sector because most of the nursing staff who work at private hospitals are trained at public sector hospitals. Also, private sector hospitals are expensive. According to him the public sector just needs to focus on improving quality of service, provide adequate staff and more equipment and medicines.

The management interviewee focused on areas where the public sector was "better" than the private sector. He stressed the empowerment aspects that the private sector does not take into consideration when procuring goods or services, which the public sector does. Paradoxically, the public sector was seen as "developmental" when it allowed black businesses to benefit even if hospitals were dysfunctional for patients and workers.

The CEO argued that some services can be outsourced whilst others can be retained. Neither method is perfect, certain aspects of one are better than the other and vice versa but a balanced mix of both can work better. Elaborating on the significance and

disadvantages of the outsourced services he argued:

> In-house mechanisms are better to a certain extent but also carry their own risks. The difference from in-house mechanisms is that they can be monitored and dealt with quickly. Outsourcing carries a risk of exposure to fraud and corrupt practices such as over pricing. However with the involvement of more senior management in evaluating and adjudicating tenders and ensuring these goods comply with South African Bureau of Standards (SAB). In terms of length of time taken to deliver private sector services are delivered better for example procurement of specialised equipment but in terms of quality and patient satisfaction there is no difference (Cecilia Makiwane, CEO , Interview , 20/06/2014).

A newspaper report revealed that the partnerships that CMH has entered into with Frere Hospital and private companies are supplementing the facility's resources, providing access to high tech equipment and providing skills transfer opportunities:

> The partnership has seen registrars (doctors training to become specialists) based at Frere, who also practise at Cecilia Makiwane Hospital, trained at the eye hospital with access to the new technology (Daily Dispatch, 12/03/2013).

In summary the adoption of privatisation was appreciated but risks associated with it were also highlighted. It appeared that the preferred option was more on in-house service because it was thought that in-house services are easily monitored and remedial steps can be taken quickly where there are challenges.

Conclusions

The major issues that come out of the interviews are: complexing and its reversal, significant levels of outsourcing, corruption and Bee and the failure of Performance

management systems

Like private hospitals, most of the soft services at CMH are outsourced to private companies. The CEO's view on transfer from inter-sectoral policy or organisational practices transfer was that a balanced mix of both can work better and this will be mutually beneficial, as both will be sharing their strengths.

In summary, from one viewpoint there has been a cautious and balanced approach to the adoption and utilisation of transferred practices whilst from another there was an overwhelming acceptance and preference for transferred organisational practices from the private sector practices seen as better, advanced and more useful in improving public sector services. There was also an indicated need for strengthening and improving public sector hospitals as service in private hospitals was not considered necessarily good.

Chapter 8: Case Study of Frere hospital

This chapter describes Frere public hospital, the community served and its organisational and operational environment. Then it explores the challenges, past, current and envisaged transfers of organisational practices in relation to administrative systems and technologies. It discusses the transfer of policies and organisational practices from outside and how these fit in the recipient environment. The same sub-themes are used as in Chapter 5. Frere hospital also provides good examples of internally generated ideas and innovations. Frere hospital provides an interesting case study of exceptional improvement by using the private sector expertise in a strategic, less ideological way and by emphasising the special ethos and wider political and nation building imperatives related to healthy citizens. There is evidence of ethical and transformational leadership and team building as well as examples of how public-mindedness and commitment to serving the public can be a great motivator despite all odds.

The Context of Frere hospital.

The Frere Hospital is located in Buffalo City Metro (BCM) in the Eastern Cape Province. As the CEO noted, Frere is 133 years old. It started out only with eight wards with 32 beds and now has 900 beds (three times the size of Greenacres). It is a large tertiary teaching hospital funded by the provincial government and forms part of the East London Hospital Complex with Cecilia Makiwane Hospital.

Frere made headline news in 2007 after hundreds of newborn babies were dying every year in the hospital's overburdened maternity section – many because of negligence. At the same time, it was found that over the 14 preceding years, 2 000 babies were stillborn at the hospital and almost 200 were delivered stillborn in one year alone. The DA argued in 2010 that,

> The buck ought to stop with the hospital manager. But the fact of the

> matter is that Frere Hospital continues to fail because, rather than appointing a suitably qualified hospital manager, an ANC cadre still runs the show. At the time he was appointed it was pointed out that he had *absolutely no qualifications* in administration, and under his leadership the hospital continues to be plagued by inefficiencies and appalling shortages. Yet he remains employed – another classic case of ANC cadre deployment actively stifling the provision of services in South Africa.
> The Health Department needs to conduct a full investigation into the hospital's poor management record. We again reiterate our call for Mosana to be removed from the position of CEO of the East London Hospital Complex (which incorporates Frere and Cecilia Makiwane Hospitals), a post for which he is completely ill-qualified.[7]

Frere Hospital provides specialist services to 90% of the 2,8 million people in the operational area which include the central part of the province consisting of BCM, Amathole, Joe Gqabi and Chris Hani Districts. The situational analysis of the BCM Integrated Development Plan 2011-2016, shows incidences of diarrhoea and other water related diseases in areas with inadequate sanitation services i.e. the informal and low-income settlement areas within BCMM. HIV and AIDS remains a large and growing threat within the BC Metro's development trajectory in its quest to be a productive, inclusive, sustainable and well-governed metro. Only 10% of people in the catchment area have medical aid.

The current COE of Frere (Interview, 2014) is a former senior employee of Medicross, and was employed as medical doctor for a number of years. Also a former Chief Director in a government department in the Eastern Cape, the CEO started at Frere in

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[7] https://www.da.org.za/archive/frere-hospital-30-months-later-the-same-anc-councillor-is-still-running-the-show/

2012 amid strikes and major crises at Frere. She is well connected to private hospital leadership (on first name terms) and regularly attends "Monday meetings" at St Dominics (the local private hospital across from Frere) (Interview 2014 and 2015). She was very confident and passionate about the public sector and values and its patient centred forms of governance. In other words, she expressed few doubts about modernising and transferability although "customisation" of transferred ideas was essential. By 2015 her good work in turning around the hospital was increasingly recognised (also see: http://ehealthnews.co.za/rolene-wagner/).

Nehawu seemed more vibrant and robust at this public hospital than at the private hospitals studied. This was evidenced by the existence of the Institutional Transformation Forum, apparent constant engagements between management and labour discussing issues of mutual interests and author's observation of the shop steward's assertive posture when he related their engagements with management and how they reacted to instances of management's unilateral decision making when those disadvantaged workers.

The Frere Hospital Marketing and Communication Strategic Review document (2014) shows its basic governance structure: Hospital Board, Executive Management Team, Budget Advisory Committee, Infrastructure Steering Committee, Complaints Committee, Quality Assurance Committee and Employee Wellness Committee.

According to the CEO, Frere Hospital also attracts and helps private sector patients some of whom have already run out of benefits by mid-year. The public sector therefore indirectly supports the private sector and its profitability. The CEO noted, "Frere Hospital conducts teaching and training for the health sector and as part of contribution to the developmental agenda of the state. This contribution includes ensuring that Frere runs programs and projects that reduce inequity and unemployment and contribute towards improving social equity and creating opportunities for employment (Frere, CEO, Interview, 27/11/2014).

Organisations and Planning for policy changes and improved delivery of services

According to the CEO when they plan for policy changes and improved service delivery they consider several enabling issues. Those issues can make or break the quality of service to be rendered.

> When we plan for policy changes and improvement of service delivery we conduct a rapid appraisal of the current situation and we do strategic realignment. We also look at our infrastructure, human resource capacity needs and budget. These issues are critical in ensuring provision of good quality of care. However because we do not have delegation of authority we are unable to make

> organisational structure from a top management dominated executive to a management team composed by people leading their functional areas, we emphasize and encourage improved performance and promoted teamwork (Frere, CEO, Interview, 27/11/2014).

The shop steward thought that the organisational structure is aligned to the service delivery plan of the hospital. However, it is the things that happen in that structure that are misaligned and include some element of racism. Elaborating further on this he said:

> The structure on its own looks good but what is disturbing is what we are told is happening and what we have also observed. A director for facility management who happens to be Black has two White technicians who are supposed to be reporting to him but they choose to report directly to the CEO. This means they are undermining the Black director on racial basis (Frere Shop steward, Interview, 22/11/2015).

In summary, the organisational structure is good as it is aligned to the service delivery plan. Furthermore the "structure has been flattened" probably to cut down on bureaucratic red tape and facilitate quick decision making. There is also dissatisfaction on what is happening in the structure which was found to involve racism an example given being the – "undermining of a Black director by two White men". At face value the shop steward's contention may be right given our society's historical past of apartheid. Equally, Black subordinates can also undermine a Black supervisor for various reasons. Juxtaposing the Shop steward's view to the CEO's earlier statement it may be that he is mis-informed because the CEO had mentioned that the management structure has been "flattened and all employees leading their functional areas have become part of the extended executive management". So it may be the CEO's choice to require facility management line managers to report directly to her on all or some matters.

Perceived causes of poor quality of service delivery

The CEO maintained there has been a remarkable improvement in the quality of service rendered at Frere Hospital. When asked about the perceived poor quality at the hospital she had this to say:

> What do you base your opinion on? When were those newspaper reports about Frere published? Our service has improved quite remarkably in the past nineteen months, patients satisfaction survey results but of course there will be some areas we are found wanting and we address these areas speedily and give feedback (Frere CEO, Interview, 27/11/2014) .

Just as the CEO had done, the shop steward questioned the basis of the supposedly perception of poor quality of Frere Hospital service.

> What was that perception benchmarked on because there was no assessment of quality of service that was ever done and published. Newspapers sometimes tend to pick up one incident and make it a huge issue. All what I can say is that Frere is known for piloting best practices. Yes of course our infrastructure is not convenient. For instance you will find that the radiology section is located far from the ward and people with broken legs for example have to walk some distance from the ward to where the X-ray is (Frere Shop steward, Interview, 22/05/2015).

According to the *Daily Dispatch* newspaper the poor quality of service at Frere Hospital is not only limited to nursing but also the administrative aspects which in turn have a negative impact on the effectiveness of business processes:

> A store room that holds patients' medical records at the Frere Hospital has become so crammed that staff battle to locate files, slowing the system and delaying patient care. It's a mess. It takes a long time to find a folder and

> the racks are full and so tight that it is hard to extract a folder. If a folder is missing, it sometimes takes an hour to find. Patients complain about delays and about losing their files. The chaos also affects the dispensing of medicines. The pharmacy captures records, but if it asks for original patient records and they can't be found, the patient has to go home to fetch the old (medication) packaging because his original folder can't be found. In the meantime, a staff member said many files were extracted every day, but the storeroom was so packed that staff could barely pass each other in the cramped space. Exacerbating the chaos is the health department's policy that records must be kept for eight years before they are archived. We used to keep records for five years, but now it is longer so they are stored close to the ceiling and could cause a fire (Daily Dispatch, 04/08/2014).

According to the Daily Dispatch (08/03/2013) it appeared that the quality of care has not improved at Frere Hospital. The Strategic Review document (2014) revealed that the physical environment which include the ambiance, mood and tone of the environment was substandard. Articulating the substandard condition the document noted that:

> The hospital was run-down with certain sections having not had any maintenance repairs done in over thirty years. Despite the efforts of the staff, the facility was not kept adequately clean with dirt, broken equipment and unkempt grounds remains evident (Marketing and Communication Strategic Review document, 2014: 3).

Quoted by the *Daily Dispatch* when responding to the particular issue of infant deaths, the CEO stated that there has been a remarkable improvement in this regard. Any omissions are investigated, reported and addressed. She also noted that inasmuch as it is traumatic for any death but some are caused by natural causes that had been there even before admission.

The CEO noted "there had only been one maternal death at the hospital since January.

The death occurred in April and an investigation found the mother had complications that led to a heart attack before she could undergo surgery. Our neonatal [newborn] average is 32 per 1000 live births... The reasons for most of the deaths in the first month of life were premature births, asphyxia, and stillbirths" (Daily Dispatch, 08/03/2013).

Responding to the *Daily Dispatch* on the issue of negative staff attitudes the CEO said:

> Poor attitudes, whatever the circumstances or contributing factors, are inexcusable and will never be accepted. In previous years the main complaints were waiting times for surgical procedures and medicine and at casualty; and inappropriate attitudes and values of employees. The approach adopted to improving staff attitudes and values has been two-pronged. On the one hand, our strategies have focused on improving working conditions at the hospital because it is our belief that a positive environment contributes to improved performance. They had done this *by ensuring salaries and benefits owed to employees were paid correctly and on time,* by improving the physical environment, by providing training and development opportunities, and by giving performance feedback. The parallel approach is that of instituting investigative and disciplinary processes where there have been patient complaints about staff attitudes and patient care.

Also responding to the chaotic registry and the missing of files the CEO responded that:

> A project to review the root causes of lost medical records began after the incidence of lost files spiked to 10% in the last quarter of 2013/2014. In such cases duplicate folders had to be issued and the files reconstructed from available investigations and reports. To remedy this, new systems had been put into place and despite an increase in requests, the incidence of lost files in the last quarter now averaged just 3%.

It is clear that the issues at play at Frere were very basic ones that required consistent organisation and application of basic principles not necessarily expensive policy innovations. .

The Marketing and Communication Strategic Review document (Frere, 2014) also noted that Frere Hospital was at the centre of an expose by the local media of deaths of babies, due to strike action by employees which arose from employees' unpaid salaries and benefits. There were reports of dissatisfied patients complaining about long queues and staff shortages.

When the Public Protector Thuli Madonsela visited the hospital to check on various issues including infant mortality, the quality of care, available resources, procurement, working conditions she found patients generally satisfied but staff shortages and pay were problems (Daily Dispatch, 01/08/2013).

There have been mixed perceptions and reports about the quality of service. These mixed reactions may be partly explained by the time when the negative incidents were reported by the newspaper (15/02/2013) and the time the interview was conducted (27/11/2014) which was about twenty-one months later suggesting there might have been some improvement in the quality of service seeing that the CEO referred to the improvement during the past eighteen months.

Perceived factors in better quality service delivery

According to the CEO the good quality of service rendered at Frere is noted and recognised by the public. The management and national department and other stakeholders have also noted and recognised the good work done by the staff.

> We recognize our staff for good performance. We also receive compliments. Staff morale and patient have evidently improved and we receive more compliments than complaints. Delegates who visited us

> spoke of how the upgrades put the hospital in direct competition with private facilities.

The public sector she believed could be as good as the private and better since it has the public mission has different ethical, community and national foundations.

> We also celebrate our successes together with the community. We also conduct random patient satisfaction surveys. We also embark on community outreach programs in shopping malls. A negative incident reported we investigate and address it and give feedback; we have low staff turnover. We have also been selected by national government for Ebola readiness (Frere CEO, Interview, 27/11/2014).

The shop steward confirmed the improvement in the quality of service at Frere particularly in relation to the shorter queue and de-congestion as well as the turnaround time for receiving medication at the pharmacy.

The CEO noted,

> At some point government introduced what it called Complexing thus bringing the two complexes of Frere and Cecilia Makiwane together centralizing resources; bringing some transversal services together; sharing of services and rotation of clinical staff. Now government is de-complexing meaning the disentangling of these complexes again as stand-alone entities. What I have noted with government is that they introduce policies and these policies are not even tested before being implemented and when they are not working they are abandoned just like throw out the baby with the bath water.

Installation, maintenance, functionality and effectiveness of IT in enhancing service delivery

According to the CEO, IT installation and maintenance is done internally and sometimes done by SITA. She also noted that they also contract a private IT company. In terms of the functionality and effectiveness of the Frere IT system she confirmed that it is generally working effectively**.**

> Other significant changes include the introduction of ICT governance structure and information system. Our internal staff consist of a team of IT specialists who design our ICT systems bringing all third party information into a single clinical information kiosk. Other hospitals also benefit from this IT platform. These systems assist us to be accountable for the resources we are using (Frere CEO, Interview, 27/11/2014).

The Daily Dispatch also reported on the acquisition and utilisation of a new IT system at Frere as one of the ways of optimizing technology, enhancing service delivery, generating savings that can be deployed to other areas of need within the hospital.

> Benefits of this new system include fully automated booking of patients for radiology, decreased waiting time for patients to get definitive care, improvement of the quality of radiology services and there's also a cost-saving advantage since X-rays won't be printed on film anymore, but will be accessed electronically (Daily Dispatch, 14/01/2013).

The shop steward also confirmed that there is an IT system at the facility and is provided internally although he was not certain which other systems it benchmarked against but generally he thought it seemed to be doing well.

The CEO argued that transferred policies or practices such as privatisation of services has its own merits and de-merits. On one hand, it allows an organisation to concentrate

on “core” business, on the other, the CEO equally conceded that managing outsourced services can be expensive.

Major changes, values and leadership style

According to the CEO, Frere Hospital has gone through changes and innovations over three historical eras, reflecting the changing values and quality of services in each. These eras being the colonial, apartheid and post-apartheid era.

> The post-apartheid government has invested in infrastructure, facility upgrades and the latest state-of-the-art high technology. The introduction of ICT governance structure and information system and use of private companies has assisted Frere Hospital to overhaul its infrastructure and business processes and training of staff to improve its service (Frere, CEO, interview, 27/11/2014).

The Daily Dispatch newspaper noted recent technological innovations at Frere Hospital. (this is similar to Green Acres). A private company was involved in installing “a technology that allows doctors to see patient X-rays on their computers (DD, 14/01/2013). Describing how the new innovation was packaged and its potential benefits, Frere CEO noted:

> Implementation of the project was being done in partnership with Masivuse Medical (Pty) Ltd. PACS is a network of computers used by radiology departments that replaces film with electronically stored and displayed digital images. Benefits of this new system include fully automated booking of patients for radiology, decreased waiting time for patients to get definitive care, improvement of the quality of radiology services and there’s also a cost-saving advantage since X-rays won’t be printed on film anymore, but will be accessed electronically. The savings will be redirected to other areas of the hospital to improve patient care.

> Upgrades to equipment, training of clinicians and policy and procedure development were all on track. In year two and three of the project we aim to improve access to the system from remote locations and more enhanced planning and diagnostic features will be integrated to further advance the system's functionality. This will in return allow for improved patient care.

The CEO pointed out that "minor" but vital changes were made to the organisational culture at Frere which essential to re-dynanising the hospital. These included taking trade unions seriously, being consultative and showing respect for all staff.

> My team and I agreed that our higher purpose should be based on patient-centred care and through a range of clinical and operational changes we were able to turn the hospital around. Interview, http://ehealthnews.co.za/rolene-wagner/

> When you're leading, there are always moments of conflict and those prepare you practically on how to engage with people and how to find a way forward. I think the public sector is a good training ground for that because our culture in the EC is built around consensus. Most importantly, you must understand what values drive you and ensure that your personal values and the values of the organisation that you work for are aligned. Being empathetic to the plight of our staff and patients are very important EQ aspects that helped me deal with the conflicts that inevitably arise when leading complex organisations. http://ehealthnews.co.za/rolene-wagner/

> Cultivating awareness and good relationship management skills is key to getting buy-in from staff of the vision you're trying to bring to fruition. When I joined the EC DoH in 1999, one of the vital lessons I learnt was to be consultative in my approach. Engaging with your management team, developing a good business plan and developing great people are all

critical to success. http://ehealthnews.co.za/rolene-wagner/

Since then, private medical aid patients have used Frere and some medical schemes have started to contract with Frere for chronic medication services to their members. The Daily Dispatch reported other public-private partnerships initiatives that Frere Hospital is involved in, including collaboration on advance eye treatment and surgery in partnership with the East London Eye Clinic.

A public-private partnership has seen East London catching up with high-tech innovations in medical eye-care. Frere and Cecilia Makiwane (CMH) hospitals, have teamed up with Walter Sisulu University and the newly-established privately owned East London Eye Hospital. The partnership will have registrars (doctors training to become specialists) based at Frere, who also practice at CMH, to be trained at the eye hospital with access to the new technology. Public sector patients operated on by the registrars during the training programme will also benefit from the private facility (*Daily Dispatch*, 25/02/2013).

In an interview with the Daily Dispatch newspaper the CEO also confirmed this public-private initiative. Elaborating on how it will complement their resources and assist Frere she noted:

> The public sector has resource, equipment and staff constraints but the partnership with the East London Eye Hospital will assist us in those areas. Both patients and staff at Frere would benefit from the partnership. There is an enormous backlog in the province. At CMH people have to wait until October to get dates unless someone cancels. Because of the backlog they were unable to focus on training, so the new private hospital's contribution to training Walter Sisulu University (WSU) students and registrars was sorely needed." (DD, 25/02/13)

Confirming other innovations two paediatric operating theatre suites valued at R20-million, were unveiled at Frere Hospital (Daily Dispatch, 14/01/2013).

The Daily Dispatch quoted spokesperson of the Eastern Cape Department of Health hinting at other imminent innovations and partnerships.

> Other developments included the installation of security systems in five hospitals across the province which allowed for monitoring of those facilities from remote locations. This technology would be rolled out in more hospitals. Even the MEC (Sicelo Gqobana) is able to view what's happening in these hospitals from his office in Bhisho. Other development was "tele-medicines" which linked big clinics and hospitals across the country. A doctor in Cape Town is able to diagnose and give a prescription to a patient in Qumbu. The advantage of this was that it brought the health service from Cape Town to the patient in Qumbu without any travelling costs incurred by the patient for a diagnosis and prescription.

The Daily Dispatch also reported technological innovation that had been introduced at Frere in the area of catering and how this will assist in ensuring good quality of food, patients' recovery as well as timeous preparation and delivery of food. (DD, 09/06/2014).

The CEO also highlighted other imminent changes which include the revenue generation for self-sustainability, complexing and "decomplexing" of hospitals.

> The other part, we are more focused on, is looking for opportunities to generate revenue. The province is working on a proposal on how as an incentive we can retain some of the revenue that we could now pump back into our maintenance programme or other priority areas. We can have between a 1-3% savings if we just become more efficient and more effective (Daily Dispatch, 24/08/2013).

Explaining the origins, initial purpose and modalities of the operations of the complexed and imminent de-complexing of the facilities the CEO noted:

> Complexing is part of a provincial policy which looks at rationalisation and pooling together of resources to address the historical inequities. Its implementation process involves the centralizing of certain functions and resources, rotation of clinical staff bringing some transversal services together and sharing of services. In centralizing the resources a Corporate Services Centre consisting of clinical services, facility management, HR and ICT was established. Its usefulness was cost-effectiveness and saving. However, the challenge is that if you don't finance it and the staff have not been taken through a change management process you are going to run into problems. For instance the staff did not take it kindly because some felt they were being second-guessed and also management offices were now located far from the facility and you will find that even for approval of requisition the staff had to go from the facility to the Corporate Service Centre.
>
> She noted that the seemingly rational idea of "complexing" had to be reversed.
>
> Now, again we are going through a process of de-complexing thus moving away from that complexing process. In my experience I have found that in government policies are not tested before being implemented and when they are not working we abandon them just like throwing out the baby with the bath water (Frere, CEO, Interview, 27/11/2014).

As part of the changes that are taking place at Frere, its Marketing and Communication Strategic Review document (Frere, 2014) highlighted the introduction of the National Core Standards for health establishments in the country which will also be implemented at Frere. The review also highlighted other global and national factors and trends that

define world class standards of healthcare which include rapid technological advancements, cost effectiveness and the need to become cost effective and efficient, emergence of society and work environments that are information-driven. The document also confirmed that the driving forces behind Frere Hospital's change process were political imperatives and Executive Managements' understanding of the healthcare market and how its behaviour impacts on Frere.

This Complexing policy creates some contradictions in the sense that the CEO lamented the Provincial Department of Health unwillingness to decentralize as hampering decision making and service delivery whilst the government was continuing with complexing. It emerged from this that in some instances government makes policies and when it sees that they do not work "it throws them away", which raises the questions whether these policies are a "right fit" in the public health sector environment and whether they are evidence-based.

The shop steward on the other hand highlighted changes such as the abolition of segregation of wards along racial lines. "Here there was B and C Sections. B section being for Blacks and C being for Whites. We have also seen the appointment of hospital managers who had no medical background and then again that was later changed and hospital managers needed to be persons with medical background. From this period they became known as CEOs".

The shop steward also pointed out that like private hospitals,

> We also saw the outsourcing security services to uXhobani, a private security company. What I have noticed with employers is that when they want to reduce (operational) costs they privatize and the first target is always the staff. We have also seen the establishment of what is called Institutional Transformation Forum which is a platform where the management and organised labour sit to discuss institutional matters of mutual interest (Frere Shop steward, Interview, 22/05/2015).

It is clear from these accounts that major changes (reversals) and innovations have taken place at Frere during the last decade and that these changes range from historical, political (transformation), infrastructural designs to technological innovations. In addition to the political and technological changes, change in management approach and service delivery mechanism cited as "change of hospital managers from being administrators with business background to managers who must have medical background as well as outsourcing of security services" were couched in and reflected the reversal of NPM theory.

> These changes have been evolutionary, having phases and being part of the political history of the country through the colonial, apartheid and post-apartheid eras. In each phase the values and quality of the services rendered reflected earlier neglect of the interests of the majority of citizens of the country through to the later values of equality, caring society and inclusivity. The post-apartheid era has been was characterised by "investment in infrastructure, facility upgrade and the latest state-of-the-art high technology, introduction of ICT governance structure and information system and use of private companies to assist Frere Hospital to overhaul its infrastructure and business processes and training of staff to improve our service (Frere, CEO, Interview, 27/11/2014).

Policy transfers/practices have been implemented

The CEO noted that *all the hospital's services are provided in-house e*xcept those provided through public-private partnerships.

> We have outsourced radiology services and obviously infrastructure development and maintenance. We also intend to automate our performance dashboard and we are already done with clinical services and this obviously will be outsourced or provided through public-private

> partnership. We are also waiting to receive human resource management, financial management and supply management delegations from Head Office. These delegations are part of the decentralisation process that is outlined in the policy. The delay in decentralizing delegations is holding us back (Frere CEO, Interview, 27/11/2014).

The shop steward confirmed that most of the hospital's services are provided in-house except the security services. He also mentioned that there are no other imminent planned outsourcing of services and functions. He however, raised suspicion with the cleaning and maintenance function that appear to be partially outsourced without organised labour being involved or consulted on that decision. Elaborating on the services and functions rendered at Frere he said:

> All our services namely medical and nursing service, catering, cleaning, laundry, facility management are all provided in-houses except the security services that are provided by Xhobani Security. There is something unclear about the maintenance part of facility management and cleaning services. For instance Coega Development Corporation is involved in maintenance of some parts of the hospital. Also with cleaning there are some moves towards involving a private company but it is not clear to us as organised labour as we have not been consulted on it (Frere Shop steward, Interview, 22/05/2015).

The Marketing and Communication Strategic Review document (Frere, 2014) also mentioned key policies that will have to be taken into consideration in the course of business of the hospital and these include the National Core Standards, the National Development Plan and the National Health Insurance reforms.

In summary, the responses to this question indicated that although most of their services are still provided through in-house mechanisms, some have been outsourced. Another imminent innovation included outsourcing of automation of the performance dashboard

to a public-private partnership. The purpose of this dashboard would be to track the performance of the clinical staff. Outsourcing of security services and maintenance was also mentioned although there was no certainty about these because there had not been any formal communication with regard to them. There seemed to be some move towards outsourcing of cleaning services although there was also no certainty about this as well. The CEO had earlier said the Mangaung Conference of 2012 of the ruling party declared that outsourcing must be abolished. What the facility has done has been to train the cleaning staff through a private company in order to professionalize cleaning, improve cleaning service and retain their staff which would have otherwise became victims of retrenchment had outsourcing been introduced. The apparent uncertainty on the matter also shows lack of communication and consultation or selective communication and consultation between management and organised labour.

Origins of policy ideas/organisational practices and types of sources of changes

The CEO indicated that as a historically centralised and hierarchical environment all policy related ideas and developments come from government either national or provincial. There are also other practices that the hospital adopts from external sources.

> All the policies come from national and provincial administration. There are also internally developed policies and standard operational procedures, innovations and best practices that are derived from externally. National and provincial policies are centralised but cannot be considered as coercive in terms of implementation because they are the framework and define the manner in which the mandate of government should be executed and therefore they are part of government's policy imperatives (Frere CEO, Interview, 27/11/2014).

Commenting also on the origins of policy ideas the shop steward also indicated that

policies implemented come from national or provincial government.

> Policies are made at national and provincial government level and get implemented at facility level. We have no choice but to implement them but we challenge those that are imposed and threaten the interests of workers. There are also policies that are developed internally such as operational policies. For instance, we are busy with developing of the bereavement policy which the management has not yet approved. Some policies particularly operational ones begin from practice and because practices must not be in breach of legislation and regulations they must be consistent thereto and therefore are translated into a policy (Frere Shop steward, Interview, 22/05/2015).

There was consensus that most policies implemented come from national or provincial government. There are also policies that are developed internally such as operational policies and procedures. Other "innovations and best practices" that are externally derived are evident. In most instances, these policies are not considered to be coerced because they define what the work should be. However policies that threaten the interests of employees and union members are challenged. The Marketing and Communication Strategic Review document (Frere, 2014) revealed that the Frere transformation blueprint has taken into account other factors and trends that globally and nationally define world class standards of healthcare which include rapid technological advancements, cost effectiveness and the need to become cost effective and efficient, emergence of information-driven social and work environments. That position reflects acceptance of the influence and role of NPM theory in the planned transformation of the Frere hospital. It is evident that although the ideas, policies and organisational practices that are being implemented are government policies, there is also a lot of private sector influence and ideas. Even those ideas and policies that come from government have a tinge of private sector which can be attributed to the NPM influence.

Issues of scale considered or elements selected from the "package" of changes and innovations

The CEO observed that the public sector is highly regulated and it is difficult to pick and choose from policies and regulations that are introduced from national and provincial level. However, innovative ways are found to customize some of these policies.

> The only area where have made selection from a package of changes was the cleaning services area. At the 2012 Mangaung Conference of the ruling party they adopted a resolution among others that directed government to stop contracting out services. Because we feared that ordinary people who work as cleaners in our facility may lose jobs we decided to introduce the professionalisation of cleaning services and because we were aware that we will not get additional funding from government for this initiative we mobilised our own funding. We therefore decided that we will train our cleaning staff utilizing private training service providers using funds from Public Services Sector Education and Training Authorities (PSETA) and Coega Job Fund (Frere CEO, interview, 27/11/2014)

The shop steward responded that he did not know how decisions are taken to choose which policies or practices to implement or not to implement because those are management prerogatives. At the same time he did not think it is possible to choose which policies or practices to implement because 2.27 4(tin TJET EMC /P <MCID 1626>4P <MCID 2413>BDC BT

cleaning

autonomy (Frere, CEO, interview, CEO, 27/11/2014).

The shop steward argued it is difficult to innovate because of the rigid government operations. In addition, the management themselves do not enable innovation.

> Government has a culture of rigidness and management also makes it worse by not creating an environment that welcomes innovation. I do not know whether by bringing new ideas you are undermining their thinking (Frere Shop steward, Interview, 22/05/2015).

In summary there is little space for innovation and this was attributed to the rigidity of government. This lack of space for innovation was seen as having opportunity cost implications and this was illustrated with examples such as the manner in which the facility loses revenue generation for self-sustainability and how government loses money on its construction projects because it wants to do everything all at once not considering the economies of scale. Aside from government structures and systems it was also found that the attitude and tendencies of management is such that that they do not trust subordinates and they think subordinates seek to "undermine them". Another reason given for the lack of adequate space for innovation was the system of bureaucracy and the authorities or Head Office. The facility's management was cited as a reason for this inadequate space for innovation because it was seen as not receptive to employees' views on how to improve service delivery.

Agents of change and networks

The CEO noted that the change agents are her Executive Management Team. The shop steward's understanding was that the change agents are head office officials who write memos to introduce certain policy changes.

The CEO also indicated that although there are learning networks these are not sufficient.

> Networks for sharing best practices and innovations are not adequate as they should be. National department of public service is looking at developing or establishing a programme to share best practices. However there are provincial management meetings, workshops, research seminars and conferences where our staff go and present research papers as way of sharing best practices. We are also looking at visiting overseas countries like UK and USA to go and learn best practices. We also use internet to generate innovative ideas and best practices. Our clinical engineering staff also develop very good case studies and are keen to share those case studies with other institutions (Frere CEO, Interview, 27/11/2014).

The shop steward thought that there are platforms for sharing changes and innovations such as Institutional Transformations Forum which are not utilised and that leaves workers outside of what is happening in the facility.

In summary, the platform for sharing change and innovation ideas exist although they were seen as inadequate. The workers are not exposed to those platforms and ideas which leave the, ignorant of what is happening and where these changes are coming from. This results in working not owning these changes because they have not been part of their conception. It was further acknowledged that resistance to change is something common but what is important is to use those very resistant individuals to be the change champions.

Policies and practices

The CEO believed there is always a tension between a policy as an ideal and implementation. Policy does not always fit 100% in the environment and you have to adapt and customize at times because sometimes the environment is not enabling.

> For example you find that there are personnel and financial constraints and at times staff attitude and resistance particularly among labour

> organisations who see the implementation of a new policy as more workload (Frere CEO, Interview, 27/11/2014).

According to the shop steward policies and practices that are adopted from outside do not always fit perfectly in the recipient environment and if they are to work they have to be consulted with the people they are going to affect.

> There is a tendency among managers where they just introduce policies and procedures without consulting the workers. They only start talking to workers when they see that there is resistance. They forget that we also have contribution to make in the running of this facility (Frere, Shop steward, Interview, 22/11/2015).

The findings revealed a gap between participatory ideals and its practical application. There tends to be tension between organisational environments and the policy or practice. In some instances this tension results in dysfunctionality and failure of a policy or practice.

As the shop steward saw it the issue of discretion and localisation of service delivery is a management decision and it has a potential for malpractices.

> The issue of discretion rests with management and it always goes without being checked. Take the issue of privatisation and outsourcing if they want to do it they just do whether we agree or not. They use their discretion to appoint companies they have relations with so that they can benefit (Frere Shop steward, Interview, 22/05/2015).

There is space for discretion and localisation of service delivery more especially on internal policies and operational procedures but with nationally prescribed policies it is difficult. Furthermore, employees regarded localisation and discretion as a management issue and which is open to abuse by those in management. It has also appeared that the

issue of discretion and localisation brings unintended consequences.

Business/Citizens process model

In the CEO's view there are a lot inefficiencies in the workflows and they are not appropriate. She also noted that the infrastructure is not closely matched to the workflow. Also inadequate staff capacity contributes to inefficient and ineffective business processes. She further noted that these days the workflow is more appropriate than when the hospital was established. On her assumption of duty she was quoted by the Daily Dispatch newspaper as saying:

> We are now making representation to Head Office to update and upgrade our infrastructure. We are also considering reviewing our business processes and map out our service delivery processes. Our patients waiting area is congested, the administration and registry are too far from where the wards are, poorly ventilated waiting area and there is also a shortage of theatre and we are now making representation to the Head Office for upgrading of our infrastructure to be in line with the current workflow. The first critical issue was the pharmacy waiting time. One way we've tackled it now, we've interviewed five pharmacists, two for CMH and three for Frere. We also have a help desk in place because patients come and sit in the wrong place, so they wait a few hours then they have to go somewhere else. Now when the new pharmacists come, we're going to divert to a new system that worked very well for us before, but because of the shortage we couldn't implement. The one queue is for nought to four drugs on the prescription, so that's a quicker turnover of numbers while the other queue is for those who have longer scripts. We've placed an order and we've budgeted for an automata – this is a pill counter, so I think that will also make it quicker (Daily Dispatch, 24/08/2013).

The dramatic improvement of the business processes and the impact this has had was confirmed by the shop steward. As he noted, the waiting area has been de-congested and there seems to be free flow of patients and lesser waiting times.

> There has been some improvement lately with introduction of information desk whereby people first get information on where they should go so that they do not wait where they are not supposed to wait. Also the registry and files issue has been sorted out as files are retrieved way before patients arrive. As a result of these improvements I have noticed that the turnaround times have improved at the pharmacy as I no longer see overcrowding and congestion in that area. This can be attributed to new innovations that has been introduced in relation to service delivery improvement (Frere Shop steward, Interview, 22/05/2015).

It was indicated that the time taken to attend to a patient ranges from one to four hours depending on the nature of the case. The processes are clear, simple and effective. It is based on closely looking at problems in the unique setting and then looking at basic changes and details.

The CEO noted that the hospital has no choice but to implement all government policies. Their implementation is not without challenges and they position themselves strategically to deal with such challenges.

> Implementation is difficult but we also have multi-disciplinary teams to address those challenges. These policies bring with them demands on the already limited human resource capacity (Frere CEO, Interview, 27/11/2014).

The shop steward indicated that the transformative policies are implemented but they are not implemented properly. Labour Relations and recruitment policies in particular are being abused by management to serve their interests. If management wants to discipline

an employee or want to recruit they do as they wish.

In summary, although agreeing that there was major improvements, two different views emerged in response to the issue of transformative health policies. The CEO's view was that the implementation of government transformative policies is difficult and needs some adaptation and customisation whereas the shopsteward's view was there was nothing wrong with the policies other than the fact that they are not implemented properly and also abused by the management for their own ends.

Recruitment processes and procedures

According to the CEO the recruitment process is slow and tedious and this is further compounded by the fact that the hospital management has no human resource and other forms of delegation as everything is centralised at Head Office.

> Our recruitment processes are far too slow and inefficient. You need to have budget allocated, advertise, compile a master list before you shortlist. Advertising is centralised at Head Office and this takes very long and I have to personally take the appointments for approval to the Head Office. Sometimes you find that Head Office does not approve these appointments because maybe a moratorium is placed on filling of posts. We put an application for advertising of posts in June 2013 and they were advertised in December. We cannot even juggle around the posts we have to address challenges in other areas as we deem necessary because we don't have delegations. When all the Head Office approval processes internally are completed here we take three months to fill our posts (Frere CEO, Interview, 27/11/2014).

According to the shop steward the recruitment process is problematic and is not implemented properly. Besides its slow and tedious nature there are also other issues that are involved in this process which include nepotism and budgetary constraints.

> The recruitment policy is not implemented properly. There is a lot of nepotism and favouritism. Sometimes you will find that go to an interview is merely a matter of formality as that particular job has been earmarked for someone else already. We have also noted that the recruitment policy is not aligned to the Employment Equity Act (EEA) hence you find that transformation is slow in this facility. Other issues that negatively impact on recruitment process are the shortage of staff and limited budget. For instance there the position of Human Resource Director has been vacant for some time (Frere Shopsteward, Interview, 22/05/2015).

Notwithstanding the CEO's complaint that they do not have delegations the Daily Dispatch newspaper reported that hospital managers were granted delegations to appoint the staff they needed. The report continued saying:

> The provincial government has granted hospital bosses the authority to appoint all staff in a new fast-track policy designed to cut through recruitment red-tape. The move is a bid to stop the exodus of health professionals from the Eastern Cape. This was one of the recommendations agreed upon at an Academic Retreat for Health Professionals held in East London last week. The recommendations included proposals around recruitment, deployments and transfers as well as investing in the training of staff. Michelle Walsh, a surgical registrar at the East London Hospital Complex, said allowing medical doctors to appoint staff themselves would improve the quality of recruitment and retention of professionals. Previously staff were recruited through the Department of Health and appointments could take months to be finalised resulting in frustrated candidates simply leaving the province (Daily Dispatch, 11/08/2006).

The Daily Dispatch highlighted malpractices in the recruitment processes in the East

London Hospital Complex. In its expose it said:

> A report from the Joint Management Team (JMT), appointed by the national government to investigate the looming disaster facing Frere Hospital, is highly critical of the hospital's management style. The complaints included racism, nepotism and favouritism, and some staff members were critical of the management styles of chief medical superintendent Narad Pandey and acting deputy director Lungiswa Maqaqa (Daily Dispatch, 17/03/2005).

In summary, there was consensus that the recruitment process is too slow and cumbersome and this was attributed to the lack of appropriate delegations. The shop steward's view was that the recruitment process is managed improperly and is fraught with "nepotism and favouritism." A newspaper report also seemed to concur with claims of complaints of alleged "racism, nepotism and favouritism". There also seem to be conflicting messages about these delegation as the newspaper report claims delegations have been issued whilst the CEO is still complaining about lack of delegations. This can be attributed to the nature of bureaucracy wherein there is often a huge time lapse between and announcement and the actual implementation which is often caused by unnecessarily long and time-consuming administrative processes.

Training and retraining of labour

The CEO's view was that if an organisation has a high staff turnover there will obviously be a need for staff training. Due to high nursing staff turnover they were compelled to train the new incoming staff. There is also an ongoing training of staff as the environment changes and technological developments constantly bring about changes. The CEO elaborated on one of their training programs:

> On cleanliness, we are contracting now with Siyaya to retrain our staff. Ultimately we'd like a career path for our cleaners so that they can emerge

> with a certificate. We've also allocated and purchased R1.2-million worth of cleaning equipment, with trolleys that have cleaning materials that are organised for specific types of dirt that you find in a hospital, and all our staff will be trained in the use of those trolleys. I've also met with the private sector because we need to benchmark cleanliness, and they've agreed that we can start looking at partnerships where our workers can see the standard for a clean hospital in the private sector. They were also now able to cook according to the provincial menu. The in-service training was held for the kitchen employees, which did not just improve their cooking, but also improved their attitude. In addition to the changes we've implemented this past year, we are now planning the implementation of a pre-plating system (Frere CEO, Interview, 27/11/2014).

The shop steward agreed that there are training opportunities and programs. He felt that training at Frere could be better managed if workers suggestions on which types of training programs should be conducted.

In summary there are training programs in the facility and the existence of this program is linked to the staff turnover, arrival of new staff and an ongoing need to catch up with new professional and technological developments. The Nehawu representative argued for training to be informed more by employees needs and understanding of what they consider important for their own development rather than a top down approach of training provision being applied.

Procurement processes and procedures

As pointed out by the CEO, the procurement processes are far too cumbersome, far too long and involve too many signatures. Relating the stages of the procurement process she said:

> It takes up to three days to generate an order number for small items and up

> to three months for equipment and other capital assets. The cumbersome part is really with the bid committees that your procurement has to go through. For instance a tender has to be advertised and after a tender has been closed it goes through bid specification committee, then to the bid evaluation committee and then through to the bid adjudication committee and the people sitting in these committees are responsible for other things as well and they do not have time to sit frequently to deal with these bids (Frere CEO, Interview, 27/11/2014).

Commenting on the hospital's procurement processes the shop steward argued that there is nothing wrong with the procurement processes and that it is the officials who are not implementing the policies effectively and opening it to malpractices.

Procurement is done through the tender system and there are corrupt practices that are done by other officials. I would not say there is anything wrong with the procurement processes, the only thing I can say is that it is the responsible officials that mess up the system through corruption. For instance, there are suspicions though not proven that confidential supply chain information is leaked to suppliers and as a result you find that same company win tenders over and over again and therefore you find that the bid outcomes are always skewed in favour of certain companies (Frere Shop steward, Interview, 22/05/2015).

In summary the findings highlighted that procurement processes are too long-winded, tedious, time-consuming and carrying a high administrative burden. A contrary view from the shop steward was that it was not necessarily the processes that were ineffective but rather that the officials messed the processes up through maladministration and corruption.

Staff performance management and development

The CEO believed there have been challenges with the implementation of the PMDS one

of which was that the staff complained about management taking the issue of PMDS seriously which led to the staff not taking it seriously. She also expressed her own views on the manner in which it is packaged and implemented. Explaining the issue further she said:

> The issue was really with compliance because staff used to argue that we comply and we are not paid for PMDS so why bother. The system now has been improved and we enforce compliance where necessary by writing to people to give reasons why they should not be disciplined. Let me also hasten to say the system is cumbersome and has a lot of administrative burden and needs to be streamlined (Frere CEO, interview, 27/11/2014).

The shop steward also cited challenges with the implementation of PMDS. He placed the blame on management's attitude and apparent inability to implement it. He elaborated further saying:

"The PMDS is not implemented effectively here at Frere. You will find sometimes that staff performance assessment is not done quarterly and that these quarterly assessments accumulate and ending up all of them having to be done at the end of the year. It is not because the staff does not want to be assessed instead it is because some managers refuse to assess their staff claiming that they are unable to administer the system because they have not been trained on it (Frere Shop steward, Interview, 22/05/ 2015).

I found that there are challenges involved in implementing the PMDS. These challenges were attributed by the CEO to the lack of understanding of its purpose as it appeared to be understood as merely a compliance issue. The blame was also apportioned to the management's indifferent attitude towards PMDS which was in turn attributed to management's lack of understanding of the policy. It also seemed that this issue was sorted out in some degree and that the situation has improved and management measures have been put in place.

Lessons that can be derived from inter-sectoral policy transfer

According to the CEO, there is a lot of interaction and exchange of ideas and equipment between Frere and St Dominic's Private Hospital which is close by. As to what impressed the CEO in the private sector operations, intersectoral policy and organisational practices that can be transferred from the private healthcare sector to the public healthcare sector a Daily Dispatch report quoted her saying:

> One thing I enjoyed at Medicross is the way in which it was managed, and so there are basic practices in the private healthcare that we can learn from. The basics that should be happening, do happen. It might be that the profit margin is what drives the private sector, but the reality is, their systems are very effective and efficient, especially their financial systems. I've also met with the private sector because we need to benchmark cleanliness, and they've agreed that we can start looking at partnerships where our workers can see the standard for a clean hospital in the private sector (Daily Dispatch, 15/01/2014).

The CEO also noted that they also use an external research and development company to assist them to analyse and re-engineer their infrastructure, ICT, staffing and how to implement standard operational procedures and business processes using their social responsibility programs. The information gathered from the external company's information helps them to improve their service. In some instances, some staff members approach private sector or private companies approach the Superintendent-General or the Member of Executive Council requesting to enter into partnerships with the hospital. In a recent interview (2016) she noted:

> PPPs are a good idea as long as they don't become overly bureaucratic. There are definitely areas where the strengths of the respective sectors can be leveraged for better health outcomes of the people we serve. I think the

> private sector realises that there are good things in the public sector too and we are all keen to work together.

She explained

> In some instances myself and management team go out and explore strategic partnerships to share resources and expertise. For example we are working together with the adjacent private hospital. Frere attends St Dominic's management meetings to share ideas, innovations and resources. We also assist the private hospital on how to grow specialist services because they are not accredited to do training and teaching. We come from a period where specialists had no scope in the public sector. Also, I am impressed with how they manage their cleaning services, how they allocate cleaning staff per square metre so that the work done can be quantified and measured." (Frere CEO, Interview, 27/11/2014)

The Marketing and Communication Strategic Review document (Frere, 2014) reported that there is a strong cooperative relationship and sharing of resources between Frere and adjacent private hospitals to the extent that some specialists in the private sector do sessional work for Frere and thus supplement the scarce resources in the public sector.

The hospital leadership felt that there are many areas, opportunities and resources that public sector can take advantage of and leverage upon from the private sector to improve service. These opportunities range from sharing of expertise, resource, IT up to business process re-engineering. This view was reiterated by a representative of a private hospital holding company in an interview with a Daily Dispatch newspaper (14/10/2014). In that report there were indications that partnership initiatives that are already underway.

Conclusion

It is evident that there have been considerable positive changes based on stringently

applying basic rules and a good professional sense driven by public ethos. These have been linked to political transformation and desire to catch up with developments locally and internationally. The vocabulary and tone of the executive management reflects confidence in private sector practices to improve the quality of service delivery in the hospital. Nehawu seem to be providing qualified support to these changes though organised labour argued that these changes must be consulted and should not threaten workers' interests.

It is also evident that management and labour agreed that transfers of policies and external organisational practices are not necessarily easy exercises, being fraught with tensions and conflicts arising from asymmetries between themselves and the recipient environment. The environment itself has its own dynamics which are not necessarily commensurate to or amenable to foreign elements. Therefore any transfers need to be carefully negotiated and adapted they are to succeed.

The success of these imported practices have not been conclusive. This could be partly because some changes have long term impacts which are not visible immediately or because the environment is not conducive to their successful implementation and realisation of positive outcomes. This is one area that requires further investigation.

The international literature on policy/best practices transfer seem not to have accounted for possibilities of corruption that tends to arise in the recipient environment in the course of implementation due to the fluidity and opportunistic nature of the environment during transition from the old to the new order.

The changes, innovations, policy and organisational practices that have been introduced seem to have been contested by Nehawu in the public sector more especially the outsourcing and PPPs. The reason for this contestation seems to be based on their perceived wastefulness, ineffectiveness and negative impact on the lives of ordinary workers in terms of job losses.

The presence, role and strength of organised labour in both public and private hospitals has emerged as a significant issue for consideration. There appears to be a structured, functional and vibrant engagement platform between labour and management in the public sector hospitals reviewed, compared to the private hospitals. Also, Nehawu in the public hospitals is relatively vocal and strong in terms of representing the interests of their members, influencing or opposing any policy decisions. This difference can be attributed to the brutal nature of private capital in respect of enforcing their will on labour which goes with threats of dismissal in cases of deviant conduct in the form of protest action and strikes.

Among the issues mentioned in the literature (Dolowitz and Marsh 1996:54 - 55; Fawcett and Marsh 2012:182; Legrand 2012:333) as reasons for non-success of transfer experiments are contextual factors such as "attitudes", "organisational culture", "political values and ideologies" and "paucity of information on the recipient environment". Little is attributed to the role of the labour movement which this research has highlighted or recent events have demonstrated such as the labour movement involvement in recent student campaigns in South Africa have demonstrated.

The issue of the presence, role and influence of the labour movement in mediating the encroachment of private practices and their effects on the institutional processes of transfer requires further investigation.

Chapter 9: Analysis of findings of policy/organisational practices transfers across the public and private healthcare facilities

The central aim of this study was to contribute to understanding the processes in the transferability of practices between public and private health systems given specific South African legacies and challenges. The thesis explored issues around how these notions of best practice are contested in workplaces, and what lessons can be drawn and implemented in both sectors' health service delivery systems to transform and improve them. In this research special focus was placed on different agents' understandings of challenges, transfers, forms of transfers, immediate results and impediments, lessons, ambiguities and contradictions between these paradigms. The research strategy was to get at least two sides of the story (management and labour) and then use newspapers and other sources. This final chapter will tease out, analyse and compare the responses of different agents and consider the lessons for transferability of policies. This final chapter locates the findings within the theories of policy change. I will start with the public sector hospitals and then consider private ones and then look at both.

Public sector hospitals

In South Africa, as I noted in Chapter 1 it is conventional wisdom that the private sector can contribute skills and capacity building to the public sector (Treasury, 2007; Shuping and Kabaneii 2007; Broomberg, 2011; Van den Heever, 2012). Policy transfer and "best practice" became a mantra for policy makers under the sway of NPM.

In South Africa's public health sector since 1994, as shown in this Eastern Cape study, there have been numerous policy challenges and changes. Some of these changes were rapid so that the terms "policy churning" and "policy fatigue" have become more common place. A key finding is that the use of NPM discourse for understanding

problems and formulating solutions is widespread in the public hospitals. Managers (called CEO's) think and speak in the language of mission statements, strategic objectives, core business, outputs, performance measurement, ownership by staff and customers and "transformational leadership. The vocabulary used with public sector officials in interviews suggested that they were well versed in neoliberal rhetoric and this might be evidence of 'bandwagoning". These included terms such "embracing, driving and justifying these changes include "core function, cost effectiveness", effectiveness and "leveraging on private sector resources". It is evident from the language used by some of the respondents that there has been NPM influence in the changes introduced. Again, labour was very critical of these changes arguing, "privatisation leads to retrenchments".

Regarding poor quality of services, the problems encountered at public hospitals differ fundamentally from private ones: Symptoms of poor quality of service in public hospitals included staff overwork, delays in procurement processes which lead to shortage of medicines, high mortality rates and overcrowding, long queues at OPD and pharmacies. It appeared that there are generally poor relations between CMH and Frere Hospitals. The transfer of dying patients from Frere Hospital to CMH was also cited as one of the causes of negative perceptions on the quality of service at CMH.

Managers in the public hospitals were not averse to privatisation but also highlighted the risks involved in using outsourced services. The preferred option was for in-house service because according to them in-house services are easily monitored and remedial steps can be taken quickly where there are challenges.

The idea of an expansive comprehensive public service has been rolled back in favour of a diminished concept of core services backed by outsourced privatised contracts thereby creating a complex mélange of actors and measurements with contradictory effects and unstable outcomes. This, however is not uniformly so as we have seen in the case of Frere Hospital where a progressive approach to the idea of serving the public seems to

have emerged.

In the second place I found that many traditional criticisms of the public sector as rigid, slow, inept, unresponsive to public needs when compared to the private sector rings true but the picture is uneven. The 'wicked" problems (whether to centralise, decentralise and how much and whether to employ specialists or generalists to lead) are also evident. In South Africa, the adoption of market-like mechanisms and policies in the public sector has eroded the space for creative and democratic experiments in transforming public institutions, The idea that patients are customers and even hospital workers should think like entrepreneurs rather than professionals driven by a vocation and committed to public service has perversely taken root.

The ruling party has not been sensitive to the contested effects of outsourcing and has not resolved to abolish it. The 2012 ruling party's Mangaung conference resolved that outsourcing should be abolished.

A more generous view of what the public sector managers espouses is related to Dolowitz and Marsh (1998: 41) term as the "middle ground" which involves a transfer experiment originating from "the actors' perception that their sector is falling behind their competitors" and they therefore need to catch up. This need to change the status quo, catch up with others or save costs resonates with the post-1994 South African situation in general and the research for this thesis on healthcare facilities.

A third observation is that at the same time as "serving the public", the state also wants to use hospitals to promote a black capitalist class (Bee deals for PPP's and preferential procurement for black business feature as important aspects of the public sector dynamics). In the Eastern Cape especially seeing the public sector as a vehicle for rapid accumulation of wealth through contracts, theft and corruption looms large. Curbing corruption and improving accountability therefore is central to the drive to fix up the public health system. Weak governance and management; weak human resource planning, development and management; ineffective planning, budgeting, monitoring

and dysfunctional evaluation were key stories that shopstewards related in my interviews.

CEO's of public hospitals interviewed readily conceded in interviews that they had high regard for the private model. But they also noted that their problems were different. One CEO blamed the citizens and the failure of referral system for the excessive number of patients that have to be helped. Another took a more transformational leadership role and had built strong public ethos and a working relationship with the unions (Frere Hospital).

Within the public sector, managers chose different approaches In Frere Hospital, the manager (Rolene Wagner) was more open about valorising the publicness of the hospital but at CMH management was seeking to emulate the private sector. At Frere there seemed to be significant efforts to retain workers as in-house staff and build a public spirit and ethos. Only security services were outsourced and where staff were found to be poorly skilled, special efforts were made to train them (eg PSETA) All services namely medical and nursing service, catering, cleaning, laundry, facility management were provided in-house. Wagner pointed out that government. rarely follows through once a problem emerges in a given policy. It rather churns by dumping a policy and running after a new fashion.

An interesting finding was the zig-zag pattern in policy transfer and change (this was highlighted by Clarke and Newman 1997). "Complexing" was meant to ensure rationalisation of resources. The reversal of "complexing" (a form of centralisation) and the reversal of the appointment of non-medical hospital managers are key illustrations. In the public sector from 2000 onwards hospital managers with business backgrounds with no medical background were brought in to transfer their private sector skills. These reversals show how that NPM principles and ideas go through a zig-zag pattern and can be reversed in the face of evidence and resistance.

Policy transfers discussed in this thesis have been from the top down but managers can act in ways that reduces labour resistance. In general, I found that transfers and change

are heavily contested by organised labour in workplaces in both sectors. Shopstewards had a keen sense of and well formulated responses to organisational changes while managers tended to focus on technological change or in some cases were vague about organisational changes affecting labour. Labour organisations are central to the opposing or easing the path of transfer. Rapid policy change has brought unintended challenges especially in confronting organised labour. In some cases, policy change/innovation is motivated by the need to undercut labour itself. Worker leaders in both place saw change and policy transfer as a product of relentless search for profits and squeezing unions and job losses.

Another key finding is the "extensive array of actors" (Legrand 2012: 332) namely well-paid consultants that operate in the Eastern Cape and the long list of private entities are employed by the Department of health to facilitate policy change. The public sector could be seen as "hollow workplace" with more contingent workers and with consultants and accountants who manage outsourcing contracts. Networks, however, seemed to play a role in the transfer of new ideas. A number of networks or platforms exist for sharing changes and innovations. KHAEDU is a national program driven by the Department of Public Service and Administration where officials learn from each other on how to improve service, internal training sessions, conferences and quality improvement workshops. Evans and Davies (2009) have accented the role of policy networks and epistemic communities. Policy transfer literature placed limited emphasis on how "evidence is construed and constructed by policy officials looking elsewhere" (Legrand 2012:330).

Key changes and innovations in organisation models have happened across the public sector. An interesting innovation was offering private hospitals space to operate in public hospitals under the rubric of facilitating knowledge and skills transfers from the private sector.

At a public sector hospital, the rigidity and lack of innovativeness of government left

little space for innovation. I found that change agents in the public sector are politicians, senior administrative officials and consultants.

In the public sector healthcare facilities were reported to have ineffective business processes and these contribute to overcrowding and poor quality of service. Compounding congestions in public sector healthcare is the ineffectiveness of the primary healthcare system which leads people to go to hospital even for "minor ailments". Other factors leading to congestion are shortage of staff, shortage of medicine, absence of a pre-booking system as well as an un-enabling infrastructural designs of the facilities. It is evident that there is no screening of patients to determine whether their cases require hospitalisation. It also emerged that patients in public healthcare facilities can take up to six to eight hours to be attended, receive medication and be released. Frere Hospital however indicated that they have introduced an information desk to address the issue of screening and thus reduce queues and waiting times.

Cecilia Makiwane Hospital and Frere Hospital had a very cumbersome, long-winded and bureaucratic processes for recruitment. Respondents suggested that if these processes were decentralised the recruitment period could be much shorter, pointing to the short time taken by HR officials in the hospital to complete shortlisting, interviews and making recommendations to appoint. The negative effect of the absence of HR delegation was confirmed by the former of MEC for Health. The context of this is the issue of nepotism and budgetary constraints.

At Cecilia Makiwane Hospital respondents attributed the challenges of procurement to fraud, corruption and improper tendencies of supply chain management officials who would deliberately stall procurement process and manipulate procedures so that they benefit their own preferred service providers. The impact of cancelling tenders in the context of already long and tedious processes falls on service delivery and implies a lengthy re-advertisement process, project commencement and completion before citizens

can benefit from any improved service.

In the public sector procurement processes have to go through a series of bid committees who evaluate and adjudicate on compliance of the applications with related legislations. Some respondents felt that the procurement system is not necessarily bad but that officials manage these processes improperly to favour their associates.

Public hospitals experience a challenge with the implementation of PMDS, which can partly be attributed to their different understandings of the objectives and implementation procedures of the system. Some executive management members were of the view that the system is being opportunistically abused by the staff to get maximum financial benefits which some of the employees do not deserve and further, the system has been politicised. Also, job descriptions and the performance indicators are not quantified so that an objective assessment on performance cannot be done. PMDS was regarded as merely a compliance issue rather than a performance management and development tool. Labour representatives thought deployment is done arbitrarily and is not even informed by policy.

In the public sector IT has not been utilised optimally whereas in the private sector the IT systems were found to be used optimally to enhance service as well as for effective management of personnel. This sub-optimal utilisation of ICT has been confirmed by the Office of the Auditor-General (OAG) report which revealed that by 2011 only 21% of government departments had implemented sufficient but unsustainable governance controls.

Private hospitals

> At a private hospital management argued that policy transfer choices are made on the basis of the value and cost-effectiveness. Employees felt they are not consulted on the choices of change and managers will not compromise the profitability of the facility. At private hospitals, *all*

> services except nursing services were outsourced. Nehawu members "felt betrayed by the union" when it appeared the "relentless outsourcing" was adopted. Nehawu issued a statement against outsourcing in 2011 (Nehawu Press statement, 12 January 2011). At private hospitals, the union believes an electronic time management system, quality of service assessments and new information technology have been employed largely to discipline labour and increase rationalisation driven by a profit squeeze.

At both private hospitals, there was minimal space for policy learning and experimentation since only operational decisions were localised. A strategic idea had to be discussed at Management Board level for consideration. Here as well labour saw no space for involvement. It is evident from the findings that bureaucracy is not limited to public organisations but is found in the private sector as well. The fact that the respondents remarked the centralised and prescriptive nature of their respective environments indicates the pervasiveness of bureaucracy in both sectors. Also, it emerged that in the private sector innovative initiative is viewed with circumspection as if it would threaten the status quo which is maximisation of profit.

Networks however seem to play a role. A number of networks or platforms exist for sharing changes and innovations. Hospitals Associations of South Africa (HASA) organises conferences, seminars, quality assurance forums and sages or study groups, provincial management meetings, workshops, research seminars and conferences where staff go and present research papers as a way of sharing best practices. In most instances policy transfer is facilitated through several different kinds of networks and platforms. The interviewees' responses did to a considerable extent resonate with the theory on sharing of policy ideas and attendant transfer.

Respondents referred to "human attitudes", "institutional compatibility and readiness of the organisational environment and personnel", "availability of adequate human and financial resources", "resistance, confrontation and demotivation" in reaction to

uncritical and unreflective policy and organisational practices transfers on the recipient environment. These are political, cultural and sometimes "non-traditional" aspects of policy transfer that need to be recognised as central. In addition, publicness and public ethos are of critical value in health systems.

Business processes of private sector healthcare facilities seemed to be simple, quick and effective. The reason for this effectiveness includes the pre-booking system and probably the fact that they attend to smaller volumes of patients compared to the public sector healthcare facilities. Patients are also prioritised according to the severity of their cases.

In the private sector, Netcare Head Office was found to formulate a recruitment policy framework which is utilised by all associated hospitals. The facility recruits only nursing, administrative and auxiliary staff. Medical staff such as doctors are not employed by Netcare but they just have consulting rooms. Posts are advertised internally in the intranet for two weeks. It takes two months to fill a position but some posts take longer to be filled. Workers viewed recruitment processes as questionable and not in line with the facility's BBBEE Plan. Black/Africans do not stay long in the facility because they are denied upward mobility opportunities. Greenacres Netcare Private Hospital has its own training facility run by Netcare as well as having professional training programs.

Private hospitals procurement processes were reported to be relatively quick and simple compared to the public sector ones. Procurement is done online and on a needs basis deduced of course from the trends. There is also an electronic system of reconciling what has been ordered and utilised with what has not been utilised to ensure efficiency. Prices are also negotiated centrally by Netcare. Suppliers and service providers are drawn from the existing database. Procurement typically takes three days to seven days depending on the nature of the goods.

At Greenacres Netcare Private Hospital there is also a performance management system in place. It includes contracting between supervisor and supervisee and setting of

performance and service levels which are rated and monitored twice or four times in a year. Organised labour rejects performance management because it not developmental but serves to determine an "employee's worthiness to the company" and is a victimisation tool.

Information technology (IT) is used extensively in Greenacres Netcare Private Hospital. This system is managed by the Netcare Head Office but it is also regionalised.

In the private sector it has emerged that IT systems are used not only to enhance service and effectively manage labour but also to determine the value to the facility of the number of hours an employee spends doing his or her work and can link that to the investment made on the personnel and equipment. This is considered controversial by employees who seem to be rejecting the utilisation of this IT system on the basis that it is un-human and does not take into account other variables involved in the work environment and employee performance and all it is concerned with is cost minimisation and profit maximisation. The public sector views IT as a tool of enhancing service delivery and meeting developmental goals of the country whilst the private sector views IT utilisation as a control, cost minimisation and profit maximisation mechanism.

At private hospitals managers stressed stability in employee relations as a key consideration when bringing in new ideas. Transferred policies and practices have not been that difficult to implement but are not necessarily better where they cause instability and adversarial relations. Outsourcing is seen as useful in providing space for an organisation to concentrate on socalled "core" business but equally it can come at a considerable cost.

Common issues

Thus it was found that both public sector and private sector healthcare facilities have

PMDS with different understandings of its purpose, strategic objectives and underlying values and with different implementation procedures across the two sectors. In the public sector monitoring still done manually whereas in the private sector is done electronically and more scientifically. The private sector healthcare staff seem to be against this "non-human" form of determining the deployment of personnel as it does not consider important variables when determining the categories of patients who need comprehensive care and those that need less comprehensive care. It also disadvantages some staff by giving some fewer working hours while putting a strain on others. Another issue was that in the public sector facilities performance bonuses are awarded and in some instances even non-deserving personnel demand it whereas in the private sector there are no bonuses. Paradoxically it would seem, there are only non-monetary incentives for high performance in the private sector. In one facility a move towards performance related pay is under consideration. Labour is against this move.

There are many areas, opportunities and resources the public sector can take advantage of and leverage upon from the private sector to improve service. On the other hand private sector respondents mentioned that their sector can learn how to manage positive relations with organised labour, multi-skilling of nursing staff as happens in the public healthcare facility. In the private hospitals nurses are exposed only to the sections they have been employed at but in the public sector nurses are rotated which exposes them to different work environments including the psychiatric field.

The Hybrid hospital: Port Alfred

McQuaid (2010) argued that whilst PPPs are complex, demanding and time-consuming but under the right conditions and in the right sectors, they can offer significant benefits to government, the private sector and consumers. The key issue is to identify and choose an appropriate type focusing on the main dimensions of partnership which include understanding the nature of the project, purpose, key actors and the structure of their relationship in the partnership, the stage of development of partnership and changing

relationships and activities over time and how these activities are carried out. In individual situations, different types of PPPs need to be carefully selected to adapt to real situations (Tang, 2009).

Managers concurred that there are lessons that both sectors can learn from each other. The private sector respondents also saw opportunities wherein the private sector can share with and learn from the public sector in terms of prioritisation of development of its human resources, meaningful consultation and communication with labour organisations in decision making affecting the organisation. The private sector can learn service ethos and humaneness in the delivery of service rather than being profit driven only. The public sector can learn from the technological inventions of the private sector. The public healthcare sector has good equipment and has highly trained nursing staff and medical specialists that private sector can learn from. The private healthcare sector can learn and adopt inter-generational mix in the appointment of their executive management so as to groom young managers to take over when the current ones retire. The public sector can learn the adoption of non-monetary rewards to recognize, acknowledge and motivate staff, inculcation of professional ethics in its professional staff such as issues of punctuality and accountability for performance.

Therefore respondents from both sectors considered that a mix of elements from both sectors would be beneficial. Some within the public sector considered the private sector to be qualitatively better, advanced and useful and could assist in improving public sector services. This viewpoint noted opportunities for the public sector could take advantage from the private sector, ranging from the sharing of expertise, resources and IT through to business process re-engineering. That view could be combined with admissions of some advantages in the private sector health care discussed above, to agree with Tang's (2009) assertion that PPPs enable both public and private sector to bring their complimentary skills for the purposes of providing public services or a project. There has also been a dismissive view which indicated that there was nothing that the public sector can learn from the private and that the private sector is basically

parasitic upon the public sector resources, which services the needs of vast majority of the population.

Reflecting on the applicability of the notion of transferability, lessons, contradictions

This study explored forms, agents and elements of transfer. Dolowitz and Marsh (2000) mention policy goals, policy content, policy instruments, policy programs, institutions, ideas, ideologies, attitudes as some of the elements that can be transferred in the policy transfer process. Some of these elements resonate with the findings of this study. Policy goals, policy content, policy instruments as mentioned by Dolowitz and Marsh (2000) are embedded within policies, organisational practices and service delivery mechanisms that have emerged from the findings.

The transfers that have occurred have taken place through clearly defined agents some of whom resonate with the policy transfer theorists' transfer agents. Agents that have emerged from the findings include politicians, administrative officials, consultants and think tanks, conforming to Hudson and Lowe's (2004) classification of agents; Steinberg (2011) and Prince (2012) identification of officials and consultants as being in the forefront of policy thinking and promoting policy transfers often in inappropriate ways in South Africa.

Turning to impediments that have characterised transfers it was found that tansfers may involve incompatible values that elevate economic considerations above enhancement of quality of service delivery. The environment itself has various characteristics such as the culture of the organisation, the organisational structure which may or may not enable policy changes. In the nutshell an unreflective and uncritical embracing of transfers is one major impediment to successful transfer. Dolowitz and Marsh (1996:353) argued that "the transfer of policies cannot be regarded as a mere technical exercise as it also takes into account political values and ideologies'. Randma-Liiv (2008:3) argued against

"the uncritical transfer of a mixture of public administration tools from various countries, which different resources as well as institutional framework may easily lead to substantial problems". Rose (1993) also argued that the realisation of policy transfer is contingent on the substitutability of institutions and symmetry and equivalence of assets of the receiving country. Common (1996) argued that it needs to be considered that policy transfer is also dependent upon the political system possessing the political, bureaucratic and economic resources to implement it.

In terms of lessons learned, it is evident that despite the different philosophical underpinnings, values and operational environments in each sector's governance model, some lessons could be drawn by each sector from the other. Emerging lessons that the public sector could learn from the private sector include sharing of expertise, resources, information technology, business process re-engineering and redesign of infrastructure. The current infrastructural design was found to be one of the contributory factors to congestion and overcrowding. It was also noted that the public sector could begin to professionalize their cleaning services by developing a training program for this group of workers so that they can add more value to the facility and become skilled. This would also assist in quantifying and measuring the work of the cleaners for performance management purposes.

Government needs to encourage and invest more funding on training of staff. It also emerged that there needs to be a reorientation of the performance management and reward system to also include non-monetary rewards as these is would contribute towards staff motivation. This has been a most contentious issue in the public sector where employees have focused on its monetary rewards rather than its development element. The public sector healthcare can also learn to provide non-monetary performance awards such as "carer of the month" as one way of giving recognition for a job well done.

The public sector seems to have low levels of professionalism and work ethics and

therefore they can learn to be more professional in areas such as punctuality. In the private sector punctuality is a norm and is not negotiable.

The public sector needs to empower its employees with life skills such as budgeting and financial management to help them avoid sinking into debt and ending up having their work performance affected. There is also a need to introduce an Employee Assistance Program to assist the employees to cope with the stressful and strenuous conditions of the job as happens in the private sector. The public sector needs to optimize the utilisation of its IT systems to shorten its administrative, procurement and recruitment processes and so improve its service delivery and image. It should also optimize its IT systems to properly manage its employees, promote accountability, quantify the work that is remunerated and so ensure that public funds are spent effectively.

Lessons that the private sector can learn from the public sector

Areas where the private sector healthcare facilities can learn from the public sector include the management of labour relations, human resource development, employment equity and psychiatric nursing. It emerged that labour relations environment in the private sector healthcare facilities are characterised by adversarial relations between organised labour and the management. Therefore the hospital managements have felt a need to learn from the public sector how to engage with labour organisations to build a sound and harmonious labour relations environment. The private sector also thought they could also learn multi-skilling of the nursing staff through rotation of staff to other

entrepreneurs are unable to provide in most instances. Small entrepreneurs are unable to access this industry due to its specialised nature. There is a need for synergisation and alignment of all related policies and pieces of legislation. There is also a need for special regulatory regimes, flexibility and support in certain cases more especially with the development of small entrepreneurs who experience difficulty in benefiting from the health sector

The PMDS policy also has contradictions. Some key performance areas and outputs are unquantifiable against expected outputs and performance levels and yet employees' performance has to be measured. Also although the PMDS is intended as a performance management and development tool the employees view it as cash reward exercise and have a sense of entitlement towards it.

Some of these policies bring unintended consequences. For instance, with the introduction of free health services in public hospitals, though necessary, put pressure on workers as the hospitals were flooded with patients leading to overcrowding, shortage of staff and medicines, the overstretching of existing staff leading to demotivation and burn-outs by some staff; a rise in sick leave taken and absenteeism rates; exodus of health professional to private hospitals and a further decline in the quality of service.

Contradictions were noted between various policies and legislations across the sectors which defeated the very purposes they were intended for. There were also incompatibilities resulting from the unwelcoming dynamics of the recipient environment including organisational environment constraints such as inadequate human, financial resource capacity, organisational culture and attitudinal issues, which led to unintended consequences. This can also partly explain the continued substandard quality of some of the public sector healthcare facilities. Policy making has been muddled and incoherent and little about rational learning (a finding consistent with Hudson and Lowe, 2004).

Areas of further research

The findings from this study raise issues suggesting further areas for research. I focused on agents, networks and contestations in policy transfers. The thesis has however not dealt with the issues of policy outcomes although in the case of public hospitals little progress has been registered after the adoption of NPM style policy changes. Second, and related to the first could be an assessment of transfers in selected localities or sites. Thus Evans and Davies (2009) identified twelve stages in a typical policy transfer process. These processes include recognition of a problem by the politicians and bureaucrats; the need for and deliberate search for policy solution/s; interaction between transfer agents and knowledge elites who bring their cognitive into the transfer networks; the emergence of an information feeder network which is used to justify and induce the client to understand and accept the need and benefit of the transfer. Such an investigation will assist in understanding how transfers are initiated at intra-national and inter-sectoral level whether the transfer is "informed or uninformed"; and/or "incomplete; and/or inappropriate" so as to better understand what makes transfers succeed or fail in given contexts.

As this theses has argued, an appropriate policy transfer takes into consideration the "contextual factors" such as cultural, labour, political and value issues among others in the recipient environment which might be vastly different to those of the transferer/originating environment. It is only through studying the transfer pipeline from conception, initiation, conceptualisation and implementation that a better understanding of what makes a successful or failed transfer can emerge.

The study has argued that government rapidly introduces policies based on ideas drawn from consultants mimicking the private sector and when they see that these policies are not working they also rapidly abandon them. An example of this "policy churning" was the introduction of the "complexing policy" by the Eastern Cape Department of Health which involved the centralizing of certain functions and resources, rotation of clinical

staff bringing some transversal services together and sharing of services. The negative reaction that complexing received led to its replacement by "de-complexing." This raises a question of whether these policy or organisational practices were evidence-based or not or simply serving the vested interests of consultants in the policy industry for whom churning of policy becomes a necessary condition for increasing their own earnings.

The findings of this study about policy reversal and abandonment (churning) and the absence of thorough policy evaluation calls for a more incremental approach conducting due diligence or feasibility studies within the prospective recipient environments to determine the appropriateness of "best" practices in given contexts before a policy transfer is introduced. It also requires assessment of past policy implementation experiments, monitoring, evaluation compilation of policy implementation experiences inventory which can be used to enhance further policy implementation experiments or at least informed "abandoning". An assessment of the Eastern Cape Department of Health's complexing policy linked to EBPM could be one such area requiring further research.

This study has argued that PPPs are dependent on government resources. Evaluation of the PPP initiatives in specific localities and sites can be considered as an area of further research to determine the cost or benefit of these initiatives to government. It needs to be investigated whether the South African public servants have the capacity to understand and manage the complex contracting processes of PPPs. Therefore an investigation into the conceptualisation, implementation and performance evaluations of PPPs in their specific locales is necessary. The issue of the presence, role and influence of the labour movement in responding to, monitoring and mediating the effects of introducing private practices into the institutional environment requires further investigation.

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List of interviewees

	Interview with ...	Place	Date and Duration	Research technique
1.	Nursing Manager	Netcare Port Alfred Private Hospital Port Alfred	21/10/2013 9am- 12 noon; 1.15 pm - 4.30 pm	Personal interview cellphone recorder and notes
2.	CEO	Cecilia Makiwane Hospital (public) East London	15/11/2013 9.30 am – 13h15	Personal interview, cellphone recorder and notes
3.	Netcare PE		20/06/2014 10.00 am – 12.30pm 13/10/2014	Personal interview, cellphone recorder and notes

			3pm – 3.15pm	
4.	Professional Nurse	Cecilia Makiwane Hospital (public) East London	27/08/2014 6.30pm – 7.45pm	Personal interview and notes
5.		Cecilia Makiwane Public Hospital – East London		Telephonic interview and notes
6.	General Manager	Netcare Greenacres Hospital Port Elizabeth	20/11/2014 10.00pm – 12.30pm	Personal interview, notes, cellphone recorder
7.	CEO – interview	Frere Hospital (public) East London	27/11/2014 1.00pm – 3.00pm	Second personal interview, cellphone recorder and notes
8.	Nursing Manager	Netcare Port Alfred Private Hospital – Port Alfred	09/12/2014 1.00pm – 1.20pm	Telephonic interview and notes

9.	Shopsteward (FH)	Frere Hospital (public)	22/05/2015 10.30pm – 1.15pm	Personal interview with detailed notes
10	Professional Nurse	Cecilia Makiwane Hospital (public) East London	26/05/2015 6.00pm – 7.30pm	Personal interview with detailed notes
11.	Shopsteward (CMH)	Cecilia Makiwane Hospital (public) East London	27/05/2015 10.00pm – 12.30pm	Personal interview, notes and cellphone tape recorder
12.	CEO -	Frere Hospital (public)	29/05/2015 2.00pm – 3.30pm	Personal interview and notes
13.	Shopsteward (PA)	Port Alfred Private Hospital	12/06/2015 3.00pm – 3.45pm	Personal interview and notes
14.	Shopsteward (GA)	Netcare Greenacres Private Hospital Port	20/06/2015 12.40pm – 2.45pm	Telephonic interview and notes

		Elizabeth		