Workers within Progressive Structures

Critical Health

Progressive organisations are often "shockingly bad employers, with poor conditions of service and a lack of protection for their workers' rights, which is the consequence of an unprofessional approach to staff development."

This quote, from a member of a community health organisation, is being increasingly echoed by other workers in progressive structures. In another article included in this edition, Julie Binedell and Tracey Miller highlight ways in which workers within community health projects are exploited.

Struggle, Communities, Workers' Rights

The poor working conditions within many progressive organisations is, in large part, the result of a failure of these organisations to distinguish between, on the one hand, their quest for democracy and accountability to their communities and, on the other, the individual rights of workers within their projects.

This failure can be understood from the point of view of the urgency people felt in the struggle against apartheid during the 1980s, when many projects were first established. There were a number of burning issues that needed to be tackled and workers in progressive structures were often prepared to make large sacrifices. In many cases, this has led to large numbers of health workers in progressive teams having minimal control over the running of projects and being overworked and underpaid.

It is clear that the issue of wages and working conditions in progressive structures needs to be addressed urgently. Workers have a right to fair conditions of employment. Furthermore, workers who feel comfortable in their working environments will have the space to make an effective contribution to their respective organisations.

In an attempt to encourage debate on this issue, *Critical Health*

talked to Dave Robb, the Administrator at Alexandra Clinic, and Mamiki Montoedi, a National Education Health and Allied Workers' Union (Nehawu) shop steward at the clinic. This article looks at ways in which the clinic has tried to deal with workers' wages and conditions.

Wages at Alexandra Today

The minimum starting wage for domestic and general workers is R962,50 a month, while the highest paid general workers receive R1112,50 a month. These wages were agreed at the Alexandra Clinic's negotiating forum in October 1991, between the clinic's board and the four shop stewards of Nehawu, the union which represents these workers at the clinic. The previous minimum wage was about R812. The new minimum therefore represents an increase of about 18,5% over the previous year.

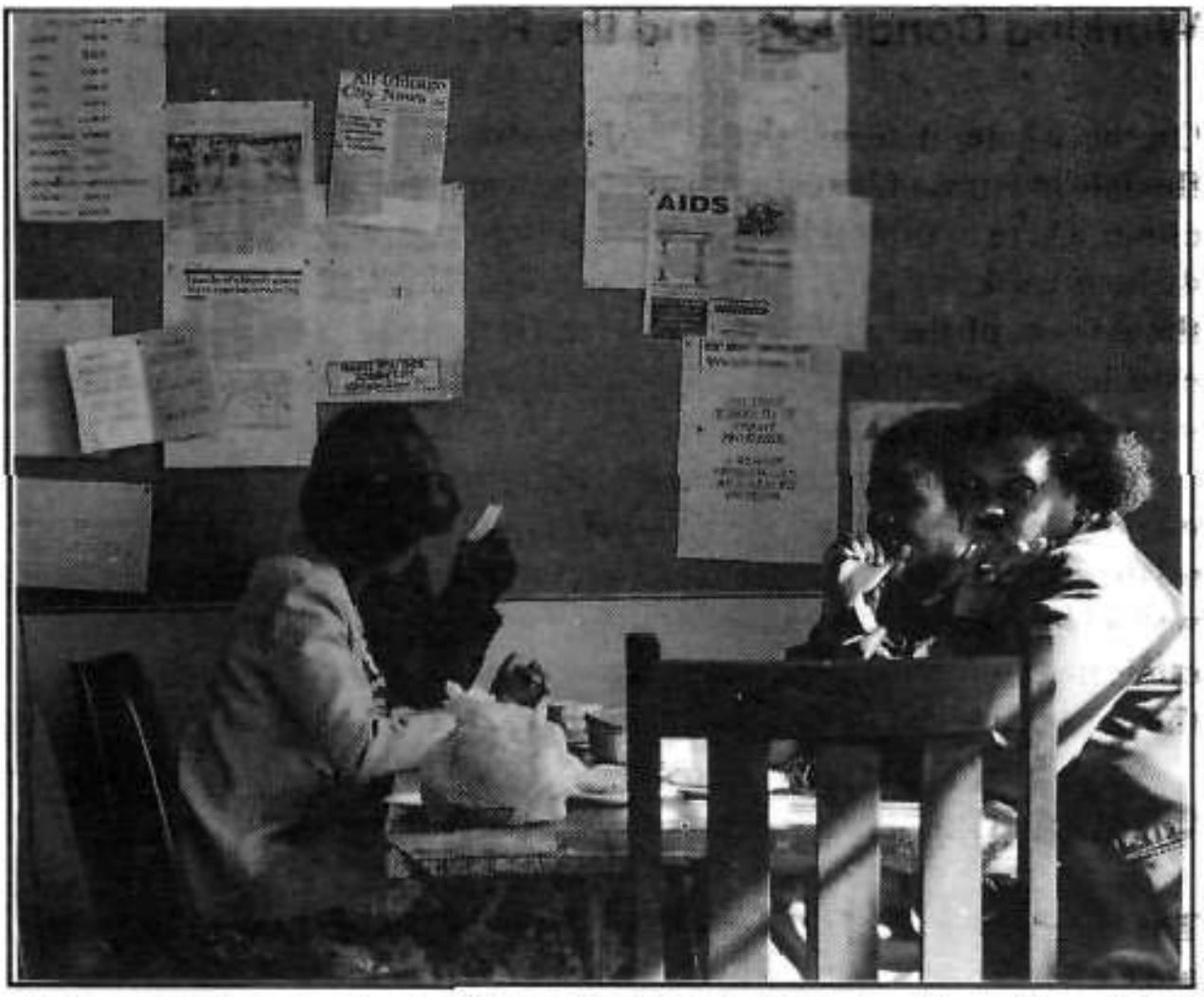
These wages are far higher than those in the state sector. The minimum wage is far above the R440 offered by the state to general workers in its hospitals last year. According to Robb, nurses' and doctors' salaries at Alexandra Clinic are comparable to the state sector. The clinic is, however, not in the financial position to offer some of the benefits, such as housing allowances, which are available to certain state sector staff.

Lay Health Workers and Nehawu

Lay health workers at Alexandra say they are unhappy that their wages are similar to those of general assistants, who are less educated and less skilled in the performance of certain functions at the clinic. Their demand is to be paid R1 600 a month, which is almost on par with wages paid to senior nursing assistants.

According to Dave Robb, this demand was not based on careful advice from the union as it would involve ancillary workers earning more than nurses. Such a situation would not accord well with an established hierarchy of profession and promotion. This hierarchy, Robb argued, is a key to a highly motivated health care team. He said the four Nehawu shop stewards at the clinic are inexperienced in negotiations and do not receive adequate advice and support from the union.

Shop steward Mamiki Montoedi agreed that there are problems which need to be tackled. She said that the Nehawu shop stewards met only once last year, at the time of wage bargaining in October. Nehawu has 40



Unions need an understanding of the hierarchical structure of medical institutions in order to adequately represent their members interests.
Photo: Critical Health

members among nursing assistants and general workers at the clinic. The membership is not fully paid up and stop order facilities will only be established once arrears in fees are paid. The union's presence at the clinic is further weakened by the fact that none of the nurses will join it. Most of the nurses prefer to be members of the South African Nursing Association (Sana).

Dave Robb argued that Nehawu "needs a detailed knowledge of the hierarchical structure of medical institutions, in order to gain an expert understanding of the occupational interests of clinical levels of medical staff". In this way, the union would be able to provide adequate support and advice to people representing the interests of these workers.

Working Conditions and the Right to Organise

On the whole, it seems that the Alexandra Clinic board is reasonably flexible in terms of bargaining over wages and working conditions at the clinic. There is a full schedule of conditions of employment, including a 40 hour week and paid maternity leave. The duties of clinic workers and the powers of the clinic board are clearly defined. The board has also established conciliation procedures over conditions of service, to which workers may make representations.

These procedures of employment and the formal right of clinic workers to belong to trade unions and organise around their demands are relatively recent developments. In the early 1980s, the Alexandra Clinic was a University of Witwatersrand project run by a superintendent. The clinic had not yet achieved full desegregation. A stark reminder of this was the existence of segregated toilets and canteens.

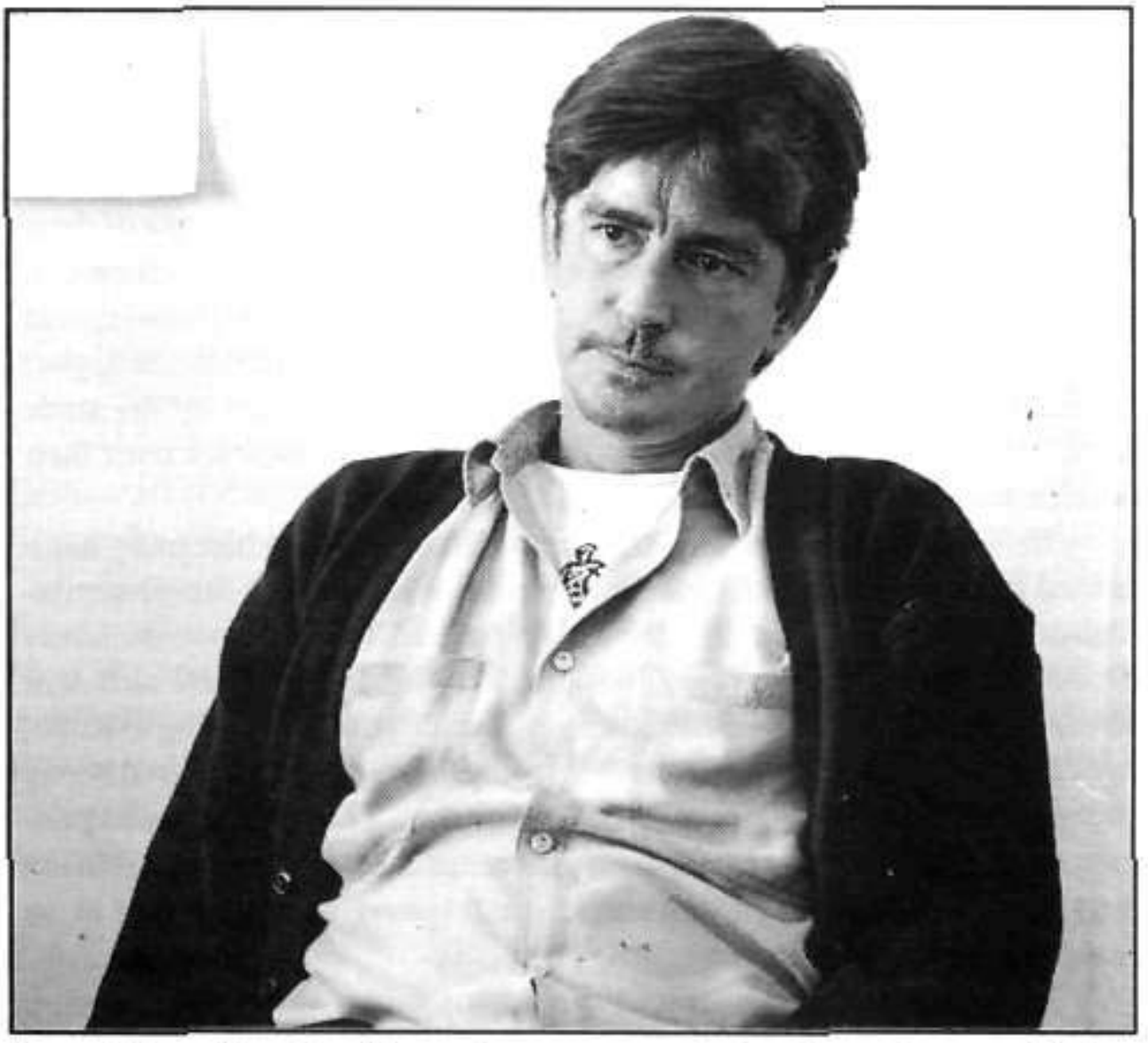
Changing of the Guard

The clinic board was established, consisting of 13 members. Six members are elected by Alexandra residents at an Annual General Meeting and one is elected by the clinic staff. The board desegregated facilities, although it initially faced opposition from some nurses who did not wish to share the same facilities with general workers.

The board also began instituting procedures of employment. By the late 1980s, it had gained credibility among clinic workers, who, in turn, were becoming more confident in asserting their rights. They started to join worker organisations, namely the Health Workers' Association (HWA) and the General and Allied Workers' Union (GAWU).

These changes took place within a context of intense debate. One point of view was that all staff should be able to participate in and contribute to a non-hierarchical health care team. An alternative view was that staff members should be part of a hierarchical structure under community control and that workers should be able to exercise their right to join trade unions. The latter has informed many of the developments which have taken place at the clinic.

According to Dave Robb, we can learn some lessons, concerning democracy and community control in progressive structures, from the Alexandra experience. The development of a structured relationship to the



A non-hierarchical health care team approach has flaws when applied to Alex - Dave Robb. *Photo: Critical Health*

Alexandra community and its civic association is one of the changes at the clinic which was opposed. The argument against this structure was that progressive staff members are sufficiently able to represent the interests of the community, by virtue of their direct links to the wider democratic movement. The vast difference between the status and class of many progressive health care personnel and the communities they may try to represent was ignored.

Hierarchy, Promotion and Access to Unions

Robb argued that the case for a non-hierarchical health care team was similarly flawed. The differences between the various categories of personnel in such a team were not fully considered. For instance, a person

who is a clerk or nursing assistant might participate fully in discussions about the running of a clinic, but would not find a health care team an appropriate forum in which to raise grievances related to work or pay. Doctors in a team often make the final decisions on these matters.

Robb claimed that workers at the clinic wanted a clear sense of their conditions of employment and prospects of promotion and development. He said that it is necessary to have a hierarchy with a management structure and that there should be opportunities for promotion to higher levels. Workers should have free access to representation by the trade union movement, so that managers do not have sole influence over their salaries and conditions of employment.

In South African hospitals, the established medical hierarchy has a limited career path for nurses and lay administrators. Most senior administrators in South Africa are doctors, promoted to that position. Many British hospitals are, in contrast, administered by non-graduate nurses or administrators. Progressive structures in South Africa, according to Robb, have generally been unable to retain doctors on a long term basis. Many doctors engage in these structures as junior doctors to gain some experience and then move on to benefit from more specialised institutions. In the early days of Alexandra Clinic, the high turnover of doctors led to an unstable clinic environment.

The present board of the Clinic is pursuing a strategy to develop intermediary managers among the nursing staff. This provides the clinic with a sense of functional continuity, even when doctors leave. The board is committed to affirmative action. It is placing emphasis on developing the skills of African and female staff and, thereby, providing them with opportunities for promotion.

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