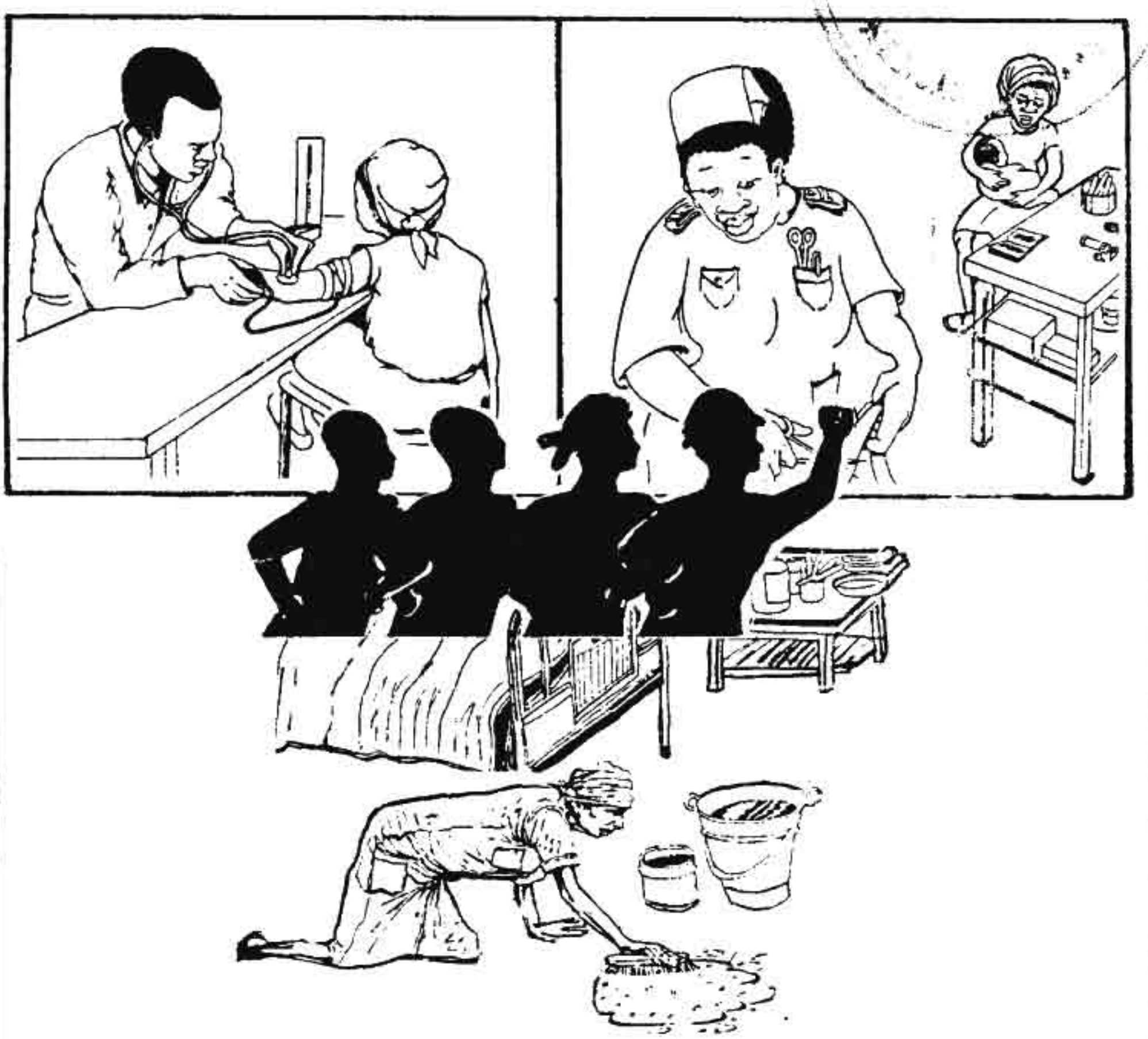
CRITICAL HEALTH

number 15 may 1986



health worker organisation

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EDITORIAL

Generally speaking, health workers in South Africa are extremely divided and exploited. Nevertheless, in some hospitals, they are working against all odds to fight for unity, better wages and working conditions and trade union rights. This struggle, and the harsh reaction from the health authorities, was brought to the public eye through the Baragwanath hospital workers' strike in November 1985. This strike follows closely on the Durban hospital workers' strike in February 1985. In both cases, the workers demanded mainly better wages and working conditions. In both cases, workers were re-instated and some of their demands were met to a very small extent. But the end of the strikes did not mean the end of worker action. Ever since the strikes, union organisation of health workers has become stronger. The strikes have also encouraged workers at other hospitals to voice their grievances and strengthen their organisations.

At this stage, however, independent trade unions organising health workers are generally not recognised by employers. This is what makes their task of representing workers a very difficult one, as the interview with GAWU in this issue shows. Another major difficulty in organising health workers is the fact that they are divided. These divisions between various categories of health workers are enforced by differential positions, working conditions, wages, staff associations, and benefits. This is highlighted by the articles on health worker organisation and workers in the state sector. The latter article argues that only a nationally organised health workers' union can strengthen the bargaining power of health workers. This is, in fact, what COSATU plans to do. A national union of health workers is envisaged for the near future.

The divisions in the health services do not only apply to workers, but, in a different way, also to patients. The directive recently issued to Transvaal Provincial Administration hospitals allocates certain hospitals to certain areas. It stipulates that patients must be treated at their 'regional' hospitals. What this means, in effect, is that health services are to be more strictly racially divided. Coronation Hospital staff and the communities affected by this ruling resist the directive. They believe that a policy of regionalisation should be carried out on a non-racial basis, and should make health care more accessible to all.

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BARAGWANATH HOSPITAL STRIKE 1985

Divided interests and joint action

The deep divisions between health workers in general are also to be found amongst people working at Baragwanath Hospital. Nevertheless, the strike did bring about some joint action and can be seen as one step forward in uniting workers.

The nurses' part in the hospital strike was well monitored and received much attention. They could consult among each other easily, as they were all staying in the residence. Many of them kept diaries of the events. The workers, in contrast, were dispersed; many of them have not learnt how to read or write; and the union had difficulty in co-ordinating their strike.

At the beginning of the strike, the nurses' and the workers' issues were quite unrelated. Some of the grievances of the nurses were directed at the privileges that higher categories of hospital staff were getting. Nurses were demanding, among other things, to be able to use hospital transport for purposes not directly related to their work; recognition of their SRC; better quality food for nurses and an equalisation of salaries among nurses. So initially, the nurses' grievances did not match up with the workers' grievances. It was only once the workers took action, that the nurses included some of the demands of the workers into their own demands, for instance the poor pay of workers, the demand to re-instate the dismissed workers, and the demand not to be forced to act as scabs in the place of the striking workers.

Secondly, there were clashes between nurses and security staff. But even within the security staff itself, there are different categories. Members of the security staff were offered higher wages if they volunteered to undergo

special security drills or paramilitary training. Those who underwent this training now make up the hospital's special security force. In this position, they are divided from the rest of the security staff and from the other hospital staff. It was these security men who beat up the nurses - an incident in which six nurses were injured. When the nurses, for fear of intimidation, refused to send a delegation to the superintendent, some nurses were harassed by security guards. A TPA vehicle with Bara special security men carrying batons was parked outside the nurses' home.

Officials of the General and Allied Workers' Union (GAWU) and of the Health Workers' Association (HWA) decided to address workers and nurses separately, according to COSATU's policy of organising workers along industrial lines; for different categories of workers would use different organisational strategies.

But in all the meetings, report-backs were given on what had happened to other categories of hospital employees. In order to make joint demands and exert joint pressure on the hospital authorities, both nurses and workers were represented by one and the same legal team. Along with an interdict to prevent the nurses from being evicted, the lawyers applied for the re-instatement of workers. For both workers and nurses, this legal action was successful. All striking nurses and workers except one were re-instated.

Events leading up to the nurses' action

The nurses at Baragwanath Hospital had repeatedly voiced their grievances to the matrons - and repeatedly the matrons refused to address those grievances. The first response from the Chief Matron came on the third day of the crisis: She read out a letter from the Deputy threatening to dismiss the nurses.

Intimidation and harassment

That same day, a group of nurses met with the Superintendent. The meeting was to be continued the next day.

The nurses felt intimidated by the police who, by that time, had made their presence felt. They therefore asked the Superintendent to come to the nurses' residence to continue the negotiations there. But he refused to come. Instead, he demanded that the nurses should send a delegation; the rest of the nurses were to go back to work or otherwise hand in their uniforms and collect their pay-cheques. The nurses did not send a delegation, as some of them had been harassed by security. They locked themselves in the residence for fear of more harassment. Subsequently, the Superintendent arrived with five policemen and cameras. The nurses were told to go to work within 30 minutes, or face dismissal. Security guards tried to arrest some of the nurses, but were not successful. At that stage, negotiations broke down.

No 'strike' of nurses

The nurses' action cannot, in the strict sense, be called a 'strike'. They attended all meetings in full uniform. In that way, they showed that they were prepared to go to work. In fact, the night nurses did go on duty. It was only on Saturday, four days after the outbreak of the crisis, that nurses stopped working - after they were told by the Superintendent that they should not work in the wards because they would not be legally covered. Two days later, the Superintendent announced that all nurses were dismissed and had 24 hours to vacate the residence.

A subsequent court interdict ruled that the nurses (except one, whose court decision is still pending) were to be re-instated and not to be evicted from the nurses' residence.

Aftermath

After the re-instatement of the nurses, most of their short-term demands were met. Among other things, they are now allowed to attend HWA meetings without fear of victimisation. But some long-term grievances still remain.

DEMANDS OF THE BARA NURSES DURING THE STRIKE

Short term demands

- Extension of closure time of the access gate to the nurses' home from 8.00pm to midnight
- Lifting of restriction from visiting radiographer and doctors' quarters and Glyn Thomas House
- An end to harassment and intimidation by hospital security
- Availability of transport for special purposes
- Recognition of SRC
- Improvement of food and service at the dining hall
- An end to victimisation of students
- An end to discriminatory criteria for admission to midwifery

Long term demands

- Clarification on contribution to recreation club
- Recognition of other organisations, e.g. HWA
- Equalisation of salaries for black nurses
- Address the grievances of the non-classified workers.

Events leading up to the workers' action

The non-classified workers at Baragwanath Hospital had long-standing grievances which had not been addressed by the authorities for a period of almost two years.

In March 1984, the non-classified staff did not get wage increases along with other hospital employees. By March 1985, they still had not received an increase. In September/October 1985, finally, they were told by the authorities that there was no money, but that the final decision on wages was to be announced by the end of October. But the end of October came, and the workers still had not seen any increase. At a meeting with the authorities, they voiced their anger. The authorities replied by announcing another meeting for 13 November. At that meeting, workers were again told that there was no money, and that they would be considered for an increase in March 1986. After another meeting on the following day had brought no satisfactory solution to the workers, they decided to go on strike. The police was called in and the workers were arrested, and later forced at gunpoint to collect their pay-cheques.

Subsequent events

What followed was a series of meetings convened by HWA and GAWU, and banning orders on some of those meetings, and further police intimidation and harassment.

GAWU's written applications to the various health authorities did not get any reply.

During the course of the strike, a smear pamphlet discrediting GAWU was distributed at Baragwanath, Hillbrow, and Natalspruit hospitals, issued in the name of BHAWUSA (the Black Health and Allied Workers' Union of South Africa). BHAWUSA dissociated itself from this pamphlet, which was presumably issued by the security police.

Bara workers discuss the strike

Baragwanath Workers' Resolution

passed 16 November 1985 at a meeting convened by GAWU

WE THE WORKERS OF BARAGWANATH, AS REPRESENTED BY GAWU, NOTING:

1. That the task of health workers is important, and vital to community service
2. That no wage increment has been given since 1983, and that this wage increase has only been suggested for 1986
3. That management has constantly refused to negotiate with workers or their representatives with regard to their grievances
4. That white employers have assaulted our fellow colleagues
5. That management has chosen to make use of military and police personnel to intervene in this dispute
6. That health workers work under general poor conditions and unfair labour practices
7. That the present condition of hospital patients is rapidly deteriorating as a result of the action of the management!

THEREFORE RESOLVE:

1. That the blame for this crisis must be placed squarely at the door of the management and not the workers
2. That management begins immediate negotiations with workers and their representatives over wage and working conditions
3. That police and military personnel are withdrawn immediately
4. That assaults on our colleagues are stopped
5. That our fellow comrades are unconditionally released from the prisons of apartheid
6. That we call upon the assistance and solidarity of all progressive organisations here or abroad, be they political, cultural, women, workers' or civic organisations.

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OTHER STRIKES AT OTHER HOSPITALS

Hillbrow Hospital strike, November 1982

Hillbrow Hospital workers went on strike in November 1982. They were promised immediate wage increases. But later, these promises were taken back, and the workers did not get their wage increases.

Strikes at Durban hospitals, February 1985

On 4 February 1985, over 1000 workers at Durban's major hospitals, King Edward VIII, Wentworth, and R.H. Khan went on strike. The strike lasted for seven days. During the strike, it became clear that hospital workers were struggling not only for higher wages, but also for trade union rights.

The most burning issue for the Durban hospital workers was the low wage rate. The average wage for a hospital worker was below R200 per month. Furthermore, hospital workers did not have adequate pension provisions. Many of them who had to work night duty did not get any allowances. Workers further complained about abusive matrons and supervisors, harsh and arbitrary discipline, tiring and monotonous work, and the high injury rate.

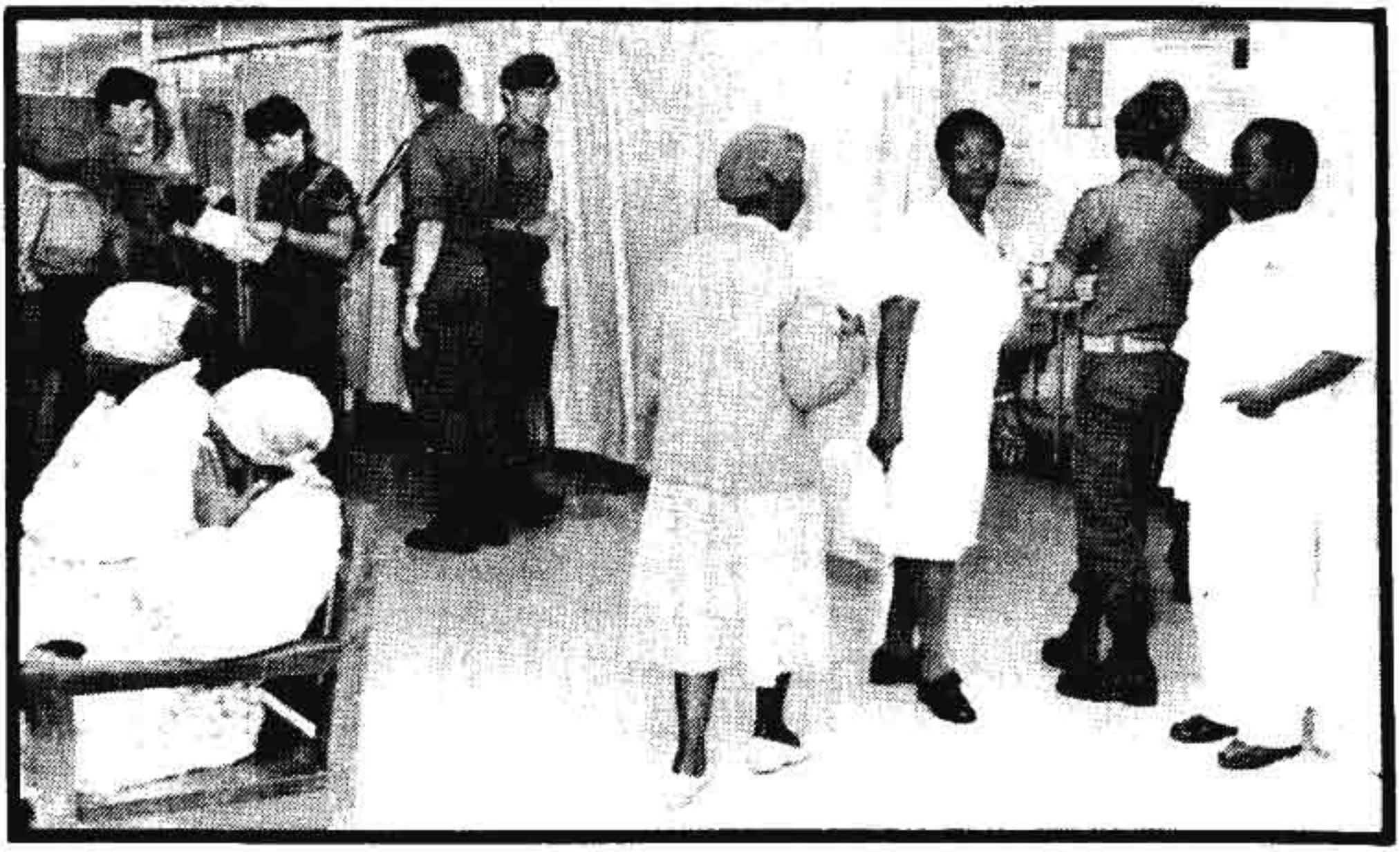
So far, the conditions of Durban hospital workers look very similar to those of Baragwanath Hospital workers: low wages, temporary positions, no allowances for long working hours. The strike at Baragwanath Hospital involved a similar number of workers (if we exclude the nurses), and lasted a similar period of time.

There are, however, important differences.

Representatives of Durban hospital workers had made clear wage demands even before the strike. They initially demanded R700 per month, and later modified this demand for an increase of R100 across the board for all

non-classified staff. They decided to go on strike if there was no wage increase.

As in the case of Bara, Durban hospitals were in chaos when the workers went on strike. But the Bara staff as a whole showed greater unity than the staff of Durban hospitals. In Durban hospitals, nursing staff and maintenance staff took over doing the jobs of the striking workers. This was not the case at Bara. Nurses at Bara refused to be used as scabs. As a result, the SADF was brought in at Bara.



The SADF at Casualty in Bara during the strike

On the other hand, workers at Durban hospitals were more united in the sense that the strike spread over several hospitals. This was probably because the strike was

more organised and planned beforehand, and worker representatives from several hospitals had joint meetings. Workers from King Edward VIII, Wentworth and R.H. Khan Hospitals met beforehand and decided on a joint work stoppage. They all went on strike together on February 4, and all presented the same demands (even though the strike lasted longest at King Edward VIII).

Durban hopital workers were further supported, as Bara workers were, by sympathetic doctors, medical students, and patients.

Like workers and nurses at Bara, Durban hospital workers experienced that talks with the hospital authorities brought little, if any improvement. In the case of both Bara and Durban hospitals, representatives of health authorities arrived on the scene, but they did not address themselves to the grievances of the workers. Nevertheless, a workers' committee of Durban hospital workers in the end managed to negotiate a settlement with the Provincial Administration. The settlement included:

- a 20% wage increase
- unconditional re-instatement of all workers
- withdrawal of all charges against workers
- agreement that all workers report for work again.

The majority of workers accepted the wage compromise, on condition that the workers' committee continued to negotiate with the Provincial Administration.

In a similar way, nurses and workers at Bara hope to negotiate a better deal. But their chances of achieving that are, at the moment, much more slim because the authorities still refuse to negotiate with worker representatives.

THE AUTHORITIES' ATTITUDE TOWARDS THE UNIONISATION OF HEALTH WORKERS

At Baragwanath Hospital, neither GAWU nor HWA is recognised as negotiating partners by the hospital authorities.

Interviewed by the Star, Daan Kirstein, MEC in charge of Transvaal hospital services, said that the authorities will only talk to representatives whom they consider "genuine".

Asked whether hospital authorities would meet and accept workers' committees which GAWU and other unions are forming, Mr Kirstein was cagey. "It depends where the committee comes from. Every genuine committee of people in the hospital's employ is more than welcome to come and discuss their situation. The superintendents would not be prepared to meet people from outside who instigate problems... We would not be prepared to meet unions from outside. In the government service no unions are recognised. We are not in a position to recognise them."

A BRIEF HISTORY OF HEALTH WORKER STRUGGLES IN SOUTH AFRICA

The first available historical record of involvement of blacks in nursing dates back to the time period 1685-1825. In the 18th century, nursing involved private work without the strict regimentation, rigid supervision of labour and intense supervision as we have it today in modern hospitals. Colonial settlers in the Cape used male slaves for nursing duties.

The development of capitalism made for far-reaching changes in the health sector. It affected the distribution of health services, the position of health workers, the division of labour in the health service. Health services, as far as the labour process was concerned, became organised along the lines of a factory. In addition, technological development changed the position and the skill requirements of health workers. The need arose for a trained, skilled and stable labour force of nurses.

1891	South African nurses were able to achieve professional status in the Cape Province.
1913	South African Trained Nurses' Association (SATNA) was formed. The original aims were to promote the professional interests of nurses and to suppress the practice of nursing by unqualified persons.
1925	South Africa's first medical council was formed and nurses were represented by two delegates.
1940's	Only few black nurses were trained. The reasons were poor schooling and widespread discrimination against black nurses enroling for nursing courses.
1942	The General Workers' Union held a series of meetings in Johannesburg hospital to discuss organising nurses into a trade union. The South African Trained Nurses' Association

opposed unionisation. When the union was about to be formed and the launch was planned, SATNA began a nationwide membership drive and campaign to enlist the support of parliamentarians and other influential people for a Nursing Act that would make unionisation of nurses impossible. A draft Bill was made for a nurses' association with compulsory membership, denying nurses the freedom of associa=

1944 tion. This Bill passed as Act 45 of 1944.

1949 Student nurses at Victoria Hospital in Lovedale went on strike in support of a colleague who was unfairly suspended, apparently because she had taken part in a petition complaining about aspects of the hospital. After the parents intervened and made representation on behalf of the nurses to the Hospital Board, the nurses went back to work. Later that year, another crisis occurred at the hospital when nurses refused to attend certain religious meetings. Eventually the Superintendent had the hospital closed as a training hospital for nurses.

1958 The government ordered that all nurses required pass-book numbers in order to register for nursing or to do further courses in their training. The Federation of South African Women and the ANC's Women's League opposed pass-books for women, and organised a public protest campaign. Over 200 women attended a protest meeting inside Baragwanath Hospital.

1959 The South African Congress of Trade Unions (SACTU) started a Hospital Worker's Union and began organising in Durban and Cape Town.

1960 Health workers at Karl Brenner Hospital in Stellenbosch went on strike for better wages and working conditions. White nurses supported the black unskilled hopital workers who were striking.

1961 A strike was organised by the Hospital Workkers' Union at King George TB Hospital in Durban in protest against an incidence of corpor-

al punishment of nurses by a matron. Skilled and unskilled workers supported the demands that the matron be fired. They furthermore demanded equal eating facilities, proper food, the establishment of an employment insurance fund and an end to racial discrimination in the hospital service. Over 300 hospital workers participated in the two week strike. As the police cordoned off the hospital, the strikers were supported with food from the local community. The strike also received international support. Some of the demands of the workers were met, others ignored. 21 workers were fired.

1961 A hospital superintendent was fired after releasing details of the number of deaths and casualties in the Sharpeville massacre. Community health workers in the area supported the superintendent.

1973 Student midwives at Zulu McCord's Hospital went on strike for higher salaries. They were earning less than R40 per month at the time.

1980 Hospital worker's organisations were formed in Natal, the Transvaal, and the Cape. They aim to break down barriers between health workers by bringing them together in one organisation. These organisations accept all hospital workers as members, regardless of their skills and level of training.

1980 Hospital workers in Cape Town asked the General Workers' Union to assist them in organising themselves so that they can raise problems and grievances with the authorities. The Union soon achieved majority membership in many hospitals and representative workers' committees were established in these hospitals.

1981 37 radiographers left Baragwanath Hospital in protest against unequal and poor training and salaries. Community members and trade unions pledged their support.

1982 Nurses opposed forced segregation into separate homeland nursing associations, and white nurses' domination of the organisation.

1982	400 workers at Hillbrow Hospital went on strike for better pay and working conditions. Striking workers included cooks, cleaners, clerks, and typists. An elected committee met with hospital authorities and presented the demands of the workers to the Superintendent. The workers' demands were not met.
1984	800 Groote Schuur Hospital workers in Cape Town went on strike.
1985	Over 1000 workers at Durban's major hospitals went on strike for 7 days, mainly for higher wages. A workers' committee negotiated a settlement with the Provincial Administration in which a 20% wage increase was laid down.
1985	Baragwanath Hospital crisis: Student nurses' negotiations with authorities on grievances broke down after intimidation of nurses by security guards and police. Nurses dismissed, then (all except one) re-instated after successful court interdict. At the same time, 718 non-classified workers went on strike, mainly for higher wages. All arrested, then released, dismissed, re-instated after succ= essful court order. Nurses' grievances are in the process of being met; non-classified workers received small increments.

THE GENERAL AND ALLIED WORKERS UNION (GAWU): ORGANISING HOSPITAL WORKERS IN THE TRANSVAAL

Health workers' unions in South Africa are still relatively young, and as yet there is no overall national structure to unite all unionised health workers. In the Transvaal, it is mainly the General and Allied Workers' Union who, together with the Health Workers' Association (HWA) organise health workers - that is, nurses and non-classified hospital staff. In Natal, this work is done by the Health and Allied Workers' Union (HAWU), an affiliate of the National Federation of Workers (NFW). Hospital workers in Western Cape hospitals are organised by the Cape Town-based Health Workers' Society and the General Workers' Union.

Critical Health spoke to Samson Ndou, president of GAWU, about the work the union is doing in the field of health worker organisation. He gave the following description of the history, the membership, the organisational structures, the difficulties and the future plans of the union.

History of the union

(GAWU) was formed in May 1980. As a general union, GAWU's aim was to organise all workers who had not been organised at that time. The union suffered a set-back when, at the end of 1981, the government clamped down on it. Several of GAWU's organisers and spokespersons werde arrested. It was only in May 1982 that they were released.

Organising health workers

Membership

In 1983, GAWU organisers started unionising health workers hospitals and clinics, mainly around Johannesburg/Soweto, and on the East and West Rand. At present, GAWU has members in the following hospitals:

- Sanatorium Hospital (West Rand)
- Millsite Hospital (West Rand)
- Leratong Hospital(West Rand)
- Rietfontein Hospital
- Baragwanath Hospital (Soweto)
- J.G. Strydom Hospital (Johannesburg)
- Hillbrow Hospital (Johannesburg)
- Other private hospitals and clinics

When GAWU officials talk about health workers in their union, they mean non-classified hospital staff and nurses. Most of the health worker members of GAWU are women; and most of these are non-classified hospital employees, mainly cleaners.

In Baragwanath Hospital, GAWU has over 800 members. Almost all the non-classified workers at Rietfontein Hospital are members of GAWU. And at Sanatorium Hospital, GAWU claims majority membership.

Union Structures

GAWU's organiser for the health sector is Boy Nethavhani. Once workers' committees have been formed, one shop steward is elected from each hospital. At Baragwanath Hospital, this was changed recently. Now GAWU members working at Baragwanath elect a representative from each department (e.g. the cleaning, kitchen, and laundry departments). The number of representatives from any one department depends on how large the membership is in that department. The representatives from each department then have joint meetings.

For their Baragwanath branch, GAWU holds a weekly meeting, to which all workers are invited. This, however, does not as yet happen at any of the other hospitals. Also, there are no regular joint meetings of workers from all the hospitals where GAWU has organised. Such meetings would be very important if there is to be unity amongst health workers; for GAWU's president, Mr Samson Ndou, believes that the differences between workers of the various departments will be bridged once they are unionised.

Uniting health workers: Plans for a national union

GAWU has taken part in the move to unite unions under the new union federation (COSATU). In order to find better ways of working together and to cut out any competition, COSATU has started a policy of organising one union in each industry. Many unions organising within one and the same industry will join to form one union under this policy. And the general unions (of which GAWU is one) will make its members in the various industries join the relevant COSATU union which has been appointed for that industry. There are similar plans for the health workers' unions around the country. Health workers' unions are preparing to form a national union of health workers by the end of this year.

Difficulties in organising health workers

Samson Ndou talks about the difficulties of organising and representing health workers. He gives the following reasons for this problem:

"Unlike other workers, hospital workers cannot go on strike, and do not have access to industrial courts as is the case with other workers. The reason for this is that these workers are said to be working within the so-called 'essential services', and therefore it is considered a crime for workers to take part in any labour action such as strikes etc. for whatever reason.

"As a result of this, hospital workers have been faced with terrible conditions which they have been unable to do anything about. To give you an example of what happens, I only have to mention things such as poor salaries, no grievance procedures, bad working conditions, irregular increments etc."

GAWU and the health authorities

These problems show that the union has to take on a very hard-handed employer. Until now, the union has only managed to represent workers on an individual basis. Sanatorium Hospital is the only hospital where GAWU has come to an informal agreement with management. GAWU has asked for a recognition agreement with management at Rietfontein Hospital. The matter was referred to the Department of Health; and the official response was that workers were not allowed to join a union. At the moment, this question is being investigated by GAWU's lawyers.

Problems of representing workers

But even to represent workers on an individual basis causes problems. With any grievance, the union has to write to the superintendent, who then refers the matter to the health authorities.

The health authorities, in turn, are not known for taking speedy and appropriate action. During the Baragwanth Hospital crisis, for example, GAWU requested a meeting with the superintendent, but never got a reply. The union then approached the Director of Health Services of the Transvaal - again no reply. Union officials then sent a telex to the Minister of Health, and again to the Director of Health Services. From the Director, there was no reply. The Minister of Health replied by referring the union to the Medical Executive Council (MEC). The union took the advice and approached the MEC - but again without getting any reply.

Bara Workers discuss the strike

Baragwanath: "Back to square one"

Samson Ndou describes the situation of Baragwanath Hospital workers after the strike as "back to square one". Some time after the strike, workers did get small wage increments which were backdated to 1 November. However, their wages, working conditions, employment conditions, and pensions remain poor. Also, the discriminatory and divisive pay categories, employment conditions and differential benefits have not changed to bring about more equality for the workers.

CORONATION WORKERS GET ORGANISED

The Coronation Hospital Workers Committee (CHWC) was formed partly in response to the strike by Baragwanath Hospital workers in November 1985; but establishing this Committee also meant that Coronation Hospital workers could voice their own long-standing grievances which relate mainly to poor wages and working conditions.

The Coronation Hospital Workers' Committee was formed at a meeting of hospital workers on 20 November 1985. The meeting was called by concerned individuals at Coro. Representatives from most groups of workers (domestics, porters) were elected onto the Committee. The Committee further includes representatives from other hospital staff (clerks, nurses, and doctors).

At the initial meeting, the workers present decided that the first task of the Committee should be to concern itself with the appalling working conditions of the non-classified workers at Coronation Hospital. Representatives from the non-classified workers asked their fellow workers about their grievances. They drew up a list of grievances from each category of non-classified workers. From these lists, a document was drawn up, entitled "Working Conditions of Local- Rate-of-Pay Workers at Coronation Hospital". This document was handed to the Superintendent. The Superintendent was asked to attend a meeting with the Comittee in December 1985.

At this stage, the hospital authorities started reacting to the Committee in a hostile way by attempting to divide the workers. The authorities called one meeting with the non-classified workers and a separate meeting with the sisters. At these meetings, separate committees were formed which were partly elected and partly appointed by the authorities.

On 5 December 1985, the CHWC met with the hospital au-

thorities. Each point on the lists of grievances was discussed. The authorites promised to look into the problems, both locally and, if necessary, through the central authority. The Superintendent also announced a pay rise for the non-classified hospital workers.

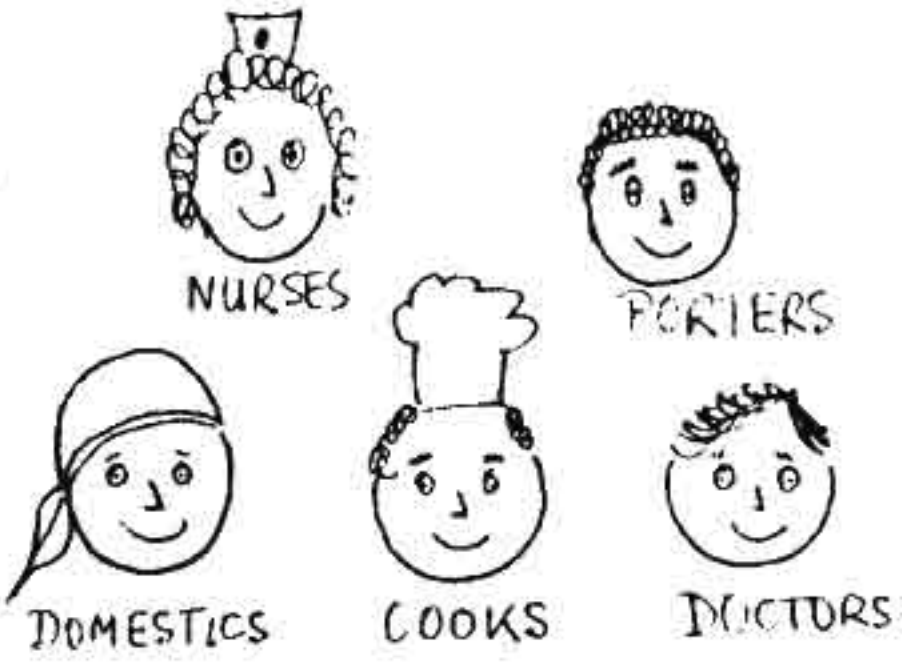
The CHWC then invited all hospital workers to a report-back meeting. Workers present at the meeting voted unanimously in favour of a central committee which would have monthly meetings with the Superintendent and which would represent the workers in negotiations with the central authority. This Central committee was to have various subcommittees for the different groups of workers at the hospital.

Since that time, the Superintendent has refused to meet the Central Committee, maintaining that the workers prefer to have separate committees.

CORONATION HOSPITAL WORKERS COMMITTEE

WHO IS THE COMMITTEE ?

- It is a group of representatives of hospital workers, concerned with the welfare of patients and hospital employees.
- It includes members from all categories of workers: domestics, porters, clerks, nurses, doctors.
- It was elected at a meeting of hospital workers.
- Its most immediate concern is the unacceptable work situation of the local-rate-of-pay workers.



ORGANISING HEALTH WORKERS:

OVERCOMING DIVISION AND CONFLICT

The following article deals, in very general terms, with the experience of hospital workers and their unions in Canada, the United States, and Britain. The thread that runs through all their experiences is the theme of division - division between different categories of workers, between workers' importance in providing patient care and their very low status in the health hierarchy, between health 'professionals' and health workers, between men and women, and between health workers of different ethnic backgrounds. These divisions do not come about because workers are 'naturally' divided; rather, they arise out of the work process itself. This is what makes the task of health worker unions very difficult. Along with poor wages and working conditions, they have to tackle the whole issue of division of labour in the hospitals.

Health workers in South Africa are only beginning to become unionised, and their unions are facing many difficulties in representing their members in the face of employers who deny them the right to union organisation and labour action.

This article highlights some of the problems of the organisation of health workers and points to some long-term goals which progressive health worker unions in other countries are working towards.

The hospital as a workplace

Hospitals do not, like other industries, produce goods, but they provide a service. The hospital work force is in some ways similar to, but in other ways quite different from,the industrial work force.

The hospital service has almost become an industry in itself. Semi-skilled and unskilled hospital workers are no longer casual labourers, even though that might be the status that management gives them. On the contrary, many hospital workers have become long-term employees who expect a day's wage for a day's work. They face working conditions which have become more and more like those in a factory.

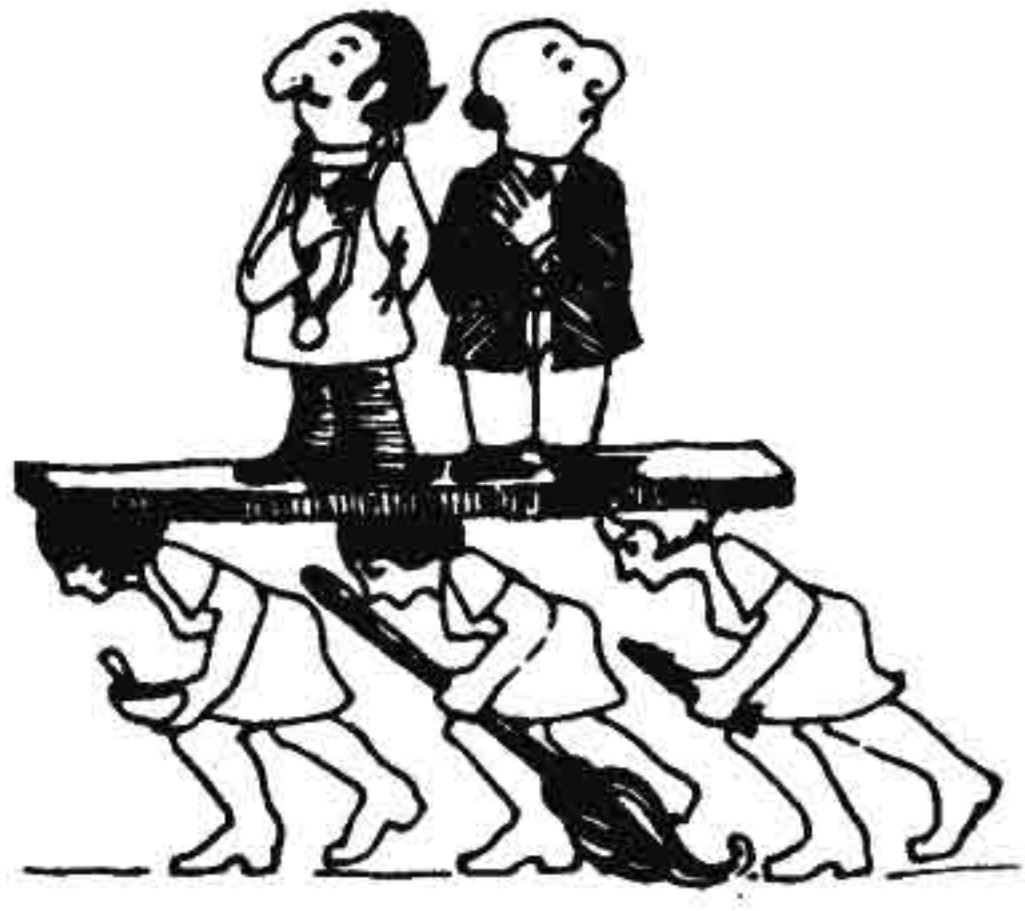
There are a great number of different job categories - there are many different pay categories even within the broad divisions of clerks, nurses' aides, porters, kitchen workers, registered nurses, laboratory technicians, x-ray technicians, etc. Being divided into so many categories, workers lose an overview of what makes up the hospital service as a whole.

In other ways, hospital work is quite different from work in a factory. No matter how menial their jobs and how bad their working conditions are, most hospital workers have some commitment to their work, because their work is a service to people. This commitment of workers is what management often uses against them, so as to keep workers from joining unions and going on strike.

Secondly, hospital workers have to work in teams on many occasions. No matter whether professional, skilled, or unskilled, they all take part in providing patient care. But this is where the worker faces a contradiction. He or she has an important part in the service, but does not have the status that would go along with important work.

Division and conflict within the health sector

Under bad working conditions, many unskilled hospital workers come to see their job like any other job where they have no say and no rights. When such workers get involved in labour action, it is to change the conditions under which they have to work.



For 'professionals' and skilled workers, on the other hand, the story is quite different. 'Professionals' are trained in some very specialised skills, and, as a result, they develop the idea that they, more than anyone else working in the health field, should have the power and the right to make the most important decisions. They are careful to keep this power and status. So when 'professionals' voice their dissatisfaction, it is not usually to change working conditions on a broad level, but to keep up their status as 'professionals'.

When people talk about 'professionals' in the health field, they usually mean doctors, sisters, and nurses. Nurses are often placed a class above hospital workers. To make nurses get a sense of 'class', nurses are trained to be 'ladies'. They learn to imitate the manners of upper-class women. They are told that, as nurses, they will become 'professionals'. They learn to identify only with members of their 'profession' and to look to a professional association (in South Africa this would be the South African Nursing Association) for their career ambitions. In this way, nurses will not become a threat to the 'super-professionals' - the doctors. And, at the same time, they will not identify with the workers, whom they learn to see as a class below themselves.

Apart form workers and 'professionals', there is a great number of skilled workers employed in the hospital ser-

vices. They, too, come to think of themselves as 'professionals'. Because of their 'professional' status, they identify with doctors and nurses rather than with the workers.

The health service is run by a minority of doctors, hospital administrators, insurance company directors, government officials, medical school educators, and corporation managers - most of whom are men.

The majority of hospital workers, in contrast, are poorly paid women who have no control over their workplace.

Ethical Issues

Many hospital workers spend as much or more time with patients than doctors or nurses. Their contact with patients forms an important part of patient care. Nevertheless, they are not paid for that, and they are pushed to the bottom of the health hierarchy.

Management, on the other hand, often plays on workers' concerns with patient care. Health care is often seen to be a religious and moral duty. Health workers are expected to hold the same ethical values as doctors and nurses, without getting any acknowledgement in the form of income and benefits.

The argument that health workers' strikes are illegal and unethical often comes from people who are not so much concerned with patient care as with keeping things the way they are. One could turn their argument around: strikes can be one step in changing the conservative health system into a more democratic organisation for all its workers - which, in the end, would improve patient care.

Management strategies against unions

Health workers' unions often have to deal with a par-

ticularly hard-handed employer. In many cases, labour action in the health sectors backlashed. The most common tactic that management used following unionisation and strike action was to redefine and reclassify workers' jobs on the basis of cost- efficiency.

Unions' Demands

Progressive unions in Britain, Canada and the United States have shown that if they fight for better wages only, they will not be able to overcome the divisions and hierarchies in the health sector. In that case, non-classified workers hospital staff will be no better off than they are now, in terms of their income and their position in the health hierarchy.

Some progressive unions have taken account of this and have included the following demands in their struggle for an alternative health system:

- An equal and standard measure for paying all workers according to their experience and training
- Workers' rights to collective bargaining
- Each job category being represented (the number of representatives depending on the size of each department) in health councils from hospitals to government boards
- The possibility for workers to move between health jobs
- Legalising strikes by health workers along certain laid-down procedures.

This article was drawn from papers in Organization of Health Workers and Labor Conflict, edited by Samuel Wolfe

JOB EVALUATION: THE PATERSON SYSTEM

The strike of Baragwanath Hospital workers in November 1985 highlighted not only the poor wages of hospital workers, but also the rigid pay categories into which they are divided.

The issue of the wage payment system used for hospital workers came up again when workers found that their jobs were being redefined and reclassified on their return to work after the strike.

Most workers in provincial hospitals in South Africa are paid according to a job evaluation system that has become known as the Paterson System. Workers in provincial hospitals generally earn less than workers in private hospitals or clinics. But even from on one provincial hospital to another, wage rates are different.

This article explains how the Paterson System works and what it means for worker organisation.

What is job evaluation?

Job evaluation or job grading involves

- describing a job in the smallest detail
- grading that particular job in relation to other jobs within the same unit, branch, or industry
- laying down wages accordingly

There are a number of different job evaluation systems used in South Africa.

The Paterson System

The Paterson System grades jobs according to how many

decisions a worker has to make in his or her job, and how important these decisions are in the running of the overall unit, branch, or industry.

Paterson has laid down six levels of decision-making, which he has called Bands. Each one of these he has linked to a certain position within the branch or industry.

These levels are:

Band A - defined decisions - unskilled workers
Band B - automatic decisions - semi-skilled workers
Band C - routine decisions - skilled workers
Band D - interpretive decisions - middle management
Band E - programming decisions - senior management
Band F - policiy making decisions - top management

Where do workers fit in?

Most workers in South Africa are restricted to the lowest levels of decision- making (in this case Band A and B). They give workers hardly any control over the work-process. A worker in Band A, for instance, has little choice; he or she is told exactly what to do and when to do it.

Further grading

Apart from this broad grading system, there is further grading within each Band.

For Band A and B, there are the following sub-grades for health service workers:

Band	Decision Level	Title	Grade	Kind of Grade
B	Automatic	Semi-skilled	5	Supervisory
			4	
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			3	
			2	Automatic
			1	
A	Defined	Unskilled	3	Sec. guards (c. R324p.m.)
			2	Ward helpers, porters, messengers, cooks, dispensary attendants - R230p.m after 6 years
			1	cleaners, assistant cooks, laund.workers R220p.m. after 6 years

(The wages given in this table might have been reviewed and adjusted in some sections of the health service.)

Many South African employers using the Paterson System use four factors to decide which sub-grade a worker should fall under. These factors are:

- Variety of tasks: The more tasks, or the more complicated the tasks within a job, the higher the sub-grade that the worker falls under.

- Length of a task: If a task takes longer to do, or if it involves any other activities, the worker is placed in a higher sub-grade.

- Pressure of work: The higher the mental or physical stress in a job, the higher the sub-grade that the worker falls under.

- Tolerance or precision: Jobs that require a high level of precision rank in a higher sub-grade. The same goes for jobs where errers of workers would have serious effects.

In short: Sub-grading merely decides whether job x is more important than job y.

How does management go about applying the Paterson System?

If and when management decides to make a job evaluation, workers and their unions hardly have any say in the procedure. They usually have no choice in which evaluation system is to be used, and how it is to be applied. It is usually the personnel department that goes about setting up the job evaluation system. The personnel department finds out what kinds of different jobs there are. They then decide on how many job writers they have to train to write up the job descriptions. The Paterson System requires written job descriptions that should be read and signed by the workers. Usually workers have to describe their jobs, and then the supervisors are asked about the correctness of those descriptions. Once all the jobs have been described, the job descriptions go to an evaluation (grading) committee.

The Paterson System - from the workers' point of view

From the workers' point of view, there are a number of problems with the Paterson System. Band A, which most workers fall under, has got less sub- grades than Band C,D,E, and F. That means that for the bulk of workers, there are very few different types of jobs; and there is no chance of moving up the scale. Secondly, the Paterson system is mainly based on one single factor -

namely decision-making. This strengthens the existing hierarchies; it is taken for granted that supervisors and co-ordinators make higher decisions. This is what excludes workers in Band A and Band B from decisions about their work and working conditions; instead, decisions are being made from top downwards. In this way, the Paterson System fixes the channels of communication from the top of the hierarchy downwards, and strengthens that hierarchy.

This article is an excerpt from Len le Roux's Guide to Job Evaluation Systems Used in South Africa, South African Labour Bulletin, vol. 10, no. 14, January-February 1985

WORKERS IN THE STATE SECTOR

The state has found ways and means to keep the various categories of civil servants united under common interests. At the same time, the state has brought about division amongst other sections of workers. This means that it becomes very difficult to organise workers in the state sector into unions, as their interests seem so different.

What is the 'public sector', 'state sector', or 'civil sector'?

The 'public sector' includes all businesses, departments or other institutions which produce goods or provide services and which are totally or partly owned by the state.

Services such as roads, hospitals, traffic police, sanitary and other services are handled by provincial administrations and local municipalities. Both these regional (provincial) and local (municipal) levels of government cannot be different in policy from the central government.

The Commission for Administration lays down the employment condition for people working in the central state sector and in the provincial administrations. This commission can make recommendations, but they have to be approved by a second party, usually a cabinet minister.

Workers employed by provincial administration authorities have very similar wages and working conditions as workers employed by the central state authorities.

Health workers, along with administrative and clerical workers and forestry workers, fall under the civil sector.

The civil sector has grown over the last few years. It is likely to grow even more with the opening of the new departments for 'general' and 'own affairs'.

The civil sector has traditionally been marked by job reservation and racial discrimination. Blacks employed in the civil sector in the past usually had to do menial tasks, and they were employed in temporary positions. This is still the case for non-classified workers employed in the provincial hospitals. On the other hand, the sate is trying to make the public service more attractive to black people. The state would like to see more black people working as 'officials' in the state sector, so as to give them a stake in its political system. But even so, they are likely to be confined to departments of 'own affairs'.

Race and class divisions in the state sector

There are three kinds of employees in the civil sector:

- 'officials' with permanent posts. They include administrative officials, clerks, professionals (such as engineers and lawyers), artisans, and all those who have a specific technical skill or qualification. They fall into the "General A Division". Most of them are given supervisory positions, for instance matrons, inspectors, storemen and others.
- 'non-classified workers': they are either temporary workers or contract workers. They usually do manual jobs. Contract workers are worst off: They are usually employed for specific tasks or projects, and once these have been finished off, their contracts run out. Contract workers therefore face extreme job insecurity.

The class division between 'officials' and temporary workers can further be traced through the state's personnel strategy. The state wishes to co-opt the permanent officials; they are the ones who get offered

increased benefits in return for their loyalty. Temporary workers, in contrast, are discriminated against. Every attempt is made to divide them, so that they will not take any united action. They did not get any improvement in wages, benefits, and working conditions over the years. Contract workers, again, are worst off: they get absolutely no benefits.

The sweetheart unions

The racial and class division can also be seen in the unions into which the 'officials' and the 'non-classified workers' have been organised.

At the moment, there are three unions, called 'staff associations':

- The Public Servants Association (PSA), which caters for white employees only. PSA members are permanetly employed 'officials'.
- The Public Servant's Union (PSU), which caters for Indian employees only. PSU membership is made up by permanently employed 'officials'.
- The Public Servants' League of South Africa (PSL), which is multiracial. The majority of the PSL's members are temporary workers.

There is conflict between the temporary workers' union (PSL) and the two 'officials'' unions (PSA and PSU).

The PSA and PSU (the 'officials'' unions) are sympathetic to the state's new deal, whereas the PSL (the temporary workers' multiracial union) upholds ideals of union democracy and worker control. The PSL is somewhat critical of the state's moves. But the PSL itself has no independent bargaining-power. It is controlled from above by the authorities in the various departments of the state sector.

Until now, no democratic or independent recognised trade union has been able to represent workers in the civil sector. The result is that the sweetheart staff associations PSA and PSU have gone unchallenged.

Pensions

In the same way as state employees are divided between 'officials' and 'non- classified' staff, and as their unions are divided, so, too, are the benefits that the different categories of staff are getting.

At the moment, there are two pension schemes. The Government Service Pension Fund is for permanent officials, and the Temporary Employees' Pension Fund is for temporary workers. Contract workers are not covered by any pension provisions.

'Officials' automatically enter the pension fund. 8% of their monthly salary gets deducted for pension. Their pension fund includes gratuity and annuity.

In the case of temporary workers, it was a long battle to secure pension provisions. Temporary workers do not enter the fund automatically. They have to wait for two years before they can contribute. They pay 5% of their monthly wage towards the pension fund. Workers are not paid a gratuity if they have more than 10 years' pensionable service. Instead, an increased annuity is paid in the form of a monthly pension. This measure caused a great deal of tension among workers in the civil sector.

Housing loans and subsidies

Housing loans and subsidies are usually counted as the advantages of working in the government sector. On paper, all state employees can apply for housing loans and subsidies. But, in practice, it is only 'officials' who get these benefits. Most temporary workers live in council houses, shared houses, or they use makeshift accommodation. This is what makes them unable to apply for housing benefits.

For those workers who have been able to buy houses, getting a loan and subsidy is still not automatic. Workers must be over 21 years of age and have contributed to the pension fund before they can apply for a housing loan or subsidy. This means that workers will have to wait for at least three years before they can even start applying - two years before they can contribute to the pension fund and one year of contributing to the pension fund.

Secondly, the loans are pegged to salaries. Because wages are low, loans and subsidies are very small. Ordinary workers often find it difficult even to raise the deposit to put down on a house.

All these factors make it almost impossible for a temporary worker to buy a house. This privilege, in most cases, is only to be enjoyed by 'officials'.

Where housing benefits are made available, they usually become a way of controlling workers. For those workers who do eventually get a housing subsidy are very cautious about joining a union and taking part in worker action.

TERRIBLE WORKING CONDITIONS

TEMPORARY STATUS

This means that any local-rate-of-pay worker can be fired with 24 hours notice.

For example: In 1984, a worker was fired, because the wards she was looking after "were dirty". It was also said that "she had been cheeky to a supervisor" and that she had been caught drinking tea in a side-ward.
The authorities ignored the fact that the wards she was looking after were terribly overcrowded.
A sister working in that ward gave an affidavit:
"...She was a very good worker, and the ward was always neat. I see no reason for her to have been fired."

LEAVE

If a domestic is pregnant, she gets no accouchement leave. She has to resign, and may be re-employed after delivery. But she will have lost all the benefits from her previous work.

When one of our workers lost her mother, she was given not a single days leave. In fact she had to work until lunchtime on the day of the funeral.

LONG HOURS OF WORK

How would you feel about working these hours?
The domestics in our hospital...

- work 9 hours a day
- have only one day off per week
- have 19 days leave per year
- get half-an-hour for lunch and two tea breaks

NO TRUE REPRESENTATION

- We demand a democratic structure, that will represent us, and that will deal with our grievances.
- We demand a proper disciplinary protocol: If there is a dispute, the worker must have the right to call on assistance from a member of that democratic structure.
- We reject the Hospital Employees Association, because it has failed to deal with our grievances in an effective way.

ISSUED BY THE CORONATION HOSPITAL WORKERS COMMITTEE

Other grievances

Workers in the civil sector complain about other things, such as

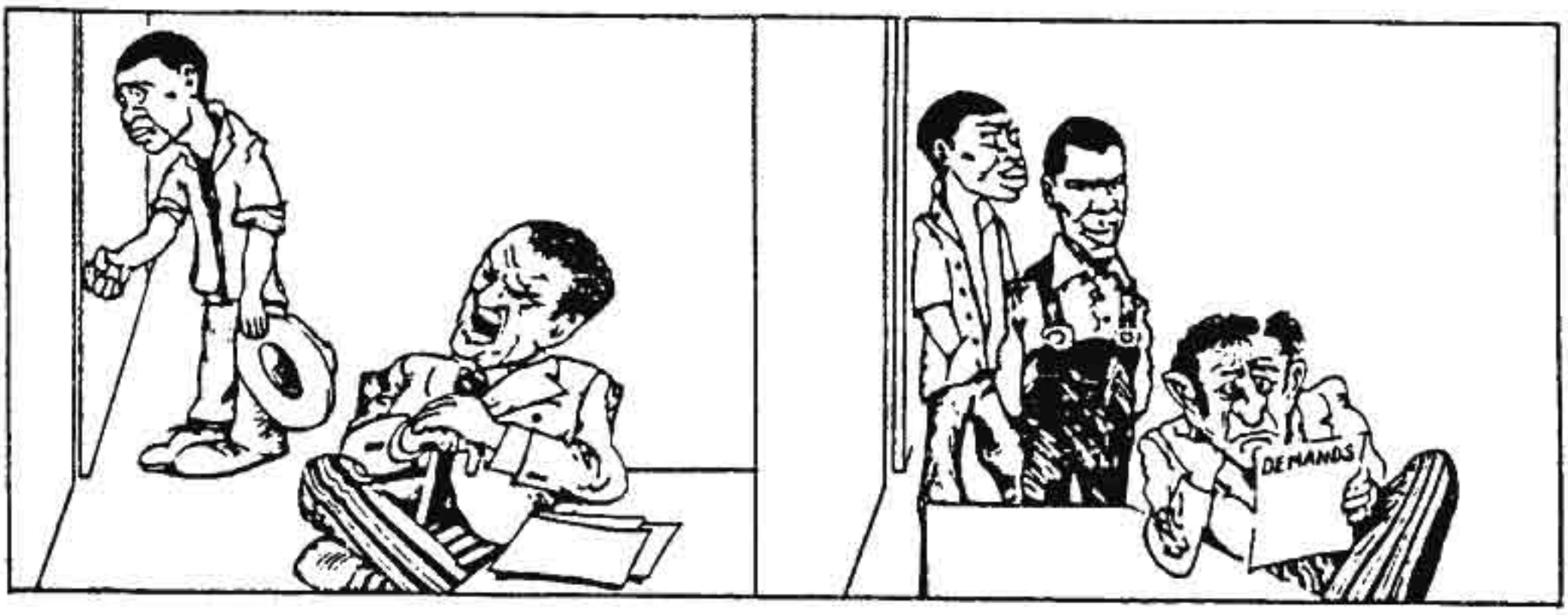
- no job promotion
- inadequate training
- injuries on duty
- working hours

These grievances have hardly been addressed, as union organisation in the civil sector is still weak. What makes this situation very difficult is the fact that public sector workers do not fall under the Labour Relations Act, and therefore there is no formal grievance procedure.

Union organisation

Union organisation in all areas of public employment is extremely difficult. As we have said, before, workers are divided according to

- permanent and temporary or contract positions
- the benefits that they can get (housing loan and pension)
- the degree of job security
- race and class (and in some cases, residential area) which determine the wages of the workers
- their membership of 'staff associations'



These divisions make united action very difficult.

Apart from these divisions which disorganise and isolate workers, workers find that their workplace is controlled very tightly. Moreover, if workers do express their grievances, it is difficult to find out whom to address them to. For example, wages at a hospital are not laid down by the medical superintendent. It is the Commission for Administration who is responsible for laying down the wage structure. This commission is far away from the scene of conflict. There is no way in which the workers can negotiate with the authorities at their workplace.

Until now, there has been very little conflict between workers and authorities in the state sector. This is because workers are divided, and only very few black workers are organised in unions, and because workers in the public sector may not go on strike. The staff associations (PSA, PSU, PSL) are helping the state to control and divide workers. Within these sweetheart unions, there is hardly any possibility for bargaining. Issues such as work rules, dispute procedure, and working hours are simply not discussed.

Nevertheless, some independent trade unions have started organising public sector workers, even though these unions are not recognised. The workers who have signed up for these unions are mostly temporary and contract workers. They are the ones who bear the brunt of low wages and bad working conditions, and have nothing to gain from the sweetheart unions. In some cases, also, workers have taken matters into their own hands. Whenever workers did express their grievances, they have been faced with a heavy-handed response from the state. The state has responded to workstoppages by dismissing workers. The authorities refuse to negotiate with worker representatives from any union.

What has become clear through all this, is that organising in the public sector, to be successful, must take place on a national basis. Too often, worker action

has been sporadic and isolated, and workers have been defeated and demoralised. A national health workers' union, organised on the basis of various departments within the health services, would give workers at a particular workplace more strength.

This article is drawn from Marcel Golding's article, Workers in the State Sector, South African Labour Bulletin, vol. 10, no 15, March-April 1985

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UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

INTERESTED IN RURAL HEALTH CARE?

THE HEALTH SERVICES DEVELOPMENT UNIT is looking for a doctor to work at Tintswalo Hospital (near Acornhoek in the Eastern Transvaal.)

WHAT FOR?

We need someone to help us train Primary Health Care Nurses. We run a year long course which is recognised by the South African Nursing Council. Our aim is to produce PHCNs who can diagnose and treat, manage clinics, and understand the relationship between health and conditions in the wider society.

WHAT IS THE HEALTH SERVICES DEVELOPMENT UNIT?

The HSDU is a unit within the Department of Community Health at Wits Medical School. The Unit is based at Tintswalo Hospital. Apart from the PHCN training programme, we also have the following projects:

- Training the trainers of primary health care workers.
- A continuing learning programme for PHCN graduates.
- Writing texts for the PHCN training course.
- Working with village based women's groups.
- A sanitation project.

WHAT SKILLS DO YOU NEED?

We are looking for someone with the following qualities:

- Some clinical experience.
- Some understanding of the health problems in rural areas.
- A commitment to providing good health care in rural areas.
- Some teaching experience - preferably in adult education.

The post is available immediately, but may be held open for a good applicant. Applicants should be prepared to commit themselves to at least one, and preferably two years at Tintswalo Hospital.

For further information contact Cedric de Beer at (011) 647-2269 or Margie Cairns at 647-2369.

Submit applications, with a Curriculum Vitae, and the names and addresses of two referees to Margie Cairns, Dept of Community Health, Medical School, 7 York Rd. Parktown.

HEALTH HAZARDS IN THE HEALTH SERVICE

Many people think that workers in the health services should know how to protect their own health, because that is the field they are trained in. But, in fact, most workers in the health service are not professionals, and do not get trained in recognising health hazards or how to protect their health on the job. One worker put it this way: "If you've ever wondered how people can manage to work with the sick and stay healthy themselves, the answer is that they can't."

This article lists some of the most common health hazards in the health service and suggests some ways of how to deal with unsafe conditions. There is no easy solution to problems of health and safety at work. Dealing with these problems in an appropriate and effective way requires strong union organisation. In other countries, and in some factories in South Africa, workers have elected safety representatives within their unions. The task of these safety representatives is to monitor health and safety at the workplace and bring them to the attention of the union as a whole, so that the worker representatives can then take up these problems with management.

Working in hot conditions

Workers in kitchens, laundries and boiler rooms often have to work in hot conditions. If the air gets too hot, workers may suffer from heat stress.

The signs of heat stress are:

- faster heart beat and pulse
- tiredness
- nausea (feeling sick)
- moist skin
- fainting
- low blood pressure
- higher body temperature
- muscle cramps

If heat stress is not treated in time, it may develop into heat stroke, which is very serious.

Workers need to be told how to recognise signs of heat stress. They can demand, through their union, that machines for ventilation and cooling are installed. The risk of heat stress is less if workers are allowed to rest away from the heat.

Working with chemicals

Chemicals are being used

- in the boiler house
- in the laundry (detergents, disinfectants, bleach) and in dry cleaning processes (solvents)
- in sterilisation processes(disinfectants) (affecting cleaning, kitchen, and laundry staff)
- in cleaning materials and detergents (disinfectants, scouring powder, bleach)
- in the laboratories
- in the operating theatres
- in ambulances
- in the hospital gardens (herbicides, pesticides) (affecting gardeners)
- in the workshops (degreasing agents, epoxy, glues) (affecting building workers and workshop assistants)

People often complain about the short-term effects that chemicals have on them, such as:

- nausea (feeling sick)
- loss of appetite
- breathing trouble
- skin irritation and/or inflammation of the skin
- suffocation
- irritability
- numbness of limbs
- tiredness
- blurred vision
- nose and throat irritation
- headaches
- drowsiness

Chemical solvents used in dry cleaning can cause nausea, confusion, fatigue and dizziness! . . .

The long-term effects are even more serious, and more difficult to find out. They may include:

- liver damage
- cancer
- heart disease
- lung disease
- kidney disease
- blood damage
- bone marrow damage
- nervous system damage
- reproductive hazards (miscarriages, damage to babies before birth)

Working with chemicals of any kind requires many safety precautions. Measures must be taken against spilling and leaking of chemicals. Chemicals must be stored safely so that they do not become a fire hazard. In working with chemicals, it is important to see that there is enough flow of fresh air.

Hazardous chemicals are not just liquids. They can also be dusts, pastes, droplets, powders or vapours. They can cause damage by entering the body through the mouth and nose when the person is breathing or swallowing.

Workers should demand to know what chemicals they are working with. For some of these chemicals, there is a legal exposure limit. The union and other organisations can help in finding out whether the chemicals used at the workplace go over the legal limit.

The union can also arrange for independent health checks. Health checks in themselves do not prevent ill-health; they just find some of the signs of illness early, and therefore make the treatment more likely to be successful.

The kind of health checks for the effects of chemicals may involve blood and urine tests, as well as tests of the lung, liver, and kidney functions.

Working with gases

Different kinds of gases are used for medical research and laboratory work, in operating theatres, and for industrial work in the workshops and in the boiler rooms.

Most gases are safe if they are contained in cylinders, valves, or pipes. They become dangerous to workers if they leak. They have health effects similar to those of chemicals.

Workers who handle or use gases should be properly trained and should be told about the possible hazards.

To prevent gases from leaking, the cylinders must be safely stored, handled with great care, and checked regularly. Damaged cylinders must be sent back to the supply company immediately.

For gases used in the operating theatre, extractors are

available which suck up any extra gas. But even with these machines, a good air flow is important.

Hospital staff exposed to gases should have regular health checks.

Removing waste

Clinical waste can be poisonous, infectious, and dangerous. It includes:

- Human or animal tissue or excretions
- Drugs and medical products
- Swabs and dressings
- Instruments

Training of waste removers is very important, for it is necessary to know which wastes are removed in what way. All precautions should be taken to make sure that the waste does not spill. Workers should be taught what to do if, by accident, some waste does spill.

Hand hazards

With the kinds of materials - chemicals, waste, etc. - that many hospital workers have to handle, any cut or injury to their hands can be very serious; for they can easily pick up any infection from the materials that they handle. Bacteria and viruses could enter through the cut and spread through the body.

Hospital workers may get cuts from broken ampoules, scalpels, broken bottles or scissors and other sharp things that were not disposed in the proper way.

To prevent this, all sharp things must be disposed in boxes, which must then be sealed and marked properly.

Infection hazards

All hospital workers who have contact with infected patients, such as

- nursing infected patients
- cleaning the rooms of infected patients
- transporting them
- transporting and cleaning their linen
- taking, transporting and examining samples of their tissue or blood

are at risk, for they might get infected themselves.

They therefore should demand the right to know what disease has infected the patient. It is necessary to mark all rooms, samples, linen, or waste bags. Workers who have to do these jobs should be told about how they can keep contact with infectious bacteria or viruses to an abolute minimum. They should have the option of free immunisation where there is a risk of infection. They can be immunised against TB, German measles, polio, tetanus, typhoid, jaundice, flu, diphteria, and rabies.

Infection is particularly dangerous to pregnant women; for many diseases are known to cause birth defects or miscarriages (for instance German measles , shingles, chicken pox, infectious jaundice, mumps).

Lifting, back pain, back injuries

Nurses, sister, assistants, porters, ambulance workers and other hospital workers have to lift things, materials, and patients who are unable to move themselves. People who lift heavy weights for a long time are likely to suffer from back pain or back injuries. It is therefore important to cut down on the stress put on the back day by day.

This can be done by providing enough hoists, trolleys, and other wheeled carriers, and enough space within which these mechanical aids can be used (for instance in toilets, bathrooms, etc.). Secondly, there must be enough trained staff to do lifting and handling jobs, so that it is not one worker alone who has to carry a heavy weight at any one time. Thirdly, hopital staff must be trained in easy ways to lift and handle weights.

In the course of one hours work, two nurses on a geriatric ward lifted the equivalent of TWO AND A HALF TONS!!! . . .

The International Labour Organisation (ILO) has recommended the following maximum weight limits for frequent lifting without mechanical aids:

Age	Men	Women
16-18	31,50 lbs (15 kg)	19,12 lbs (9 kg)
18-20	38,25 lbs (19 kg)	23,25 lbs (11 kg)
20-25	41,25 lbs (20 kg)	24,75 lbs (12 kg)
35-50	34,50 lbs (17 kg)	21,75 lbs (10 kg)
over50	26,25 lbs (13 kg)	16,50 lbs (8 kg)

Many other things have to be taken into account, such as how often the weight is lifted, what shape the weight is, whether it is flexible or not and what position and posture workers have to take to lift the weight. The Health and Safety Commission in Britain has suggested that employers should provide mechanical aids for weights between 35 lbs (17 kg) and 75 lbs (37 kg).

Noise

Hospitals should be quiet and restful places in which to work. But certain jobs and certain areas of work can be very noisy, and may even be a hazard to hearing. These include:

- laundries
- workshops
- pressure steam sterilisers
- machines used by gardeners

To find out whether there is a noise problem and what to do about it, the union organising workers in the hospital can arrange to have a noise survey done.

Shiftwork and stress

With the 24-hour service that hospitals provide, many hospital workers have to work shifts. Shiftwork disrupts the body's natural rhythm of eating, sleeping, working, etc. Shiftworkers, especially nightworkers, have less sleep, and the sleep is often of poor quality. As a result, they are tired and irritable most of the time, and with increased tiredness, the accident rate goes up. Shiftwork and the stress that goes with it will lower the body's ability to cope with toxic materials and physically demanding conditions (such as heat or cold).

To lower the stress of shiftwork, workers should press for the following changes:

- shorter working hours
- longer holidays
- organise shifts so that new workers or workers returning have longer breaks to get used to shiftwork
- good canteen and rest room facilities
- provision of transport for shiftworkers who start or finish during unsocial hours
- lowering of shiftworkers' exposure to noise, heat or cold, toxic materials and other hazards.

The union organising workers in your hospital or clinic can arrange to find out about all these hazards and their effects, and, together with worker representatives, workers worried about their health and safety at work, can decide on a plan of action.

If you, as a health worker, would like any more information or advice on any of these work-related health problems, you can contact the General and Allied Workers' Union at any one of the following addresses:

WEST RAND: GAWU
P.O. Box 43
P.O. Kagiso
1744

JOHANNESBURG: The Secretary
GAWU
P.O. Box 61954
Marshalltown
Johannesburg

or:

The Secretary
P.O. Box 7549
Johannesburg

or:

GAWU
20 Tudor Mansions(4th floor)
78 Troye Street
Johannesburg

Health workers in Natal are being organised by the Health and Allied Workers' Union (HAWU). HAWU is an affiliate of the National Federation of Workers.

Street address: NFW
15 Ecumenical Centre
20 St Andrews Street
Durban
4001

Postal address: NFW
P.O. Box 47011
Greyville
47011

Tel. (031)306-3993

Health Workers in the Cape are being organised by the General Workers' Union (GWU).

Street address: 11 Benbow Building
Beverly Street
Athlone
Cape Town

Tel. (021)638-2592

SHUNTING OF PATIENTS:

ANOTHER EXAMPLE OF RACIALLY DIVIDED HEALTH SERVICES

There is a long history in South Africa of segregation of hospitals according to skin colour, and, moreover, according to patients' so-called 'ethnic' background. More recently, the Transvaal Provincial Administration has tried to draw the lines of racial discrimination even further by shunting patients from one hospital to another, according to their racial classification.

The action of the hospital authorities

For a long time, so-called 'African' patients coming to Coronation Hospital have been labelled with a 'red dot' which means that these patients should be transferred to Baragwanath Hospital as soon as possible.

In late January 1986, the Transvaal Provincial Administration has issued a directive which says that patients must be treated at their 'regional hospital'.

Regionalisation

This directive was issued in the name of the policy of 'regionalisation'. Regionalisation of health services is carried out in many parts of the world, so as to avoid duplicating facilities, to give people more easy access to health services, and to simplify administrative matters and follow-up of patients. What is called a 'regional' health service in other parts of the world, though, is very different from what the South African health authorities mean by 'regionalisation'. In other countries where the health services are allocated more equally, the health services are divided up into several large areas. People from one area would attend the

primary health facility responsible for their area, and if they show more complex symptoms of an illness, they would be referred to the next hospital in the area which has special facilities to treat that illness.

In South Africa, however, white hospitals are excluded from the regionalisation programme. This means that patients attend a health service not according to its accessibility, but according to the racially exclusive areas in which they live.

Reasons for 'regionalisation' in South Africa

The Transvaal Provincial Administration says that the reason for the directive is the overcrowding at certain hospitals, notably Coronation Hospital. This reasoning, however, does not hold water when we consider that other hospitals, to which patients are to be referred on the basis of their racially divided residential area, are just as overcrowded, if not more overcrowded. In fact, compared to Hillbrow Hospital and Baragwanath Hospital, Coronation Hospital is one of the less overcrowded hospitals.

Hospital	Approved Beds	Present Occupancy	Surplus Beds	Surplus Patients
Baragwanath	2621	115%	-	917
Hillbrow	744	100%	-	148
Hillbrow Annex	152	7%	110	-
Coronation	585	111%	-	181
J.G. Strijdom	540	70%	154	-
Johannesburg	1800	50%	540	-
Total	6442		704	1246

What appears as the real reason for issuing this directive is the attempt by the health authorities to further entrench apartheid in health services, this time in the guise of the tricameral constitution. When the Transvaal Provincial Administration in 1985 opened the Annex of the Hillbrow Hospital as a 'New Indian Hospital', there was a public outcry. Very few patients went to this hospital. In January 1986, the TPA very quietly closed this hospital. It appears that the recently issued directive is an attempt to force Indian patients to go to Hillbrow Hospital, and to make Coronation a 'Coloured Hospital'.

What the racialisation of health services means in practice

The proposed 'regionalisation' of health services therefore, in effect, means a racialisation of health services. It would mean that patients form Lenasia must drive past Baragwanath and Coronation Hospitals to Hillbrow Hospital in order to be treated. If, for instance, a family from Lenasia is injured on the Golden Highway, the parents have to go to Hillbrow Hospital (which is to be the 'New Indian Hospital') and the children to Coronation Hospital (because Hillbrow Hospital has no children's ward).

How serious the consequences of the directive are, can further be shown by some examples of patient referrals where the patients were critically ill.

The response

Patients

Patients have been turned away from the hospital at casualty. Some of these patients tore up their referral notes. At the antenatal clinic, pregnant mothers who have been attending Coronation Hospital regularly for months, were turned away; they responded with great distress.

REFERRAL OF PATIENTS -

Three Examples

Mr P is 22 years old and comes from Lenasia. He came to Coronation Hospital on 3 February 1986. He had vomited blood the night before, and had pain in his abdomen. The Casualty Officer examined him and said he needed treatment by a surgeon. The surgeon would look into his stomach to see where he was bleeding from. Before he could be seen by the surgeon, however, he was transferred to Hillbrow Hospital, and the special examination was delayed until then. Mr P could have bled to death before arriving at Hillbrow.

Mr W is 39 years old and comes from Alberton. He came to Coronation Hospital on 18 February 1986. He was coughing green sputum, had a high fever, and had lost a lot of weight. He is zoned for Boksburg Benoni Hospital (BBH) and the form for his transferral was completed. It was only because Boksburg Benoni Hospital had no space that he was given a bed at Coronation. Mr W was very ill with tuberculosis and pneumonia.

Mr R is 71 years old and comes from Boksburg. He came to Coronation Hospital on 10 March 1986. He had severe chest pain and was coughing yellow sputum mixed with blood. He also could not breathe easily. His family were unhappy with his treatment at BBH and brought him to Coronation Hospital; but Coronation Hospital staff were told to refer him back to BBH. A Coronation Hospital doctor insisted he be admitted. He was found to be dehydrated and suffering from pneumonia.

The Community

Various meetings were held to inform community organisations about the directive and its implications. An ad hoc hospital crisis committee was formed of doctors and community workers.

At the initial meeting, the following resolution was passed:

This meeting of health and community organisations, NOTING the recent TPA directive on regionalisation of hospital services which refers patients to hospitals in their own group area;

BELIEVING that such action constitutes:

1) the extension of apartheid in hospitals by further segregation along racial lines
2) contravention of accepted principles of medical ethics
3) an attempt to consolidate the rejected tricameral system

RESOLVES to:

1) call for the immediate withdrawal of this directive
2) urge the immediate alleviation of overcrowding by the full integration of all hospitals including the Johannesburg Hospital and the J.G. Strijdom Hospital, and
3) work, with all resources at our disposal, for the establishment of a non-racial, just and equitqable health service for all South Africa's peoples.

Doctors at Coronation Hospital

Following a meeting called by the Superintendent to discuss ways in which the directive could be put into practice, doctors at Coronation Hospital issued a public statement in protest against the directive. The statement reads:

> "We, the doctors at Coronation Hospital, mindful of our Hippocratic Oath, are unable to comply with the directive compelling the transfer of patients to other hospitals against their wishes or against the assessment of their health care.
>
> We see the optimum use of presently under-utilised hospitals on a non- racial basis as a solution to the over-crowding at Coronation."

It became clear that no doctor was willing to assist in applying the directive. So the Superintendent said that he would go ahead and implement the directive single-handedly. Following these events, a meeting was held between the Director of Hospital Services and the Medical Advisory Council (MAC) of Coronation Hospital. It was apparently decided to start implementing the directive "in a humane way" through a "phasing in period".

In response, the Doctor's Liaison Committee (DLC) at Coronation Hospital has issued the following statement":

> "We, the undersigned doctors of Coronation Hospital, wish to state our support for the principle of <u>regionalisation</u> of health services in South Africa.
>
> We believe that, integral to such a system, must be:

1) A non-racial organisation of health services on a regional basis, and
2) Equal access by all to equitable health facilities in these regions

Until such time as the recent directive on regionalisation fulfils these requirements, we are unable to comply with the directive."

This statement is supported by many doctors. The DLC has submitted this statement to the MAC.

It now appears that the Superintendent has, in fact, made attempts to carry out the instructions of the directive single-handedly. At the end of January, a second instruction sheet, issued by the Patient Affairs Department, was circulated among Coronation Hospital staff. This instructs nurses and clerks to report any patient from a different 'region' directly to the Deputy Superintendent for referral. In this way, patients do not even see the examining doctor. Doctors at Coronation Hospital see this as an attempt to undermine their opposition to the directive.

The National Medical and Dental Association (NAMDA)

The NAMDA Transvaal Regional Council issued the following statement in protest against the directive:

"The attempt by the authorities to make Coronation a "Coloured" hospital is another proof that economic sense and a reasonable and equal standard of health care for all South Africans are subservient to the policy of racial segregation.

We do not believe that the new directive thrust onto Coronation Hospital is aimed primarily at

improving health care for "local" patients. It is apartheid masquerading as geography, and will further divide South Africans. It will inconvenience sick people and pregnant mothers seeking care at the hospital.

We believe that the problems of overcrowding should be solved within a single non-racial health care system, planned with the involvement of all South Africans. Health care needs should be the only factor in distributing resources geographically. Health care delivery should not be made to serve apartheid.

We support the staff of Coronation in their desire to provide health care to those who need it, in a place they find most convenient to seek it."

The Coronation Hospital Board

The Coronation Hospital Board was informed of the directive before it was issued. But it appears that the members of the Board were not fully aware of what the directive would mean in practice. The directive was presented to them as a measure to relieve overcrowding at Coronation Hospital. Also, most of the members of the Board are not health care workers themselves, and are therefore not familiar with the health care needs and health services in the community. The Board accepted the directive. One member of the Board, Ms Dorothy Cornelius, resigned in protest against the directive.

THE ORIGINAL DIRECTIVE

CORONATION HOSPITAL

PATIENT AFFAIRS DEPARTMENT

RE: PATIENT REFERRALS

In order to reduce the overcrowding at Coronation Hospital it is necessary to refer patients who reside in areas that are serviced by other Provincial Hospitals to the relevant facility.

Hence the following procedures must be followed:

1.0 ADMINISTRATIVE STAFF

1.1 When it is determined on admission that the patient resides in an area serviced by another hospital such information must be passed on to the attending Doctor, by completing the relevant form.

1.2 A note is to be made on the Casualty/Out-Pa-patient card, that the relevant form was completed.

2.0 ATTENDING DOCTOR

The condition of the patient is to be assessed with the view of referring such patient to the hospital which services his area of residence.

2.1 The appropriate referral form is to be used in this instance.

3.0 REGIONAL HOSPITALS AND AREAS SERVICED

The following hospitals service the relevant areas:

HOSPITAL	RESIDENTIAL AREA
BOKSBURG BENONI	Germiston Boksburg Benoni Alberton Kempton Park
FAR EAST RAND	Nigel Springs Brakpan
LERATONG	Randfontein Roodepoort Krugersdorp Florida Maraisburg Muldersdrift Panorama Honeydew
HILLBROW	Lenasia Central Johannesburg Alexandra Randburg

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