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TITLE **TRADE UNIONS AND THE RESTRUCTURING OF
WORKING CLASS HEALTH CARE IN SOUTH
AFRICA CASE STUDIES IN THE CLOTHING,
LEATHER AND TRANSPORT SECTORS 1992-
1996**

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**TRADE UNIONS AND THE RESTRUCTURING OF WORKING
CLASS HEALTH CARE IN SOUTH AFRICA**

**CASE STUDIES IN THE CLOTHING, LEATHER AND
TRANSPORT SECTORS 1992-1996**

Submitted by Judith Emily Cornell
In fulfilment of the requirements of a Ph.D. Sociology,
Department of Sociology
University of Warwick
6 November 1997

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SUMMARY

Health care is an unusual issue for collective bargaining. It was forced onto the bargaining agendas of some unions in South Africa by a combination of failing and racially discriminatory public sector health care and inflationary private sector health care. Sick Funds are industry-specific health insurance schemes in South Africa, which give their members access to specific and limited private sector medical benefits, sick pay and sometimes maternity pay. They are jointly funded and managed by employer and trade union representatives, through the collective bargaining structures of Industrial Councils. This research, a case study of three Sick Funds for clothing and leather workers, and a more elaborate health insurance scheme for workers in the public transport sector, examines the process of restructuring the content and delivery of medical services, and the management of the schemes. This is done in the context of dramatic political developments on the national stage from 1992, through the period of South Africa's first democratic election in 1994, to 1996. The membership of the Sick Funds was highly homogeneous, comprising low-paid black workers, predominantly women. Recommendations for reform and expansion of the Sick Funds focused particularly on a shift from reliance on contracted doctors to the establishment of a network of neighbourhood-based worker health centres, with medical staff employed directly by the Funds. The other major recommendation was the extension of benefits to dependants for the first time. The fourth case highlights the difficult process of transforming a much more elaborate scheme in a complex multi-union situation in a large publicly owned company facing privatisation. Membership of the transport scheme was much more heterogeneous: overwhelmingly male and predominantly black, there was a substantial minority of white members and a far greater range of income. The argument is that under certain conditions, trade unions can transform existing arrangements for health care for their members, imprinting a trade union character on both the services and their management. The projects achieved their aims to varying degrees. The thesis explores the conditions for success and failure. The studies do not produce a model, which can be extracted from its context and applied generally. The argument is that struggle is part of the model. Nevertheless, these projects raise crucial questions about proposals for mandatory social health insurance and have important implications for the national project of restructuring the health system for equity.

List of abbreviations

ACTWUSA	Amalgamated Clothing and Textile Workers' Union of South Africa
ANC	African National Congress
AZACTU	Azanian Congress of Trade Unions
BCEA	Basic Conditions of Employment Act
BLATU	Black Labourers and Allied Trades' Union
CCIC	Cape Clothing Industrial Council
CCMA	Cape Clothing Manufacturers' Association
CEC	Central Executive Committee
CFLU	Cape Federation of Labour Unions
CHP	Centre for Health Policy
CLOWU	Clothing Workers' Union
CMT	Cut-make-trim
COSATU	Congress of South African Trade Unions
CUSA	Council of Unions of South Africa
DF	Dependants' Fund
DHMEF	Diploma in Health Management (Economics and Financial Planning)
DNH	Department of National Health
DOH	Department of Health
EUSA	Engineering Union of South Africa
FAWU	Food and Allied Workers' Union
FEDSAL	Federation of South African Labour
FEDUSA	Federation of Unions of South Africa
FOSATU	Federation of South African Trade Unions
FMF	Footwear Manufacturers' Federation
FWMBF	Foodworkers' Medical Benefit Fund
GATT	General Agreement on Trades and Tariffs
GAWU	Garment and Allied Workers' Union
GDP	Gross Domestic Product
GMA	Garment Manufacturers' Association
GNP	Gross National Product
GNU	Government of National Unity
GWUSA	Garment Workers' Union of South Africa (merged with NUTW)
GWU-WP	Garment Workers' Union - Western Province
HEU	Health Economics Unit
HPCU	Health Policy Co-ordinating Unit
HST	Health Systems Trust
IC	Industrial Council
ICEM	International Chemical, Energy and Mineworkers Federation
IFP	Inkatha Freedom Party
IHRG	Industrial Health Research Group

IPA	Independent Practitioners' Association
IR	Industrial Relations
MASA	Medical Association of South Africa
MBF	Medical Benefit Fund
MDM	Mass Democratic Movement
MRC	Medical Research Council
MSAA	Medical Schemes Amendment Act
MSC	Medical Schemes Council
NACTU	National Council of Trade Unions
NALEDI	National Labour and Economic Development Institute
NAMDA	National Medical and Dental Association
NCIC	Natal Clothing Industrial Council
NCMA	Natal Clothing Manufacturers' Association
NEDLAC	National Economic Development and Labour Council
NICLI	National Industrial Council for the Leather Industry
NHI	National Health Insurance
NHS	National Health Service
NUGW	National Union of Garment Workers
NULW	National Union of Leather Workers
NUTW	National Union of Textile Workers
OMAC	Old Mutual Actuaries and Consultants
PAC	Pan-Africanist Congress
RAMS	Representative Association of Medical Schemes
RDP	Reconstruction and Development Programme
RSC	Regional Services Council
SA	South Africa(n)
SAA	South African Airways
SAAEAU	South African Airways Engineering and Artisans' Union
SAAFEA	South African Airways Flight Engineers' Association
SAAPA	South African Airways Pilots' Association
SAAWU	South African Allied Workers Union
SACL	South African Confederation of Labour
SACP	South African Communist Party
SACTU	South African Congress of Trade Unions
SACTWU	South African Clothing and Textile Workers' Union
SALB	South African Labour Bulletin
SAMWU	South African Municipal Workers' Union
SARHWU	South African Railway and Harbour Workers' Union
SAHSSO	South African Health and Social Services Organisation
SAHWCO	South African Health Workers' Congress
SALB	South African Labour Bulletin
SALSTAFF	Salaried Staff Association
SATS	South African Transport Services
SF	Sick Fund

SFMC	Sick Fund Management Committee
SHI	Social Health Insurance
TATU	Transport and Allied Trades' Union
T&LC	Trades and Labour Council
TB	Tuberculosis
TBVC	Transkei, Bophuthatswana, Venda and Ciskei
TCE	Total cost of employment
TGWU	Transport and General Workers' Union
TLATIU	Transvaal Leather and Allied Trades Industrial Union
TUACC	Trade Union Advisory Co-ordinating Council
TUCSA	Trade Union Council of South Africa
TWIU	Textile Worker' Industrial Union
TWU	Tegniese Werkers Unie (Technical Workers' Union)
UDF	United Democratic Front
UIF	Unemployment Insurance Fund
UK	United Kingdom
US	United States
UWC	University of the Western Cape
UWUSA	United Workers' Union of South Africa
WPGWU	Western Province General Workers' Union

Chapter 1. Trade unionism in South Africa

1. *Introduction*

This thesis is about trade unions entering the domain of health care on behalf of their members. It opens up a series of questions about trade union practice, which in turn highlight the more fundamental issue of union purpose and specifically the relationship of trade unions to politics. The familiar territory of trade union activity is bargaining with employers over wages and conditions for members. Health care is not a standard bargaining issue, but dependent on country-specific organisation of the health sector. Only in certain countries are health care arrangements linked to work. At the time of these studies, South Africa had neither a comprehensive national health service nor a national health insurance system. Instead, it had a mixed system of public and private health care. Health insurance was a voluntary matter, left to agreement between employers and employees, by collective bargaining or otherwise. When health care was added to the agenda of union bargaining, the issue was usually dealt with as part of the social wage and limited to bargaining with employers over the division of the cost of health insurance.

A fundamentally different trade union intervention is explored in this thesis. Faced with existing health care schemes, judged unsatisfactory by its members, a trade union undertook interventions which extended both the scope and the location of its core

activity of bargaining. It did not restrict itself to bargaining over costs, but precipitated and actively participated in a process of re-structuring the content, delivery and management of health services for its membership. Union leaders challenged the instrumentalism of medical schemes which covered only workers and not their families, and which combined medical benefits with punitive sick leave and sick pay arrangements. In doing so, they engaged with new parties, most notably health care providers in both the private and the public sectors, and challenged professional control of the process of defining health needs and designing health services, by opening up a way to feed the experience of members into that process. The relationship between union leaders and members was a crucial determinant of the outcome and the success of projects.

The focus of the thesis is the process of negotiating and implementing change in four medical schemes in South Africa between 1992 and 1996. From analysis of the implications and consequences for the unions involved and for their members, I argue that models for health care delivery and financing cannot simply be transplanted from one situation to another. Struggle is part of the model and the bargaining process is crucial in determining the outcome, as is the political context. The survival of the schemes depends on their appropriateness for changing times. The approach is assessed in the light of the development of health services and health policy in post-apartheid South Africa, in order to explore its usefulness in informing decisions about working class health service provision in the current period.

Emerging democracies, especially those with struggling economies, are subject to conflicting pressures. On the one hand, they face expectations of social justice and consequent demands for improved services from their citizens, services which they must fund from restricted budgets. The issue of restructuring health care systems in developing countries has been addressed by a number of authors, including Lee and Mills (1985), Hoare and Mills (1986), Green (1992), Mills and Lee (1993), Mogedal et al. (1995), Cassels (1995), Ugalde and Jackson (1995), and Zwi and Mills (1995). One response is to relieve the pressure by requiring the employed to fund their own care. State funds can then be devoted to the unemployed and indigent, improving services without increasing the overall health budget. On the other hand, this transfer of costs to employed people will meet resistance: organised workers will clearly not accept sole responsibility for funding their own health care and employers will resist the imposition of compulsory social welfare commitments, arguing that they need maximum 'flexibility' in order to hold down increases in the cost of labour and strengthen competitiveness in world markets. In this context, the new South African government can neither fund a national health service nor impose National Health Insurance (or Social Health Insurance) on all employed people in the short term. I argue that union-led initiatives in the restructuring of health care for their members are not contradictory to the longer term aim of redressing the inequity of the South African health system: rather, they have a powerful contribution to make towards achieving that aim.

2. Unions and politics

The thesis connects with a number of key debates and developments in the independent trade union movement in South Africa, particularly in the last decade. These debates have drawn on international debates and developments, and developed arguments about the role of trade unions in relation to the state, more explicitly since restrictions on open political discussion (and, especially, publication) eased, less explicitly during the years of repression (for example, Nicol 1980; Fine, De Clercq and Innes 1981; Foster 1982; Friedman 1987; Baskin 1991; Mboweni 1992; Godongwana et al. 1993; Murphy 1994; Torres 1994; September 1996; Ronnie 1996; Von Holdt 1996; Buhlungu 1997; Shilowa 1997). The work in this thesis connects with two areas of intellectual concern: the politics of trade unionism and the politics of health (Doyal 1983; Bond et al. 1997). There is very little literature which draws the two together, examining health care as a trade union issue, either in South Africa or internationally (exceptions include Pillay and Bond 1995; and London 1993). I have attempted to relate key elements of a sprawling debate on union purpose and politics on the one hand and an equally wide-ranging body of literature on health care on the other. Dramatic political changes resulting in and flowing from a change of government shifted the scope of the analysis, rendering inadequate retrospective analysis of the projects in the context in which they took place. They had to be subjected to a new test, of their appropriateness for a new dispensation in the process

of development. The immediacy of this task concentrated the analysis on South Africa.

Current debates about trade unions and politics are rooted in a long history. In one sense, trade unions were politicised simply by their location in South Africa. Workers in many countries suffer from discriminatory and unfair laws. South Africa is unique only in the systematic oppression of workers on the basis of colour: 'Restrictions on their freedom of movement, employment and organisation as workers were bound up with the national oppression of the black majority by the white minority.' (Kraak 1993, xxv) During the 1970s, the independent black trade unions revived after a period of intense state repression.¹ A number of young students moved into worker advice bureaux and worker education organisations as part of a deliberate strategy of rebuilding the movement. A conscious choice was made to avoid overtly political activity, which would have attracted state attention and repression, and to concentrate on building strong shop floor structures. This approach was informed by an analysis of the fate of the South African Congress of Trade Unions (SACTU), which saw it as weakened by its alliance with the nationalist movement in the 1950s, a 'captive of the nationalists', having neglected factory organisation to support the campaigns called by the Congress Alliance and lost a vital cadre of union officials to the armed struggle (Friedman 1987). The new unions concentrated on organising a factory base and developed their structures on the fundamental principle of worker

¹ The term 'black' is used inclusively throughout the thesis (for all those other than whites), and 'coloured', 'Asian' (or 'Indian') or African only where this is necessary to highlight some pertinent point, arising from apartheid state differentiation between these groups.

control. At this stage, black unions were technically illegal and were excluded from the legal industrial relations system, so their first battle was for recognition from employers, in order to bargain on behalf of their members. Recognition battles in the 1970s were often bitter and extended, involving mass dismissals, violent police action and banning orders for prominent unionists (Baskin 1991, chapter 1). In this sense, even the issue of wage bargaining, a standard function of even the most economic form of unionism, took on political overtones.

The late 1970s was a watershed period for the unions. The government finally opened up the industrial relations system to black unions, but conditional on registration. This gave rise to a stormy debate, dividing roughly between those who argued for registration on strategic grounds, on the basis of exploiting all avenues to advance workers interests, and those who argued that registration essentially amounted to incorporation and emasculation (De Clercq 1980; Nicol 1980; WPGWU 1980; FOSATU 1980; Fine, De Clercq and Innes 1981; Fine 1982; Innes 1982a; 1982b). The unions of the Federation of South African Unions (FOSATU) argued for strategic registration, while several Cape-based independent unions and a new group of 'community' unions, which organised on the basis of mass mobilisation, held the opposing view. These 'community' unions were the most overtly political of the emerging unions, openly aligning themselves with the then illegal African National Congress (ANC) and affiliating to the United Democratic Front (UDF) after its 1983 launch. FOSATU, on the other hand, acknowledged the role of the nationalist groups but emphasised the primacy of creating 'an independent working class movement' built

on strength in the factories and argued that this was 'a fundamental political task' in itself (Foster 1982; Friedman 1987, 437). This position came under attack for its abstentionism and was characterised as 'a hallmark of trade union syndicalism... because it did not accord a sufficient leadership role to the vanguard party' (Copelyn 1997, 76). Nevertheless, despite divisions on the key issues of registration and political involvement, organisational tactics and the structures for worker control, the first half of the 1980s saw a series of unity talks between the different groupings, which culminated in the launch of the Congress of South African Trade Unions (COSATU) in November 1985.

The launch did not dissolve political differences among the affiliates, which emerged clearly at the first Central Executive Committee (CEC) meeting in February 1986 (Baskin 1991, chapters 5 and 6). The four political proposals put to this meeting outline the different tendencies within the new federation. They also reveal something of the background to the two main unions with which the thesis is concerned. The motion from the South African Railways and Harbour Workers' Union (SARHWU) proposed that COSATU 'promote working-class leadership in the struggle' and commit itself to co-operate with 'other democratic forces'. The metal union similarly proposed including 'other organisations of the working class, especially the students and unemployed workers' in the discussions of union role. At the other extreme, the National Union of Textile Workers (NUTW), one of the unions which later merged into the South African Clothing and Textile Workers' Union (SACTWU), stressed that the unions should remain independent and should not affiliate 'to any political

tendency or organisation', but called for 'consultation and co-operation' with other democratic organisations which included worker members or took up issues which affected workers. Another resolution, from the food unions, proposed 'disciplined alliances with progressive community and political organisations'. A sub-committee was given the unenviable task of creating a composite resolution from these four, a compromise which did not create unanimity beyond the obvious: that COSATU would be active politically and would work with other organisations.

3. *COSATU and the new government*

COSATU was an active participant in the extended process of political negotiation which led up to South Africa's first democratic election in 1994 (Buhlungu 1992; 1994a; Collins 1994a).² The ANC went into the election in alliance with the major trade union federation, COSATU, and the South African Communist Party (SACP), winning an overwhelming majority. Well before the change of government, trade union leaders had extended their engagement beyond immediate shop floor issues to the broader sphere of industrial restructuring (Godongwana 1992; Smith 1997).³ Involvement in a broad range of bipartisan and tripartite structures put serious strains on union organisational capacity, created a tension between efficiency and participation and opened the potential for a distancing between union leaderships and

² The extent of COSATU's involvement is clear in the head office structure, which included four negotiation task forces (political, economic, social development, labour market) (Zikulala 1992b).

³ Godongwana, General Secretary of the metal union, argued that both mass struggle and negotiations were necessary tactics for fundamental economic transformation.

their memberships (Marie 1992; Vavi 1992; Mkhosana 1992; Von Holdt 1993a; Buhlungu 1994b; Isaacs 1995; SALB1996; NEDLAC 1997). Participants in the debate argued variously for strategic unionism (Von Holdt 1992), bargained corporatism (Baskin 1993), new 'social unionism' (Waterman 1995), and a programme of radical reform using the space created by democratic conditions (Gostner 1996). The movement was hit by a serious brain drain in the 1990s, particularly around the time of the election, as new opportunities opened up: leaders went to Parliament and government and management started to recruit actively among union officials (Buhlungu 1994b; Schreiner 1994).⁴

The change of government resulted in a fundamental shift in COSATU's relationship with government, highlighting the problems of alliance with a political party, especially when that party is in government. COSATU was faced with shifting identities: at times their erstwhile partner was the party (accountable to its members and alliance partners); at times it was the government (accountable to the electorate, balancing relationships with other parties, subject to demands from a broad range of interest groups); and sometimes it was the state (caught in the machinery of administration run by professional bureaucrats sometimes hostile to the new government). This situation required of the trade union movement a subtle and

⁴ The role of intellectuals inside and outside trade unions has been debated over the years, for example in Gwala and Murphy (1994), an account of a discussion between Murphy, a white intellectual, then an official in SACTWU, and Gwala, then General Secretary of SACTWU, a black working class leader who rose from the ranks, having started his working life as a gardener. Adler (1997) disputes the 'brain drain' theory, pointing out that the September Commission was constituted entirely of black working class intellectuals.

strategic approach, using the different avenues available but never neglecting its fundamental power base of direct bargaining with employers.

The debate in the South Africa labour movement about unions and politics centred on social democracy and democratic socialism. Some contributions to the debate came from international participants. Higgins (1993), an Australian left social democrat, proposed the Swedish social democratic route to socialism. In response, South African socialists (some from the labour movement, others from the ANC and the SACP) raised concerns about reformism, the development of industrial policy to support a socialist position and the appropriateness of imported models for the South African situation (Godongwana et al. 1993). Underlying all these responses was a concern about the prospects for the socialist project after the decisive moment in the national liberation project, the first democratic election. Another series of responses included Torres' (1994) caution against uncritical adoption of 'the Swedish model', which raised the question whether social democracy worked in Scandinavia because the country could afford it, in comparison with poorer countries like South Africa. She warned also that 'the ANC may make policies on the basis of national interest rather than labour's priority. Labour would also have to take the "national interest" into account in a transitional reconstruction period, maybe even at the expense of their own members' (Torres 1994, 66). Stilwell (1994), another Australian, examined the appropriateness for South Africa of an Australian-style social contract, highlighting in particular the depoliticisation of the trade union movement and disempowerment of the rank and file membership which may result from a social contract, with its 'high

price in terms of the internal processes of union decision making' as negotiations take place at the highest level between a small number of top union leaders and government decision makers (Stilwell 1994, 84).

Murphy (1994) was sceptical about claims that South Africa was on a social democratic path, re-emphasising the importance of 'democracy on the ground' as the essential feature to secure socialism in the future as follows:

The most "socialist" bit of our experience to date was not the illusion of a worker-friendly, powerful central state, but our own involvement in democratising our own immediate lives through our own grassroots organisations in our factories and in our communities. (Murphy 1994, 61)

One of the underlying ironies of the old regime was that a politically repressive state was, in economic terms, protective. Along with political liberation went economic liberalisation, with serious implications for labour as the rhetoric of competitiveness took hold. The ANC manifesto economic policy had been developed in consultation with the alliance partners, the title (Reconstruction and Development Programme - RDP) revealing the major thrust towards job creation, growth and redistribution (Von Holdt 1993b). Nevertheless, there was unease in the trade union movement about the broadness of the programme and its lack of detail about implementation (Cargill 1993; Etkind and Harvey 1993). Murphy (1994) argued that the RDP could be seen as a social democratic programme only by the 'lowest common denominator standard'. The unease proved well founded. The RDP office, which had been headed by Minister Jay Naidoo (ex-General Secretary of COSATU) and with many ex-unionists among its key personnel, was closed in 1996 and its functions

brought under the control of the Deputy President, Thabo Mbeki, a move widely interpreted as weakening labour's influence (Gotz 1996). The economic framework shifted towards economic neo-liberalism and the RDP was replaced by a policy of Growth, Employment and Redistribution (GEAR), a set of neo-liberal economic policies, developed without labour involvement, which aim to reinsert South Africa into the world economy through competitive exports, which in return require labour flexibility, moderate wage increases and the removal of tariff barriers, all policies with serious implications for labour (African National Congress 1994b; Pillay 1997; Clark and Isaacs 1996; Bond 1996).⁵ GEAR was developed without consultation with COSATU and was resoundingly rejected by COSATU's national congress in September 1997, despite a direct appeal from President Mandela (Clark and Isaacs 1996; Bond 1996; Pillay 1997; kaNkosi 1997). COSATU's president expressed the overwhelming response of delegates by accusing the government of 'putting the country into reverse GEAR' (ka'Nkosi 1997).⁶ This rejection was an expression of the strains that had appeared in the working relationship with government over the first four years (Shilowa 1997; Buhlungu 1997).

There has been continuing debate in trade union circles about the future of the tripartite alliance: on the one hand, there is a view that COSATU is 'flogging a dying

⁵ For an analysis of the impact on health sector restructuring of the change in policy from the RDP to GEAR, see Bond et al. (1997).

⁶ The engagement between trade unions and government on trade policy highlights one of the effects of the political transformation. The current Minister of Trade and Industry, Alec Erwin, is one of the union veterans sent to parliament on the 'COSATU list' (Webster and Von Holdt 1996). The same pattern is seen in the Department of Labour, whose Director-General is an ex-unionist, along with many of the Minister's advisers (SALB 1995).

horse' (Buhlungu 1997), on the other, COSATU's general secretary argues that it is possible to 'revitalise and galvanise the alliance and the people behind transformation' (Shilowa 1997, 71). Some unionists argued that social contracts and co-determination were insufficient weapons to change the nature of capitalism and that the union movement needed to develop militant strategies to support workers' demands (Ronnie 1996; Alexander 1995).

The federation recognised the seriousness of the problems and established the September Commission to investigate the future role of trade unions and formulate proposals on a range of issues, including political alliances and economic policy, as well as internal questions such as organising new members and democratising the workplace (Von Holdt 1996; September Commission 1996). The September Commission spelled out a redistributive economic strategy and a political commitment to extend democracy and revitalise the alliance, as part of an explicitly political project (Adler 1997).

4. *The trade unions in this thesis*

In the period covered by this thesis, there were three trade union federations in South Africa, organising less than a third of the working population. Union density for the country as a whole was 31.3% in 1994, after dramatic growth in the 1980s (Macun 1993; Filita 1997). The largest and most powerful of the federations was COSATU, whose membership was 1.9 million in 1994 (Filita 1997, 36). Non-

racialism is one of COSATU's fundamental principles, but its membership remains overwhelmingly black, and its affiliates have had little success in recruiting and organising white workers. Stumbling blocks include closed shop agreements, white racism and black suspicion (Zikalala 1993a). Where white workers have joined COSATU unions, there have been problems of assimilation (ibid.). There have also been divisions between Indian and African workers, and between coloured and African workers, to some extent related to divide and rule tactics on the part of government and employers (Amra 1993; Coetzee 1993; Valodia 1993). Although it was the dominant federation, COSATU could not claim to represent the working class as a whole. Most COSATU affiliates were industrial unions, their membership predominantly African blue-collar workers below the level of artisans (Von Holdt 1993b).

In October 1986, the Council of Unions of South Africa (CUSA) and the Azanian Congress of Trade Unions (AZACTU), merged to form another federation of black unions, the National Council of Trade Unions (NACTU), which had 23 affiliates and 170,000 members (Kraak 1993, 180). NACTU placed strong emphasis on the development of black leadership and had strong links to the political traditions of black consciousness. CUSA and AZACTU withdrew from the unity talks between the independent unions which had preceded the formation of COSATU because of their opposition to the principle of non-racialism. In the process, CUSA lost its most powerful affiliate, the National Union of Mineworkers, which decided to join COSATU. The high point of NACTU membership was 327,000 in 1994, dropping to

230,000 in 1996 (Filita 1997). NACTU did not recruit white members, but otherwise its unions, membership and operating style were similar to COSATU's and despite ideological differences the two federations co-operated on some of the mass protests of the apartheid era.⁷ Since the change of government, the two federations have been involved together in a range of tripartite institutions. However, repeated attempts to unify them during the late 1980s and into the 1990s have not yet succeeded.

The third federation was the Federation of Unions of South Africa (FEDUSA), whose members were predominantly white. In 1996, FEDUSA had 255,000 members (Filita 1997; Von Holdt and Zikalala 1993; Von Holdt 1993d).⁸ Though the federation had black members (claiming some 30% in 1993), it experienced problems of assimilation equivalent to those which COSATU faced with white members (Von Holdt and Zikalala 1993). FEDUSA organised predominantly white-collar workers and artisans in craft unions, presented itself as 'the moderate voice of labour' and pursued an economic form of unionism:

Our particular image ... stems from the fact that we restrict ourselves to purely economic, labour and consumer issues.... Our style is one of negotiation rather than one of mass action...(Von Holdt and Zikalala 1993: 58).

The thesis focuses on two unions which are affiliated to COSATU, but come from very different political and organisational traditions. The studies which follow trace the influence of these different traditions and practices on the unions' practices

⁷ In 1988, for example, the two federations called a national stay-away, which involved 2.5 to 3 million workers and lasted three days (Kraak 1993, 245).

⁸ FEDUSA was previously named the Federation of South African Labour (FEDSAL).

and approaches to the issue of health care. Other unions are involved in two of the studies: they are either unaffiliated or affiliated to FEDUSA.

SACTWU

The first three studies involved SACTWU, a union which was the product of a number of mergers of unions with very different memberships and traditions. The first study was undertaken with the Western Cape branch, whose precursor was the Garment Workers' Union - Western Province (GWU-WP), a union with a history of close alliance with employers (Nicol 1983; 1984b).⁹ The second study was with SACTWU's leather sector and the third with SACTWU's clothing sector, this time in Natal.¹⁰ This last branch came from a very different tradition of unionism, being dominated by leaders who had come from the old textile union which was part of the new wave of radical, largely African, unionism of the 1970s (Friedman 1987, 37-68; Baskin 1991, 18-17-18; Kraak 1993, 127-129; Khwela 1993).

The GWU-WP was a much older union, established in 1927. However, it was a paper union from the start, the impetus for its establishment having come from the employers' association (Nicol 1983). The employers sought to pre-empt government regulation of wages in their industry by establishing an alternative mechanism for wage agreement by negotiation with a trade union. The only problem was that in order to establish an Industrial Council (IC), they needed a union and clothing workers were unorganised. After unsuccessful attempts to organise a union themselves, employers

⁹ Unionisation in the Western Cape is close to the national average rate, at 29,7% (Filita 1997, 38).

¹⁰ Unionisation in KwaZulu-Natal is 30,6% (ibid.).

approached the Cape Federation of Labour Unions (CFLU) for assistance and in 1927 the GWU-WP was registered under the Industrial Conciliation Act. The first Industrial Council collapsed as a result of rank and file opposition, and the industry was regulated by the Wage Board rather than an IC for the next 10 years. The union effectively collapsed, though it retained its paper registration and its secretary, who continued to attempt to draw employers into an IC. Meanwhile, garment workers elsewhere had been organised by very different trade unions, most notably by the Garment Workers' Union (GWU) in the Transvaal, led by the radical Solly Sachs.¹¹ The paper leadership in the Cape rebuffed the Transvaal proposal to form a national union, which was followed by several robust attempts in 1930-1 and 1935-7 to establish a rival union in the Cape (Nicol 1983, Lewis 1976b). The CFLU leadership were firmly opposed to both party political affiliation and trade union militancy and fought off the challenges from the north and a take-over bid in 1937 from supporters of the idea of a national union, with the assistance and encouragement of employers (Nicol 1983). By the time the Industrial Council was registered by the Minister of Labour in 1937, the battle to develop an alternative organisation for garment workers in the Cape was effectively over. In the end, the union 'entered its first industrial council agreement already structured as a compliant bosses' union, which the manufacturers had "organised" by arranging the enrolment of their workers' (Nicol 1983, 255). Thereafter the union settled down to five decades of 'sweetheart' style

¹¹ Solly Sachs, an immigrant from Russia, was reviled by the South African government and employers as 'the Jew Communist'. He was in fact expelled by the South African Communist Party in 1931, a fact which did not stop the SA government from 'listing' him under the Suppression of Communism Act of 1950 (Lewis 1976b, 73).

unionism, disturbed only briefly by several campaigns by the Transvaal union in the 1940s and 1950s which failed, despite support from shopfloor workers, another frustrated bid to 'clean up the union' from the inside by ousting the executive and the General Secretary in the mid-1970s (Maree 1976) and a short-lived attempt to organise a rival union, the Clothing Workers' Union (CLOWU) in the early 1980s (Nicol 1984a; Gool 1985).

The union was unaffected by the repression of the 1960s and 1970s, indicative of its incorporated position. As Lewis (1976a, 58) points out, it was significant 'that this supposedly powerful union... [did not attract] the hostility of the state, but nor has it attracted the support of an articulate element of its rank and file'. As the largest union in the Western Cape, the GWU-WP was a challenge to political activists, a number of whom took jobs in the union from the mid-1980s and began quietly to transform it from within. In 1987, this transformation of the union was manifested in the launch of a new union, the result of a merger with another union with a conservative history, the Garment Workers Industrial Union (Natal) (Labour Study Group 1985; Bernickow 1988; GAWU 1988a; GAWU 1988b).¹² The new Garment and Allied Workers' Union (GAWU):

committed itself to align the new union to the progressive labour movement in South Africa and to unity with other unions in the industry. Our doors have been open and remain open and we hope to see faithful unity talks taking place between unions in the industry over the coming months. (Bernickow 1988, 76)

¹² Both unions had been affiliates of the Trade Union Congress of South Africa, which dissolved in 1986.

SACTWU was a relative newcomer to the leather sector, the subject of the second study. Recruiting in this new sector began under ACTWUSA and accelerated after the formation of SACTWU. The union had had to fight a legal battle for representation on the National Industrial Council for the Leather Industry, where it competed with the two established unions, a small regionally based union, the Transvaal Leather and Allied Trades Union (TLATIU) and a national union, the National Union of Leatherworkers (NULW). SACTWU took recruitment into new areas to extend its base and wanted, like the NULW, to absorb the TLATIU.

The Natal branch of SACTWU, the subject of the third study, was rooted in a very different tradition of unionism from the Cape. A separate series of mergers resulted in the formation of the Amalgamated Clothing and Textile Workers Union of South Africa (ACTWUSA) in November 1987, just a month before the launch of GAWU.¹³ The COSATU-affiliated National Union of Textile Workers (NUTW) merged with two smaller unions (formerly affiliated to the Trade Union Congress of South Africa - TUCSA), the National Union of Garment Workers (NUGW-SA) and the Textile Workers Industrial Union (TWIU) (NUGW 1987; NUTW 1987; TWIU 1987; Markham 1987). Though a national union, ACTWUSA's base was in Natal, the centre of the 1970s wave of worker militancy (Friedman 1987, 37-68; Baskin 1991, 17-18). The NUTW was a founder member of COSATU, and leaders from NUTW were highly influential in the new union, ACTWUSA.

¹³ ACTWUSA's membership (71'000) was predominantly in the textile industry in Natal and the clothing industry in the Transvaal. GAWU's membership (98'000) was in the Cape and Natal clothing industries.

Attempts to bring the constituent unions of GAWU and ACTWUSA together in one merger had failed and, despite positive public statements about 'unity', there was considerable tension between GAWU and ACTWUSA, especially in Natal (Baskin 1991, 304-7). ACTWUSA felt strongly that the COSATU general secretary should not accept an invitation to address the launch of GAWU, because of the GAWU unions' history of collaboration with employers and their 'bureaucratic style'. The COSATU Central Executive Committee overruled these complaints, judging that 'progressive and militant individuals had gained the upper hand within both GAWU (Natal) and WPGWU [sic]' (Baskin 1991). There was also apprehension among Cape workers, as expressed by a prominent worker leader:

The workers were beginning to feel comfortable with the idea that they had a union called GAWU. But a lot of fears emerged amongst us: will we still be the same union, are we being taken over, *benefits*, leadership etc. It was a painful period, because there were two big unions each with its own way of operating and traditions. (Gabriels 1991, 94) [emphasis mine]

GAWU and ACTWUSA finally merged in September 1989 (SALB 1989; Kraak 1993; Baskin 1991).¹⁴ The new union was the third largest affiliate of COSATU and was notable for bringing a substantial group of coloured and Indian workers into the federation for the first time, as well as for dramatically increasing the number of women in COSATU (Baskin 1991, 304-307; 393-395). The post of General Secretary of the new union went first to Lionel October (ex-GAWU) and the head office was based in Cape Town for the first year. Subsequently, the position was

¹⁴ Despite large-scale retrenchments, SACTWU (with 160'000 members in 1996) remains the third largest affiliate of COSATU, behind the mining and metal unions (Filita 1997).

resumed by John Copelyn, the powerful ex-General Secretary of ACTWUSA (and previously of NUTW), and the head office moved back to Natal, where it has remained since.¹⁵ The Durban building, owned by the union, houses both the national and the regional offices.¹⁶

SARHWU

The last study developed from a relationship with the South African Railways and Harbour Workers Union (SARHWU), but entered the complex ground of multi-unionism in a multi-layered workforce, in comparison with the relatively homogeneous workforces of the clothing and leather industries. SARHWU was launched in 1936 by African railway workers in Cape Town, in response to moves by Afrikaner nationalists to expel black workers from the railway union. South African Communist Party (SACP) militants were active in the organising campaign (Lewis 1976a), which resulted in a national membership of 20,000 by the early 1940s (Luckhardt and Wall 1980, 53). In the early 1960s it ceased to function, along with many other unions, in the wake of severe state repression. In October 1986, several months into the second state of emergency, it was re-launched. The new union was strongly political, aligned to the ANC, and formed part of the United Democratic Front (UDF) bloc within COSATU.

¹⁵ John Copelyn remained General Secretary until he left the union to enter Parliament as one of the official COSATU nominees for the ANC parliamentary list. He subsequently left Parliament to join a very large investment company (Copelyn 1997).

¹⁶ The majority of union head offices are in Johannesburg, with a few exceptions, notably SACTWU in Durban, and the food and municipal unions in Cape Town. SACTWU also lets space in its Durban building to the Industrial Council, the central Sick Fund clinic, a clothing co-operative formed in the wake of widespread sackings after a strike wave, and the Natal branch of the Workers' College.

The South African Transport Services (SATS) was a massively powerful state corporation, incorporating a substantial proportion of the entire transport sector.¹⁷ As a state corporation, it was exempt from general labour legislation. The Condition of Services (SATS) Act of 1983 banned all strikes, defining transport as an 'essential service'. Nevertheless, the early years of the re-launched union were overshadowed by two massive and violent strikes, in 1987 and 1989/90.¹⁸ The union was faced with an intransigent management, but had an equally intransigent membership: 'SARHWU members were renowned for their militancy, SATS for its conservatism and inflexibility' (Baskin 1991, 418). SATS management refused to negotiate with SARHWU, declaring that black workers were represented by the Black Trade Union (BLATU) a management-founded union which was one of the eleven in-house unions then recognised for negotiating purposes (Baskin 1991, 172). The escalating strike was finally settled when management caved in and reinstated strikers without loss of benefit and extended the right to permanent status after two years employment to black workers, who had previously remained temporary, however long their service. However, the company still refused to recognise SARHWU. It was only after the second strike that the company finally bowed to the inevitable and extended interim recognition to the union, pending registration. SARHWU attended its first wage

¹⁷ In 1984, transport amounted to 7.2% of South Africa's GDP, 77% of which was contributed by SATS, which employed 240,000 out of the sector total of 339,000 (Green 1986, 27). Since this time, and especially since commercialisation in 1991, there has been considerable downsizing (Macun 1995).

¹⁸ In the 1987 strike, more than 10 people (strikers and scabs) were killed, more than 800 detained, the police twice laid siege to COSATU House, subsequently destroyed by a right-wing bomb attack, a SARHWU office was destroyed in an arson attack, at least 50 railway coaches were torched and there were bomb blasts on railway property. In the 1989/90 strike, more than 30 strikers and scabs were killed (Baskin 1992, 171-181, 417-8; Matiko 1987).

negotiations in April 1990. Between the two strikes, SARHWU struggled to consolidate its membership, hugely swollen by mass enrolments during the first national strike. It also suffered from convulsions in leadership, which compounded the difficulties of creating a smooth administration (Zikalala 1992a).¹⁹

This was the background to the fourth study: a militant black union and a company with a conservative history as one of the bastions of protected white labour, and very poorly developed industrial relations. The scars of bitter disputes were barely healed and memories of violence and repression had entrenched black workers' distrust of the management. The nine other unions in the company had a very different background: they had well-established relationships with management and were recognised parties in negotiations with Transnet (the company name since commercialisation), which was still the largest transport company and fourth largest company in the country in 1995 (Macun 1995, 13).

5. Trade unions at work

Unions develop a range of practices to pursue their purposes. These include recruiting, organising, educating and representing members. Recruitment may be passive (with the closed shop the most extreme example) or active (member by member, or campaign style recruiting). Trade union mergers like those described

¹⁹ At the 1988 congress, all office bearers except the president were replaced. This precipitated a series of resignations of key officials, and the removal of the general secretary and another office bearer (Baskin 1991, 310-11).

above are a form of relatively passive mass recruitment. Closed shops pose the danger of lack of engagement by leaders, who have a captive membership. This had been the case in the Cape clothing industry, where some members did not know the name of their union and others did not even know that they were union members, though union dues were deducted weekly from their wages.

Campaigning

Campaign style recruiting poses its own problems, especially when associated with strikes or other industrial action, as union growth can be too rapid for organisational stability, as in SARHWU's case. This kind of recruiting was a feature of South African unionism, particularly in the early to mid-1980s, when general unions were common and functioned as organisations of community political mobilisation as much as (and in some cases more than) workplace based organisations (Baskin 1991, 28-29).²⁹ The campaign style may extend to broader organisational practices. During the 1980s and into the 1990s, there was a constant call to South African unions to join in solidarity campaigns with community and political organisations on a range of issues from opposition to value added tax, to support for school, transport and rent boycotts (Kraak 1993, chapter 8). Solidarity appeals went both ways, as striking unions often appealed to community organisations for support in terms of product boycotts and fundraising (Kraak 1993, chapter 7). Populist solidarity work is demanding of a union,

²⁹ The general secretary of SARHWU, Derrick Simoko, is a veteran of the best known of the 'community' unions, the South African Allied Workers' Union (SAAWU), based in East London. SAAWU was extremely active in mass mobilisation in the early 1980s and was consequently the target for particularly intense state repression.

tying up scarce organisational resources and potentially distracting from less glamorous organisational groundwork. When it takes on an overtly political line, it may alienate non-activists and even endanger union members, in polarised situations, by identifying them with one particular political tendency. This danger was particularly acute in Natal, the stronghold of the Inkatha Freedom Party (IFP), as SACTWU was aware from its experience in the province. Public attacks on the IFP by COSATU leaders intensified the organisational difficulties of unions in Natal (Baskin 1991, chapter 4). Engagement by the trade union movement in party politics reached its height in the pre-election period of the 1990s, when COSATU entered a formal alliance with the ANC and SACP to fight the election on a common ticket. The strains on this alliance in the post-election period have been referred to earlier, especially in terms of shifts in economic policy and their impact on the labour movement. At an immediate level, inside the unions, the alliance also absorbed leadership energy and contributed to an increasing distance between leaders, engaged in multiple tripartite policy making bodies, and members, whose working lives were not significantly altered by the new political order.

Bargaining structures

South Africa does not have a uniform system of collective bargaining for the country as a whole. In some sectors (including clothing and leather), there is centralised bargaining, sometimes on a regional basis and sometimes on a national basis. Some sectors, like mining, have elements of centralised bargaining; others

bargain at enterprise level and some (most notably domestic service and agriculture) have little or no bargaining.²¹ The first three studies take place in Industrial Councils (ICs), voluntary institutions for centralised collective bargaining established under the Industrial Conciliation Act (No.11 of 1924, as amended). ICs have jurisdiction over a defined industrial scope and geographical area, which may be local, regional, provincial or national (Godfrey 1992).²² Employers and trade unions have equal representation and the Act allows for the extension of the agreements made to all employers and workers within the Council's jurisdiction, provided that the Minister judges the parties to the Council to be sufficiently representative. The Act does not regulate trade union participation, or specify majoritarianism or proportional representation. The only explicit regulation restricts representation on the IC to *registered* trade unions. The parties to the IC negotiate minimum wages for job categories and working conditions, establish benefit funds and negotiate procedures for dealing with disputes. The Main Agreement is re-negotiated annually or bi-annually and the IC meets regularly, appointing full-time officials to run its affairs, including a Secretary/General Secretary, agents (who police the agreements) and administrative staff to administer benefits and finances. Council business is financed by a levy on all employers and workers.

²¹ The Labour Relations Act of 1995 introduced 'flexible regulation', and aimed to shift from an adversarial to a co-operative framework (Baskin and Satgar, 1995; Cooper 1996; Smith 1997).

²² For this section, I have drawn extensively on Godfrey's study of Industrial Councils. In 1992, there were 7 national councils, 33 regional councils, 31 local councils, 6 single company councils and 8 local authority councils (Godfrey 1992, 44).

The Councils were originally established in order to promote self-governance and minimise state intervention (though the Minister retained the discretionary power to refuse to sign agreements, which then lacked legal force). The Act imposed a duty to maintain industrial peace. In the early years, Councils were mostly dominated by employers, some employer groups going so far as to establish unions in order to be able to set up ICs. On the union side, the dominance of artisan unions can be seen in the elaboration of job categories and large differentials between artisans on the one hand and semi-skilled and unskilled workers on the other. Until 1979, 'pass-bearing Africans' were legally excluded from representation on ICs, for fear that majority power would enable their unions 'to exercise such influence on the fixation [sic] of wages as to have a detrimental effect on the wage levels of European, Indian and Coloured workers in the same industry...' (Report of the Industrial Legislation Commission of Enquiry, quoted in Godfrey 1992, 24). Instead, they were relegated to a separate industrial relations system, consisting of liaison and works committees.

Legislation in 1956 imposed a further division on trade unions, forcing them to split into separate branches for white workers on the one hand and coloured and Indian workers on the other.²¹ This legal separation remained in place until 1979, when the government accepted the recommendations of the Wiehahn Commission of Inquiry that African workers be allowed to join registered unions and that trade unions be allowed to admit members from any racial group. The debates on the issue of registration centred on the questions of co-optation by the state or strategic entryism

²¹ Some unions paid little more than lip service to this requirement.

(Nicol 1980; Fine, De Clercq and Innes 1981). Many of the new unions had developed on the basis of organisational principles which stressed 'factory-floor organisation and the building of strong shop steward structures, workers control and plant-level bargaining' (Godfrey 1992, 28). They were inherently suspicious of the government's motives and held that the Industrial Council structures were inappropriate to their organisational style. There were, however, strong voices in the new unions, arguing that the Councils provided the mechanism for inter-company links and opened the way to broader mobilisation, if tactically used (Friedman 1987, 326-331). By the mid-1980s, especially after the formation of COSATU in 1985 and the subsequent mergers in the 'one industry-one union' policy, the rapid growth of these unions led to increased concentration on centralised bargaining, and greater involvement in Industrial Councils (Patel 1990).²⁴

Organising style relates closely to the bargaining structures which operate within a particular sector. If bargaining takes place at plant level, organising will tend to focus on the plant, with less attention to inter-plant linkages, particularly given the labour-intensive nature of plant by plant bargaining. Though links between members and the union officials responsible for the particular plant are developed through regular contact, broader links and incorporation into union activity at branch level or above may be stunted. There are major economies of scale in centralised bargaining, at regional or national level, allowing a far more rational deployment of union

²⁴ Debate about the Industrial Council system continues, with Theron (1993) raising concerns about the undermining effect of a growing trend towards small business and Von Holdt (1994) focusing on whether the system constrains or renews industry.

resources (Toerien 1989; Patel 1990; Baskin 1995). The attendant danger is that bargaining may become the preserve of national officials, who centralise bargaining skills and experience and have minimal contact with members. Only where there are strong shop steward structures, backed by established practices of obtaining a mandate and reporting back to members, can this danger be minimised. There were centralised bargaining structures in all four studies, regionally based in the two clothing studies and national in the leather and transport sector studies. The arguments for centralised bargaining were cogently expressed by Ebrahim Patel, a SACTWU strategist:

Firstly, centralised bargaining allows for the most efficient use of skilled union and employer negotiators... Secondly, [it] allows trade unions and employers to establish industry wide minimum and fair standards... Thirdly, where centralised bargaining is conducted through institutions which allow the legal regulation of minimum standards, for example industrial councils, it sets a clear rate for the job. This prevents wage cutting by weakly unionised competitors of companies paying fair wages... Fourthly, some industries consist of a large number of small operations and plants, and wage agreements cannot realistically be concluded at each such plant... *Fifthly, some negotiations such as those involving benefit funds or training schemes benefit from economies of scale which can only be achieved through centralised agreements...*[emphasis mine] Finally, [it] increases the power of both parties. Labour is strong because it is able to close down an entire industry during industrial action. (Patel 1990, 50)

The studies

The first study was in a single-union IC with regional scope, covering the clothing industry in the Western Cape, the union being SACTWU. The second study was in a multi-union IC with national scope, covering the leather industry. Here SACTWU was a minority union, competing with the established majority union, the unaffiliated National Union of Leather Workers (NULW) for members and power.

The third union, the Transvaal Leather and Allied Trades Industrial Union (TLATIU), had a static and limited membership, and was targeted by both of the other unions for takeover. The third study was in another single-union council with regional scope, covering the clothing industry in certain parts of Natal, mainly in the Durban area. SACTWU was again the only union. Each of these councils had jurisdiction over many employers and representation consisted of employer organisations, along with some individual employers. SACTWU, given existing structures for collective bargaining in the Industrial Councils in two of the sectors in which it organised (clothing and leather), engaged with them vigorously and fought for their scope to be extended to all employers, including those in the 'decentralised areas' (Von Holdt 1993a; Collins 1995; Rossouw 1997).

Although there was an Industrial Council in Transnet, the company which is the subject of the fourth study, the medical scheme was not dealt with in this forum. Instead a new body was established. The Board of Trustees had equal representation for the 'employer' (by way of appointees from the ranks of management) and for trade unions. This study was distinguished from the IC studies by the single employer, the large number of unions involved, the fact that they were all effectively one-company unions and the heterogeneity of the unionised workforce which ranged from railway labourers to pilots.²⁵ The decision to create a new structure, rather than to situate the issue in the Transnet Industrial Council, had far reaching effects, which are explored in

²⁵ SARHWU organised a small number of non-Transnet workers, in the airports authority and two small airlines.

the fourth study. The first three, by contrast, place health care directly in the arena of bargaining, rooting it in the familiar exercise of a core trade union function.

Inter-union relations

Though each study has a primary focus on one union, this union cannot be considered in isolation from its relations with other unions. At the most direct level, two of the studies (leather and transport) took place in multi-union situations. Relations within bargaining structures may be competitive or collaborative, depending on the organisational definition of the unions concerned. Competition for members and for political advantage colour the bargaining process and open a wedge for employer manipulation, particularly when multi-unionism goes along with bargaining across the spectrum of employment, which adds the factor of sectional material interest. Two kinds of multi-unionism are seen in the studies: in a homogeneous employment group (leather) and in a very heterogeneous group (transport), the latter case made more complex by historic discrimination on racial grounds.

At a less immediate level, unions relate to others within the same federation and are affected by developments and debates at a federation level. COSATU has followed a policy of 'one industry, one union' which has gradually reduced the number of unions in a series of mergers. The mergers minimised but did not entirely eliminate inter-union tensions, as political and strategic differences remained. Traces of the pre-merger identities of the component unions are discernible in the different approaches of the Cape and Natal regions of SACTWU. A projected move towards 'super

unions', drawing all members into no more than a handful of unions, will inevitably revive some of the tensions which characterised the merger period.²⁶

Lastly, there are relations between unions across federations and between the federations themselves, in countries with more than one national federation. In South Africa, new tripartite structures such as the National Economic Development and Labour Council (NEDLAC) have required a greater degree of contact and collaboration between the three remaining federations on national issues affecting labour, but political differences make for an uneasy partnership.

Trade unions are rooted in a particular political economy and their purpose is worked out in a dynamic relationship with the politics and economics of their time. This is clear in the trajectory of development of trade unions in South Africa, where political disenfranchisement and repression suppressed most forms of political activity of the black majority. Legalisation of black trade unions was in the end an economic necessity, to regularise industrial relations and minimise disruption of production. But this legalisation also opened the door to the development of organisationally based resistance to the regime in a form of unionism which went far beyond workplace issues. While repression greatly complicated the operation of trade unions, it also created the conditions for a renewal of trade union power. Political liberation has raised new problems and restrictions on trade unions' pursuit of working class advancement. Political enfranchisement has provided other outlets for political activity

²⁶ Initial discussion at the 1997 COSATU congress envisaged no more than six super unions, one of which would unite the transport sector, public and private, uniting SARHWU and the Transport and General Workers' Union (TGWU).

for members and presented the challenge of recrafting a relationship with the political party turned government, which is responsible for a range of policies which threaten labour. The shift is highly problematic and requires 'defining a new etiquette of opposition and support' (Adler 1997).

6. The limits and possibilities of trade union action

I argue that there are certain circumstances in which trade unions can pursue an agenda on health care that is political as well as practical, strengthening democratic practices inside unions and broadening union responsibility beyond the workplace and workers, to families and communities. This is a process of 'extending the frontiers of control', though not *inside* the workplace (on this latter point, see Goodrich 1975). In this case, trade union leaderships use workplace strength as a base from which to act for their members and challenge the power which medical and other professionals exercise over health care planning and provision. In the process, they open up a way to bring workers' experience to bear in the processes which will determine the health care to which they have access. The power of trade unions in health care is directly linked to their organisation as democratic structures, which uniquely enable them to represent the views of their members as health service users and rescue them from the general isolation and disempowerment typical of the 'patient' experience.

The debate about democratic workplace activism took a particular slant in South Africa, addressing the potential for workplace activism to become a political

force. European debates focused on the capacity of workplace activism to overcome the bureaucratisation of established unions and to dilute the power of distant leaderships, thereby renewing their unions (Hyman 1979; 1989; Fairbrother and Waddington 1990). In South Africa, the repression of the 1950s and 1960s had wiped out most black unions, often before they had the opportunity to establish bureaucratised forms of unionism. An exception was the precursor to the first union branch studied, which had a highly developed bureaucratic structure, challenged by a new leadership (Maree 1976; Lewis 1976a; Nicol 1983; 1984b). The 'workerist' stance was in opposition not to bureaucratic relations, but to 'populism', identified as too great an identification with broad front community and liberation politics (Foster 1982; Friedman 1987; Baskin 1991). The danger was hijacking of the trade union project not by paid officials, but by community and political organisations. 'Workerists' placed particular emphasis on the development of strong structures of workplace democracy to guard against a repeat of the 1950s, when the union movement was undermined by alliance with the nationalist movement. This time round, they argued, the union movement must first develop its own base in the membership, in order to engage at a political level from a position of strength and independence. Over-concentration of leadership at the official level was problematic in strategic terms, given state hostility. For survival, the union movement needed to keep generating worker leaders (Gool 1985; Gostner 1995; Keet 1992).

The bases of trade unionism

Trade unions are based on relationships, the most basic being the relationship between members and leaders (Collins 1994b). Each of the studies in this thesis had a particular set of relations, arising out of different histories and developing in distinct ways. Only one was in a union branch with a bureaucratic history. Like bureaucratised unions in general, it was characterised by centralised structures, often remote leaders and relatively quiescent members, presenting a particular challenge to a new cadre of leadership, intent on transforming it. Unions built on participatory democracy have structures for representation and accountability which link leaders and members more closely and in an ongoing way (Heery and Fosh, 1990). No system is static, however, and democratic unions manifest an ongoing tension between efficiency and democracy. Where unions become bureaucratised around entrenched leadership, renewal may be sparked by the emergence of new leaders, who establish links with members and develop this support base by articulating and developing demands which strike a chord in member experience, but are also winnable. They invest their credibility in these issues and distinguish themselves from the entrenched leadership by the nature of their relationships with members. In a competitive multi-union context, leaders also pursue strategic objectives, sometimes building alliances with other unions by acting in solidarity, sometimes defending or advancing the sectional interests of their members, sometimes taking the lead in order to attract membership from other less active unions. Access to official leadership positions holds the danger that they

may in turn become entrenched and bureaucratized. Taking office exposes the principles of democracy to the test of practice: can new leaders maintain an open and accountable relationship with members once in office and are the habits and expectations of democracy sufficiently firmly grounded for the membership to challenge the new leaders if they fail?

Trade unions and struggle

The concerns of the thesis connect with debates about the scope for union renewal (Fairbrother 1996; Fosh 1993; and for a critique of these positions, Mellroy 1995). Are trade unions tied to the workplace, the wage relationship and bargaining, and does this restrict their capacity for fundamental change? This study approaches these questions through the prism of trade union action on health care. Unions cannot neglect the basic relationship with employers, in which they bargain over the wages and working conditions of their members, but they can question the assumptions and limitations of the bargaining agenda. These trade unions were involved in challenging an instrumental view of worker health care by expanding its scope beyond workers to their families. They also moved beyond the sphere of the bargaining relationship with employers into a more political sphere, by exerting their right to determine the nature of the health services provided for their members and engaging in active management of these services.

This process is a dynamic one, involving an ongoing struggle at different levels: a struggle to get health care onto the union agenda and then to keep it there. Inside

the union, the health care issue is defined, shifted and re-defined in relation to other demands and priorities. In negotiation, these priorities shift again in response to the exigencies of bargaining. Without strategic support from key union leaders, health care issues may give ground to more high profile or immediate demands. Without active engagement in the management of health schemes, there is the danger that they become again the domain of medical professionals. Thus, struggle is a part of the model of health care provision which emerges in the studies which follow, in which success is related directly to a number of key factors: the identification of union leaders with the issue; the degree to which membership support is elicited and maintained; the complex equilibrium between the health care demand and others in the bargaining process; and finally, broader economic and political developments at the national level.

How the study is organised

Chapter 2 is a reflection on the methodology of the studies. Chapter 3 provides an introduction to the South African health system, in order to contextualise the projects. The system, with its mix of public and private services and public and private funding, has features which may be surprising to readers from countries with national health services or national health insurance. This is followed by four chapters (4 to 7), each on a union health care project. Chapter 4 concerns the restructuring of the Sick Fund of the Cape Clothing Industrial Council (CCIC) with the South African Clothing and Textile Workers' Union (SACTWU). This chapter focuses particularly

on the possibilities for union action, while those that follow highlight the constraints and limitations. In Chapter 5, I explore the way in which a multi-union context and national scope affects the way in which the same union, SACTWU, pursues an agenda about health care in the National Industrial Council for the Leather Industry (NICLI). Chapter 6 focuses on failure, exploring the reasons for this failure and the difficulty of transferring a model of health care, even within one union and one industry, from the Cape to Natal. In this study, the unsettling effects of political transformation are seen in acute form. Chapter 7 concerns a project after the change of government and provides a dramatic contrast to the earlier studies, in almost all respects. This time the major union is the South African Railways and Harbour Workers' Union (SARHWU) and the study of Transmed focuses on a medical scheme in the state transport sector, highlighting the particular problems and challenges of restructuring in a situation of multi-unionism of a very different type from NICLI, with a heterogeneous membership far more typical of the South African population. This chapter highlights the way in which competition between the leaderships of very different unions affects the process of restructuring. After the four studies, there are two chapters which draw out analytic themes from the four study chapters, focusing on trade unions in chapter 8 and on health care in chapter 9. Chapter 10 returns to the argument and looks to the future.

Chapter 2. Reflections on methodology

1. *Advocate research*

This thesis arises out of extended work on medical funds with South African trade unions from a base in a research group established to provide support for the trade union movement. It has features of a number of styles of research: 'advocate research', in that it is coloured by my political belief in the role and importance of trade unions; 'participatory research', insofar as it was carried out *with* the unions, rather than *on* them; and 'action research' in that I was not simply an observer of processes that would have occurred without me, but an actor whose involvement was part of the processes which I also observed (Burgess 1984, 20; Cornwall and Jewkes 1995).

Features of the earlier phase of this work with simple Sick Funds (1987-1994) are highlighted by analysis of an intensive period of work in 1995/6 on a more complex medical aid scheme. The research is based on description, comparison and analysis of these medical funds, focusing particularly on union involvement in the process of re-structuring the funds and managing the process of changing them. Tracking and analysing this process (and my relationship with it) is the heart of the thesis. It is a process which does not fit neatly with a conventional definition of research design, starting with a literature review and progressing to design, research and write-up.¹ Instead it is grounded in a 'pre-fieldwork

¹ Bryman (1988, 7) is reassuringly sceptical about the suspiciously neat and linear textbook descriptions of research processes and their similarity to journal article format.

fieldwork' period of eleven years' work from 1980-1991 in the Industrial Health Research Group (IHRG), based at the University of Cape Town, where the problems associated with the provision of health care for workers demanded rapid and practical responses.

2. *The Industrial Health Research Group*

The IHRG was established in 1980 to provide services in the area of occupational health and safety to the independent trade union movement in South Africa, which had minimal research capacity at the time. These services vary from information and education on hazards and rights, through industrial hygiene and medical services, to consultancy on a range of issues, in my case, medical schemes and health services for workers. The IHRG's purpose has naturally influenced the direction of our work and the balance between 'service' and academic work, as has the fact that we have been funded primarily by the international trade union movement, in solidarity with South African unions, especially in the apartheid years.² This leads to a constant, and only occasionally productive, tension between responding to immediate demands and carving out the time to write up the work for publication. The two aspects are not as contradictory as may at first appear: the rigour required for journal publication improves subsequent research design (at the very least it minimises repetition of mistakes) and our credibility as union consultants is enhanced by publication.

² The university gives us offices. We fund all other costs, including salaries, from international donors, consultancy or research. All staff are on one year contracts.

Our working situation imposes constraints which are relevant to this study. Time is always a problem, in terms of both competing demands and the deadlines of unions (sometimes unrealistically urgent, sometimes vulnerable to re-prioritisation). Over the past ten years, consultancy on medical schemes (for many unions) has constituted an increasingly large and urgent proportion of my work, informing a desire to 'research' this area, to move towards a more rigorous study which would in turn feed into future work. The natural conclusion was to follow this through in a Ph.D. I used a brief sabbatical (3 months in 1991) to develop the research design and plan the project in some detail and planned to complete the major fieldwork involved in the study during a six month period of unpaid leave on my return to South Africa. In the event, I returned to work and took on another project, pending agreement between the union and employers. The union had decided that I should be an 'Industrial Council consultant', with a mandate from both parties, rather than a 'union' consultant. The advantage was that I had far greater co-operation and access to workplaces and information. The IHRG would also be paid, which had implications not only for the precarious finances of the group, but also for the seriousness with which the employers and the IC would view the research Report. Payment raises certain fundamental questions about the nature of the process: it turns the researcher into a consultant, imposes an organisational rather than academic timetable on the work and necessitates a form of output suited to those who contract the research. Unlike Fryer et al. (n.d. iii), I was not exercised about the title of 'consultant', which the union simply appropriated from management discourse to legitimate my role.¹

¹ Fryer et al. (n.d., iii) were concerned because for them the term '... implied connotations of

The fill-in project was re-designing the Leather Sick Fund, which was valuable experience, though the research style was different from the clothing study. In the end, the clothing study happened in the middle of IHRG work, rather than during sabbatical. This had both positive and negative effects: positive in that it could take its natural course, without pressure to fit my timetable (this was helpful in my relations with union leadership and removed a source of personal tension), negative in that I had to juggle conflicting demands on my time. My appointment was only agreed in May 1992, dangerously close to wage negotiation season. There was a danger that the emotions of negotiation would colour the research and skew the results and consequently I had to 'leave the field', in Beynon's (1988) term, to avoid public identification with the union in a time of conflict and consequent erosion of trust and possibly access. Serendipity played a part in the Transmed project. I had been systematically clearing my commitments in preparation for a sabbatical planned to start in April 1996, but funding problems resulted in a delay to September, leaving me with fewer commitments than usual and consequently far more time and energy to devote to Transmed.

During the 1990s, cuts in donor funding led to shifts in the style of the IHRG's work, as the deficit had to be made up from other sources (research grants, policy work and consultancy). The result for me was twofold: my work as director (planning, fundraising, organising and accounting for funding) became more demanding and the income from my consultancy work more crucial. Both features made it hard to take time out. Hickson's comment on '...juggling thinking

expertise, advice to heads of authoritarian hierarchies and a generally un-democratic approach to organizational change that we associated more with business enterprises than trade unions'.

time against fieldwork time against research-grant-proposal-composing time' strikes a chord (Hickson 1988, 147).

In the past ten years, my written work, other than research reports (for non-academic audiences), has been largely for non-academic conferences and policy fora. In 1994 I registered for a postgraduate Diploma in Health Management (Economics and Financial Planning) (DHMEF), partly for exposure to a literature which I had not previously read which I thought would be relevant and partly to brush up on my increasingly rusty academic writing.

A feature of 'advocate research' is the necessity to take the process further than the delivery of a research report. In the Cape clothing study, the follow-up work was far more time-consuming than the original research. It was much more difficult to measure or chart, but fundamental to implementation. This involvement was both a consequence of my working base in the IHRG, with its trade union funding and role, and also the price for union co-operation in a study, the style of which was unusual and, in their terms, dubiously necessary. I could, for instance, have reported on the Fund on the basis of analysis of IC and employer records, with user information derived from union meetings at various levels. Instead, I undertook a sample survey, which took far longer. However, employers were reassured by the 'scientific' basis of the research report and my time was cheap. (It turned out that the union and I had arrived at absurdly low rates, as the employers informed me at the end of the project).

The research was followed by a battle to carve out time to write it up. Plans to publish several articles on aspects of the study during the research process, to gather comment and criticism before the final write-up, had to be abandoned

because of time pressure. This was frustrating, not only in terms of the thesis process, but also because publications (and higher degrees!) aid our credibility in the university, whose hierarchy is dominated by natural scientists and where there is some dispute about whether we should be allowed the use of the word 'research' in our title. The work of the IHRC is not easily comparable with the output of, say, the ornithological research institute but I argue that our undertaking as a whole should be seen as a valid part of a broader definition of research. This means taking seriously such issues as the production of the results of our research in accessible and popular form (which takes time as well as a set of skills not often recognised) and through worker education (again a specialised skill ironically not much recognised in universities outside of education departments). During 1996, the university began to shift its position on 'research', in the first place by starting to develop guidelines for recognition of policy research, recognising that contracted policy work (usually for government) by its nature does not result in peer-reviewed publications. The IHRC is increasingly gaining access to domestic research funding, for example in major projects for the department of labour, and enough qualifications have been gained (or are in process) to reduce pressure from our Board of Control.

Since I registered for this degree in 1991, change around me has inexorably affected the thesis process: major political change, health sector change and change in the nature of my work have all expanded my role and increased my experience - though they have also diluted my concentration and consumed my time. Twice during the process, I suspended registration because of the pressure of work. There were times when it seemed both impossible that I could ever take enough

time out to write the thesis and also dubiously justifiable to disappear when there were so many demands from unions. It was easier to use the sense that I was needed to justify sidestepping the fearful prospect of sustained and lonely analytical writing. I would have dropped the thesis altogether, had it not been for the encouragement and persistence of my supervisor. On three brief visits, en route to funding meetings in Europe, I argued my case against revisiting the thesis on the grounds of warring duties, the practical usefulness of my non-thesis work and exhaustion, but found myself persuaded into reworking the thesis proposal each time. These discussions (and arguments!) brought the issues to life again and reinserted the thread of intellectual inquiry into the work when I went home. Contacts inbetween were largely by electronic mail: on my side, frequently a rapid overview of current work, whether in or out of the thesis outline, and complaints about pressure of work; on my supervisor's side, notes of challenge, occasional derision, but mostly encouragement. During this year's sabbatical, as in the previous contacts, he has spurred me to open out issues, to go against my natural inclination to confine myself to the specifics of my own experience. In the process, I have learned that practical experience does not preclude analytical construction, though it complicates it with the awkwardness of ill-fitting facts, feelings and phenomena. The result is not neat, but it is absorbing.

In the end, it became impossible to leave the thesis design the way it was: it would have been a piece captured in amber, historically interesting, but with diminished relevance. First, the leather study was included and then, as time went on, the Natal clothing study. Alongside these I was working on many other projects with unions in the mining, paper, food, transport and other industries. I

was also increasingly caught up in policy work at a national level, for government and the unions. The research focus of the thesis was clear - medical schemes for low-paid workers - but my working life was full of synergies and contradictions, and I puzzled about how to incorporate these within the academic study. During this period, the issue of union involvement and its centrality to the developments in health care gradually took shape, partly as a result of discussions inside the country with union strategists.⁴ This sense of the importance of unions was reinforced by the lacuna in discussions in progressive health circles on labour issues. I frequently found myself in health policy fora where the focus was entirely on the public sector, for progressive reasons to do with views of the centrality of the public sector.⁵ This was incontestable, but neglected to take account of the fact that a substantial number of people, including the working poor, were tied to the private sector, like it or not. The dominant policy line which seemed to be emerging was that the employed could look after themselves, which by default meant in the private sector, leaving the public sector for the unemployed. I was frustrated by the crudity of this analysis and by the lack of debate on alternatives, and especially the failure to consider seriously points of connection between the public and private sectors. This bolstered the sense that the Sick Fund studies were more than self-contained exercises, but had some important lessons - positive, negative and cautionary - for broader policy developments, which urgently needed to be

⁴ Mike Murphy, Bernie Bernickow, Wayne van der Rhee, Mark Bennett, Kevin Perumal, Mel Clark and Tsidiso Moshao.

⁵ For example, at one meeting in Cape Town attended by health systems researchers and health economists from around the country, each participant spoke of her or his area of work and interest. All except me worked on the public sector. There are a couple of researchers who do private sector work, but they are few and far between. Most private sector work is done in the commercial sector.

explored in a rigorous fashion. Then I spent 1996 working intensively on Transmed, a large and difficult project which was about as different from the Sick Fund projects as it was possible to be. I was struck by the contrasts and implications for a more nuanced and complex analysis of trade union involvement in health care and consequent policy development and keen to include the Transmed study within the scope of the thesis. At this stage, a combination of impending burn-out and an overweight of material lent urgency to the need to remove myself and start writing, which I finally managed to accomplish in October 1996.

3. *Methodological issues*

Aside from its 'advocate' nature, what kind of research is this? I have very little formal training in research methodology. Most of the research skills I have were learnt on the job and have the strengths and weaknesses of that source: they are practical and efficient, but their rigour is often constrained by time, access and financial constraints. Since 1980, I have been involved in a large number of medical surveys run by the IHRG.⁶ Before the research for this thesis, I had also done one survey alone, a postal survey of workplace health services in greater Cape Town. Later, in 1994/5, the DHMEF provided some exposure to formal research methodology, though I quickly discovered that the tools of economic evaluation were not directly relevant to my work. I have had considerable

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experience of interviewing, mostly workers, but on occasion also people with whom I am not naturally in sympathy, useful practice for the complex interactions in the studies. I am a sociologist come lately: my first degree was in drama, English and ethics and contained not a single credit in Sociology. With hindsight, these factors (lack of formal training in the discipline, exposure to the methodology of natural science and a certain lack of confidence in my own less conventional skills) reinforced the sense that the Ph.D. must include some quantitative work. After five years in the IHRG I took a year out for an M.A. in Comparative Labour Studies at Warwick, in order to situate and formalise what I had learnt in practical work. I went back from the M.A. with greater confidence, not radically changing my practice, but probably more able to describe, analyse and criticise it. Five years later, I knew I needed to step back again and place my work in a more rigorous framework, which is one of the purposes of this thesis.

An unfolding methodology

The methods used in the research changed and shifted in direction along with my research plan. Some parts of the planned study were dropped, others expanded. Some methods were unworkable because of lack of information, others because of the context of the research (specifically when part of a study would have served no purpose for the union research partners and was therefore difficult to implement and/or lost out against the demands of other work seen by the unions as directly 'useful'). The studies involved a mix of qualitative and quantitative methods: quantitative because any substantive change to medical schemes had to be carefully planned and costed; qualitative because such changes had to take

account of the members' experiences and perceptions of health care. Their perceptions of what would be 'good' health care, based as they inevitably were on their experience, were at times at variance with the model/s which the union organisers (and I) saw as preferable. Unaddressed, these differences could have undermined the success of the projects. For this reason, these were also interactive studies. The last stage was not merely tracking the progress of the proposals through negotiations, but also (and more importantly) their reception and modification by workers in the workshop process which preceded negotiations. This process had a clear didactic purpose: to give workers the opportunity to examine the kind of health care they had been accustomed to and to participate in designing an alternative model.

All four studies started with analysis of documents of various sorts. Most Sick Funds produce enormous quantities of regular documentation. Though I occasionally rued their prolix habits, they were preferable to the Natal situation which, from a researcher's point of view, resulted in an impoverished source. Not only was the data sketchy in the extreme, but there was no sense of the debates leading up to decisions. Transmed produced a mass of documents, from the administrators, the company, OMAC and others. The information coming from the administrators was often seriously flawed and working through it was a forensic exercise, never satisfactorily concluded.⁷

Only the Cape Clothing study incorporated a structured questionnaire, used with a representative sample of scheme members. Instead of a structured

⁷ As I write, I receive regular updates by email on problems uncovered in the accounting system at Transmed, the latest involving a mistake in the region of R20 million in annual accounts.

questionnaire-based survey, the leather study used group meetings with members in each of the widely-scattered geographical areas of the Fund, whose responses were noted and post-coded. This provided a rich vein of information on both utilisation patterns and member attitudes, which fed into the parallel process of finalising the questionnaire for the Cape Clothing survey, which was designed to establish current usage of health services both in the Fund and outside (for dependants) and attitudes towards these services, as well as vital information on family structure and residence, vital to the costing, planning and siting of new services. I chose not to use a team of interviewers, working with only one research assistant. We travelled together and shared an interview room (often the canteen or change room). As a result, I was in close contact with her interviews as well as my own: for each group of workers, I would briefly introduce the purpose of the survey, confirm its confidentiality and explain how the information would be used. Though labour-intensive, this process was very productive. Workers often commented outside of the formal questions and I learnt as much from tone and facial expression as from the direct answers. It became clear to me that certain questions would not produce useful data, especially if workers did not know me and assumed that there were 'right' answers or were worried about being critical.⁸ Though this information does not feature in the written report, it fed into the analysis and the planning process. For example, with the exception of those who knew me, workers were clearly uneasy about criticising doctors. However, many were revealingly slow in identifying positive features of their interaction with doctors.

⁸ Bresnen (1988) writes about his growing recognition of the fragility of his questionnaire in early fieldwork. I experienced something similar, but also a compensatory awareness that the process was serving purposes other than data-gathering.

I do not have mainframe computer skills, and so drew on the expertise of the Medical Research Council (MRC), who did the mainframe data analysis. In retrospect, I believe it was problematic to involve the MRC in the design of the survey. Their focus is medical and though they accepted that my research covered broader issues, I am not sure that the final design was appropriate to the issues I wanted to explore. They lacked exposure to qualitative research, but I lacked confidence in my experience in formal research design, and their bias tended to prevail. Some of the questions were designed to meet accepted guidelines in medical research, for example, asking for details of last medical experience only if it happened in the last fortnight, on the premise (supposedly epidemiologically sound) that memory beyond that cut-off is unreliable. From the experience of the studies, I think this cut-off is of dubious value, at least as far as experiences of medical care with children are concerned. Most people recalled such experiences rather vividly, which probably relates to the care and expense of the choices they made for their children's health.

It is questionable whether the Cape Town survey produced any really surprising information and certainly the project could have proceeded without it, but it is clear that the process of visiting so many factories and interviewing workers at each of them spread consciousness of the project very broadly, reaching inactive members who would have had little or no previous exposure to the plans to change the Sick Fund. Having gone through a very exhaustive process in the Cape, I thought I could avoid re-inventing the wheel in the Natal study. In the event, the survey was a fiasco because the IC failed to involve shop stewards to explain the process to workers, as planned.

The Transmed project involved no direct quantitative work on my part, as this was done by the actuaries. However, actuarial science is not absolute and projections depend very crucially on the assumptions built into the calculations. My task was to question these assumptions and raise strategic issues, in terms of the workable speed of change, the degree of financial intervention necessary from the company to shore up the Fund while the process of re-design was being completed and the relationship between potential changes inside the scheme and broader developments in the private and - more particularly - the public sector. Transmed involved primarily qualitative work for me, in a range of situations in which I was both an observer and an actor:

- chairing/facilitating/mediating/informing the labour caucus
- translating the parties to each other (not strictly mediating between them, given my declared relationship with labour) in Board, sub-committee and working group meetings
- assessing the credibility and usefulness of various potential service providers, and
- analysing design proposals in terms of their impact on users and so on.

My work consisted primarily of meetings, in retrospect an endless round of meetings, with different groups, in different cities, playing different roles. I think it is misleading to call this 'participant observation', which assumes that participation is protective colouration for the researcher, masking or distracting from the observation which is her/his true purpose. My involvement was highly visible, and I was not agenda-free.

Progress reports were a regular feature of the research process in the Sick Funds: to the SFMC's and to the union at all levels. Though essentially labour advocates, our effectiveness depends on credibility, so we report to fora such as the SFMC's or Boards in a factual, neutral style but also produce simplified reports for the unions which are far less bland. This shift in style is a regular part of IIRG practice. The Reports resulted in a considerable amount of follow up work in the Cape and Leather studies (but not the Natal Clothing study), expanding on areas of concern. In addition, prior to the negotiation season, there would be a flurry of meetings with union organisers and with shopstewards, exploring negotiating positions and programmes, defining priorities and fallback positions, and weighing this issue against others currently on the union negotiating agenda. This was a vital part of the process, ensuring that policies and programmes were not decided in isolation from the membership, but with the broadest possible participation. Reaching the membership involved mass meetings, education sessions at union 'locals' (area based structures within the branch) and use of union media.

Education is an integral part of any IIRG project and I had a particular interest in the development of appropriate teaching methods and materials for workers and the process of generalising these techniques within the IIRG. This has been an ongoing process, given staff turnover. It has also had its particular challenges, not least in undoing the ravages of medical education, which habituates its victims to the unvarying use of the passive voice. More recently, I have had much less direct involvement in formal worker education, although an educational element is implicit in all my projects. In the Transmed project, this involved educating the labour caucus and, more especially, SARIWU groupings (national

executive, secretariat, regional leadership). I was also involved in assessing and commenting on OMAC's educational materials and approach and 'translating' information from a variety of specialists who made presentations to the Transmed Board. However, I had much less direct contact with ordinary union members in this project than in the SACTWU projects (even the problematic Natal clothing study), which may be a by-product of increasing specialisation, greater technical complexity and financial scale, as well as a more complex client relationship. Interestingly, I wrote almost nothing in the Transmed project. There was no equivalent to the formal Reports (Cornell 1992; 1993; 1994), or the interim or follow-up reports, or further special investigations of the Sick Fund projects. OMAC and Transmed produced reams of written output. My output was the process.

Shifts and changes

The original intention in the Cape Clothing study was to focus more closely on the nature (and quality) of the services offered, through a study of a sample of consultations (direct observation or interview of provider and patient directly after consultation) or a participant observer study using mock patients. This was dropped because of concern about the dubious ethics and usefulness of mock patient studies. Quality of care is notoriously hard to measure, and observation of patient-doctor interactions fundamentally alters their nature. The Sick Fund had no diagnostic data from panel doctors and no standardised diagnostic system for the doctors in the Fund clinics. As a result, I could not use the records to evaluate or compare the care given by the panel doctors and the Fund doctors. All that was

possible was some degree of inference from a comparison of consultation rates, sick leave given and - even more dubiously - prescription costs.

The planned series of unstructured interviews with the providers of service and a selected sample of users at the Industrial Council-run clinics in Salt River and Atlantis fell away. It became clear that they would be entirely for the purposes of my thesis. The union had devoted substantial energy and resources to the research process and, from its point of view, there was quite enough information from the survey process (beyond the questionnaire) as well as from many union fora, to back the changes they wanted to make. The fact that it was not all gathered in a planned and quantifiable manner was irrelevant to the union. Further research was not a priority for the union, especially at the time.⁹ The employers had always been wary of the use of the term 'research', as a result of which I had always had to emphasise the practical usefulness of the work for the planning process.

4. *The research role and factors which influence it*

The range of research methods I used required me to take on a number of roles. I was not, strictly speaking, a participant observer as I did not participate in the illness or the experience of medical care. Nor did I have an 'ordinary' role in

⁹ Beynon (1988, 30) identifies a familiar problem: 'Researchers who have worked with trade unions have often experienced the sense that union officials feel that they know the answer and simply require the evidence to support this.' The problems of anti-academic bias is described by various writers who have engaged in research in organisations. Buchanan et al. (1988) refer to the strong negative connotations of the terms 'research' and 'interview' and Fryer et al. (n.d.) to the anti-academic bias of many union officials. I suspect that overt confrontations with unions on this issue have been averted in my work partly by their politeness and partly by my self-censorship (in that I seldom talk about 'research' or use academic terminology in trade union contexts).

any of the unions involved while researching their activities (a common feature of educational research projects): when I was present, it was specifically for the research (or, in the accepted term, the consultancy). However, the unions saw my work as useful and supported my appointment. I had a long history with SACTWU, which had resulted in a fairly high visibility. Workers could have seen and/or heard me in a range of settings: mass meetings, organisers' forums, joint shop stewards' councils, shop stewards' committee meetings, women's meetings in the union and elsewhere, union conferences and cultural events, TB screenings, IHRG education sessions, inter-union meetings such as Mayday rallies and other COSATU events, political meetings and protests.¹⁰ I imagine this would match the description of field research which Burgess gives: 'Field researchers have, therefore, to take roles, handle relationships, and enter into the commerce and conflict of everyday life.' (Burgess 1984, 5) Certainly what Burgess (1984, 82) describes as the 'disadvantage' implicit in advocate research of '... combining data collection with an area of social conflict especially in union-management relations...' is part of everyday life in the IHRG.

Although I was officially a 'joint' consultant, there was clearly some reserve on the part of the employers in the Cape and Leather Sick Funds, especially at first. By the end of the (extended) process, grudging respect had given way to a degree of relaxed good humour, except around wage negotiation season, when both sides used this forum to rehearse positions and rattle sabres. In Natal, I had

¹⁰ I would agree with Fryer et al. (n.d., 16) that '... there are many situations... where there is no neutral, fence-sitting stance available, even if researchers want one'. Fence-sitting was not the IHRG style and we openly associated ourselves with union political campaigns and protests.

much less contact with the employers or the committee and relations with Industrial Council staff were decidedly strained.

My role in Transmed was fundamentally different. SARHWU, an established client of the IHRG, offered to 'share' me with the nine other unions in the company, an offer accepted with reservations unexpressed but radiantly obvious. This united labour front was presented to management, who promptly also asked to 'share' me, arguing that health was an issue of common concern. After a caucus, the labour team agreed and so did I, but on condition that if there was a management-labour split, I would go with labour, and if there was a split in labour, I would go with SARHWU. The shifts and complications of my role, building and maintaining credibility with such a diverse group, are explored in the chapter on Transmed.

The notion of a 'friendly stranger' is probably quite accurate as a description of my role in the clothing study. I was certainly seen by the union and by organisers and workers who had had contact with me, as 'on the workers' side' and I would unhesitatingly place myself in that position. This closeness to the unions did not give rise to major problems, because the immediate focus of analysis and criticism in each of the studies was the Sick Fund, not the union. However, there was some delicacy in listening to the demands of the membership in relation to the fund and giving them the weight they deserved, while recognising their possible limitations and providing the opportunity for members to re-think their attitudes and demands. Relationships with union officials also called for a delicate balancing act. In the Sick Fund studies, I had a number of key informants, specifically organisers and branch officials. I also liaised with the union's education

officer and with officials in the national office with responsibility for both Sick Fund issues and the development of broader policy on Industrial Councils. Certain of these relationships dominated at particular times and all of them shifted over the period, for reasons both intrinsic and extrinsic to the study itself.¹¹ There was also a small group of people inside the union who regarded themselves as key informants because of their length of service and knowledge of the fund. Their loyalty to the fund tended to make them conservative about change and they had to be won over, because they had the power to influence at least some of the members and thus undermine the process of change.

The 'friendly stranger' role held through the Cape Clothing project and National Leather project and extended into the Natal clothing project, though I had much less exposure to workers there, partly because of distance but mainly because of the different design of the project, in that there were no interviews or structured meetings with members. In Transmed, management initially saw me as a hostile figure, to be incorporated because this might make me less dangerous. The actuarial consultants were also initially wary, because of uncertainty as to my role and concern about potential interference in their accustomed sphere and style of work. However, my situation had changed from the beginning of the clothing research. First, I had five years more experience and exposure, resulting in a much higher profile, and was seen in some quarters as an 'expert' (in a very small pond) so I no longer had to answer to cross-questioning on my credentials. Transmed management and the actuarial consultants knew of me, though the white unions did

¹¹ Buchanan et al. (1988, 54) describe some of the complications and frustrations of these relationships as follows: 'But the members of organisations block access to information, constrain the time allowed for interviews, lose your questionnaires, go on holiday and join other organisations in the middle of your unfinished study.'

not. Second, the change in government had also had an impact: I had been on the ministerial committee on health financing and was on the statutory council controlling medical schemes. This was useful in giving me access to a mine of information on the inside workings of medical schemes and on the major players in private medicine and managed care and it also lent me a kind of respectability through official recognition.

Before the clothing study began, it was clear that closeness to the unions, otherwise a real advantage, had implications for my later relationships with them. Over the period 1992-4 I did more work for SACTWU than for any other union and they tended to regard me as 'their' adviser, even in the leather project, which involved three unions. However, I lost contact with the developments in the Cape Sick Fund after the new medical director took over, and gradually also with the Leather Fund. The relationship with the Natal Sick Fund was abruptly broken after the joint workshop, though I kept in contact with my main union contact. In the Transmed experience, SARHWU showed signs of ownership, which have continued while I have been in the UK, raising issues generally less substantive than symbolic. The attitudes of the other unions in Transmed shifted over time, from fairly polarised politeness masking caution and suspicion, to robust and critical candour. I was in a real sense in the middle, with management testing concerns about OMAC on me and vice versa, the unions checking on management and on OMAC, and on each other (and on me), and having to balance my own judgements with a complex and unstable 'union interest', all against the backdrop of creating a new fund, sufficiently stable to survive.

The Transmed project raised an interesting set of relationships which presented a new challenge to me. In all the IC projects, my relationships with the employers had been relatively distant, developing at most to a guarded informality over the extended processes. Relationships with Industrial Council officials varied greatly, from prickly and hostile in Natal to strategic in the case of one difficult but key official in the Cape, the only really good working relationship being that with the General Secretary of the Leather Council. In the Transmed project, I worked very closely and intensively with the key employer representative and the leader of the actuarial consultancy team, in the process developing complex relationships of trust.¹² This was a new situation for me, accustomed as I was to fundamental scepticism (even mistrust) of the motives and methods of employers and employer-oriented consultants, and it occasioned regular soul searching about whether I was insensibly shifting allegiances and losing my 'workerist' base.

The visible researcher

In a provocative and thought-provoking article on research method as social practice, Fryer et al. (n.d., 1), talk about 'the real world and the imaginary researcher' as follows:

If research monographs and field study reports are accepted at face value, then readers are obliged to believe that whilst the subjects of enquiry plotted and planned, promised and deceived, lived and died, the impassive investigator maintained a consistently bland, preter-scientific posture. Apparently, the real world of organisation and struggle, failure and success is something which in common with road accidents, affects only other people (especially those unfortunates who figure as part of the researcher's 'sample').

¹² In terms of these relationships and the many more relationships with trade unionists developed in the course of my work, I can empathise with the concern expressed by Buchanan et al. (1988, 67) about being seen to hold 'a wholly instrumental attitude to friends and friendship'.

I have often felt in writing this thesis that I am all too visible. I have dealt at some length above with my experience and the access which this gives me. As with all researchers, a number of other factors influenced the way in which I was perceived and operated. I am a middle class white woman, English-speaking, unmarried and childless, and I was 41 when I began this study in 1991. This is a mixed bag of positive and negative features: it helped to be a woman in the clothing study (as this is a predominantly female industry) and to be older rather than younger. There was an assumption, often expressed in meetings by women workers, that I would know something about life. Like Blum (1952), I spoke about myself on occasion, referring for instance to experiences of illness and health care in my family. The fact that I am unmarried and childless is not as obvious as my age but on the occasions when it did emerge, it struck most workers as distinctly odd. (It also sometimes gave rise to a certain wistfulness in women with families. The result was a combination of 'you don't know what you're missing' and 'what freedom!'.) Women workers in the Cape spoke hesitantly (and only when no men were present) of the problems of 'the change' and the lack of male understanding about the impact of menopause on their lives. The same issue was tentatively raised by older women shop stewards who were active in the Task Group in Natal, chatting before the men joined us one day. I was too young to understand, they ventured, but 'women's problems' didn't end with the last baby. In fact, they had substantially underestimated my age, perhaps in order to avoid offence or perhaps as a result of the easier ageing of middle class (and childless) life. Once they knew my real age, by then mid-40s, they launched into passionate and often extremely funny stories about the menopause, not daunted even by the

arrival of the men. I would speculate that female gender (because of its relative powerlessness) goes some way towards counteracting the distancing effects of class and racial difference.

In the Transmed experience, my gender was again probably useful, this time in a subversive way. It was a very male environment indeed. I was an oddity, to the white unions because my entry point was with a black union, to management partly for the same reason and also because the main representative had never worked with women before. He had to put up not only with me but also with a woman consultant from OMAC and in the end a (black) woman as his new boss. I was probably least odd to my original clients, who would simply have placed me as a 'com'.¹³

Both SACTWU and SARHWU have a strong policy of non-racialism, in common with all COSATU unions. However, SACTWU had no white members or officials in Cape Town at the time of the first study so I was certainly noticeable at most union events: people may have non-racial principles, but this does not yet mean in South Africa that they do not *notice* colour. Ethnicity and class intersect in different ways with different groups - there were some officials who shared elements of my background (university education and middle class families). However, the vast majority of the members lived in the townships of the sprawling desert of the Cape Flats, while I lived in the city. There is one feature of my class position which may have tempered some of these distancing features. Although I am an intellectual, a professional, 'from the university', I am not a doctor. In the context of a discussion about experience of health care with a worker, we were

¹³ Short for 'comrade', see discussion below.

both patients and had that experience and perspective in common. In the leather and Natal clothing studies, many of the same features were obvious. Though there were a couple of white union officials involved (Mike Murphy and Mark Bennett), the majority of union officials were black and the membership a more representative cross section of South Africans: African, Indian and coloured workers.

There were very interesting class features in the Transmed case. This was the first time I had had to deal with white workers and their unions, and for that matter with white collar unions organising highly paid groups such as pilots and airline technicians. I was used to working with progressive (politicised, democratic and non-racial) unions which organised black unskilled or semi-skilled workers, who were usually very low-paid. These other unions were new to me and rattled my assumptions. I had to become accustomed to the idea of a labour solidarity broader than I was accustomed to, and sensitive to the limits on that solidarity, generally unignited but occasionally erupting in the labour caucus and even more rarely (and shockingly) in joint meetings.

Language is a complex issue in South Africa.¹⁴ English is my home language; I speak Afrikaans fairly fluently, Xhosa (and other African languages) not at all. There are very few African workers in the clothing industry in Cape Town, so the major issue there was the English/Afrikaans one. Though the majority of the workers probably speak Afrikaans as a home language, SACTWU's official language is English. However, meeting language is a mixture of 'pure'

¹⁴ Many of the language issues raised in Lawrence (1988) about cross-country studies apply in multi-lingual societies like South Africa.

English, 'pure' Afrikaans and a mixed patois. On the other hand, in the country towns around Cape Town, the meeting language tends to be Afrikaans, of a more formal variety, with very little use of 'mix'. In administration of the questionnaires in the Cape, I discovered rapidly that the language in which you asked people about their language preference was important: if in English, they agreed to English and often struggled to speak 'pure' English; if in Afrikaans, almost all elected Afrikaans and spoke much more freely, moving between English, Afrikaans and 'mix'. If English had been chosen but respondents seemed uncomfortable, I would ask the odd question in Afrikaans, which generally resulted in an immediate switch to Afrikaans or 'mix' and a relaxed fluency.

In the Natal clothing project, the language of meeting was English, with occasional translation into or from Zulu. Afrikaans is not an issue, as there are very few coloured workers in the area. In the leather project, the language of meetings was English, with translation into the African language of the particular region on (infrequent) request and occasional use of Afrikaans in the Western and Eastern Cape. National projects raise more complex language issues where there is a heterogeneous workforce. In the Transmed project, English was the language of meetings, though Afrikaans was the home language of the majority of the white unionists. A few, who struggled with English, occasionally spoke Afrikaans in meetings, generally when they felt particularly passionately on a subject. None of the white unionists could speak any of the African languages, nor indeed could any of the management representatives or consultants, including me. Black unionists had a fascinating relationship with Afrikaans - all could speak it to some degree and occasionally did so, either when addressing a point raised in Afrikaans, or for

rhetorical flourish (most notably by the president of BLATU, a part-time preacher with a fine turn of phrase and an unstoppable flow). However, when tempers were high on an issue, the use of Afrikaans could give rise to formal protests and objections from the black unions and requests for translation. I consciously used Afrikaans strategically on occasion, generally in the labour caucus and one-to-one discussions outside of formal meetings. This was particularly important in developing relationships with the white unions. The main management representative was Afrikaans speaking but extremely fluent in English. He too used Afrikaans strategically, but had to be more careful in joint meetings than I did: if I spoke Afrikaans it could be seen as courteous, if he did, it was one Afrikaner talking to another.

Multi-lingualism is not the only language issue, there are also issues about home language vocabulary, accent and style which surface even in research in a monolingual society.¹⁵ How did I, as a researcher, talk to workers, to managers, to joint fora, to medical professionals? I know that I shift language style with these different groups.¹⁶ I found that with medical professionals (and managed care operators) an offhand familiarity with (and strategic use of) medical terminology was useful, together with the ability (and confidence) to cut through medical obfuscation when necessary. (It is helpful to have worked with doctors in the IIRG for many years.) With managers, a bland and confident style is generally important, with the occasional use of polite intransigence: too much deference is

¹⁵ For example, I observed a WEA training course in Coventry in the research for my MA dissertation and was strongly aware of the alienating effect of the language of bookwork and of teaching, at odds with the rhetoric of student participation and despite the fact that the course tutor was himself an ex-worker.

¹⁶ Bulmer notes that 'Even within one's own society, different speech patterns can be a barrier to communication and need careful attention.' (Bulmer 1988, 154)

seen as a sign of weakness.¹⁷ On the whole, I was more comfortable speaking to workers than to managers, despite my own class origins. Without assuming a consciously 'working-class' accent and style, which would have been ridiculous and condescending, I sometimes noticed myself shifting subtly in meeting contexts where my normal accent or usage would be seen as 'posh'. (This was one of the few times it helped to have been an actor.) For example, though the general form of address in union as in political contexts is 'comrade' ('com'), in SACTWU meetings in the Cape middle-aged and elderly women are often addressed as 'Auntie x'. The use of this terminology places one quite clearly. ('She may be white, but she's got respect' was a comment passed on to me with some amusement by an organiser.)

Before I started the thesis, I had anticipated that the ethical issues I would face would mostly relate to sensitive health questions, access to and use of confidential medical information and intrusion into the patient-doctor relationship. These issues fell away, as there was no diagnostic data to use and I chose not to observe consultations or conduct mock patient studies. The questionnaire data was not very sensitive, medically speaking, and links to individuals were broken in the analysis. However, the issue of confidentiality was very important in the questionnaire process. Stressing that the forms would not be shown to management, but would stay with me, though the information they gave me would be used to design the new scheme, was important in getting people talking. Instead of the predicted ethical problems, I faced others, which centred on my role

¹⁷ Often, I can leave the intransigence to the unions, sometimes briefed by me, sometimes spontaneously. For example, when Transmed administrators questioned my experience and competence in one of the early (pre-study) confrontations, SARHWU took magnificent umbrage and demanded a formal, even abject apology for the insult to 'our expert'.

and responsibilities. Loyalty to trade unions and intellectual independence sometimes conflicted. It was not easy to maintain an evenhanded responsiveness to the unions in the multi-union studies, though there was an implicit acceptance in both the leather study and Transmed, that I was closer to my original 'clients', respectively SACTWU and SARHWU. Rather more difficult was the process of working with management, to an extent never before required of me. I was not always sure where the role stopped and I started.

5. *Does research make a difference?*

Whether research makes a difference is a question outside the scope of much methodological debate, but surely an important one. The studies in this thesis were motivated by a desire to make a difference to workers' lives, however evangelical that may sound. They were successful to very different degrees and part of the purpose of this thesis has been to reflect on the reasons for these differences, in order to inform my future work and also to examine the implications for broader policy debates both inside the trade union movement and with government about the direction for future working class health care. These issues are discussed more fully in the concluding chapter: here I focus more narrowly on methodological considerations.

The fluidity of the work process, subject to both internal and external changes, especially massive political change, meant that 'snapshot' style research such as cross-sectional surveys would have been seriously misleading. A great deal of the work took place outside the scope of the formal research, but was an

essential part of the process. I tended to regard this fact as evidence of my lack of discipline and am reassured by finding confirmation of this tendency in others: 'It can ... be difficult for the researcher to decide finally to leave the organisation, to gather no more information, and to begin the process of analysing and documenting what data have been collected' (Buchanan et al. 1988, 64) and Crompton and Jones's (1988, 71) dictum that 'You have to regard all the time you spend inside the organization as part of the research'. I was not a simple observer, or a participant-observer, but an actor-participant-observer and no doubt a different analysis would result from an observer who had included my action in her observation. The diffidence of case study researchers described by Yin (1984) was true in my case, though the accumulation of case studies advocated by Bulmer (1988) as a means to promote a degree of leverage on generalisation certainly helped. The Leather and Natal clothing studies enabled me to highlight the conditions which were germane to the success of the Cape clothing study and explore the question of transferability of a model generalised from this experience. I also felt it necessary to go outside of the sphere of ICs to raise broader issues about working class health care in a very different sector and set of organisational structures. In strict terms, these studies could not pass the test of reliability: they could not be repeated with the same results by another researcher. The time, political and trade union climate and leadership were intrinsic to the research, as was my involvement. I felt that I knew a great deal about one particular situation, was hesitant to generalise from it but at the same time concerned that these hard-won lessons would be lost in the process of national policy formulation about working class health care.

I am left with a constant sense of unfinished business, despite revisiting projects for years after the formal work was completed, and still continuing at long distance while I write this thesis. In a way, it is, of course, intensely reassuring to be needed and I look forward to re-engaging with my working world, in particular to taking up the policy debate more actively. Discussions of methodology generally focus on the stern sphere of problems, pitfalls and responsibilities. They seldom reflect on the rare but real pleasures of research and writing, processes shot through with moments of achievement and insight, hilarity and sheer exhilaration.

Chapter 3. Trade Unions and Health Care

1. Introduction

Health care was forced onto the agenda of the independent trade union movement in South Africa by a combination of factors which directly affected members, especially the structure and nature of apartheid public health services and rampant cost inflation in the private medical sector. Health care was politicised under apartheid. It will continue to be, because there will be losers as well as gainers in the process of dismantling apartheid and restructuring the health system for equity.

South Africa has a population of about 40 million people, growing at a rate of 2.5% a year. It is an upper-middle income country, with vast income inequalities.¹ Until recently, its main claim to public notice was its institutionalised racism, aspects of which are directly relevant to the studies. The population is made up of 76.2% Africans, 8.6% coloureds (people of mixed race), 2.6% Asians and 13.3% whites (McIntyre et al. 1995, 4). Until 1994, a minority white government ruled the country, which was divided along racial lines into four (white) provinces, four (black) 'independent states' and six (black) 'self-governing territories'. Those classified as coloureds and Asians fell into an uneasy position: subject to some restrictions in common with Africans, such as residential and educational segregation, they were free

¹ The GNP was US\$2,560 per person in 1991. 51% of annual income goes to the richest 10% of households, while less than 4% goes to the poorest 40% (World Bank 1993).

of others, most notably restrictions on freedom of movement. They were relatively privileged in the labour market, generally occupying skilled and semi-skilled positions, while the African majority were overwhelmingly confined to the ranks of unskilled labour. In the Western Cape, this relative privilege was enshrined in the Coloured Labour Preference Policy of 1955, which barred employers from employing Africans without a certificate from the Department of Manpower (later Labour) indicating that no suitably qualified coloured worker was available (Kraak 1993, 6). The legacy of this policy is still visible in the clothing industry in Cape Town, which is dominated by coloured workers. Similarly, the high proportion of Indian labour in the Natal clothing industry reveals an equivalent preference for Indian labour, though never enshrined in formal policy and therefore not as pronounced.

After the 1994 election, South Africa's administrative structure was drastically reorganised. The artificial borders of the past were dissolved and the 'independent' states reincorporated. The old tricameral parliament (with separate chambers for whites, coloureds and Asians) was replaced by a single elected national parliament headed by a President. The internal borders were redrawn, forming nine provinces, each with an elected legislature headed by a Premier. Considerable power was delegated to the provinces, including responsibility for health services. The provinces vary enormously in size, population and level of development. Gauteng (the Johannesburg-Pretoria area) is the smallest and richest of the provinces, the economic centre. Two of the studies have a provincial base: the first in the Western Cape, a relatively prosperous and well-resourced area, the third in KwaZulu-Natal, a markedly

poorer area, scarred by endemic violence.² These two provinces are also the only ones which do not have ANC majorities: the Western Cape legislature has a National Party majority (but an ANC Health Minister) and KwaZulu-Natal an Inkatha Freedom Party (IFP) majority. The other two studies have a national scope, though only a small proportion of membership is in the less industrialised provinces.

South Africa's population divides roughly into about 17-20% high earners, with about a third in the low to middle income group, and the rest - approximately half the population - defined as poor (below the household subsistence level of R183 per week for 1993) (McIntyre et al. 1995, 8). The clothing and leather workers in the first three studies (though organised and relatively privileged in comparison with the unemployed, rural subsistence farmers and many in the informal sector) were perilously close to poverty (SALB 1992a). Many were household heads in single income families and supporting extended families on an income of between R185 and R240 per week in 1993 (Collins 1994d).³ (The Rand-sterling exchange rate has been highly unstable for the last few years. At the time of writing, the rate is approximately R8 to the pound sterling. However, a figure of roughly R3 to the pound would give a more useful sense of wage values and buying power.) Some 16% of all employment in 1995 was in manufacturing (Standing 1996). The clothing and leather industries were in decline, particularly the clothing industry, which was highly threatened by the

² The Western Cape is third in contribution to GDP, second in income per capita and highest in the Human Development Index, a composite of indicators of health status, education and income. KwaZulu-Natal, while second in contribution to GDP, is only sixth in income per capita and seventh in the Human Development Index (McIntyre et al. 1995, 5-8).

³ In 1994, a clothing machinist earned R265.50 weekly in Natal and R263.00 in the Western Cape (Collins 1994d).

reduction of tariff protection which was introduced in the early 1990s and accelerated after the new government rejected a strategic plan for restructuring the clothing and textile industries developed by a tripartite body over a two year period (Hirsch 1993; Hirsch and October 1994; Altman 1994). The fourth study focuses on the public sector transport company, Transnet, which went through major retrenchments in the process of commercialising. The transport sector (public and private sector combined) accounted for 5% of all employment in 1995 (Standing et al. 1996).

2. *The South African health system*

South Africa had neither a national health service nor a national health insurance system at the time of these studies. Instead, it had a mixed system: public sector health care funded from taxation and private sector health care usually funded by private medical insurance schemes, related to employment. In the late 1980s, when the preliminary work leading up to this thesis began, the health care system mirrored the apartheid state (Savage 1979; De Beer 1984; Dorrington and Zwarenstein 1988; De Beer et al. 1988; McIntyre 1990; Pick 1992). South Africa spent 8.5% of its Gross Domestic Product (GDP) on health services in 1992/3 (McIntyre et al. 1995, 16). Other indicators of health service provision such as hospital beds and health personnel were reasonable for a country at its level of development (McIntyre et al. 1995, 16-17). However, South Africa compared very unfavourably in health status indicators such as infant mortality, life expectancy and tuberculosis incidence with other middle

income countries. The table below highlights the obvious fact that resources were not optimally used to produce a healthy population.

Table 1: Health status indicators related to health expenditure

Country	Health expenditure as % of GDP	Infant mortality rate (per 1,000)	Life expectancy at birth (years)	Incidence of TB (per 100,000)
South Africa	8.5	49	63	250
Botswana	3.3	36	68	-
Hungary	6.0	16	70	38
Malaysia	3.0	15	71	38
Venezuela	3.6	34	70	44
Chile	4.7	17	72	67

Source: World Bank Development Report 1993. (HST 1995, 2)

The most obvious reason for the discrepancy between input and output in health highlighted in the table above was the distribution of health care expenditure between the public and private sectors: average private sector expenditure per medical aid scheme beneficiary was nearly fifteen times public sector spending per person in the poorest magisterial districts (McIntyre et al. 1995, 20).

The public sector

This thesis is informed by an unashamed bias against for-profit health care and a concern to maintain and build up the public sector in health care. When this thesis began, the public health sector in South Africa was underfunded and overstretched,

characterised by multiple authorities (the central state, four provinces and about 800 local authorities) each level having responsibility for different elements of health care provision. In addition, each of the four 'independent' states and six 'self-governing territories' had its own Department of Health. A few figures will illustrate the endemic problems of maldistribution of resources in health care. Averages reveal more when they are disaggregated: the overall South African infant mortality rate of 49 was shocking enough, but it concealed a range from 7 for whites and 10 for Asians, to 36 for coloureds and 54 for Africans (McIntyre et al. 1995, 13-14). Similarly, the national averages masked provincial differences: public health care expenditure per capita in 1992/93 varied between R491 in the Western Cape and R137 in the Eastern Transvaal (op. cit., 40). Inside provinces, less was spent in the poorest districts. Given the strong correlation between low income and high incidence of illness, this pattern was disturbing.

Though 83% of the population was dependent on the public sector, it had only 38% of general doctors, 34% of specialist doctors, 7% of dentists, 11% of pharmacists and 40% of supplementary health professionals. Nursing was the only category of health staff in which an appropriate proportion (79%) worked in the public sector (McIntyre et al. 1995, xiii). Once again, these personnel were maldistributed between provinces, with a ratio of nurses to population nearly five times as high in the Western Cape as in the Eastern Transvaal (McIntyre et al. 1995, 17; Masobe 1992).

Government spending was heavily concentrated on hospitals, and primary services were seriously underfunded.⁴

The private sector

In 1992/3, 61% of all health service expenditure was in the private sector, which serviced less than a quarter of South Africa's population.⁵ Most medical schemes locked their members into private sector health care, especially medical aid schemes, the most expensive and elaborate of the hierarchy of schemes and the pinnacle of aspiration for most people. Few *medical aid* scheme members had any experience of the public sector, except perhaps for specialised public health functions such as inoculations against childhood diseases or for foreign travel. The exposure to the public sector increased in *medical benefit* schemes, many of which tailored their hospital benefit to public hospital cost levels, and was most extensive in the *Sick Funds* (exempted schemes), whose members used the public sector for their own specialist and hospital care, all care for their families, and all care for themselves after retirement, with the exception of the occasional use of private doctors on a cash basis.

⁴ 81% of public sector health funds were spent on hospitals in 1992/3. Nearly half of the budget was in tertiary or referral hospitals (Health Systems Trust 1995, 10).

⁵ 17% of the population were covered by medical schemes, while a further 6% had access to health services at work, or hold health insurance policies (Health Systems Trust 1995, 3; 7).

3. *Medical schemes*

Medical scheme membership is generally associated with employment and contributions split between employer and employee. The schemes work on a group basis. Very few accept individual members and when they do, their contributions are loaded. Generally, membership is compulsory within a defined employment group. In the past in South Africa, this was not always the whole workforce, as many companies differentiated between white and black employees (and sometimes between different black groups) or between salaried and waged workers, in respect of medical cover.⁶ As companies moved towards equalising benefits, they encountered a legal problem, as they were unable to impose a new condition in the course of employment.⁷ As a result, in many companies medical aid scheme membership became compulsory for new black employees, while for existing black employees it was optional. This undermined the basic principle of cross-subsidisation and introduced the possibility of adverse selection (joining just before predictable heavy use). Compulsion was a vexed issue for unions, caught between the basic union principle of solidarity and distrust of institutions which previously excluded them and now wished to forcibly include them.

It is important to stress that these medical schemes were not strictly speaking insurance schemes, but worked on a 'contributions in-benefits out' basis, with some provision for reserves to cushion against fluctuations in use. They were legally 'not

⁶ Unequal distribution is a feature of occupational welfare benefits in general, including pensions, education subsidies, housing and bonuses, as well as medical aid scheme membership (Torres 1996).

⁷ This would be deemed an Unfair Labour Practice in terms of SA labour legislation.

for profit' schemes, whose surpluses (and deficits) belonged to the collective membership. Until 1993, medical schemes were divided into different categories, which will be used in this thesis for clarity, because there are still major differences between the different kinds of schemes in cost, structure and benefit design. The categories are: exempted schemes (Sick Funds); medical aid schemes and medical benefit schemes. The terms 'medical schemes' or 'funds' will be used to refer to these schemes collectively.

(a) Exempted medical schemes (Sick Funds)

The first three studies were all Sick Funds, the simplest and cheapest kind of schemes, falling under the jurisdiction of the Department of Labour, because they were negotiated and administered within the collective bargaining framework of Industrial Councils (Chapters 4 to 6).^{*} There were 34 industry specific Funds in 1994, most covering only workers, excluding dependants and pensioners. Most members were black workers. They were administered by Industrial Council staff and managed by joint employer-union committees. They provided limited medical benefits: consultations and medication from contracted general practitioners ('panel doctors'). In addition, some schemes ran small-scale medical services ('clinics') of their own, run by salaried medical staff, which members could use as an alternative to the panel doctors. Additional benefits sometimes included simple dentistry and optical benefits. Few Sick Funds offered hospital cover, as their membership was largely drawn from

^{*} The average annual contribution per beneficiary in 1992/3 was R713, a figure raised by schemes for higher paid industries like the motor industry (McIntyre 1995a, 22). The contributions in the Funds studied were R152 (Natal clothing workers), R208 (leather workers) and R385 (Cape clothing workers).

an income group for whom state hospital care was extremely cheap.⁹ Some provided maternity benefits and most covered sick pay, usually with conditions inferior to statutory sick pay.

Statutory sick leave and sick pay is regulated in terms of the Basic Conditions of Employment Act (No. 6 of 1983). This law allows for 10 days per year of sick leave on full pay, paid by the employer. Medical certificates are required for absences of three days or more (for one or two day illnesses workers may self-certificate). Unused sick leave is carried forward over a three year cycle. These conditions apply to all employees in the formal sector, with the exception of groups covered by collective bargaining agreements with alternative sick leave and pay arrangements, supposed to be 'no less favourable' for members. All the Sick Funds studied had alternative sick pay arrangements, which allowed for longer periods of sick leave but at reduced wages and with no payment for one or two day absences.¹⁰ Taken alone, the sick leave conditions were distinctly unfavourable, but comparison was complicated by the link with medical benefits.

(b) Medical aid schemes

The last study focused on a medical aid scheme (Chapter 7). Medical aid schemes (of which there were 165 in 1992) were at the luxury end of the private health insurance market.¹¹ They were usually administered by commercial administrators and

⁹ These workers would have paid R13 for an outpatient visit and only R26 *per admission* for inpatient care at a tertiary hospital in 1994/5 (McIntyre 1994; 1995, 33).

¹⁰ The leather fund was the worst, with 52 days sick leave per annum, but at about 22% of wages.

¹¹ Average contribution per beneficiary (1992/3): R1,800 (McIntyre et al. 1995, 22).

few had representative management structures.¹² Medical aid schemes offered the widest range of benefits and the greatest freedom in choice of providers. They paid for medical services according to an agreed 'tariff'.¹³ Some schemes imposed limits on utilisation for particular benefit categories (especially dental and optical care). Their membership profile reflected the racial and class distinctions of South African society. Though whites made up only 13% of the population, they accounted for 55% of medical aid scheme membership in 1991.¹⁴ Black membership grew from 28% in 1982 to 45% in 1991. All medical aid schemes covered dependants and were legally obliged to allow members to retain membership after retirement.¹⁵ Some schemes were company-specific (closed), others were 'open' to membership from different companies.

Medical aid schemes fall under the jurisdiction of the Registrar of Medical Schemes (in the Department of Health), with the exception of medical aid schemes for government employees which are exempt from reporting. Transmed, the subject of the fourth study, was the largest of the non-reporting schemes. Other non-reporting schemes included those for the police, defence force and national intelligence force.

¹² The maximum allowable administration fee is 10% of contributions. The average fee in 1992 was 5.3% (Valentine and McIntyre 1994, 40).

¹³ The tariff was a list of fees for medical services issued by the Representative Association of Medical Schemes (RAMS).

¹⁴ 1991 was the last year in which the Registrar kept racial statistics (McIntyre et al. 1995, 4; 22; 25). The issue of race and statistics is a vexed one: though classification by race is offensive, its removal makes it difficult to track and analyse changing patterns of access, distribution and advance in equity.

¹⁵ Subsidy was a matter between the employer and employee. Given the cost of unsubsidised membership, few pensioners could retain membership without an employer subsidy.

(c) Medical benefit schemes

There were no medical benefit schemes in the studies. They are similar to Sick Funds, though they fall under the jurisdiction of the Registrar of Medical Schemes rather than the Minister of Labour. They are cheaper than medical aid schemes, the benefits simpler and subject to lower financial limits than in medical aid schemes.¹⁶

4. Health policy after 1994

This was the health service inherited by the new government in 1994. The clear priority of the new government was to restructure the public sector, concentrating on primary care in order to increase access by the poorest. The new Department was faced with an administrative nightmare, required to create a new structure with a central department and nine provincial departments from the mass of overlapping Departments. This was to be underpinned by a new district health system, with broad community participation. At the same time, government had to provide new services and re-design the system of resource allocation. A program of clinic building started almost immediately, and a policy of free primary care for pregnant women and children under six was announced in May 1994, with immediate effect.¹⁷ The process of adjusting the provincial allocations began, along with a gradual shift of resources within budgets from the tertiary to the primary level. Later a policy of free

¹⁶ Average contribution per beneficiary (1992/3): R1,408 (McIntyre et al. 1995, 22).

¹⁷ The result was to increase the load on public sector services, putting them under severe strain (Mathiane 1994; Skosana 1994).

primary care for all residents was announced (in April 1996), though there was some confusion about whether this included medical scheme members and some provinces delayed implementation.¹⁸ Hospital care was to be charged at more realistic rates and more effort was to be put into recovering fees.¹⁹ The national and provincial Departments of Health started to look to the medical schemes as sources of income, provided they could attract their members into public hospitals.

The issue of National Health Insurance (NHI) was part of the ANC's election manifesto. Because it introduces a new dedicated contribution, NHI is attractive to health departments looking for new sources of funds to bolster and develop struggling health services. Social Health Insurance (SHI) is a variant which generally privileges contributors above non-contributors to some degree, thus benefiting those in formal employment (Normand and Weber 1994). There has been a great deal of concentration on this mechanism to deal with the funding problems of many third world and developing countries (Abel Smith 1986; 1994; Ron et al. 1990; Ron 1993; Normand and Weber 1994; Henderson et al. 1995; Liu and Hsiao 1995; Arhin 1994; Yang 1991). However, there are a number of arguments against its usefulness as a universal model. NHI works best in countries with relatively high employment levels in the formal sector, as the employed can more easily subsidise the unemployed when

¹⁸ In October 1996, the Minister of Health appeared to remove the right of medical scheme members to free primary health care in the public sector. Later, she announced that the Government Gazette had been issued in error and would be withdrawn (South Africa 1996). However, confusion continues and some provinces continue to exclude medical scheme members from 'free' access (Dr McIntyre, personal communication, 5 October 1997).

¹⁹ Under the previous system, hospitals did not retain fees: all fees recovered were deducted from their grant from central government. Obviously this was not an incentive to fee recovery.

unemployment is low. In countries with high unemployment, the cross subsidies are harder to sustain. The problem is exacerbated where there is a large informal sector, from which contributions cannot easily be collected.²⁰ Income from contributions is vulnerable to economic downturns, especially if accompanied by large-scale retrenchments. New contributions may also cause more problems than they solve: government may react to a new inflow of funds to the health sector by cutting the allocation from the general budget and contributors are likely to expect new benefits for new contributions. If their expectations are already raised by political change resulting in a new government with broad popular support, the problem will be intensified. This is borne out in the studies and is likely to prove a serious problem in any new national scheme.

NHI/SHI was investigated by two commissions, but final decisions are still pending at the time of writing (McCutcheon and Price 1994; Broomberg and Shisana 1995). In 1995, I attended two workshops for COSATU affiliates on the NHI proposals. A document was drawn up, outlining a response to the proposals, but never submitted to the Department of Health. In 1997, a delegation from COSATU met with DOH officials. At COSATU's request I drew up a briefing document for discussion inside the federation (Cornell 1997). The latest version of the policy document was published for comment in September 1997 and is discussed in the

²⁰ A recurrent objection raised in South African trade union meetings about NHI centred on free riders in the informal sector, particularly the infamous mini-bus taxi industry, which is largely outside the tax system.

concluding chapter (South Africa 1997a). COSATU's response to the new SHI proposals of September 1997 is currently being drafted.

The NHI commission also made a series of far-reaching recommendations about regulation of the private sector (Broomberg and Shisana 1995). The private sector argued strongly for self-regulation and against 'interference' by government, though group interests divided on specific issues. The pharmaceutical industry protested vigorously about a proposal to make primary drugs available generally, either free or at very low cost (Sidley 1996). The administrators were cautiously optimistic about NHI, arguing that they alone had the expertise to run such schemes and that they could do so far more efficiently than government. The medical profession was very concerned about 'nationalisation' and the threat to their medical independence (and income), though their concern about commercial 'managed care' initiatives from medical schemes (a concern shared with pharmacists and hospitals) drove a wedge between them and medical aid scheme administrators. At the time of writing, the Department of Health is holding fire on reform of the private sector, though an updated document has been issued (South Africa 1997b). In the meanwhile, this billion Rand industry is monitored by a tiny section of the Department of Health, run by the Registrar of Medical Schemes, with a minimal staff.

These developments are directly relevant to the schemes studied. Members of the Sick Funds depend on the public sector for some of their care, specifically specialist and hospital care, and the Funds are building links with the public sector to

create payment mechanisms and improve the flow of information between practitioners dealing with different levels of patient care: primary care in the Funds' clinics, secondary and tertiary in the state hospitals. These links have to be created province by province, in line with the devolution of responsibility from the central Department of Health to the provinces. There is a lingering stigma attached to the public sector. This stigma is a common theme amongst workers, often despite socialist politics. It has a material base in the poorly resourced and overcrowded nature of public facilities, but relates also to a racist past when whites at the top of the pile had almost exclusive access to the private sector. The end of apartheid raised expectations to a high pitch: for many, the expectation for health care was that all would have what whites enjoyed in the past. This expectation permeates the studies, complicates the process (and my role in it, as a white) and colours the outcome.

5. *Health care as a union issue*

Health services, whether public or private, are generally not delivered at the workplace. Where workplace services do exist, they tend to be provided by employers rather than the state and to be limited in scope, with the extent of services indicating their instrumental purpose (Derickson 1989). They would generally provide first aid and treat minor ailments and injuries (thus reducing time off work due to accidents and illness) and possibly some occupationally-specific services, such as lung screenings in

dusty occupations. The instrumental purpose of factory services was clearly highlighted in a survey of factories in Cape Town, which revealed that the commonest of all services provided was 'family planning', especially in female-dominated industries such as food and clothing (Cornell 1984). The obvious exception to this trend in South Africa is the mining industry, which has its own in-house health services, part of an extensive system of social control including single-sex housing for their predominantly migrant workforce. With these exceptions, workers go outside the workplace for health care. In the process, they lose their collective identity as workers and are individualised as 'patients'. The terminology is telling, with all its implications of passivity. This passivity is compounded by the power relations of the interaction with health professionals and the vulnerability of illness, which may subdue the most vocal activist.

By the 1980s, South African government policy was explicitly directed towards the increasing privatisation of health services and the deregulation of the private sector, in line with broader policy aimed at making the South African economy more competitive (Price 1988a; 1988b). The doctrine of individual responsibility and its correlate of freedom of choice was an essential part of the ideological thrust of 'modernising'. In terms of health care this translated to a view that, on the one hand, workers were responsible for the health care of their families and, on the other, that they should be free to choose the level and style of care to which they had access - in the private sector. The only constraint on choice was affordability. This formulation is based on two assumptions: that health care is an individual responsibility and that

ability to pay should determine the nature of the care to which an individual has access.

Unions taking up health care as an issue are, in effect, challenging both these assumptions. They are asserting that the responsibility for health care is not individual but collective and that need, rather than ability to pay, should determine the nature of the care to which an individual has access. In this way, the issue of health care connects directly with the central trade union principles of collectivism and solidarity. Consequently, it has a rightful place on the agenda of any trade union, other than those with a very narrowly economic definition of their role. By taking up health care in a collective way, trade unions take a quantum leap, extending their support to their members in time of illness and giving them the backing of a collective organisation which will assert their rights and challenge the attitudes and practices of health professionals. As individuals, workers might well be afraid to confront doctors, but jointly they have far more power, especially when their unions are directly involved in the management of health care schemes which employ medical staff to deliver services. When unions *employ* medical staff, on behalf of their members, the power relations shift dramatically.

In formulating demands, members' views and wishes on health services are important, but cannot be taken up simplistically. Union leaders have a responsibility to explore the source of these views and to engage with them dynamically, questioning received opinions and exposing members to alternatives in discussion and debate. In

the dying years of the apartheid regime, there was an extensive debate in progressive health circles about the kind of health service that should be built for the 'new' South Africa.²¹ The union movement took very little part in this debate, and the few articles which referred to the trade union movement had little practical basis (Price and Tshazibane 1988; 1989; Broomberg et al. 1991). A rare exception was London (1991), written by a doctor who worked in a trade union clinic outside of Cape Town. There is a danger in separating decision-making about health care from other union issues, because other factors have more impact on health than health services (Pillay and Bond 1995; Vagero 1994). Some of these other factors fall within the sphere of union bargaining, most obviously wages, which provide the basic necessities of life.

It is possible (for individuals and for countries) to spend too much on health services and too little on health and there are clear indications that health status does not rise in direct proportion to the amount spent on care. 'More' does not necessarily equal 'better'. This is one argument for a gradualist approach to improvements in health care, alongside active pursuit of other trade union goals such as improvement of wages (enabling workers to pay for better food, housing and education) and working conditions (reducing the harmful impact on health of exposure to hazards at work,

²¹ The broad thrust of the debate was towards a system of nurse-based primary health care (a broader definition than 'medical' care, including a stress on preventive and promotive health), which should be 'progressive' (a broad formulation incorporating ideas of greater involvement of patients and their communities, as well as replacing the classical medical hierarchy with a health team approach). The debate included a conference in Maputo on 'Health and Welfare in Transition', which drew together progressive health activists from inside South Africa, exiles and international sympathisers, with the liberation movement (Zwarenstein 1990). A major theme in the debate was the need for a National Health Service or National Health Insurance. See, for example, Price (1987); Owen (ed.) (1988); Centre for Health Policy (1988); de Beer (1988); Broomberg and De Beer (1990); Bachmann (1994); Price (1994); Blecher et al. (1995); (1996). Some concentrated on women's health (Klugman and Weiner 1992).

extended working hours or unhealthy shift systems). However, in a country like South Africa with a historical legacy of savage inequality, the gradualist approach is difficult to argue, smacking as it does of reinforcing the divisions of the past, when 50% of all health expenditure went to 20% of the population, leaving the other 80% to the care of the state (McIntyre et al. 1995).

6. Health care as a subject for bargaining

What does it mean to *bargain* about health services? It means accepting that health care is one need among many, which cannot be fulfilled in isolation. It means an economic approach in the strictest sense of economics as the science of scarcity, of choice, of allocating finite resources between competing demands (see for example Drummond et al. 1987).

Health care is not usually the subject of bargaining. In general, health services are designed by health care funders and/or providers, not users (see for example Walt 1994). Planning and provision are the domain of experts in both public and private sector health care (Zaidi 1994; Cassels 1995). In theory, public sector services are designed to meet objective needs. The pattern of need is assessed by experts (health economists and planners and/or medical professionals), rather than articulated on the basis of their experience by users of the health services. Health service users have little or no part to play in the process (Carr-Hill 1994). In practice, political considerations

colour the process of deciding where to direct resources and to whom. This is seen in acute form in the South African public health system under apartheid (see for example McIntyre et al. 1995; McIntyre 1997).

In the private sector, different imperatives drive the process of health service planning. Users of the private sector have greater latitude in choice of services, and private sector providers compete with each other in a way foreign to the public sector. Services are designed to meet the demands of users (and potential users), who have the power to go elsewhere. Private hospitals and clinics compete on facilities and advanced medical technology, to attract not only patients but also specialists, many of whom situate their consulting rooms in private hospital complexes, and tend for convenience to direct patients to these facilities for treatment. Competition over technology has the effect of raising user expectations and stimulating demand for high technology interventions, especially when both users and medical practitioners are cushioned from consideration of the cost by the third party payment systems of medical insurance (Broomberg 1990). The result is the inflationary spiral seen in medical aid schemes in South Africa, leading to consideration of methods to regulate private sector medical care (Broomberg 1991; Fourie 1993; McIntyre et al. 1995; Price and Masobe; Pillay and Bond 1995; Van den Heever 1994, 1996).

Union bargaining agendas are shaped by political context. In countries where there is an NHS or unified NHI/SHI system, health care drops off the bargaining agenda for individual unions (Navarro 1989; Swartz 1993; Taylor-Gooby 1996).

Health sector unions take care of the issues affecting their members as workers, and the task of taking up issues which affect all union members as health service users is generally left to the national federation, which interacts with government, registering protest at cuts in public health service budgets. It is impossible to *bargain* with the state on behalf of members on an issue like health care because the state is too large, too departmentally discrete. Decisions about budget allocations to departments are made at a level remote from citizens and the organisations of civil society. There is no mechanism for budgetary flows between departments, and departmental autonomy and power is fiercely guarded. The Minister of Health cannot offer to improve health care in return for reducing or delaying a demand on housing, pensions or education, which fall under the jurisdiction of other Ministers.

In contrast, bargaining with employers generally allows a degree of flexibility in the decision of how to cut the wage/social wage cake. In countries with compulsory health insurance, but a choice of schemes, health care will be on the bargaining agenda with employers, but bargaining will focus on choice of schemes and division of costs between employer and employee (Taylor-Gooby 1996; Graf von der Schulenburg 1994; Deppe and Oreskovic 1996; Nonneman and Van Doorslaer 1994; Chinitz 1994). In countries like the US, where health insurance is not compulsory, the scope of union bargaining with employers includes both the choice of schemes, the division of the costs and also the basic demand for cover in industries or companies without current cover (Staples 1989; Navarro 1989). The principal division between the two systems -

the social insurance 'Bismarck' system and the social welfare 'Beveridge' system - is summed up by Taylor-Gooby (1996) as follows:

In a social insurance system the central problem is how to control medical costs; in state-controlled systems, it is whether funding is adequate and how to handle the problems of deciding priorities and deal with waiting lists and rationing measures. (Taylor-Gooby 1996, 217)

Bargaining assumes an ongoing relationship and structures. These are more common and more developed between employers and unions than between unions and the state, especially outside of mature liberal democracies. In general, employers are more familiar bargaining partners. The collective bargaining process involves the membership to varying degrees. Leaders may do the negotiating, but with an agenda defined by (or at least acceptable to) their members, and they are accountable to those members for the outcome. There is no equivalent structure to the relationship between unions and the state. The base of representation lacks the symmetry of the employer-union relationship: the unions' base is their membership; government's base is either its party membership (likely to overlap with union membership to varying degrees according to the nature of the ruling party) or more broadly the citizenship (which incorporates union membership). Union powers and weapons are different, less focused and more constrained in relations with the state. For example, a strike against the state is possible, but more difficult and dangerous than a strike against an employer or group of employers.

Nevertheless, unions have to engage with the state around health care.²² Even when there is no direct relationship between unions and the state in terms of health care, the state is part of the picture. It creates the legislative structure within which all health services and funds must operate; it creates and administers policy on crucial matters such as drug pricing and distribution; it regulates access to public services and operates those services. The legislative and regulatory framework may be either favourable or prejudicial to the development of union-initiated schemes. For this reason, if no other, it is necessary for unions to engage with the state in bilateral or trilateral fora to protect and advance their members' interests.

Change of government may require a radical shift in the approach towards engaging with the state, especially where this change involves a movement towards formal democracy. In South Africa after 1994, despite an apparently privileged new relationship with government, trade unions have continued to keep the issue of health care on the bilateral bargaining agenda with employers. The relationship with the state Department of Health is being developed in parallel with, rather than as a replacement for, the collective bargaining relationship. There is an argument for using the combined strength of the unions to back a demand for broad class demands, not limited to their members. On the other hand, there are sectional concerns within the trade union movement, and divisions between the organised and unorganised, and between the employed and unemployed, all of which militate against such action.

²² Swartz (1993) points to the danger of dropping the struggle prematurely, arguing that though Canadian unions won health insurance, they did not achieve fundamental redistribution of resources.

There is also the risk that, given economic and political constraints on the new government's capacity to deliver in practice, the response from government would be premised on uniformity at the lowest level. Unions with established health care arrangements and a powerful base for bargaining with employers would be reluctant to surrender hard won gains in return for a least common denominator outcome.

Management of health care

Though the bilateral structure of bargaining may be familiar, health care brings new challenges to the process: when the scope of bargaining is extended beyond the division of the costs of health care to the restructuring of the content and delivery of that care, unions enter uncharted territory and encounter new parties, with whom they have to develop relationships. Health care professionals and consultants enter the picture, along with financial intermediaries (such as medical aid administrators and managed care enterprises). Dealing with these different and potentially conflicting groups presents trade unions with particular problems. The imbalance of technical knowledge and expertise in a specialised area can be crippling for a union, rendering it vulnerable to manipulation by vested interests. On the other hand, gaining the expertise necessary to negotiate with specialists on relatively equal terms can result in over-concentration of skills in a small group of full time officials, cutting other officials and, more particularly, worker leadership out of the negotiating process and distancing the membership from the issue. The challenge is to retain a reasonable degree of worker control of the issue, so that it does not become a technical question only, while

at the same time ensuring that union negotiators can hold their own against specialists, rather than being forced onto the defensive.

In most countries, health insurance schemes are managed and administered independently of unions or bargaining structures and their relationships with unions or employers are at arms length. This thesis focuses on the unusual phenomenon of schemes which are jointly managed by unions and employers within an industry. This is a much closer relationship, particularly when the schemes run their own health services, rather than simply contracting with private providers. The trade unions involved have to develop a set of relationships, as *employers*, specifically as employers of professionals, and even more specifically, of medical professionals, one of the most hierarchically organised, minutely divided and professionalistic of groups (Doyal 1983; Swartz 1993).

Employment relations inside trade unions can be complex, embodying a conflict between the rights of union employees as workers and the rights of the membership whom they serve. The relationship with medical professionals is even more problematic. They have a right to express demands to their 'employer' (the joint management structure, in which the union participates) and are likely to be particularly demanding on the basis of professional status. The union as joint 'employer' is in turn accountable to and employed by its members, with whose interests the professional demands conflict. How will unions manage to be at one and the same time employers of the medical staff and representative of the workers who rely on the services they

provide? Unions have to intervene in a number of relationships to facilitate a shift in the balance of power: within the group of medical professionals (the web of medical manager-doctor-nurse relationships) and, more importantly, between them and the union's members, in order to increase those members' involvement in their own health care. There is a significant imbalance in power between health care professionals and users. Health care is not an ordinary consumer good: you cannot be certain when you will need it or how great your need will be. When you do need it, you are vulnerable because of pain and/or fear and reliant on advice and decisions which you lack the expertise or vocabulary to challenge. You are also usually alone. On the face of it, this would seem to be a very difficult area for trade unions to enter, requiring intervention in an individualised and confidential relationship.

7. Conclusion

The central task for unions is to maintain the 'union' character of their health services in the face of a number of conflicting pressures. The involvement of professionals gives them a stake in the process and results in pressures towards 'efficiency' and professionalisation. There are competing demands for union leaders' involvement, which may result in withdrawal from involvement once the decisions are made. This is problematic because health service developments need ongoing union involvement in the implementation of decisions and monitoring of outcomes to ensure that they do not revert to professional control as a result of losing the vital contact with their user/members. As the health system develops, it places increasing demands

on the lay management structures. In order to manage appropriately, representatives need skills, training, experience and continuity, which can centralise decision-making power in the hand of a small group of union 'experts'.

There is a continuing tension between the need to highlight health care as an issue, recognising the importance of appropriate union structures and procedures, and the need to locate it as a **union** issue like any other and one that is intimately related to the mainline issues of wages and working conditions, in terms of their impact on health status. Health care must not overtake health as the central union concern.

The Sick Funds which are the subject of the first three studies in this thesis operated in an uneasy middle ground between private and public sector. They provided access the private sector via a system of contracted private (panel) doctors (though in the second-class queue), sometimes supplemented by simple primary clinics. Sick Fund members, unlike members of most other medical schemes, shift between private and public sector care. For secondary and tertiary care, they used the public sector.

I argue that it is possible to reclaim this middle ground and to create funds which are public in form, though technically private, by transforming the existing clinics and using them as the base for an expanded system of neighbourhood primary health care centres, employing medical staff to operate them under the control of Sick Fund structures, and developing strong relationships with state health services for secondary and tertiary referral. Such funds protect members from the inflationary

spiral of private medicine. Though they are part of a tiered system, privileging members above workers with no health cover and the unemployed, the differences are less acute than with medical aid. The style of the services is similar to public sector services, the major difference being the degree of control which the users, via their representatives, can exert. It would be romantic to characterise this as 'worker control', but it is at least worker influence. The next chapter describes the process of restructuring a Sick Fund for clothing workers in Cape Town with the South African Clothing and Textile Workers' Union.

Chapter 4. The Cape Clothing Industry Sick Fund

1. Introduction

The focus of this chapter is on a trade union project: its origin, development, implementation and outcome. This project was informed by a broader purpose among a key group of new trade union leaders, engaged in a broad process of renewal within the union, one thrust of which involved the process of restructuring members' health care (on renewal, see Fairbrother 1996). The union had more than 48,000 workers, members of the Sick Fund, the overwhelming majority coloured women. They were spread over 399 factories in the Western Cape, the majority in small and very small factories, earning low wages.

The nature of the state and the political environment influences the way in which unions function. When this project began, the South African state was still constituted on racist lines and unsympathetic to the organised working class. This situation combined with a legacy of state resistance to independent trade unions and the vacuum in formal party politics for black South Africans (legal parties were discredited, credible parties were illegal) to politicise a significant part of the trade union movement and broaden the scope of union activity and responsibility. In the 1980s the state was intent on dismantling the remaining elements of intervention and protectionism in the economic system. In health care, the decay of the state health system and rampant inflation in the private health sector fuelled worker

dissatisfaction. At this juncture, it was obvious that the state would not respond to demands for improvements in public sector health care.

This pressure intersected positively with an organisational imperative. The union project was undertaken to legitimate and concretise an existing union agenda, an agenda which was in turn closely linked to the need to legitimate and establish a new leadership. The new leaders moved beyond the defence of historic benefits, extending and improving them, and entered political terrain by asserting the union's right to involvement beyond bargaining over the division of the costs of health care into the new area of design and management of health services for their members. Locating the issue in the familiar structure of bargaining required conscious weighting in relation to other issues being pursued simultaneously, tested commitment and allowed for delays in return for key concessions.

Workers looked to their union for assistance. Union leaders made a strategic decision to develop the project within the bilateral framework of the existing Sick Fund management structure, translating a union policy document into a joint project shared with employers (GAWU 1989). They believed that this would require the appointment of an independent 'expert' acceptable to both parties to research the Sick Fund and present proposals for its restructuring for negotiation by the parties.¹

The study traces the way in which the issue was defined, related demands articulated and embedded, and membership commitment secured in order to

¹ In all four studies, I was nominated by a trade union to act as consultant to both parties (trade unions and employers): this was then agreed by the employer/s (and by the other trade unions in the two multi-union studies). Differences in the extent and nature of my involvement are highlighted in the studies and discussed in more detail in the methodology appendix.

support the leadership in the bargaining process. The union leadership's investment in the project kept the issue on the bargaining agenda and resulted in the negotiation of crucial agreements, in which delays were conceded at terms and times advantageous to the union project.

Unlike the other studies, it contained within it a formal piece of planned research, in the form of a sample survey. The original research plan was constantly modified in response to a volatile situation, incorporating new developments and demands and shifting its timetable and pace to accommodate the rhythms of the industrial relations negotiating process. My involvement extended beyond the formal study, developing from internal work in the union started some four years prior to the study, and including an intense two-year period of involvement in the process of implementing the recommendations.

This first study focuses particularly on the possibilities for union action on health care, while those which follow highlight the constraints and limitations. This chapter charts the way in which a 'great notion', as expressed in the union's internal policy document, was brought to the bargaining table, legitimated by 'independent research', paced by the collective bargaining process, and then implemented in a process subject to the checks and challenges of the joint management process (GAWU 1989). In the process, a model for working class health care provision emerges: this is - crucially - not a technical model which can be transferred with ease, but rather a model of process, which is founded on struggle.

2. *Origin: the union agenda*

The impetus for union renewal may come from different sources: membership dissatisfaction and pressure, shifts within the leadership, entry of new leaders, external forces, and any combination of these. New leaders must distinguish themselves from the old order where this is problematic, but identify and lay claim to the elements of tradition which attract the loyalty of members. To do this, they must define an agenda for action which builds on these issues. In order to understand this project it is necessary to understand the ideological weight of Sick Fund benefits for clothing workers in the Western Cape and the challenge posed to a new leadership intent on extending the boundaries of a narrow but paternalistic form of unionism.

This study was rooted in a crucial stage of the transformation of the trade union involved from bureaucratic quiescence to democratic activism (Hyman 1989). The origins of the Garment Workers' Union - Western Province (GWU-WP) and its establishment as a compliant, non-militant union were described in chapter 1. One of the bulwarks of the union was its benefits, and the leadership presented the Sick Fund as chief amongst these. The Sick Fund of the Cape Clothing Industry was first established in 1942, 15 years after the formation of the union.² It provided for partial replacement of wages lost due to illness, as well as a simple health care benefit, giving workers (but not their dependants) access to contracted general practitioners ('panel doctors') and medication and, in time, a

² Note that though formed in 1927, the union did not function as a union until the mid-1930s (Nicol 1983).

number of other benefits.³ At the time of the study, there were 96 panel doctors in 103 surgeries (some had two surgeries). In most areas there was a choice of doctors and workers were not bound to one doctor but could change at will, visiting doctors where they lived or worked. Doctors near factories tended to have particularly busy practices.

The first medical clinic was opened in 1964. A maternity benefit was introduced in 1991. These benefits were administered by the Industrial Council and funded by equal contributions from employer and worker. (See chapter 1 for a description of the Industrial Council system.)

The Fund represented a major advance for clothing workers, giving them access to sick pay twenty five years before it was written into the Factories Act in 1962. Once the benefit was introduced, however, its administration was removed from the arena of struggle. Though there were occasional minor improvements in benefits over the years, there was no systematic analysis of their value, especially in comparison with statutory sick leave and pay, until the late 1980s.⁴

The spur to re-examination of benefits was the entry of the new officials in the 1980s. Most of them came from an activist tradition, either from youth and student movements, or from experience in other, more radical unions (specifically those which had emerged in the new wave of unionism which began in the 1970s). There was a change in the top leadership, as the grip of the Petersen family was

³ Regular sessions with a gynaecologist (1958), an ante-natal clinic (1962), an optical clinic (1963), dental clinic (1973) (Cooper 1979).

⁴ The problems of (other) Sick Funds had been raised, for example in IHRG (1981), which arose from an analysis of the Foodworkers' Medical Benefit Fund (FWMBF) undertaken by the IHRG at the request of the Food and Canning Workers' Union. As a result of this study, the FWMBF established a workers' clinic in Paarl. For a description of this clinic, see London (1993).

loosened.⁵ When GAWU was formed in 1987, it adopted policies and principles consciously aligned to those of COSATU affiliates (non-racialism, non-sexism, democratic worker control and 'one union, one industry') and called for six months observer status in COSATU structures to be followed by affiliation (GAWU 1988a; 1988b). The new officials were faced with a largely passive membership, unaccustomed to participation in union affairs, anxious about radicalism and 'politics' (Nicol 1983; 1984a; 1984b; Bloch 1982). The membership was overwhelmingly 'coloured', a disenfranchised group, marginalised in national politics, whose only forum for political representation was a discredited puppet parliament (the House of Representatives), which had responsibility for a narrowly defined list of 'own affairs', related to people classified as 'coloured' and delegated to it by the white-only parliament.

At work, clothing workers in the Western Cape had long been 'represented' by a paternalist, highly centralised union leadership which had a close relationship with the employers, of which it was proud:

What marks our Industry, by and large, is a happy relationship between workers and management. Where else in the world would you find a Trade Union running an inter-factory Spring Queen competition with management and workers co-operating just for the fun of it?" (Clothes Line 1982, quoted in Suttner 1983, 17)

The task of organisers (full-time officials) was described in the union's own pamphlet as follows: 'ORGANISERS: Are employed full time to deal with workers' problems or problems relating to benefits due to workers. They visit

⁵ The long serving general secretary was Louis Petersen, his son Cedric was assistant general secretary, and other family members were also employed by the union (Nicol 1984a). Cedric Petersen was also editor of the weekly union newsletter 'Clothesline'.

factories periodically to enlighten workers on Trade Union policy and act as liaison between employers and employees in order to resolve any disputes and maintain amicable understanding.' (GWU-WP n.d., quoted in Suttner 1983, 88) In line with this top-down approach, wage agreements were simply announced to workers. Though there was a shop steward structure on paper, shop stewards' scope of action was limited to minor tasks related to benefit administration. They were not involved in negotiations and there had been no industry-wide industrial action since 1936 (Nicol 1984a).

The GWU-WP's proprietorial attitude towards the benefits associated with membership was somewhat misleading, as most of the benefits were in fact jointly funded by employers and administered by the Industrial Council.⁶ The benefits arose from being a clothing worker, rather than from being a union member, though given the fact that there was a closed shop, the confusion is understandable and compounded by the fact that the clinic and the Industrial Council offices where sick pay was collected were in the same building as the union, Industria [sic] House.⁷ This confusion undoubtedly suited the 'old' union: during the brief period when the Clothing Workers' Union (CLOWU) attempted to organise in the industry in opposition to the GWU-WP, the old union used its newsletter to warn that workers who joined CLOWU would lose their benefits.

⁶ The confusion was undoubtedly strengthened by the fact that all workers were provided with a set of four pamphlets of identical format, two on the Sick Fund and the Provident Fund (both Industrial Council benefits) and two on the union. One of the 'union' pamphlets provides a long list of benefits for 'bona fide members' of the GWU-WP, from funeral assistance to Xmas cheer. *Clothes Line*, the weekly newspaper, aimed 'to make workers aware of their advantages and disadvantages in the social, economic, management and labour fields'. Last on the list was 'the trade union' (representation in negotiations and affiliations to national and international organisations) (Suttner 1983).

⁷ Industria House was owned by the union, which let offices to the Council.

One of the new entrants to the union, Howard Gabriels, appointed as research officer, was assigned the task of formulating a proposal for improvements to the Sick Fund.⁸ He and others among the group of new officials saw this as a way to connect with members, tapping into their attachment to the Sick Fund in the process. In engaging with a central benefit, the new leadership did two things. First, they struck a blow at the image of the old union by questioning the real value of the benefits on which its reputation rested. Second, by raising the possibility of improved and expanded benefits, they claimed the mantle of authority and leadership, establishing a continuity with the positive aspect of the union style to which clothing workers were accustomed (that is, protectiveness), and dramatically enhancing it by taking on responsibility for families for the first time. In the absence of adequate state provision for working class families, the union took on responsibility for organising this aspect of social reproduction.

It was important to establish some continuity, because the new leaders were challenging the old union in a fundamental way, questioning both the content and the style of the old unionism. In relation to the Sick Fund, this was the first time that members were asked about their experience of the system and given the opportunity to voice problems. The new representative structures being developed by the union provided a mechanism for this process. The project was part of the process of schooling workers in democracy, but it also required the exercise of leadership. Alongside the question of extending benefits to dependants, generally positively and enthusiastically embraced by members, the leaders raised a more

⁸ Before joining GAWU, Howard Gabriels had worked in two unions from the 'political' wing of South African unionism: first the General Workers' Union (based in Cape Town) and later the National Union of Mineworkers.

contentious issue, questioning the value of the sick pay benefit for the first time and introducing the possibility of its replacement by statutory sick pay. This was a highly emotive issue for all parties.

3. A summary of the project

A brief overview of the project highlights the slow pace of change, closely related to the fact that the project was rooted in collective bargaining arrangements. Internally, it was subject to all the checks and balances of a bilateral decision-making structure and a ponderous Industrial Council bureaucracy, as well as the impact of developments in wage bargaining. Externally, it was affected by factors including union mergers and escalating political change on the national stage.

The issue of improvement of benefits offered by the Sick Fund (SF) of the Cape Clothing Industrial Council (CCIC) was discussed first in the union from early 1988 and then in the various fora of the IC for a number of years before the formal project began. A special sub-committee of the IC was appointed in December 1988 to 'examine all aspects of the Sick Fund and Provident Fund' and the union (at this stage GAWU) presented a proposal for a replacement SF agreement in May 1989 (GAWU 1989). In the first two years, the sub-committee focused on two areas, sick pay and maternity benefits. A maternity benefit was introduced for the first time in January 1991 and during the 1990 wage negotiations, the parties agreed to change the sick leave and sick pay system in

mid-1992.⁹ Sick pay would no longer be paid and administered by the Sick Fund, but directly by employers, in accordance with the Basic Conditions of Employment Act (No. 3 of 1983) (BCEA).

Attention now switched to medical benefits. In May 1992, the Industrial Council approved the Sick Fund Management Committee (SFMC) proposal to appoint me to investigate the restructuring of the Sick Fund.¹⁰ By proposing and supporting my appointment, the union was apparently moving away from an established informal behind-the-scenes relationship to a formal relationship which included the employers. In fact, it was establishing the new relationship in parallel rather than as a replacement: a formal relationship via the Sick Fund Management Committee in addition to the informal relationship, which continued and expanded in the course of the project. The union presented my appointment as a union victory, part of the process of claiming ownership and a 'union' character for the project.¹¹ Throughout, I had very much more contact with the union side at all levels (officials, shop stewards and workers) than with employers. Other than the SFMC meetings (where the union was also present) and contact with individual manufacturers to organise interviews at their factories, the connection with employers was mediated through the Director of the Cape Clothing Manufacturers' Association (CCMA). In the project, the union expected me to shift between the

⁹ Members with two years' continuous service were entitled to 25% of the weekly wage for 13 weeks. This was in addition to maternity pay from the Unemployment Insurance Fund (UIF).

¹⁰ I had been working behind the scenes with Howard Gabriels, formulating the union policy document on the Sick Fund since 1988.

¹¹ After my initial presentation to the SFMC, the employer party proposed an alternative consultant. We both made presentations to a follow-up meeting. Despite a suggestion from the employers that their consultant be given a copy of my presentation in order 'to orient him' before another presentation, my appointment was confirmed. This background may explain both the union's sense of victory and the employer party's initial concern about my appointment.

roles of independent authority and union advocate, as strategically necessary and on demand, shifting language (between English and Afrikaans or 'mix') and style (social scientist to activist) to suit the context.¹²

The mandate for the study, as defined by the parties to the Council, was to investigate the viability of establishing additional clinics and extending benefits to members' dependants.¹³ In a move which highlighted the context of the study, the SFMC asked me to delay the membership survey until agreement had been reached in the annual wage negotiations, fearing that the project would be 'politicised' by the conflictual atmosphere of the negotiating season.¹⁴ Background work, drawing on the Sick Fund data, began immediately. My formal relationship with the SFMC lasted through 1992, with implementation and follow-up through to the end of 1994. The quantitative aspect of the study included:

- calculation of the number of dependants likely to enter the scheme
- mapping the distribution of membership (residence and workplace)
- establishing patterns of panel doctor usage and expenditure in different areas
- establishing optimum sites for new clinics based on all these factors
- costing clinics (set-up and running costs)
- drawing up guidelines for staffing, opening hours, facilities and equipment

¹² This issue is discussed in greater detail in the methodology appendix.

¹³ The scope of the study was consciously narrow and informed by a number of assumptions:

- the scheme would provide only primary health care
- it would facilitate access to public sector secondary and tertiary care and co-ordinate care
- expansion of the panel system made neither financial nor clinic sense: it was expensive and quality and abuse were impossible to monitor
- a team approach to health care, using the skills of nursing staff more fully and appropriately, would be preferable to the system of over-reliance on doctors
- there was considerable scope for rationalisation in the Sick Fund.

¹⁴ The decision was made at the IC meeting of 7 May 1992, confirmed by letter from the Secretary on 21 May.

Qualitative information came from an extensive membership survey, which established current usage of health services and attitudes towards these services, both in the Fund and outside (for dependants). This was fleshed out through the process of interaction with the union and its members at all levels, as well as with employers, Council and Fund staff, panel doctors and other interested parties.¹⁵

The context influenced the design of the research and the style in which it was conducted. In addition to providing the data necessary to cost and plan new services, the quantitative aspect of the study was also designed to allay employer fears. Exaggerated estimates of family size fuelled concerns about an explosion in Fund expenditure. The source of these estimates can only be speculatively traced to unexpressed racial stereotypes.¹⁶ The sample survey did not yield substantial new information, particularly in relation to the time costs, but the process had importance beyond the data it provided, taking the issue into a wide range of workplaces and giving workers a chance to talk about their experience. The spread of interviews was also important to establish the breadth of worker support for the proposed changes and counter any potential claims by employers that only a small group of activists backed change. The most significant feature of the survey was that it clearly identified the project with the union: though the study was backed and funded by the SFMC, a joint structure, the union presented it in *Clothes Line* and in union fora as a union project. Shop stewards facilitated the

¹⁵ 1,107 workers (of a total of 48,348) in 86 factories (of a total of 399) were interviewed, in factories of all sizes throughout the area covered by the IC (Cornell 1993).

¹⁶ Official concern about the threat of 'population explosion' amongst black South Africans lingered from the 1960s, when white women were urged by government to have babies 'for South Africa' at the same time as 'family planning' programs urged blacks to 'plan a smaller family for a bigger future'.

administration of questionnaires in the factories (though the respondents were identified by random selection from payroll lists). The process linked the activity of a previously remote structure (the SFMC) with workers on the ground. The survey was deliberately based on practice ('what did you do the last time one of your children was sick?') rather than being open-ended ('what do you want?') and thus avoided acting as a conduit for demands which were unlinked to costs (and therefore likely to be unrealistic and lead to disappointment).

A number of important changes were introduced before the Report was finalised. The most significant was the change to the sick pay system (and accompanying computer and staffing changes). Staff changes were urgently needed because the delay in starting the survey meant that the Report could not be completed before the end of 1992. The Executive Council decided not to renew the annual contracts of the two doctors and dentist employed by the Fund (see section 7 below for a discussion on the medical staff), so that new staff could be selected in late 1992. The SFMC also agreed to begin the process of upgrading the central medical clinic and dental facility, recognising the necessity of physical changes to assist in changing members' attitudes towards clinic-based services.¹⁷

The formal report on the research was presented to the SFMC in January 1993 (Cornell 1993a). This was followed by a joint workshop for employers and the union in March, which drew up an agreed plan for implementation. The central recommendations were: first, upgrading and expanding the existing medical and

¹⁷ The upgrading of the dental facility was done in response to a horrified report from the new dentist who found that the steriliser had rusted through, and had clearly not been used for some time (Makenete 1993).

dental clinics; and second, establishing a network of local clinics, run by Fund-employed staff, to provide health care for the membership, including dependants.

The second recommendation involved a shift from dependence on panel doctors, with Fund clinics playing a minor role in service provision, to a system based on direct service provision, retaining panel doctors only in areas where membership numbers were too low to make a Fund clinic viable.¹⁸

The research process then entered an expansive phase in which I undertook new tasks on request in order to provide greater assurance of feasibility and affordability. The requests came from all parties, and were indicative of the different concerns of the parties. The employers were concerned about cost overruns and the implications for their future financial liability, and about efficient management of medical services.¹⁹ They asked for:

- three year budget projections, incorporating a range of options for benefits changes and different timetables
- actuarial evaluation of the soundness of these projections
- projections of drug costs for dependant children
- proposals for a new management structure for the fund.

The union asked for numerous projections of variations in benefit design which would result from different budget levels, as well as costings for improvements in other benefits (specifically the maternity benefit introduced in 1991). The union's requests were associated particularly with preparation for

¹⁸ The minimum number of members in an area required to support a clinic was 2,500. This allowed a small margin for safety.

¹⁹ A repeated refrain (noted in my notes of SFMC and sub-committee meetings) as 'We're in the clothing business, not the medical business' [sic].

wage negotiations, and union strategy meetings in the course of negotiations. Council staff asked for advice on staffing, verification and modification of budgets, and (sometimes explicitly) reassurance during the process of implementing the changes. They were concerned about the rate and degree of change and the management demands of an expanded system. The new doctor in the central clinic asked for advice on new information systems, the development of an essential drug list and staff issues.

The first four new health centres (plus a new dental facility attached to one of them) opened on 7 April 1994, just three weeks before the first democratic elections in South Africa. In the three and a half years since then, developments have continued. At the time of writing, there are nine health centres, three dental facilities, one optical facility (and another planned) and a full X-ray facility.²⁰ The Fund has employed four full-time social workers and plans to expand this service. There are special sessions in key clinics for members with chronic illnesses, such as asthma and diabetes, and this system will be extended to all health centres. A health promotion officer has been appointed to expand this area of work, with a staff of clinical nurses, who are currently being trained. A Well Women's Centre was opened in early 1997. The first change in the panel doctor system was made in February 1997, when the contracts of all doctors in the area surrounding the central facility at Salt River were terminated. A joint union-employer workshop was held in February 1997 to decide on direction for the Fund for the next five year period. Among other issues, the parties agreed on a system of parental leave, in

²⁰ Source for information on recent developments: personal communication from Ronald Bernickow, October 1997.

terms of which workers could take time off to care for sick children against their sick leave entitlement. Panel doctor consultations were restricted to eight per year, in addition to unlimited access to the Fund's health centres. The Fund has bought an entire factory complex behind the union building for development as a major health facility. This will be the central facility, to which the satellite clinics will refer patients for specialised tests and services. Despite all these expenses, the Fund has healthy reserves. The Dependants' Fund is invested for long term development and drawn on only for capital expansion, all running expenses being met from contribution income. The Health Fund (as it has been renamed) is, in short, thoroughly healthy.

4. Relationships

Trade unionism is essentially concerned with relationships: transforming a union involves re-defining and restructuring these relationships. This section focuses on an analysis of the complex and shifting web of relationships around the issue of health care provision for union members. Health care provision is an unusual issue for trade union bargaining agendas (see chapter 3 for discussion) and it brings into the labour-employer-state equation additional interest groups, who may potentially disturb the balance, despite their avowed professional neutrality. All the parties bring their own agendas to their involvement in health, with sometimes clashing effect.

Relations between leaders

The project of restructuring the Sick Fund was both an example of the new style of unionism and leadership and part of the way in which the new style was created. Relationships between leaders were particularly complex in the early stages of the project (1988-1989). The interim GAWU leaders were insecure and suspicious of the motives of the new entrants. They were particularly uncertain about challenging the worth of a core benefit. The first hurdle faced by the research officer was to persuade the general secretary that this was a legitimate issue and not due to the intervention of 'outsiders'. There was an organisational imperative to this early process, given the merger with GWIU (Natal) and the secretariat's intention of merging the Funds of the two ICs. The new entrants had to prove their capability by providing workable plans for reworking the Sick Fund, without overtly threatening their 'seniors'.

The late 1980s was a time of realignment in the clothing and textile sector, culminating in the merger which formed SACTWU in 1989. By this stage, few of the old guard remained and the Young Turk entryists had taken control of the Cape Town branch: indeed, one of them (Lionel October) was elected first General Secretary of SACTWU at the founding congress. The next organisational challenge was to incorporate the new group of organisers and officials from the textile and leather sectors into the Cape Town office and develop a coherent regional identity and a relationship to the other regions and the national union. The union devoted considerable energy in the years following the merger to attempts to centralise bargaining: the leather sector already had a national Industrial Council; in the

textile sector bargaining was done at company or plant level; clothing was organised in four regional councils.

The Sick Fund project had a relationship with these developments. Union strategists wanted to create uniform conditions in the four clothing councils, bringing wages and benefits to equal levels. The Cape Sick Fund project was a flagship development, which union leaders saw as a model to be introduced into the other regions, first Natal, then the Transvaal and finally the Eastern Cape. They envisaged similar developments occurring in parallel in the leather and textile sectors and ultimately a merger of the three into one giant Sick Fund.²¹

Relations with members

For the new leaders, the project was one of the routes by which they developed and established a new kind of relationship with the members, differentiating themselves from the remote leadership of the past. They were in the process of developing shop steward and local structures, into which the project was linked. These new structures were crucial as fora in which workers from different factories met for the first time, in the process creating horizontal networks and relationships, as well as vertical connections between members at the workplace and union leaders.

²¹ The Leather and Natal Clothing Sick Funds are the subjects of the next two chapters. A proposal to revamp the clothing Sick Fund in the Transvaal did not progress beyond the level of discussion. I advised on a number of textile company medical aid and medical benefit projects around the country, and did a small project on the Cotton Textile Sick Fund in the Cape (Cornell 1995). I also advised in an ongoing problem with medical aid in the clothing industry in the Eastern Cape, the only region without an IC Fund. All these projects fed into SACTWU discussions about policy and strategy on worker health care.

The leaders also had to look at the existing structures in which the union was involved, such as the Sick Fund Management Committee (SFMC). The balance of continuity and innovation in structures like this is a delicate one. On the one hand, there is a need for continuity, but on the other hand, a danger of entrenchment and a need to spread skills and exposure amongst workers. Representation on the SFMC was strengthened by the appointment of several of the new officials, but the existing worker representatives were retained. They were highly respected elderly workers, who had served for many years on the committee and were strongly identified with the Sick Fund. Their support for the changes was vital in the process of garnering broader membership support. The SFMC was linked to the new Shop Stewards' Council meetings, at which SFMC representatives spoke regularly about the progress of the project and gave the stamp of their approval to the process, to the new officials' action on the Sick Fund, and to me. The continuity of representation on the management committee was a key factor in the success of the project.

Relations between the union and employers

Formal structures existed for the primary external relationships involved in the Sick Fund: between the union and the employers, and between the union and Industrial Council staff. The challenge was to transform these relationships and to explore and exploit the powers of the structures. Employers and union had equal representation on all Council structures: the Industrial Council itself, its committees for the Sick Fund and Provident Fund, and all sub-committees and ad hoc committees. The main employer representative on all structures was the full-time

Director of the Cape Clothing Manufacturers' Association (not himself a clothing employer). The rest of the employer party would consist of individuals from the industry, potentially including those affiliated to the smaller Garment Manufacturers' Association (GMA).²² As a full-timer, the CCMA Director was more extensively involved in Council business than individual employers. He reported back to CCMA structures, was mandated by them and served as the main liaison with employers in this project.

Relations between union and employers in the SFMC had clearly shifted over time, as the union became more assertive and active. The SFMC was a sub-committee of the Industrial Council, tasked with the management of the Fund, but required to refer all substantive changes for ratification by the IC. Decision-making was generally on a consensus basis and there was an established format for meetings, which usually proceeded in a routine fashion. The consensual mode fell away at certain key moments, sometimes related to internal Sick Fund issues and sometimes infected by more general tensions, especially during the negotiation season.²³ This was largely unproblematic, other than when it reinforced entrenched positions, but it did tend to result in delays. Times of tension were characterised by formality, with committee members speaking through the Chair and addressing

²² CCMA membership comprised 34% of factories but 74% of employees. The GMA, many of whose members were owners of extremely marginal 'cut-make-trim' establishments, played little part in the SFMC and maintained a resentful attitude towards the union, the IC and the CCMA (Theron 1993). 'We believe that the executive of the CCMA have sold the industry down the river for a number of years.' (GMA Newsletter September 1989) The only unco-operative employers in the membership survey were GMA members.

²³ This was generally recognised, sometimes with humour, when one side or the other would reassure me outside the meeting that they were merely engaged in a bit of sabre-rattling. The SFMC continued to operate throughout the period of this project, even in periods of industrial dispute.

each other by title, compared with the rather more conversational mode of relaxed periods, when there was also a greater acceptance of informal contact.²⁴

Relations between the union and Sick Fund staff

As the union and the Council were situated in the same building, informal contact between union and Council staff was easy and frequent. The shared location was one of the main sources of member confusion about the source of their benefits. They came to the same building to see the union and to collect sick pay or visit the Sick Fund clinic. It was extremely easy to confuse the functions of the Council and the union and this confusion was frequently evident in the sample survey interviews.²⁵ The union's relationship to the Council as landlord and neighbour was a recurrent source of irritation to the employer party. Employers co-fund the Council and thus pay half the rent and half the salary bill for Council staff: the union gets the rent and by virtue of proximity, enjoys easy access to Council staff and resources. Over the years of my involvement, employer annoyance at this situation was a regular theme. It reached a peak in 1996 over the question of moving the Salt River clinic. The chief medical officer argued strongly that the clinic should move out of Industria House into a new building to be bought by the Dependant's Fund as an investment. The employers supported this move, arguing that it would be beneficial for the clinic, which could be purpose built from scratch, allowing room for expansion and easier access for members. The union

²⁴ For example, I might be given a task which required some response. At a relaxed time, follow-up could be ratified by a phone call to the Secretary of the CCMA and another to the union official responsible, rather than referral back to the SFMC.

²⁵ For example, a number of workers used the terms 'union' and 'council' interchangeably, saying they were members of the council and collected their sick pay from the union.

had originally agreed to this proposal but backtracked and, despite employer opposition, managed to substitute a move inside the building for a move away.²⁶ (See Section 7 below for a discussion of the tension with the doctor.)

5. *Bargaining and bilateral relationships*

One of the central questions arising out of this study is why the union chose to retain the issue of health care within a bilateral structure, and in a bargaining context. The choice was implicit: there was never a debate on the issue of the alternative of cutting loose and taking the Sick Fund under union control. It is understandable why they first took the issue up as they did: the structures were there, the management structure of the SFMC and IC, and the benefit and contribution structure of the Fund, with reserves, administrative routines and legal status. The reasons why health care remained a bargaining issue are more complex.

The management structure of the Sick Fund, like all Industrial Council structures, has equal representation of employers and workers, five from each side. On the face of it, this relates simply to the bilateral financing of the Fund but this is misleading, given the way in which bargaining is now conducted. In the past, increases were agreed by the parties on the basis of budgets prepared by the Sick

²⁶ In interview, the union officials involved confirmed that the positions taken were political rather than practical: employers wanted a relative separation between the Sick Fund and the union, to assert their own involvement and share in the credit for the Fund's advances; the doctor wanted an independent base in order to reduce union governance of the scheme; the union wanted to retain the clinic - the nerve centre of the Fund - within reach and was strongly opposed to a move which would dilute union influence. (Interview with union officials conducted by author, 31 January 1997, Cape Town.)

Fund Secretary and without reference to the wage bargaining process. There was a pattern of annual increases, always equally split between employer and worker, and generally uncontentious. Three factors undermined this practice: first, wage bargaining shifted to a global basis; second, the research report recommendations required a fundamental restructuring of benefits and contributions, in place of the incremental increases of the past; third, the introduction of dependant cover broke the pattern of equal contributions.

Global wage bargaining takes all wage and benefit-related costs into account. The parties come to a package agreement and the union then has some latitude to decide how to divide the increase between the cash wage and various benefits. This style of bargaining highlights the fact that employer contributions towards benefits are part of their overall wage bill. By extension, there is no reason why the union should not manage these benefits without the involvement of employers. In the CCIC, there were strong grounds for this argument: the fact that Fund no longer covered sick leave and sick pay (which had unavoidable links with the employer) and the structure of dependant contributions. The 'employer contribution' was kept at the single member level, because of the difficulty of factoring differential contributions into wage bargaining and employer budgeting. The costs of dependant cover were thus met entirely by the workers involved and the symmetry of 'employer' and 'worker' contributions was broken.

I would argue that keeping health care on the bargaining agenda retained the 'union' character of the issue. Bargaining is a constant balancing act: weighing demands against each other and adjusting them in the light of advances and

retreats. It involves an acceptance of the relativity of the concept of 'needs' in health. Union membership is not homogeneous: in order to take up an issue like health care successfully, a union has to create (and continually re-create) sufficient consensus amongst various groups. It has to balance the competing voices and claims of old and young, men and women, sick and healthy, the childless and those with children. The more transparent the process becomes, the more visible are the cross-subsidies and the price of solidarity. Trade union members are accustomed to the concept and practice of compromise in relation to bargained issues: keeping health care in this context reined in unrealistic expectations. The involvement of the employer party rationalised a slower pace of development than members might have demanded had the union had sole control of the Fund. The employers acted as the brakes, tempering the extent and pace of change. The union had a strong sense that employers should accept responsibility for the health of workers and their families, especially where the state had abdicated this responsibility. The flip side of responsibility was that the bilateral structure of the Fund allowed them to assume part of the credit for the advances made in health care benefits.

The structural character of the issue was reinforced by external factors. When I first had contact with the union, it was unaffiliated and regional. The merger and the affiliation to COSATU happened in the course of the project and did not shift the focus. By the early 1990s, though unions were being drawn into joint fora on a range of issues from economic development to the restructuring of local government, health tended to be low on most unions' agendas, particularly in the newer COSATU unions, most of whose members had no form of health care

cover. Health fora, whether political (such as ANC health department meetings) or general (such as the Cape Metropolitan Health Forum - which drew members from all 'constituencies') tended not to draw in unions. As a result, the policies which began to emerge from these fora were notably lacking in insight on labour.

Generally speaking, there was some consensus that the state's responsibility was for the unemployed and indigent, and that the employed should find (and fund) their own health care (by implication in the private sector). The largest part of the employed workforce, the working poor, was effectively overlooked. At this stage, COSATU had no formal policy on health care, which was generally regarded as an affiliate issue and dealt with largely on a fire-fighting basis.

There was no impetus or support from the federation to take the issue to other levels by collaborating with other unions, or engaging jointly with government. It remained an internal SACTWU issue. The union engaged with the state, but at a local level and strategically, in order to secure a crucial concession for the Cape Sick Fund. After the union merger, SACTWU used the project in the Cape in the process of working towards a single bargaining structure for the clothing industry.

6. *Breaking the connection between sick pay and health care*

One of the most significant bases for the success of the CCIC project was breaking the connection between sick pay and medical benefits, by changing over to statutory sick pay. This was crucial in terms of opening up development: in 1991, 43% of Fund expenditure was on sick pay.²⁷ This was the single largest expense, at R8.5m compared with R7.4m on panel doctors, only R1.6m on the new maternity benefit (introduced mid-year) and R1.5m on the two clinics, including dental and optical services. Switching systems released substantial resources for development of benefits without significant increases in contributions. Sick leave ('absenteeism' in management terminology) is a source of conflict in all industrial relations systems. Administration of sick leave by the Industrial Council brought this conflict from the workplace to the joint forum. Statistics were centrally collected and monitored and the issue of 'abuse' was a constant theme at SFMC meetings, with complaints from and against all parties: doctors, members, employers and Sick Fund staff.

The shift to statutory sick pay was not easily accomplished, as there were concerns from all sides. Many workers strongly believed that they were better off under the Fund's sick pay dispensation, a recurrent refrain of the old union. The Fund entitled them to 40 days sick leave at 65% of wages, with no payment for one

²⁷ Information drawn from financial statements, Sick Fund of the CCIC, 1991.

or two day illnesses. The impression that this was a better deal than that offered by the statutory system did not hold up under examination:²⁸

- the Sick Fund was contributory and so workers were collectively paying half their own sick pay (the statutory system was non-contributory for workers, employers carrying the whole cost)
- the average annual use of sick leave in the industry was 4.7 days, 51% of members made no claim at all and 30% used more than 10 days²⁹
- all workers off sick lost wages under the Fund: those off for one or two days lost 100%, the rest 35% (only workers off for more than 10 days lost wages under the statutory system)
- statutory sick leave worked on a three year cycle, with unused days transferred to the next year, the Sick Fund on an annual basis (unused days were 'lost').

Worker unease about the change was sharpened by the project's intention to shift away from panel doctors: there were fears that doctors employed by the Fund would be more receptive to employer influence than panel doctors (for whom the Fund was only part of their practice) and therefore less sympathetic to workers on the sick leave issue. This was and remains a delicate area for Fund doctors, who have to establish trust with patients without compromising their professional standards. The problem was somewhat eased by the fact that initially the new clinics dealt mostly with children, who did not need certificates for absence from

²⁸ The argument seems to have been based on simple arithmetic as follows: 40 days at 65% equals 26 days pay, compared with the 10 days at full pay allowed by the Basic Conditions of Employment Act.

²⁹ The figures refer to 1988 and are drawn from *Sick pay - special hardship fund*, a report prepared by the author for a GAWU shop stewards' meeting, 4 April 1989, Cape Town.

school. This removed the source of conflict and allowed parents to build up relationships of trust with the service on the basis of the quality of service provided for their children.

Employers were extremely concerned about the change, their fear of an escalation in sick leave illuminating the role played by the Fund's system in the past in holding down claims by penalising workers. Rough calculations of employer savings over the previous decade hardened union resolve and were used in negotiations to counter employer claims about the potential cost of the changeover.³⁰ There was, however, dissent inside the union leadership about the change. Lionel October, General Secretary and later Cape Regional Secretary of SACTWU, argued powerfully against the change on the grounds that the current system brought workers to Industria House to collect their sick pay from the Council, incidentally exposing non-active members to the union and associating the union with a monetary benefit. Changing to BCEA sick leave conditions would mean that workers received their sick pay in their wage packet from the employer: this would break the connection with the union. Other officials argued that the connection with the union was a negative one, as workers had to travel (costing time and money) to collect often negligible amounts. (It was also not universal, as some factories arranged to collect the sick pay for their workers.)

Though the demand was tabled, the current of disagreement inside the leadership remained. Ironically, this turned out to the advantage of the Fund in the

³⁰ My rough calculation, prepared for the negotiations in 1992, was that the employers had saved nearly R36 million in the eight years from 1982-1991. (Figures for 1986 were not available.)

long-term. 1992 was a difficult year for negotiations as SACTWU and other major unions struggled to keep pace with inflation and to stave off retrenchments (SALB 1992a; 1992b; Keet 1993). The influence of the two lines of argument can be seen in the agreement reached about sick pay that year: the union conceded a year's delay in implementation of the changeover, but exacted in return an extra weekly contribution from employers to a dedicated fund for dependant cover. The Dependants' Fund (DF), as it became known, was crucial to the success of the process. At the end of the agreed year (mid-1993), it had reached some R9 million.¹¹ There was some disagreement between the parties about the purpose of the DF: employers insisting that it was to be used only for capital expenditure, the union insisting that it had a broader purpose, including subsidising running expenses if necessary. In the event, its main purpose was political: it became a source of security and as such a weapon for the union in pushing through changes which inevitably had some incalculable effects. Despite actuarial checking of the projected three year budgets, projections on the drug costs for dependant children, the drug deal with the State health authorities (described below), and the constant checking and updating of budgets, the employers were still extremely nervous about a rush on facilities, uncontrollable utilisation and consequent cost overruns. Without the DF, implementation would have been even slower.

There was a down side to the sick pay switch: administration of sick pay at the workplace level opened the door to a degree of manipulation by individual employers, no longer subject to centralised control. There were reports of some

¹¹ Though contributions ceased after the agreed one year period, the DF grew to a high point of R21 million by investment, reduced by capital expenditure to approximately R12 million by the end of 1996.

employers who refused to comply with certain of the conditions of statutory sick pay, specifically the clause which allows one or two day uncertificated illnesses. Workers anxious about disciplinary action and fearful of being marked for future redundancies tended to play safe and obtain certificates for all absences.¹² There is also no doubt that the process of planning major changes in a joint working group was made more difficult by the disruption caused by the early period of the change to statutory sick pay and attendant employer resentment and unease.

7. Dealing with doctors

Doctors on the panel

In the past, the parties to the Sick Fund had had little occasion to engage with medical professionals. The panel doctors interacted with the Sick Fund largely through the Assistant Secretary, as did the medical staff employed in the two Fund clinics. The Fund contracted with doctors in most of the areas where members lived and worked. These contracts were administered by Council staff, who processed accounts from the doctors and produced statistics for the SFMC.¹³ The panel doctors had a liaison committee which occasionally met with the Assistant Secretary and several nominated SFMC members to discuss problems, requests for fee increases from the doctors, and for co-operation in cost-containment from the Fund. The committee expressed considerable concern about

¹² The statutory system did not require medical certificates for one or two day illnesses. In theory, this should have resulted in a reduction of GP consultations for minor ailments (and non illness related absence).

¹³ Routine statistics included a breakdown of consultations, drug costs and sick leave practices, indicating averages and exceptions. These figures were included in the monthly agenda pack for the SFMC.

the project and its potential impact on their practices and income.¹⁴ Despite repeated complaints about the level of the contract fees, many panel doctors depended on the Fund as a reliable source of income, given its fairly rapid payment record, unlike account patients and many medical aid schemes.¹⁵ A number of panel doctors, particularly in factory areas, made very substantial incomes from the Fund.¹⁶ They were paid a fixed rate per consultation and an agreed price for medicines prescribed.¹⁷ Payments to panel doctors were the largest Fund expense after sick pay. The average cost per consultation was 75% higher than at the Salt River clinic, despite the fact that the clinic had a higher than average proportion of chronic patients, who generally require more expensive medication (Cornell 1993a, 5).

While the cost of care under the panel doctor system was easy to calculate, quality was extremely difficult to monitor or assess, particularly with a large panel. It is clear from the range in medicine costs that prescribing practices varied widely, as did practices relating to sick leave given.¹⁸ These are crude indicators: more accurate measures of quality of care, such as thoroughness of history-taking and examination, accuracy of diagnosis, appropriateness of treatment, time spent per

¹⁴ I outlined my research and employer and union representatives stonewalled suggestions from the panel doctors that they should be involved. This was the extent of my formal contact with panel doctors.

¹⁵ Panel doctors generally had mixed practices, with cash practices and medical aid (account) patients alongside their Sick Fund patients.

¹⁶ In October 1992, the account for a panel doctor near the Salt River clinic was R44,000, more than half as much again as the monthly running costs for the clinic. A machinist's monthly wage was less than R900.

¹⁷ The refund for drugs prescribed was set at the wholesale price, plus 15%. The profit margin was greater, given the range of discounts available to dispensing doctors.

¹⁸ In October 1992, medicine costs ranged from R4 to R31.30 per consultation (Cornell 1993, 5).

patient, and advice given are difficult to apply in most circumstances, and practically impossible with a panel as large and widespread as the CCIC one.

The fee for service system under which the panel operated tends inevitably towards a curative model of health care and over-servicing. It amounts to a disincentive to doctors to practice promotive or preventive health care or to contain costs. The end result was that the Fund was caught in a cycle of escalating expenditure without satisfying either providers or users to a significant degree. In the course of the project, the Senior Medical Officer (SMO) changed the payment system for panel doctors to an all-in system (combining consultation and drugs in a set fee), requiring doctors to provide diagnostic and prescribing information in return for a fee pitched high enough to cover almost all consultations. There was some resistance to the administration involved in providing this information, which was now de-linked from payment for the drugs.

The most contentious issue relating to the panel doctors was sick leave. Before the change in sick pay system, the benefit structure of the Fund, with its requirement of a medical certificate for all absences from work (even periods of one or two days, which were unpaid), had direct industrial relations implications. Employers had an interest in the panel doctors in terms of how much sick leave they gave: patterns were regularly reported to the SFMC and doctors perceived as out of line were warned and asked to justify their habits. Members equally classified panel doctors in terms of their sympathy or otherwise on the sick leave issue, though there were also complaints about doctors who assumed that all workers wanted was certificates. (See discussion in Section 6.)

Doctors in the clinics

The relationship with doctors employed by the Fund was entirely different. Though the two doctors and the dentist had clinical independence, their scope of practice was restricted by the equipment provided and the limited drug stocks. When the project began, all three were in their seventies and had been recruited specifically because it was cheaper to employ semi-retired doctors on one year contracts. Their status translated into a semi-detached attitude towards their jobs, in that they did not challenge or question the restrictions under which they practised and were generally disengaged from management issues. Though this situation had contributed to a membership sense of second-rate service, it had at least one positive spin-off: it was easy to replace the doctors by simply informing them that their contracts would not be renewed.

The replacement of the clinic medical staff was a significant moment. Despite problems with the panel doctors, utilisation patterns indicated that members preferred them to the clinics. The reasons for this preference were complex and varied. At the simplest level the clinic hours were restrictive and their location less convenient.¹⁹ More significantly, during the survey workers with experience of the clinics often became uncomfortable when asked whether they were satisfied with the service. It was clear that many perceived the clinics as unfriendly, with reservations about the quality of care and the doctor-patient interactions. In Atlantis, workers had no choice, as there were no panel doctors,

¹⁹ The Salt River clinic kept 'office' hours, closing before factories in the vicinity. Workers had to clock out to visit the clinic, losing pay in the process.

and this emerged as a source of grievance.⁴⁰ Given this level of disaffection, it was important that the clinics were visibly reworked early in the project, in order to send a signal to members that the new system would not mean merely more of the same. The appointment of the new staff heralded the changes that were to come, as this was the first time that the parties to the SFMC were involved in the selection process. It was a new experience for all those involved: for workers, union officials and employers to interview medical professionals, and for the professionals to face non-medical people, rather than the familiar medical hierarchy. From the Fund side, the focus was not on clinical competence (which was taken on trust on the basis of qualifications, experience and references) but on attitude, motivation and ability to cope with practising medicine in an industrial relations context. The selection committee shied away from an explicit affirmative action approach, but selected one coloured doctor and one white doctor (both men) and an African woman dentist. All three were young.

The new doctors and dentist took up their appointments in January 1993, just prior to the presentation of the research Report. They were thus in on the process of consideration and implementation from the start, though they had not been involved in the research. Their presence signalled the changes that were to come and paved the way for the shift in members' attitudes towards the clinics which would be vital to rebuilding and extending the system. Within a week, a change in language indicated the beginnings of this shift: members were overheard on their way from the clinic talking about 'our' clinic, rather than 'the' clinic, as in

⁴⁰ The Fund had had persistent difficulty in persuading doctors in Atlantis to join the panel. The remoteness of the area and an under-supply of doctors combined to give them monopoly power.

the past. There was a great deal of curiosity about the new staff, evidenced by an increase in the rate of consultation at the clinics. Their youth was widely interpreted as a positive sign, even by older members.

The new medical staff started operating in a very difficult situation. They had all joined the Fund with a commitment to practising within a 'progressive primary health care' approach (see chapter 3). However, though major change of the system was in the air, for the first year their jobs were largely unchanged. Only the medical staff were replaced. Nursing and auxiliary staff were retained, their routines and relationships shaped by the old doctors and also significantly by the Assistant Secretary of the Sick Fund, their interface with their 'employers', the parties to the Council. They had mixed responses to the changes in the air, on the one hand concerned about job security and changes to their working conditions, on the other pleased about the upgrading of facilities and consequent shift in status and in members' attitudes towards the service. The new staff had first to prove themselves and then to try to rework the relationships and habits of the past.

Medical management

As 1993 wore on and plans for the first phase of new clinics advanced, the problem of medical management became more acute. The employer party was concerned about capacity within the existing Sick Fund to manage an enlarged structure of six clinics instead of two, plus the influx of new (dependant) members. The existing employment structure of the Industrial Council was ill-suited to incorporate a large group of medical professionals. Doctors are not accustomed to

being managed by non-doctors. And non-doctors, in this case the SFMC, were uneasy at the prospect of asserting authority over doctors. Their response was to delegate the medical management to a doctor. The first appointment was the young doctor who had joined to run the Salt River clinic (though the employer party had initially insisted that the Fund needed someone more high-powered, 'an MBA-type doctor'). The first wave of new clinics increased the medical staff by four doctors, a dentist, an oral hygienist and four nurses, all appointed by selection committees consisting of employer and union representatives, plus the Senior Medical Officer (SMO) and myself.

Even before his formal appointment, the SMO had gradually been drawn into the project, initially informally and later via attendance at SFMC meetings. When he took on the position, he worked in concert with the Assistant Secretary, gradually broadening his role in the period leading up to the Assistant Secretary's retirement. He had had some previous union exposure as a shop steward in the health services union while he was working in a public sector hospital. His position was complex: on the one hand, he was in a management position in relation to health staff (which was new to him and took some adjustment); on the other hand, he himself was answerable to a management committee, one of whose parties was a trade union. His management responsibilities expanded dramatically with the establishment of the four new clinics in 1994. New staff were appointed, on slightly different conditions of service, specifically greater flexibility in working hours, so that the clinics could be open for longer hours, to facilitate access. This gave rise to unease among old nursing and auxiliary staff, who were anxious about the prospect of changes in their working conditions. Worker confidence and sense

of ownership of the new system sometimes translated into rudeness to staff along the lines of 'I pay your salary, you do what I want'.⁴¹ This sense of entitlement also resulted in some resistance to treatment by a nurse (interpreted as 'second class' care) and insistence on seeing a doctor. This was predictable enough, given the conventional medical hierarchy. (It also underlines the difficulty ahead of the Department of Health in implementing a system of nurse-based primary health care.) Many of the staff found this form of patient power both personally and professionally hard to swallow, particularly as they battled with the teething problems of new facilities and an influx of patients and consequently the SMO was extensively involved in fire-fighting activities in the early days. A proposal that clinic-based committees be established to deal with problems rapidly and directly, was put to the SFMC and stalled there. The employers were clearly concerned to maintain control in a centralised structure, the SFMC, aside from the powers delegated to the SMO, who was answerable to the SFMC.⁴²

In retrospect, the medical staff should have been incorporated into the project more centrally. In particular, there was a real need to develop a way for them to interact directly with the SFMC, rather than through the Assistant Secretary. Dealing with staff issues with elderly semi-retired doctors grateful for a little undemanding part-time employment had not prepared him for young, energetic and assertive doctors. He began to refer issues to the Industrial Council Staffing Committee, which coped little better. Part of the problem arose from the

⁴¹ A Working Group meeting was called for 3 June 1994 to discuss the 'crisis' in the Health Centres. This included 'verbal abuse of staff members' (Agenda document SFMC 3 June 1994).

⁴² The issue crops up again in the minutes of meetings in 1996, this time with more explicit opposition from employers who warn against the creation of 'autonomous policy-making bodies at the local level' (Sick Fund Management Committee minutes, October 1996).

fact that the Assistant Secretary was close to retirement and though he wanted to stay on, his unpopularity with all parties was such that his request was refused, though his powers and duties were left intact until his retirement. Though he had no power to stop the changes, he had the capacity to stall them or generally make life difficult for the doctors and for me. I saw evidence of this in his treatment of the Atlantis doctor, whom he classified as a 'trouble-maker'.¹¹

From the point of view of the parties to the SFMC, the Assistant Secretary had a job to do which he might as well do up to the time of his retirement, given that he was generally recognised as doing it reasonably efficiently, if unimaginatively and in an authoritarian style. He was not so much managing the Sick Fund as documenting it, producing statistics and monitoring expenditure, but without a planning perspective. I had to develop a reasonable working relationship with him, because of his position and the information he controlled. Had he chosen to be obstructive, I could have forced him to provide information (given that the information was 'owned' by the parties and not by the functionaries who generated and managed it), but this kind of combativeness would have been fraught and time-consuming. From the point of view of the new doctors, he was a more powerful figure, whose relations with them were sometimes coloured by resentment and frustration arising from his own situation.

The SMO stayed with the Fund until the end of 1994, at which stage he resigned to study public health. His replacement came from a management job in a local state hospital. A change in style was immediately obvious - he changed the

¹¹ He routinely deferred requests for minor improvements to the Atlantis clinic (without referring these to the SFMC) while the Salt River premises went through a major face-lift, which was motivated to the SFMC and passed without opposition.

job title to 'Medical Director' and introduced a more elaborated medical hierarchy, with a new tier of Senior Medical Officers.

Expansion was slower under the new Medical Director, who concentrated on developing systems and protocols and upgrading services and opened only one new clinic in the following two years. The professionalising of the service was starkly obvious to me in one incident. I was invited to the formal opening of a clinic (more accurately re-opening, as this was not a new clinic, but a move of premises). The new premises were startlingly more elaborate than the original ones, with a large staff. The event was sponsored by a drug company. The provincial minister of Health had been invited to open the clinic and there was a sizeable crowd present. However, when I looked around, I realised that the crowd consisted of equipment and drug suppliers, panel doctors and employers. There was only one trade unionist there - the event had been scheduled for a time when the union was involved in a major conference, long-planned. This indicated at best a lack of care, at worst a disregard for the union's investment - both financial and political - in the scheme.⁴⁴

His relationships with the union, and to some extent the employers, were marked by tension. A number of incidents reinforced an image of high-handedness and personal ambition, according to union informants.⁴⁵ In one, he set up a separate account, to which he routed certain discounts from pharmaceutical suppliers. He then dispensed these funds on a discretionary basis for 'staff

⁴⁴ I incline towards the latter view, given the medical director's statement to me on another occasion that the union had 'done nothing for the Fund' and that he found it best to work with the employers, because 'democracy is so slow'.

⁴⁵ These accounts are confirmed by SFMC minutes.

development' (for example, conference attendance). This was done without discussion with the SFMC. Both parties were angry at this action and he was ordered to close the account. More disturbing was the trend towards high investment in existing facilities, rather than increasing access by developing new facilities in residential areas. This investment included both more elaborate equipment than envisaged in the first phase of implementation, in which the stress was to be on access to simple facilities, appropriately equipped and attractively furnished. In the new Medical Director's time, a number of the existing clinics were moved and upgraded at great expense. According to union officials, the re-decoration of his own offices in Salt River was particularly lavish.⁴⁶ He has since been dismissed by the Sick Fund and Dr Morar, the Senior Medical Officer appointed during the research project (who left to study further) has been re-appointed with effect from November 1997.

The experience of the two different medical managers illustrates the tension between efficiency and loss of control, the difficulty of incorporating medical professionals into a non-medical structure and the need for continued vigilance to ensure that the agenda for change is not hijacked by sectional professional interests within the Fund. Specifically, it underlines the importance of continuity and commitment on the part of the union representatives on the SFMC.

⁴⁶ According to union informants, this was done without the approval of the SFMC. (Interview with union officials conducted by author, 31 January 1997, Cape Town.)

8. Assessment

The deep roots and slow development of this project strengthened it and were crucial to its success. The central idea survived the battering of the wage bargaining system over a number of years, holding its own against competing demands and becoming embedded in member consciousness in the process. The slowness of the process tested the commitment of officials and worker leaders and associated their credibility with a successful outcome. Schemes like this one cannot be selected off the peg and implemented according to a blueprint: their design is fundamentally rooted in relationships specific to the parties and also dynamic, shifting and developing in response to the economic and political context. The process is political as much as technical.

Management of change was relatively straightforward in this Fund, primarily because the change was associated with an expansion of benefit, a new style for a new benefit. Dependants, brought in for the first time, were to be treated only in the Fund's own facilities and were not given access to the panel doctor system. The Fund had neither to force, nor to coax, primary members away from the panel doctors and into the clinic system at this stage: indeed, it was impossible to accommodate them in the clinics, given problems of capacity in the first phase. In addition, though the union made a policy decision that family membership would be compulsory for all with dependants (unless they were covered by a spouse's medical aid scheme), there was a tacit agreement not to enforce this policy. This avoided resentment about coercion and gave the new

clinics a breathing space. This was facilitated by the way in which budgets had been formulated, allowing for different levels of family membership, and by the existence of the Dependants' Fund: though never actually used to cover income deficits, it served a stabilising purpose. In the event, family membership took off rapidly and instead of coercing members into the system, the union had to issue a plea to members to stay away from the clinics and give precedence to dependants, until the next phase of expansion.⁴⁷

The irony of this project was that its success was rooted in the apartheid era. The groundwork of the Cape project was done well before the change of government. The first wave of new health centres opened just three weeks before the election. The timing significantly affected the progress of the project.

First, it was conceived at a time when workers could expect little in terms of social security from a state apparently determined to shift both responsibility and provision as much as possible onto the private sector. This concentrated the mind. Instead of pursuing the issue at political levels, responsibility devolved onto the union, and as a consequence workers had greater influence in the design of their health care system, at least at a primary care level, than they would have had as citizens.

Second, though in the late 1980s and especially the early 1990s, the union was faced with an unsympathetic state in general terms, the monolith was beginning to crack. The unbanning of political organisations and the release of political prisoners set in motion an extended process of negotiation and

⁴⁷ By the end of 1996, 25% of all consultations at health centres were for principal members.

constitutional talks. Also, there had been some changes in crucial sections of the state health bureaucracy, particularly at regional level. The CCIC Sick Fund benefited from its provincial basis to negotiate a breakthrough deal with the then Department of National Health (DNH) local office, allowing access to drugs for chronic conditions from state clinics at extremely low rates. The Fund had a bargaining chip in the imminent extension of cover to dependants, which would relieve the state health system of responsibility for primary care for some 100,000 people. The deal was also facilitated by the sympathetic interest of the Deputy Director of the DNH, who had a long history of association with progressive trade unions.⁴⁸ Since the change in government, the Sick Fund has interacted with a provincial Department of Health which is both interested and sympathetic, but restricted by a shrinking budget from giving practical expression to this support, though it honours the pre-election deal on chronic medicines.⁴⁹

The link with the state was more than a cost saving mechanism. It was part of a vision that attempted to rework a private sector scheme in the image of an admittedly idealised vision of the public sector. The doctors and other medical staff were employed on salary, rather than paid on a fee for service basis. This was intended to remove the perverse incentive to over-treat inbuilt in the fee for service system and to reduce spending on unnecessary treatment so as to redirect it more positively (for example, towards preventive and promotive health). The painful

⁴⁸ While working as a doctor in the public sector, he was a volunteer organiser for the General Workers' Union and was banned for five years as a result. He also had a history of involvement in progressive health organisations.

⁴⁹ More recently, the union has taken a new tack by actively pursuing negotiations with local government aimed at securing free land on which to erect new clinics. The size and financial status of the Fund gives it substantial bargaining power. (Interview with union officials conducted by author, 31 January 1997, Cape Town.)

irony of the panel system was that poor workers were making doctors rich in a system that satisfied nobody.

The other aspect of the link with the state was an explicit recognition of the limits of the Fund: workers got their primary care from the Fund, but were reliant on the State for secondary and tertiary care. In the past, workers had to negotiate the state system individually. In the new system, the Fund's own doctors would co-ordinate referrals, maintain contact with members through the process, and take over care as necessary. While this is not holistic care, it is certainly an improvement on the past. The CCIC Sick Fund is fortunate in that direction was well established before the change in government. It may also have influence further afield, if the union chooses to make a strategic intervention in state policy formation, based on a unique experience in the restructuring of working class health care.

The next chapter focuses on a restructuring project in the leather industry, introducing the complicating factors of national scope and multi-unionism.

Chapter 5. The National Leather Industry Sick Fund

1. *Introduction*

The second study examines a trade union project in a multi-union context. The chapter traces the way in which the South African Clothing and Textile Workers' Union (SACTWU), pursued an agenda about health care in the National Industrial Council for the Leather Industry (NICLI). The union tapped into worker discontent on this issue, maintaining a delicate balancing act between establishing itself as the driving force in the project of transforming the Sick Fund, and the need to win and hold sufficient support from the majority union in the sector, the National Union of Leatherworkers (NULW), to ensure progress. The relationship with the third union, the Transvaal Leather and Allied Trades' Industrial Union (TLATIU), was less crucial, given its small size. The NULW could, however, have scuppered the project at any stage and did impede progress at a number of points: the crucial challenge to SACTWU was to ensure that the issue was handled in a way which minimised the possibility of rejection by NULW officials. SACTWU officials had to develop an area of consensus within which NULW officials were comfortable and identify them with the process by ensuring that they acted as union spokespersons at certain crucial moments: on the one hand, this gave the NULW credit for active pursuit of the union agenda, on the other hand, it locked them into an agenda which actually emanated from SACTWU.

Workers' discontent was the spur to union action and the specifics of worker complaints shaped that action. All four studies in this thesis revealed problems with existing services, but none as vividly as this one, by virtue of an accidental effect of research methodology. A series of extended meetings around the country yielded a mass of detail about the experience of working class people in small rural towns and large cities spread widely across the country. The broad geographic scope yielded information suggesting common patterns and these experiences, rendered vivid by workers' words, echo those which emerge from the mix of formal and informal enquiry in the other projects. The chapter traces the way in which these experiences were incorporated into the recommendations for re-structuring this scheme (and others) and ends with a section reflecting on the influences which shape workers' attitudes and aspirations regarding health care.

This study provides a counterpoint to the Cape clothing study in a number of respects. First, it explores some of the dynamics of research in a multi-union situation, which are seen in a more pronounced way in the Transmed study. It also outlines the way in which SACTWU distinguished itself from the other unions in the leather sector and exhibited strategic leadership in the project, despite its status as a newcomer to the sector.

Second, while the CCIC Sick Fund was regional, the NICLI Sick Fund was national. Though the process of investigation was essentially regional and the recommendations which resulted differed by region (for reasons both practical and strategic), decisions were made centrally, at the Sick Fund Management

Committee (SFMC), where union rivalries were more open and acute than on the ground, where members of the different unions worked side by side in the factories.

Third, there were significant methodological differences between the studies, which coloured the outcome. This project had no sample survey, no questionnaire and no statistical analysis. This was due to a combination of geographical, financial and time constraints. There were 34,500 workers in the leather industry in 1992. Women were in the majority, though not as overwhelmingly as in the clothing industry. The only sub-sector in which men were in the majority was tanning. Many of the workers were in small workplaces, and very widely dispersed around the country, creating serious problems of control and management for the Industrial Council staff, whose headquarters were in Port Elizabeth. The geographical spread imparted a peripatetic style to the research process, which consisted of separate meetings with the parties in each region and working from sick fund data (centrally held in Port Elizabeth).¹ It also involved regular contact and discussion with the SFMC and the Sick Fund Negotiating Committee (commonly called the 'Nine-a-Side' Committee) throughout the process.

Fourth, the balance of involvement of the parties differed significantly from the CCIC. There was markedly more involvement from both employers and Council staff. The General Secretary of the Industrial Council, in particular, supported the process and took a major role in the implementation of recommendations. As with the CCIC project, this was an extended research

¹ Some 30 trips to the regions and meetings in Cape Town.

relationship. There are overlaps in all three Industrial Council studies: meetings for one fitted into research trips for another, budgets for one provided prices for another, deals and discoveries were adopted and adapted and, not least, mistakes and problems in one project informed new approaches in the others.

Last, the capacity for fundamental change was limited. The NICLI fund was much poorer than the CCIC Fund, with minimal (and falling) reserves, and a low contribution base.² The leather industry was even more marginal than clothing and in recent years had been particularly threatened by cheap imports (Keet 1993).³ Given the economic climate and conditions in the industry, it was unlikely that there would be a substantial increase in either wages or benefits in the near future. In addition, employers were insistent that they would not agree to change to the statutory sick pay system, thus blocking a potential source of savings, which could otherwise have been redirected towards improvement of benefits, as in the Cape. It was evident that dependant cover was not an option in the short-term in the NICLI Fund and that the first priority was to restore financial viability.

2. *Workers' experience of health care*

The NICLI Sick Fund, like those of the CCIC and the Natal Clothing Industrial Council (NCIC), was established as a joint medical benefit and sick pay fund for all workers covered by the Industrial Council. It differed from the CCIC

² In 1990, the Fund's reserve was just under R2m; by 1991, it had shrunk by 25% to R1.5m. By comparison, the CCIC Sick Fund had a reserve of R5m in 1990 and R6.5 in 1991. (Financial statements, CCIC Sick Fund 1991 and NICLI Sick Fund 1991)

³ Between 1994 and 1996, 3,000 jobs were lost because of imports from countries which were not signatories to the World Trade Organisation (mostly China) (Cape Argus 22 May 1997).

Fund most notably in retaining a sick pay system which was markedly disadvantageous to workers. When the project began, the Fund had no clinics of its own, relying entirely on panel doctors to provide services. There were 325 panel doctors, spread around the country in all areas where there were members of the Sick Fund. The doctors were paid on an all-in basis (consultation and medicine), with a small levy from patients. The Fund differentiated between consultations for acute and chronic illness, initially only in terms of reimbursement of doctors, but later in terms of limits. Contributions were low and wage differentials were larger than in the clothing industry.⁴ The leather industry was divided into three sub-sectors (footwear, general goods and handbags, tanning) and five geographic regions. It was dominated by the NULW, which also had a majority in the biggest sector (footwear) and all regions except the Transvaal, where it had no members.⁵ SACTWU had made some advances in the Transvaal region and in the smallest sub-sector, tanning.⁶

The Fund was in trouble. Concerns and complaints about the benefits were raised with increasing frequency in the SFMC in the late 1980s. Contribution increases had failed to match spiralling costs and the Fund had been in deficit every year from 1988 to 1991.⁷ A contribution increase in 1990 only momentarily checked the trend of increasing deficit. A history of unsuccessful attempts to

⁴ Contributions were R2 a week each side in May 1992, compared with R3.70 in the Cape. Wages ranged between R160 and R185 per week, with the majority of workers on R180 per week.

⁵ The NULW accounted for 76% of organised workers, SACTWU 18% and TLATIU 6%.

⁶ SACTWU had 59% of tanning sector union members and 36% of Transvaal members (the rest belonging to TLATIU). SACTWU had also organised a new area, Botshabelo, and was actively campaigning for its incorporation into the Council.

⁷ Surplus: R120,594 (1987) Deficits: R186,480 (1988); R706,528 (1989); R183,393 (1990); R459,337 (1991)

contain escalating expenditure on the panel system by appealing to panel doctors and members for restraint culminated in the imposition of limits on acute consultations.⁸ The new restriction came into effect in May 1992, just as the research stage got under way. This was not a coincidence: union agreement to the contribution increase and the imposition of limits was conditional on a fundamental review of benefits. Nevertheless, the changes, which were unpopular with members, heightened the temperature and concentrated the minds, lending a new urgency to the search for solutions to the Fund's problems.

The first stage of this process gave a broad group of members an opportunity to speak directly about their experience of the Fund, their problems, needs and preferences. For many of them, in unions not distinguished by a participatory style, this was a new experience. The consultation involved a series of workshops with shop stewards and union officials, held separately with each union, in each of the regions in which the Council operated.⁹ In each of these meetings, after I had given a brief introduction to the process, I asked all of those at the meeting to speak in turn, answering a series of questions. What was your most recent experience of the Fund? What was your most recent experience of illness of a child in your family? Where did you take the child and why? How much did it cost?

⁸ The administrators calculated that an annual limit of 8 initial and 8 repeat consultations would be more than adequate: average use in 1991 was 6.4 (combined). Registered chronics would have unlimited consultations.

⁹ National officials of the NULW and TLATIU insisted on separate meetings, which were held except in Great Brak. Local officials organised the meetings, generally in union venues on Saturdays, though some negotiated paid time off work with employers. Some 260 shop stewards and a number of officials attended 11 meetings.

The discussion was then opened to allow them to pass on experiences related to them by the members they represented. The meetings moved on to discuss options for future developments in the Fund, focusing on clinics, new controls in the panel doctor system and alternative methods of financing cover for dependants (a vote was taken on this issue after discussion). I took detailed field notes at the meetings and drew extensively on these to formulate the recommendations in the research Report (Cornell 1992).

Inside the system

The meetings yielded information which amounted to far more than a set of rough and ready statistics on utilisation patterns.¹⁰ As workers spoke, a vivid and textured sense of their experience emerged, along with the factors which informed the choices they made about healthcare. Most of the discussion centred on the panel doctors, the central benefit of membership and, for many members, the only one with which they were familiar. Only a very small minority of workers (8%) were positively in favour of the panel system. A larger group (27%) were relatively indifferent or did not use the system. The majority (65%) were strongly dissatisfied, and expressed their views strongly.

• The minority view: satisfaction with panel doctors

A preliminary analysis of Sick Fund accounts had indicated that the panel system needed urgent re-design, which must be based on an understanding of the factors influencing worker behaviour in the Fund. It was important to explore the reasons why some members liked panel doctors, gauge the extent of their

¹⁰ The utilisation patterns were calculated from my notes of the meetings.

attachment to the system and the potential to diminish distrust, and secure support for clinics in areas where they were viable.

A small minority of workers (8%) expressed overt satisfaction, which was always explicitly associated with their own panel doctor rather than the system as a whole. It was quite clear that everyone would have preferred a system of free choice of doctors, rather than a panel, but the fact that a number of workers chose to take their children to these same doctors, paying the cash rate, was evidence of satisfaction. Even when workers disliked the panel system, they would generally identify some 'reasonable' doctors in an area, whose names were rapidly spread on the worker grapevine.

Satisfaction with the panel was most uniform among members of the TLATIU. This union's attitude throughout the research process was at best wary, more often aggressive. It was a small, embattled union, struggling to survive and engaged in a complex web of negotiations with its two rival unions. Nevertheless, the meeting did yield at least two potential reasons for the low utilisation: lack of information and boycott. It emerged that few shop stewards knew, for example, about the 'chronic' benefit. (This is borne out by the low proportion of 'chronic' registrations in the Transvaal.) Many members with chronic ailments were using other facilities and not drawing on the Fund for this treatment. In addition, two shop stewards at the meeting simply stated that they 'preferred' to consult private doctors and pay out of pocket, because of the quality of the panel service. This preference must have been strongly felt to have been expressed at this meeting, as the union General Secretary controlled the meeting and announced that the union supported the panel system and opposed any change to it. SACTWU members in

the Transvaal spoke of similar action in choosing to go outside the panel (to both public and private services) and highlighted the problem of access, complaining of a shortage of panel doctors in African residential areas.

A second group of workers around the country (22%) expressed a muted satisfaction with panel doctors, or hesitancy about criticism. Some felt they were adequate for minor ailments, but chose to go private (or use state services) for more serious ailments. A small number of workers (6%) either had medical aid scheme cover (from a spouse) or used panel doctors never or very seldom.¹¹

• **The majority view: strong dissatisfaction**

Critical and often angry voices outweighed the largely tepid praise of supporters. A sizeable majority of workers (65%) was seriously dissatisfied. Complaints gathered weight through constant repetition, and were rendered credible by the individual stories from which they emerged.

Cursory examinations: Workers complained of careless, hasty examinations and, in some cases, no examinations. This was linked to a complaint that many doctors assumed that all workers were malingerers, only wanting sick certificates: 'they've got their pen out when you come in the door'. Speed of examination was particularly marked when panel doctors ('the one minute doctors') visited factories. Rates of 20-30 patients an hour seemed barely credible, but were borne out by factory sisters, Fund accounts and a particularly frank interview with one panel doctor.¹² Workers' expectations were not high: markers of excellence

¹¹ Some women workers covered by their husbands' medical aid schemes nevertheless chose to use the Sick Fund for minor ailments, to avoid co-payments and conserve their limits.

¹² This quote and all direct quotes which follow are taken from my notes of the meetings, except when otherwise indicated. I met factory sisters in the Transvaal and Natal. The factory in Great

mentioned by workers included simply having their blood pressure measured. One doctor had become popular because word had spread that he did not re-use syringes 'even on leatherworkers'.

Poor and insufficient medication: Patients frequently complained about the 'quality' of the medication ('*Panado* for everything'). They resented being given incomplete courses of medication, requiring a repeat visit (and consultation fee) to collect the rest. The 'all-in' consultation fee (examination and medication combined) gave doctors an incentive to cut back on cost and quantity of medication for acute illnesses. Workers complained that panel doctors were particularly reluctant to see patients with complaints which might require extensive medication, unless they could be classified and registered as 'chronics', in which case the Fund paid medicines separately, giving doctors a perverse incentive to over-prescribe (see section 6).

Frequent recall: Workers clearly interpreted frequent recall as a ploy on the part of panel doctors to compensate for the low consultation fee, along with the practice of 'double-signing', when doctors told workers to sign for two consultations when they presented with two complaints (for example, flu and a stomach ache). Interestingly, workers tended to be very clear about the difference about a 'real' recall (to check recovery from a non-trivial illness) and a 'manufactured' one. One of the characteristics of a 'real' recall identified by workers was a 'proper examination'.

Brak no longer employed a sister, but both the employer and the wage clerk who made appointments for the factory doctor confirmed these rates.

Discriminatory treatment: Workers identified a number of ways in which panel doctors treated them differently from other patients, which they fiercely resented. Some doctors restricted the hours when they would see leather patients, for example refusing to see them after 6pm. This seriously restricted access outside of working hours and could result in time off work (and loss of income). Some doctors even had separate waiting rooms or made Fund patients wait outside. Workers insisted that all non-Fund patients were given 'better' medicines, though it is likely that cash patients, who pay an all-inclusive fee, would be issued similar medicines to Fund patients.¹³ Cash patients were certainly often treated preferentially in terms of waiting time.¹⁴ Workers were confused as well as irritated by this preferential treatment, given the fact that the cash fee set by doctors was generally identical to the fee paid by the Fund.

Reluctance to give sick leave: A common complaint related to doctors' reluctance to authorise sick leave. This complaint was particularly directed at panel doctors who visited factories. They were seen as closely aligned with management and reluctant to jeopardise lucrative contracts by alienating employers. Sick leave is a contentious issue in all industrial schemes, but this complaint gathers weight from the markedly low utilisation rates in this scheme. The record-keeping system makes it hard to calculate how many days were actually taken, but rough estimates from sick pay result in a national average of 2.4 *paid* days per member for 1991. The Transvaal region led the field, with less than a day of paid sick leave per member. These figures are not an accurate reflection either

¹³ Medicines for medical aid members are generally prescribed or dispensed on a more lavish scale.

¹⁴ In general, only medical aid patients can make appointments and they would be given preference over both cash patients and Fund patients.

of total sick leave taken (as 1 and 2 day illnesses are unpaid and therefore unrecorded by the Fund) or of sick leave needed (as the loss of wage involved in taking sick leave may keep sick people at work in addition to its intended aim of keeping the healthy from making frivolous or fraudulent claims).¹⁵ Even unpaid sick leave had a direct impact on Fund expenditure: workers were obliged to present doctors' certificates to justify any time off work and as a consequence were forced to consult doctors even for trivial, self-limiting ailments. The result was over-medication and easy money for panel doctors.

Reactions from workers to the sick pay provisions of the Sick Fund were uniformly extremely negative. They perceived the system as punitive, designed to keep them on the job, however ill. In every meeting, workers complained about the low rate of pay, delays in payment, reluctance by management to accept certificates from non-panel doctors and opposite but equally resented attitudes on the part of panel doctors: either they were unwilling to put workers off or they assumed that workers only came to them for certificates. In a number of cases, shop stewards were aware of the provisions of the Basic Conditions of Employment Act (BCEA), comparing their own conditions very unfavourably and proposing that the industry revert to the statutory system.

These perceptions were soundly based, as the NICLI conditions were markedly worse than those of any of the clothing Industrial Councils, which themselves compared unfavourably with BCEA sick leave. Though NICLI allowed 52 days sick leave (compared with 40 in the original CCIC system and 10 in the

¹⁵ My estimate of use in the CCIC was 4.7 days (see previous chapter). NCIC does not keep records of sick days taken. Sick pay accounted for 47% of expenditure by the CCIC (1991) and 28% by the NCIC (1993).

BCEA), it was paid at a flat rate which translated to only 22% of the wage (compared with 65% in the old CCIC system and 100% in the statutory system). The extended period of sick leave allowed benefited only workers who were off sick for a stretch longer than 45 days. This was extremely rare, particularly as workers were not protected against job loss for this period. In addition, any worker with a lengthy illness would fare better by applying for sick pay to the Unemployment Insurance Fund (UIF).¹⁶ In practice, the average used was very low. Expenditure on sick pay actually dropped by 14% in 1991, a fact explained in part by retrenchments. It is also probable that in a period of retrenchment, workers were wary about taking time off work. It was not surprising that workers, without exception, wanted the sick leave and sick pay provisions improved. However, it was impossible to analyse the utilisation and costs of sick leave meaningfully with the statistics kept by the Fund at the time, or to make detailed recommendations on the basis of the information available, particularly in the light of the concerted opposition of employers to the statutory system.¹⁷ The employers, especially from the Footwear section, repeatedly threatened to withdraw from the Sick Fund altogether if the unions forced them to pay sick pay under the statutory system. They argued that the medical benefits provided by the Sick Fund were provisional on the retention of this sick pay system. The unions chose not to force the issue.¹⁸

¹⁶ This Act replaces wages lost due to illnesses lasting longer than three weeks, paying 45% of the wage. Entitlement is one week's payment for six weeks' contributions to the UIF.

¹⁷ The recommendation was to consult the Council's computer consultants on systems to record sick leave and pay as a first step towards detailed analysis, planning and costing of alternatives.

¹⁸ I consulted with SACTWU officials before formulating the recommendation on sick leave. They judged that there was insufficient support from NULW or TLATIU to force through a change. In the fragile union alliance, their first priority was to avoid potentially divisive issues and maximise common ground.

Outside the system

The meetings also provided extensive information on workers' current practices when family members were ill. In the absence of Sick Fund cover for families, workers had to choose between state and private services. Their choices, especially for children, highlighted some very interesting attitudes.

Choices for dependants: In the first instance, it was clear that parents were more concerned about their children's health than about their own. The question asked in the meeting referred to the most recent experience. A large majority of workers (69%) had taken their children to private doctors, paying cash, because they thought the care was better.¹⁹ They were prepared to spend a day's wage for the consultation and to travel (which involved additional expense) to take sick children to doctors they judged to be particularly good.²⁰

State services had been chosen by the other workers (31%) for a range of reasons: some facilities were judged to be good (workers often travelled out of their area to go to a clinic with a good reputation for treating children); for minor illness (and therefore not worth the outlay of a private consultation, or seen as within the competence of a state clinic); for serious illnesses requiring specialist investigation (where state referral hospitals clearly had the edge over general practitioners) and ongoing treatment (which cash practice doctors were often unwilling to take on within the standard fee); or - most frequently - when workers had no cash (and were not able to borrow). Fees at state clinics were very low, ranging generally between R2 and R10 per visit. Interestingly, all women present

¹⁹ The percentages relate to the 158 workers at the meetings who had dependent children at home.

²⁰ Consultations cost R30-R35 on average. The average weekly wage was R180.

knew the fees, while few men did: it was the women who took care of sick children. The restrictive hours of state clinics obliged workers to take time off work to attend with sick children. This in turn often resulted in an extra visit to a panel doctor, for a sick certificate to cover the lost day (even though there was no sick pay for a single day's absence) in order to avoid the threat of disciplinary action.

There was very strong support for dependant cover in the Sick Fund, but marked disagreement about funding options, an apparently technical issue. In fact, this disagreement was indicative of the problem of creating and maintaining consensus within a union. Cross-subsidisation was seen as a good principle (particularly by those who would benefit from it: the sickly and those with large families), but a problem in practice (by those who would subsidise it, the healthy and those with small families). Older workers, in particular, were reluctant to pay higher contributions to cover only a spouse, if younger workers would be getting cover for spouse and children for the same price. They spoke of the hardship of their own youth, when they had to provide for children now '*uitgetroud*' ('married out'). This was one of the few times that the issue of the extended family was raised by workers in any of the IC studies : older workers wanted to bring grandchildren living in their households onto the scheme.²¹

With some defensiveness, workers related their reluctance to cross-subsidise to the difference between need and choice. ('If I could be sure their kids really needed to see the doctor, I wouldn't mind, but some people are always

²¹ This was in stark contrast with my other work with African workers, where the nuclear definition of family common in medical aids was constantly raised as a problem, ignoring as it did the common phenomenon of broader family responsibility (including aged parents, grandchildren, siblings and their children).

running in about every little thing.') A similar phenomenon emerged in all the studies in a small group of workers who actively took pride in their status as 'responsible': '*ek is nie van daai wat siek vat nie*' ('I'm not one of that lot who take off sick').

3. A summary of the project

The exploration of attitudes towards health care held by workers and their unions was only a part, though a pivotal part, of a more extensive project. The process was initiated some eighteen months earlier by a request from Mike Murphy, a SACTWU official, to cast a critical eye over the benefits and finances of the NICLI Sick Fund.²² This resulted in a presentation to the Sick Fund Management Committee (SFMC) in October 1990, later expanded at the Committee's request into a preliminary report outlining steps to stabilise and improve the Fund and highlighting a number of issues needing more extensive investigation.²³ I heard nothing more from the Fund for a year, though SACTWU kept me briefed on developments. The issue of the Sick Fund was raised again at the 1991 Annual General Meeting of the IC and in the SFMC meeting in

²² Mike Murphy was a founder organiser of the Trade Union Advisory and Co-ordinating Council (TUACC), the umbrella body of the Natal-based unions which spearheaded the watershed 1973 strikes, generally viewed as marking the rebirth of independent unionism. TUACC merged into FOSATU, which later incorporated other unions in the formation of COSATU. Banned in 1976, he went into exile for 12 years, working internationally for the South African trade union movement, before returning to South Africa and joining SACTWU (Gwala and Murphy 1994). He subsequently left SACTWU and became the Regional Co-ordinator for the Africa Region of the International Chemical, Energy and Mineworkers' Federation (ICEM) (Murphy 1996).

²³ The issues were: the implications of converting to BCEA sick pay; potential revision of the chronic illness benefit; cost of expansion of benefits (specifically dental and optical); cost implications of expansion of cover to dependants (Cornell 1991).

September 1991. At this meeting, SACTWU supported the idea of a clinic system, while the NULW objected to any change in the benefit structure. The assumption by the end of the meeting was that there would be a 're-structuring process'. In response the following month, the NULW stalled outright and SACTWU said that they were waiting for my return from sabbatical in January in order to prepare their counter-proposals.²⁴

In November 1991, a decision was made to set up a Sick Fund Negotiating Committee, with nine members for each party. Each of the unions had three representatives on this 'Nine-a-Side' Committee. At the first meeting, there was extensive discussion on the issue of changing to BCEA sick pay. Employers were strongly opposed, insisting that they would negotiate on a 'package' basis (sick pay and medical benefits combined) or not at all. This decision was a significant constraint on the scope of the recommendations. The concerns of the parties and their involvement in defining the terms of reference for this study were clearly indicated in my appointment letter from the General Secretary of NICLI, which specified broad consultation to ensure balance as the first requirement for the process.²⁵

²⁴ As in the Cape, SACTWU originally intended to contract me to undertake an independent study and later decided that I should operate as a joint consultant.

²⁵ '(i) the views of all the parties in the various sections of the Industry must be solicited in order to obtain a balanced view; (ii) all regional patterns must be examined and regional views taken into account. Any abuse of the system should be highlighted; (iii) the various options relating to Sick Pay should be addressed; (iv) the general trends taking place presently in Funds similar to the Leather Industry Sick Fund; (v) to investigate any financial assistance the fund can obtain from the State; (vi) the issue of the panel doctor system and their numbers, as well as Panel Doctors visiting factories, including the legal implications applicable to doctors visiting factories must be addressed; (vii) any proposals in respect of the Fund must be cost effective and affordable; (viii) the clinic system must be thoroughly investigated.' (Letter to author from Mr L. van Loggerenberg, General Secretary, NICLI. 1 April 1992)

This project was notable for the degree of involvement by employers and Sick Fund staff. There was initial caution from employers (which resurfaced periodically) because this was a union-driven initiative, but in the end they were far more extensively involved than in either of the other two IC projects. Employer opinions were canvassed in extended interviews with two of the three sectoral employer organisations and with individual employers. In addition, the employer representatives participated actively in the Sick Fund Management Committee, the 'Nine-a-Side' Committee and the regional sub-committees. There were some very powerful employer figures, including the Chairman of the SFMC, a retired manufacturer who continued to play a very influential role in the Fund.²⁶ The strong personal interest of the General Secretary of NICLI coloured the process and influenced its outcome. He facilitated the complex process of consultation and report-back, as well as access to Sick Fund information, both published documents (such as monthly and annual financial statements and reports) and unpublished information drawn from computerised records. His approach was mirrored in the co-operation and involvement of Council staff, who provided extensive background material on request, particularly on the administration of the Fund, and identified ways to streamline procedures and improve efficiency.

After the process of consultation, the task of synthesis loomed. Broadly speaking, the central recommendations (establishment of panel doctors and increased control over panel doctors) were not altered from my earlier reports to the SFMC. However, the presentation and motivation was informed by the

²⁶ He chaired the sub-committees for Pietermaritzburg and Durban-Pinetown, which were responsible for setting up the clinics and dealing with clinic issues, and played an important role in the interactions with panel doctors.

insights gained in the consultation process. The priorities in terms of action were strongly motivated in terms of the regions where the losses were greatest: at one stroke this placated TLATIU and put the NULW on the defensive, diluting both sources of opposition. Positive features which emerged from consultation were taken into account: for example, attachment to the panel doctor system influenced the decision to attract members into the clinic system by incentives, rather than coerce them to change. The depth of support for dependant cover was consciously used to elicit union co-operation: in the Report, the introduction of dependant benefits was explicitly tied to successful cost-containment through implementation of the recommendations.

4. Recommendations

The recommendations for re-structuring of the NICLI Sick Fund were done on a regional basis, determined by the patterns of utilisation and expenditure and informed by the responses in the first round of regional workshops and meetings. Action was prioritised for the regions where utilisation was highest. These recommendations were presented and discussed in a series of joint regional meetings for employers and unions, whose responses are summarised below.²⁷

Clinics

The basic arguments for proposing the establishment of Sick Fund clinics as an alternative to panel doctors in certain areas were: cost-containment; improved

²⁷ The General Secretary of NICLI and I conducted 7 report back meetings around the country, attended by 210 shop stewards and union officials and 33 employers. Only the central recommendations are discussed here.

quality of care and potential for monitoring both quality and cost; greater involvement by users. The criteria for judging a clinic to be feasible and necessary in an area were: sufficiently large membership (at least 2,500); geographic concentration and heavy use of benefits. In terms of these criteria, I recommended the establishment of Council clinics in Natal, Pietermaritzburg and Cape Town, with a limited panel of doctors where necessitated by the geographic spread of members, along with clear incentives to use the clinic. These were three of the most problematic areas, as a result of high consultation rates, high proportions of chronic members and expensive chronic prescribing patterns.

South Western Districts posed a particular problem. Overall, it was the worst deficit area in the Fund, showing a loss of R92.35 per member in 1991 and average utilisation of more than 4 extra consultations per member. These figures were even more disturbing when disaggregated for the three small towns comprising the region. Two were lower than average in terms of utilisation. The losses were all due to the third, Great Brak. With only one factory and some 600 workers, it was too small for a clinic of its own. Instead, I recommended that the Fund negotiate with local state health authorities for access to the clinic, using the panel doctor only for referrals (cases beyond the competence of the nursing staff in the state clinic).²⁸

The recommendations were generally supported in all areas, except Great Brak, where workers expressed some reservations about the state clinic and reluctance to change. There was a surprise reaction in Midlands/Border, where

²⁸ A similar arrangement was recommended for Botshabelo, pending incorporation into the Fund.

trade union delegates from NULW expressed disappointment. Contrary to their position in the first workshop, they now wanted a clinic as a priority. On the SFMC and 'Nine-a-Side' Committee, the union representatives received the recommendations about clinics quietly. The TLATIU, safe from clinics in this phase, were untroubled by their implementation in other areas while SACTWU representatives masked their delight for strategic reasons. The NULW response was more surprising: the leaders on the SFMC had shifted from the oppositional position of the past, perhaps in response to the groundswell of support at the regional meetings. The decision to hold joint employer-union meetings in the regions to report back on the research and gather responses proved to be a useful check on the tendency sometimes exhibited by the NULW leadership to translate their members' views rather freely.

Panel doctors

Clinics were not feasible in some areas, where the Fund would have to continue to rely on panel doctors. However, the panel needed trimming and more careful monitoring, given a history of irrational practice. The Fund actually appointed new doctors in 1991 in almost all areas, in a year in which membership decreased. While there was an argument for spreading the panel for ease of access, the problems of management and control increase with panel size. Management of the panel system would need to include measures such as the introduction of a

formulary, regional peer review groups and the development of a new system for chronic drugs.²⁹

Responses to the suggestions on managing the panel doctor system varied. In general, employers believed that the system was open to abuse and should be more tightly controlled, while union officials expressed more nuanced and complex opinions. NULW officials were often cautious in joint meetings, reluctant to be seen as condemning particular panel doctors and by extension the members who chose to consult them. TLATIU officials defended the Transvaal panel and attacked others, holding up the Transvaal as a model of control and economy. SACTWU, while strongly critical of the panel doctor system, also exercised some caution about expressing this opinion in joint meetings, to avoid antagonising the other unions and also to avoid exclusive identification with the clinic concept (and consequent opposition from the other unions). There was an attempt to accommodate the wishes of rebellious SACTWU members at one Transvaal tannery described earlier, by extending the refund system to their area.³⁰ This was offered to the tannery workers as a way to open access to non-panel doctors but the concession was not well received. Once the decision had been made to proceed with clinics in Pietermaritzburg and Durban, both NULW and SACTWU officials brought their detailed knowledge and information of problems and abuses to bear on the process of pruning the panels. (See Section 6 for discussion of panel doctor reactions.)

²⁹ A formulary is a list of medicines for specified illnesses, often organised in terms of cost-effectiveness or cost. A peer review group, elected by the panel doctors in a region, would review (anonymous) case studies taken from Sick Fund records.

³⁰ In areas with no panel doctors, workers could consult non-panel doctors and were refunded at the panel rate, making up any shortfall themselves.

Factory doctors

The factory doctor system posed a special problem. It was only used in seven factories (with seven doctors) at the time of the study. The system was generally favoured by the employers concerned, because of convenience and reduction in lost time. Workers had a mixed response, recognising the convenience but complaining that the doctors were particularly reluctant to give sick leave. They attributed this reluctance to a desire to keep in with the employer and safeguard a lucrative arrangement. Payments to these doctors amounted to between 24% and 106% of contributions income for the factories in question, the lower proportions in factories which employed factory sisters, who screened patients before they consulted the doctor.³¹ Consequently, the recommendation was that the Fund should only allow factory doctors to operate where full-time factory sisters screened patients and that expenditure should be monitored, with a view to establishing an hourly rate rather than a fee per consultation.³² (See Section 6 for discussion on speed of consultation.)

Extension of benefits to dependants

This was a complex issue, made more difficult by a number of factors: the need for different recommendations for different regions; differences in use of benefits in different regions; and different attitudes towards ways to fund

³¹ Members in factories served by factory doctors also incurred other costs for the Fund: consultations with other panel doctors, sick pay and direct payments, as well as administrative costs.

³² In the absence of more comprehensive and sophisticated indices of quality of care, consultation speed is a crude but suggestive proxy.

dependant cover. It was clear that benefits could most safely and cost-effectively be extended to dependants through clinics operated by the Industrial Council.

In areas where clinics were not feasible, the principal options were: co-payment by the Fund to panel doctors; refund by the Fund of received accounts from non-panel doctors, to an equivalent level; or refund by the Fund of received accounts for state clinics, day hospitals or hospitals. However, all these issues were superseded by the overriding financial problem. All parties had agreed (though with reluctance on the union side) that extension of coverage to dependants would not be considered until the Fund was restored to a sound financial status.

The final plan of action agreed by the 'Nine-a-Side' Committee prioritised Pietermaritzburg and Durban-Pinetown for the establishment of clinics and Great Brak for an innovative contract with the local state health authorities. Sub-committees were established for the clinic projects and I was active in these and in the Great Brak developments until the end of 1994.

5. *The sources and significance of workers' attitudes*

The research process in this project provided unusually direct access to workers' views on health care. These views and those of the other parties involved had to be considered critically in order to design and plan workable changes to the Sick Fund. During the active phase of the project, this critical analysis had a practical focus and was often not made explicit for reasons of strategy or tact,

though it influenced the way in which recommendations were framed and, particularly, implemented.

Experience and observation

The most obvious formative influence was personal experience. Each worker had a slightly different version, depending on family circumstances and health status, but generally incorporating exposure to some or all of the following: self-medication, use of over the counter medication and traditional remedies; traditional practitioners (fairly rare in the NICLI case); factory services (in-house clinics, staffed by nurses, sometimes with a visiting doctor paid on a sessional basis by the employer, generally confined to the larger factories); private practice, generally cash practice (where doctors charge a standard cash fee, which includes consultation and medicine) but occasionally standard fee-for-service practice on an account basis (where doctors charge separately for each service and for medicines); panel doctors; and state services.

Workers would have been in any or all of these treatment contexts at some stage. They would also have observed and/or heard of the experience of others. For example, while waiting for treatment from a panel doctor, they would have observed the public aspects of the treatment given to medical aid patients and cash patients (waiting time, appointment system, attitude of reception staff), though they were not in the examination room and so did not observe the private aspect of the patient-doctor interaction. Experience in one context influenced attitudes towards others: for example, the more public services decayed as a result of under-funding and over-crowding, the more attractive the private sector became by

comparison. There was little health education in schools and little debate in accessible media about the nature of 'good' health care.³³

The public-private divide provided material for aspiration, reinforced by the architecture of apartheid. Trade unions are naturally in the business of negotiating improvement in benefits and in the sphere of health care this easily translates into an assumption that improvement involves moving from public to private sector care. Equally, private health care was predominantly a white domain under apartheid and in the drive to redress the inequalities of the past it was easy to assume that equality must mean equal access to the private sector. These confusions were not helped by political uncertainty. This project started in 1992, before the change of government, though it was already clear that there would be a new government, which would institute changes in the national health system.

The influence of doctors

While there was a general (and often exaggerated) respect for the professional status of doctors as a group, it was also clear that workers applied ranking within the group. There was a general tendency to infer skill level from income, with the consequent assumption that private doctors were more skilled than those in the public sector. Equally, panel doctors were ranked below other private doctors because they accepted a lower fee. There was a general sense that a Council clinic could not attract a good doctor, given the constraints on salary level (and the fact that the job was salaried, capping earning power). This

³³ Media exposure would generally be limited to television programmes such as 'ER' which reinforce a high-technology, hospital-based and doctor-centred medical model.

conviction was not restricted to workers: employers were openly sceptical, as were the panel doctors.

The influence of doctors was pervasive. For instance, panel doctors complained to patients that the low fees paid by the Fund meant that they could not prescribe 'proper' medicine, thus reinforcing the idea that 'proper' automatically meant more expensive. The power relations were quite clear: patients may have resented the actions of certain panel doctors in treating non-Fund patients first, or making them wait outside, or giving them different drugs, but on the whole they continued to go to them, to take the drugs they prescribed and to believe their diagnoses. They even signed the petitions drawn up by the panel doctors in Pietermaritzburg. It was striking that the two areas of highest utilisation in this study displayed an overt culture of sickness: workers in both Pietermaritzburg and Great Brak talked about living in 'sickly' areas and regarded their high utilisation as inevitable, quoting their doctors in support of this theory.¹⁴

At a micro level, workers' attitudes were also coloured and moulded by the structure of the benefits in their Fund. The obligation to provide a doctor's certificate for all absences resulted in over-use (and consequent over-treatment, more precisely over-medication) for trivial ailments and encouraged 'abuse' in the form of token consultations to cover non-illness related absences. The absolute association of medication with treatment was entrenched by the system. It was far quicker and cheaper for a doctor to issue drugs than to discuss health status and lifestyle. The chronic benefit not only reinforced the idea that drugs were an index

¹⁴ These comments are drawn from my notes of meetings with NULW and SACTWU shop stewards in Pietermaritzburg, 9 June 1997 and Great Brak, 18 June 1997.

of good treatment, but gave doctors a powerful incentive to over-prescribe. On the other hand, in the context of a working class practice it is unsurprising if doctors medicate where they cannot really treat, in terms of changing the conditions under which people live (in poor and overcrowded housing, in polluted areas, often far from their workplaces and subject to high levels of violence). Counselling and therapy are unthinkable luxuries for working class people, who have nowhere to go but general practice. A number of women talked with feeling about 'living on my nerves', a description which generally resulted in a display of assent from other women present.¹⁵

The influence of trade union leaders

The influence of trade union leaders on workers' attitudes towards health care emerged clearly when workers were asked about alternatives to the current benefit structure. In the case of TLATIU, shop stewards had been thoroughly briefed and had taken on the leadership opposition to the idea of clinics, seen as associated with a rival union, SACTWU, and therefore inherently dangerous.¹⁶ In the case of NULW members in Cape Town, this concern was more concrete: unlike TLATIU, they favoured a clinic, but were insistent that leather workers should have their own and not share with clothing workers. Their concern highlights one of the sources of SACTWU's strength in NICLI: though SACTWU was competing for members, influence and legitimacy as a newcomer to the industry, it loomed large by virtue of overall size (when clothing and textile

¹⁵ I did not observe the same response from the men. This may be due to peer pressure, militating against identification with a 'female' complaint, or it may be evidence of the classic 'double burden' of women workers.

¹⁶ SACTWU's inroads in the Transvaal hit the TLATIU (the NULW did not operate in the area).

members were included), organisational strength (and consequent support to officials in negotiations) and to some extent through its affiliation to COSATU.¹⁷ This strength would be particularly obvious to the NULW in Cape Town. SACTWU is the largest union in the region, occupying and owning a substantial building, in which the clothing clinic was based, just up the road from the NULW office.

SACTWU exhibited an equivalent concern about the siting of the proposed Durban clinic. After an extended search for suitable premises, the General Secretary of NICLI raised the possibility of siting the clinic in the building owned by the Council in central Durban, where there was an empty floor which could be rented at preferential rates. SACTWU opposed this, arguing in meetings that the site was inconvenient, and in private that this was a less pressing problem than the fact that the NULW had their head office in the same building.

Members of both NULW and SACTWU in Port Elizabeth pushed for a medical aid scheme. The explicitness of this demand was probably related to the fact that there were several well known medical aid schemes in the town, with large worker membership (including, significantly, the motor industry workers, generally perceived as the local labour aristocracy).¹⁸ One of these schemes had developed an option designed for lower-paid workers, to which SACTWU's clothing workers in the region belonged. SACTWU's leather members had heard of this scheme and wanted to join it. In addition, the option was being heavily promoted by one of the

¹⁷ The other two unions were not affiliated to national centres.

¹⁸ Members of the National Union of Metalworkers of South Africa (NUMSA), they were well-organised, militant and comparatively highly paid. The 1994 minimum monthly wage in the automobile industry was R1,867, compared with R1,243 in footwear and only R980 in clothing (Rees, 1995).

employer representatives on the SFMC as the answer to workers' needs.¹⁹ The basic price was far more expensive than the NICLI Fund, and the scheme was seriously mismanaged.²⁰ Ironically, while leather members saw this scheme as a step up from panel doctors, clothing workers who belonged to the scheme were seriously dissatisfied and wanted to make the step up to a full-benefit medical aid scheme.⁴¹

SACTWU members at a tannery in the Transvaal had been approached by brokers keen to sell an alternative medical aid scheme (on highly unrealistic terms). They were extremely confident about their strength at a plant level and wished to opt out of the Fund, believing that they could negotiate their way into a comprehensive medical aid scheme. SACTWU officials were embarrassed by this issue, considering that the shop stewards had raised an issue in an inappropriate forum, revealing dissension to employers and to the other unions. The union leadership in Johannesburg saw this as part of a more general rebellion against union discipline by this group of members and were unsympathetic to their complaint that panel doctors were refusing to see them other than on a cash basis.

In the Western Cape, changes in the clothing Sick Fund had been in the air since 1987, as described in the previous chapter. SACTWU members in the leather sector were also exposed to these discussions at local and national levels: in shop stewards' councils, meetings of 'locals', shop steward training and campaign

¹⁹ He was also chief executive of the two medical aid schemes in question.

²⁰ I had previous contact with this scheme and was aware of the problems, which included obstructive use of union power by NUMSA to block attempts to restructure benefits or increase contributions to meet rising costs.

⁴¹ I was adviser to SACTWU in a company threatened with a strike as a result of worker dissatisfaction with this medical aid scheme. Later, as a member of the Medical Schemes Council (MSC), I had further exposure to the scheme's ongoing difficulties.

meetings, as well as in national fora, such as preparations for wage negotiations. The general thrust of the approach (particularly the move away from panel doctors towards Fund-run health centres) percolated through the union.

The NULW had its own separate fund providing top-up benefits (a spectacle benefit and a small top-up for sick pay), to which their members contributed separately along with their union dues. This fund was a selling point for union membership and a point of differentiation from the other two unions, and the NULW defended it with great warmth and opposed incorporation into a generally improved IC-administered scheme. The NULW's reluctance to change the chronic benefit in any way (even by eliminating the more obviously absurd conditions on the list) arose, I would argue, from the same source: the need to present itself to its members as a protector and facilitator of access to benefit. In the same way, NULW representatives on the SFMC argued for extremely high annual consultation limits, at 12 initial consultations and 12 repeats (plus unlimited chronic consultations). Given average utilisation in the CCIC and in free choice medical aid schemes of around 6 consultations per annum, this is unnecessarily high. But the NULW clearly equated higher limits with better benefits and presented itself to members as both more protective and more aggressive than the other unions by fighting for a higher increase. The NULW's general approach bore some similarities to the approach of the old garment union in Cape Town, with its stress on facilitating access to welfare benefits as a key union function.

6. Implementation and assessment

By the end of 1994, three clinics were established, in Pietermaritzburg, Pinetown and Durban and the panels of doctors were reduced in these areas. In the Great Brak area, a breakthrough agreement with the local state health authorities was negotiated, controlling runaway costs for the Fund and also allowing members' families to use the clinic facilities for the first time (though not at the Fund's expense). The first moves were made towards establishing links with other Sick Funds, a slow process which later resulted in co-operative agreements allowing clothing workers in Pietermaritzburg access to the leather clinics and leather workers in Atlantis access to the clothing clinic.⁴² On the issue of chronic benefits there was little progress.

Lessons from clinics and panel doctors

Clinics were established in Pietermaritzburg, Pinetown (on the outskirts of Durban) and Durban. The process revealed a number of underlying problems. In Pietermaritzburg, the initial decision was to trim the panel of doctors, limiting them to one in each residential or working area. All chronic consultations were at the clinic, while for acute consultations members could use either the clinic or one of the panel doctors. As an incentive, there were no limits on consultations at the clinic.

⁴² The Pietermaritzburg development was necessitated by the refusal of all members of the Independent Practitioners' Association to treat clothing workers, because they were also members of SACTWU. The SACTWU official involved in negotiations was also refused treatment by his private doctor. Doctors in Atlantis had organised against a range of Sick Funds and medical aids.

The panel doctors were given advance notice by the Sick Fund that the panel would be reduced, in conjunction with the opening of a central clinic.⁴¹ They held their fire until termination notices went out, at which stage they mounted a concerted campaign against the Fund. Some doctors drew up petitions which they asked their patients to sign, others protested in heated letters to the NICLI General Secretary.⁴² The recently established Independent Practitioners' Association (IPA) threatened to expel any doctor who broke ranks and accepted a position on the reduced panel. The IPA demanded a meeting with the Fund, at which the doctors became extremely heated, taking strong exception to the 'interference' of non-medical people (specifically my involvement), and threatening a range of responses, including legal action (for breach of contract), reporting the Fund to the African National Congress (for interfering with workers' 'democratic right' to freedom of choice of practitioner), and reporting SACTWU to COSATU (for going against 'COSATU policy', which they declared was in favour of panel doctors).⁴³ The long 'service' of the panel doctors was repeatedly cited, along with their 'charity' in serving leather workers at rates well below standard consultation fees.⁴⁴

⁴¹ On 19 January 1993, a memo went to all panel doctors and on 1 April, letters of notice went to doctors whose contracts were terminated.

⁴² In July 1993, the IPA submitted petitions signed by 1,327 Fund members with a covering letter asserting that members did not accept the Health Centre because they were not consulted about it and were not permitted to consult their own doctors. The IPA also circularised members, urging them to stand united against the changes and mentioning its intention 'to negotiate a more reasonable fee'. (Circular letter from Dr A du Preez to IPA members, 1 April 1993. Attachment to agenda, meeting with IPA, Pietermaritzburg, 5 May 1993.)

⁴³ The Chairman of the Sick Fund, the NICLI General Secretary, local employers, NULW and SACTWU representatives and I attended this meeting. The IPA carried out its threat to write to the ANC, as reported with some amusement by a SACTWU official (who was on the branch executive of the ANC).

⁴⁴ As in Great Brak, the cash consultation fees charged by panel doctors to non-Sick Fund members were generally around R30, compared with the NICLI fee of R31.50.

The Sick Fund delegation held firm and the process continued. Suitable premises were found and outfitted and staff were interviewed by a joint selection committee. Two highly competent and experienced nursing sisters with clinical training were appointed. Finding a doctor was more problematic. The first two choices on the shortlist declined the offer and in the end the committee had to make a compromise appointment, of an ex-panel doctor. This had certain advantages: he was elderly and highly respected in the town and was a popular panel doctor with long experience of the fund. The IPA could not attack his competence or experience. On the other hand, he carried with him certain entrenched practices and attitudes which were incompatible with the new situation into which he was going. The clinic had been planned on a health team model, with the clinical sisters screening patients and dealing with minor ailments, as they were trained and qualified to do. The doctor refused to allow this and insisted that they act in effect as receptionists. The sisters were hesitant to challenge him, but expressed disquiet and frustration to the General Secretary of NICLI and to me.⁴⁷ Our attempts to discuss the issue with him were notably unsuccessful.⁴⁸ He flatly refused to countenance any change in his preferred style of practice, despite his high profile membership of the ANC, whose Health Plan is explicitly built on a primary health care model with nurses as first line practitioners (African National Congress 1994a). Because his final defence was medico-legal (that he would be liable for any malpractice or illegal extension of scope of practice by the nurses), we tried to track down legal clarification on this issue through a maze of

⁴⁷ They reported angry outbursts sparked by questions which he had interpreted as 'insubordination'.

⁴⁸ Like the panel doctors, he attacked my competence as a 'non-medical' person, an attack characterised by frank sexism and paternalism.

overlocking and sometimes contradictory laws and professional jurisdictions.⁴⁹ A meeting with the Department of Health in Pretoria failed to clarify matters and the doctor stood firm.⁵⁰

The second major problem was the doctor's refusal to stick to an agreed list of drugs (formulary). When the clinic was established, the sisters ordered supplies of drugs according to an interim formulary as used in the Cape clinics.⁵¹ However, he ignored the formulary and ordered other drugs at random. The drug bill rocketed.⁵² Tentative protests from the sisters only hardened his attitude. His prescriptions were collected and submitted to the Department of Pharmacy at the University of the Western Cape for comment. The response was that his prescribing practices were outdated, inconsistent and extravagant. He over-prescribed and tended to favour ethical (brand name) drugs even when reliable generics were available at much lower costs. This was part of a pattern of establishing popularity with patients by lavishness which extended to time as well, resulting in a tortoise-like patient throughput and full waiting rooms (exacerbating the sisters' frustration). It was notable that patient flow was much slower in the clinic (where he was on salary) than it had been for his panel practice (when he was paid per consultation).⁵³

⁴⁹ For example, the Nursing Act and Council, the Pharmacy Act and Council, the Medical and Dental Council, the Machinery and Occupational Safety Act.

⁵⁰ The NICLI General Secretary and I met officials from the then Department of National Health in Pretoria on 15 April 1994, only 12 days before the election. They were both unable to clarify the legal situation and unwilling to commit themselves to interpretation so close to a change of government.

⁵¹ Revised by Dr Morar of the CCIC.

⁵² The average drug costs per consultation were 70% higher than in the CCIC's Salt River clinic (Cornell 1994).

⁵³ His average monthly panel consultation rate in 1992 was 490. The panel was only a small part of his practice, which also included other panels, cash patients and medical aid patients. His average consultation rate in the clinic was 750, compared with an average monthly throughput in the CCIC clinics of 1,130 per doctor (1994).

Patients complained (to their unions) about waiting time, especially when they clocked out from factories to visit the clinic. And the panel doctors in the vicinity of the clinic (most notably the clinic doctor's ex-partner) experienced a boom in business. The Sick Fund sub-committee in Pietermaritzburg considered various means of tackling the problem, including terminating the contract of the central panel doctor. In the end, the decision was to limit access to this doctor to times when the clinic was not open.⁵⁴

The Pietermaritzburg experience informed the process of establishing the Pinetown and Durban clinics and decisions about the panel in the Cape. No doctors were retained in the vicinity of the Pinetown and Durban clinics. Formal job descriptions were built into the contracts of the doctors appointed in these clinics, specifying a health team approach with the use of clinical sisters for screening and consultation on minor ailments, and adherence to an agreed formulary and set of prescribing practices. The General Secretary of NICLI took the opportunity presented by the appointment of staff to the two new clinics to set up a general pharmacy workshop run by the UWC Pharmacy Department, which would include the Pietermaritzburg clinic staff as well. Even this attempt met with resistance: at the last moment, the doctor announced that he had a doctor's appointment on the arranged day.

The major lesson for the CCIC Sick Fund was that attempts to prune the panel would consolidate opposition to the re-structuring process and that as long as doctors remained on the panel, even with a shrinking patient base, they were less likely to mobilise against the Fund. As a result, the CCIC Sick Fund decided not to

⁵⁴ Personal communication, Kevin Perumal, SACTWU, Pietermaritzburg.

reduce the panel until the clinic system was more extensive and all teething problems with dependant cover were sorted out, given the fact that panel doctors in Pietermaritzburg had seized on each hiccup in the new clinic as ammunition in a propaganda exercise to patients.

Links with the state

The Great Brak area presented a different kind of problem. This is a small sea-side town, with one large shoe factory employing some 660 workers. It is about 450 kilometres from Cape Town and 300 from Port Elizabeth, the administrative centre of NICLI. Despite its size, Great Brak was a major loss area for the Fund. The pattern continued over a period of years. For example, in the period January to July 1994, direct expenditure (excluding administration) exceeded contribution income every month except one, despite the fact that the factory doctor system described below had been stopped. There was a high proportion of registered chronics and chronic costs were particularly high. The average cost per chronic consultation (including medicines) was nearly two and a half times the national average.⁵⁵

There were a number of explanations for the high utilisation. For a start, the panel doctor's surgery was situated less than five minutes walk from the factory, on the direct route between the factory and the township where most of the workers lived. The convenience factor was heightened for a period by an arrangement whereby the doctor called at the factory for an hour a day and saw patients there. A discussion with the doctor revealed the difficulty of involving him

⁵⁵ The national average was R99.45 in 1991, while in Great Brak it was R242.05.

in devising a solution for the Great Brak problem and the membership base was far too small to justify a Fund clinic. So we took a different route, approaching the local authority which operated a clinic near the factory. Although there was no legal reason why leather workers should not have used this clinic themselves, given their income level, there had been a practice of excluding them and their families (for which there was even less basis, as they were not covered by the Fund: as a direct result the families were obliged to use the local doctors on a cash basis). Even without this policy, there would have been the disincentive for workers of the clinic fee which, though low, was nevertheless double the paltry R1.50 levy for a panel doctor consultation (often waived in practice). Fortunately, there was a coincidence of interest between the Fund and the local health authority, the Regional Services Council (RSC). The clinic staff establishment was under threat because of low patient numbers and the official in charge of clinics run by the RSC in the area was fighting to retain posts. Over several meetings, we developed an agreement about access to the clinic, which was also thoroughly discussed with union leaders and the employer. Leather workers in Great Brak would be required to consult the clinic in the first instance, and would be referred to the doctor according to standard practice for anything which could not be handled by the nurses. The clinic would bill the Fund the standard state fee per consultation (R3.00 in 1992). For cases referred to the panel doctor by the clinic, the Fund would pay the doctor a higher fee per consultation, in recognition of the more complex case mix.³⁶ Routine monitoring of chronics would be transferred to the clinic.

³⁶ The fee was R40 for each referral patient, compared with the standard panel fee of R31.50.

The system worked reasonably well in practice, but required constant monitoring (by the NICLI General Secretary), especially in terms of the rate of referrals to the doctor, which tended to creep up, partly because of patient demand and partly because of intervention from the doctor.⁵⁷ The local authority was concerned not to antagonise the doctor unduly, as it was dependent on him for emergencies and referrals.

There were two major lessons from this experience. First, this deal worked because it was local: it was easier to negotiate a deal with the state at local level. We had strong indications that the deal would not have worked if we had tried to make it at a higher level. This was a difficult stage in health politics: there was a new government, with new faces in the national Department of Health, the provinces had been totally re-drawn (9 in place of the previous 4), the health sector was in the midst of major re-organisation and a flurry of policy exploration, and there was uncertainty all around. In the circumstances, there was understandable caution about precedents but it was possible to experiment at a local level. Second, the work involved in negotiating and maintaining a deal like this one is substantial. In this case, the involvement of the General Secretary of NICLI and support of the employers (particularly powerful in the light of their position in the town) was crucial.

⁵⁷ As in Pietermaritzburg, the sisters were uncomfortable about conflict with the doctor and tended to follow his instructions rather than those of the RSC administrators, who were not on the spot to reinforce their authority.

Chronic care

The system of chronic care in the NICLI Sick Fund developed haphazardly over the years in response to complaints and requests from panel doctors, who argued that they could not treat patients with chronic illnesses appropriately under the standard payment system. In theory, drug costs averaged out over a patient group, with some needing only short courses of cheap medication and others more expensive or extensive medication. In practice, doctors tended to look at the fee on a per-case basis, focusing on cases which needed more drugs or more expensive drugs than the average, and forgetting the cases which needed fewer or cheaper drugs.

The differential benefit for registered chronics refunded doctors for medication dispensed, at 85% of the recommended retail price, without restriction.⁵⁸ The management committee naively believed that this meant that they were obtaining medication at a discount of 15%. In fact, dispensing doctors obtain medicine from pharmaceutical companies at heavily discounted rates, in addition to rebates for bulk buying and numerous special offers and giveaways. Their profit margin on the NICLI arrangement would have been at least 70% and the incentive was therefore to prescribe both more, and more expensive, drugs.⁵⁹ In addition, chronic consultations were not limited. These two factors entrenched the difference between the treatment of chronic and non-chronic patients and gave rise to resentment in the latter group, particularly given the value placed on drugs as a

⁵⁸ This was a particularly lucrative arrangement, compared with the CCIC arrangement, which was based on the wholesale price rather than the retail price.

⁵⁹ Drug prices are marked up at each stage of the way from manufacturer to wholesaler to retail pharmacy to patient. Panel doctors obtain drugs at prices between the manufacturer's price and the wholesale price, plus additional discounts and rebates.

marker of care by this group of patients. (When asked what they would think of a consultation which did not result in drugs, most workers were frankly derisive, with responses along the lines of: 'What would you be paying for?') The panel doctor in Great Brak exploited the value placed on medicines by imposing an extra (and illegal) payment, when he 'had' to prescribe more expensive medicines. Workers, he said, 'understood'.⁶⁰ The Fund's list of chronic ailments was in no sense scientifically designed: it was neither comprehensive nor organised on rational medical lines, nor was there even a clear definition of chronic illness. It simply grew in an ad hoc way, with additions motivated by panel doctors or trade unions and approved by the Sick Fund Management Committee. Generally, the committee was uneasy about taking decisions they saw as outside their competence (there was no provision for obtaining independent medical advice) and they tended not to oppose proposals for additions to the list of chronic ailments and individual applications. In order to qualify for the chronic benefit, a member had to be examined and diagnosed by a specialist, an expensive process for the Fund and quite unnecessary for the majority of chronic ailments, such as hypertension, whose diagnosis is well within the competence of a general practitioner.⁶¹

In general, knowledge of the 'chronic' benefit was patchy. This is probably related in part to the way it developed, by individual application and motivation. The list included, for example, deafness, haemorrhage, heart failure, varicose veins, hiatus hernia and cancer. None of these should have been treated by general practitioners on an ongoing drug regime: some would need specialist investigation

⁶⁰ Panel doctor, interview by author, written notes, Great Brak, 18 June 1992.

⁶¹ The average cost of registration per new chronic was R114 in 1992. This was equal to the total contributions for one member for seven months (Cornell 1993b).

and management, others surgical intervention, others were simply not treatable (for example, noise-induced or age-related hearing loss).

The chronic issue - on the face of it, a simple 'medical' issue - proved to be extremely difficult to tackle. The SFMC requested independent medical opinion on the list, and then a second opinion. I wrote a document incorporating the medical opinions and outlining an approach to rationalising the benefit, but this too met with resistance, specifically from the NULW. If retention of the panel doctor system was the TLATIU's stand or fall issue, the chronic list was NULW's. Their leadership would concede on clinics, but not on chronics. The other unions caucused extensively with the NULW on the issue, but failed to convince them. It appears that the benefit was used more extensively by NULW members, though knowledge was not universal, which might indicate that a degree of patronage (of panel doctors as much as of members) was involved in supporting individual cases to the SFMC.⁶² Unfortunately, the national nature of the Fund made it difficult to develop a standard agreement on access to chronic drugs with the health authorities, which would have to be negotiated province by province. The chronic issue was unresolved at the end of my period of involvement with the leather fund.

⁶² There were suggestions from the other unions that the NULW's vigorous opposition to rationalisation of the chronic benefit was proof of over-use (and abuse) of this benefit by their members, as well as rumours, which could not be substantiated, of collusive relationships between specific national leaders and panel doctors. I think it more likely that the NULW had presented itself to its members as key in accessing this benefit and was reluctant to lose face.

7. *Assessment*

The significance of this study lies in the insights it provides into the complex issue of union power. This project was as much about unions' relations with each other and leaders' relations with their members, particularly in a situation of competition between unions, as it was about health care. At one level, it charts a straightforward recruitment struggle, played out through a health care issue. At another, it reveals a struggle between different forms of unionism: a narrowly focused, economic, defensive and relatively bureaucratised form (in NULW and TLATIU) and a broader, more political and participatory form (in SACTWU).

The three unions derived their power from very different sources and exercised it in distinct and contrasting ways, which shifted in response to a range of pressures and influences. The success of this project was due to SACTWU driving it. This was a role which might predictably have been taken by the NULW as the majority union, well established in the sector. However, the NULW was structurally divided in its approach, with differences between the national leadership (which was opposed to change, mostly passively, but sometimes actively) and regional and local leadership (which not only accepted the project after initial caution, but participated actively in implementation). Local officials' attitudes were clearly coloured by members' responses: they had to deal with member complaints, lived in the same communities and were often familiar with the doctors concerned.⁶¹ They also tended to have more pragmatic relationships with

⁶¹ Local officials - of both unions - also understood the community politics of their areas and were extremely useful in devising strategies for undercutting panel doctors' disruptive tactics.

their counterparts in the other unions, especially in Natal, where endemic violence occasionally had a uniting effect. The consultation process had revealed widespread support on the ground for changes to the Fund, which were very similar to the feelings expressed by SACTWU members. Why, then, did the NULW representatives on the SFMC take the position they did? One of their reasons was probably concern about poaching of membership by SACTWU and a desire to create a bond with TLATIU by common opposition to Fund changes, thus strengthening the chances of merger. Part of the answer certainly lay in the relatively removed and unaccountable character of the national leadership, which was highlighted by an incident during the research process. The NULW General Secretary wrote to me querying the consultation process (2 July 1992). At the time of the letter, I had held meetings in every region, organised by his own officials. One of these had been in Durban, where the NULW has its head office, and was organised by the Assistant General Secretary (the main NULW representative on the SFMC). The General Secretary had been invited, but had not attended. It was clear from his letter and my subsequent meeting with him that he regarded consultation as meaning consultation with him.

The smallest of the unions, TLATIU, reacted defensively on the health care issue, opposing all change to the existing system. In the absence of positive policy on health care, this position appeared to derive from the assumption that low utilisation was an index of satisfactory service. Given the level and the static nature of membership, the future held either gradual erosion of members by natural attrition and decamping to the other unions, or a merger. In the face of these options, TLATIU's strategy appeared to be to secure current membership as a

counter in the merger talks. On the health care issue, they did this by defining others as abusers of the Fund. The leaders' standard point of entry into debates was the low utilisation of benefits in the Transvaal. Support for the panel system was clearly dictated by the union General Secretary, with a vehemence directly correlated to his suspicion of SACTWU. The meeting with TLATIU shop stewards and officials was notable for the extent and forcefulness of the General Secretary's intervention and his intolerance of alternative opinions. As a union style, this could not have been more different from SACTWU's.

The strength of SACTWU leadership derived from other sources. The national leadership was heavily committed elsewhere and sufficiently confident to delegate representation on the decision-making structures in the Sick Fund and to allow delegates a considerable degree of freedom.⁶⁴ SACTWU leather officials had an advantage over the other unions in the broader base of their union and their access to a more sophisticated range of services, both inside and outside their union.⁶⁵ The union's involvement in two similar overlapping projects (CCIC and NCIC), meant there was a broader reference group in the union at large with whom to discuss issues and develop strategy. The distinguishing feature of the SACTWU delegates was their strategic skills. The main delegate was Mark Bennett, from the national office of the union, an economist by training and head of the union's collective bargaining department. His strategic leadership at the committee level was complemented by the involvement of a regional leader, Kevin Perumal, who was based in Pietermaritzburg and played an important part in the

⁶⁴ Leather was the smallest of the three sectors for which they were responsible. In addition, the national leadership were extensively involved in federation activities and national political developments.

⁶⁵ SACTWU's relationship with the Industrial Health Research Group is a case in point.

implementation process. Strong opposition from NULW and TLATIU to clinics as a 'SACTWU' idea caused SACTWU to make a strategic shift to promotion of the project as a joint union initiative, playing a deliberately low-key role in public, especially in the early stages of the project as the NULW somewhat hesitantly took the lead.⁶⁶ At the SFMC and 'Nine-a-Side' Committee, they built strategic alliances with the NULW, making use of union caucuses. As a result, the NULW often spoke for the union side, and laid claim to agreements which resulted. It was an index of confidence that the SACTWU officials felt no need for public recognition of their role.

This is a project which started with a modest and partial advance. Efforts were focused on particular regions, where a sustained commitment of the parties involved secured significant achievements, despite financial constraints and logistic challenges. Subsequently, the Fund made two major changes which affect all members. Sick leave benefits were improved, allowing for a shorter period of sick leave (10 days instead of 52) but at a much higher proportion of the wage (65% compared with 25%). Given the general pattern of utilisation, this is a major improvement in benefit. The Fund has also introduced a maternity benefit, paying 33% of wages for three months. Most significantly, the process of development continues, especially in KwaZulu-Natal, the most troubled and turbulent of South Africa's provinces. At the time of writing, the NICLI Sick Fund operates a total of six clinics, two in Pietermaritzburg and four in and around Durban. This has enabled the Fund to dispense with the panel system in KwaZulu-Natal, except in the rural areas. A further clinic is planned for the Western Cape, in a joint venture

⁶⁶ This opposition is minuted at a series of meetings in late 1991. (Minutes SFMC 19 September

with the CCIC. The success of this project can be measured not only in the clinics and the satisfaction of the workers who use them, but also in the style of unionism which shaped this outcome and was strengthened by it and which ensures that the process of development has continued. It is a style which carefully balanced solidarity and sectional interests: assessing the costs and consequences of alliance with or distancing from other unions and of confrontation with employers, either jointly or alone, but maintaining always the primary connection with workers which animates and informs an effective union leadership. The strength of that leadership is evident in the continued development of the Sick Fund during a period of major change in the health sector, conditions which halted progress in a similar scheme in Natal, the subject of the next study.

Chapter 6. Natal Clothing Industry Sick Fund

1. Introduction

The third study focuses on failure and is a counterpoint to the previous two. It explores the difficulty of transferring a model from one situation to another, specifically from one region of a national trade union to another. Like the two previous studies, this was a project aimed at restructuring a Sick Fund run by an Industrial Council. As in the Cape, the industry was clothing and the union was the South African Clothing and Textile Workers' Union (SACTWU). With so many common features (union, industry, organisational structure) and two prior examples of restructuring, this seemed an ideal situation in which to apply a model, honed by experience and adapted for the local situation. Nevertheless, it failed, primarily because of the differences underlying the apparent symmetry of the projects.

National unions are not monoliths, especially where they have grown from mergers. The process of merging two or more trade unions requires adaptation both within and between regions. The new identity cannot be imposed, but must develop organically. While the new leaders may speak with one voice nationally on matters of policy, it is harder to homogenise style and approach at the regional level and these may continue to distinguish (and potentially divide) regional branches, especially when they are geographically remote from each other and thus not subject to the influence of proximity and the necessity to develop a reasonable working relationship.

The bargaining structure for this industry was, on the face of it, the same as in the two previous studies. The Industrial Council had a main Council, with subordinate committees to manage the affairs of the various Funds operated under the Council's auspices (each with equal representation for employers and union), plus an administrative staff to carry out the decisions of the Council and committees and run their affairs on a day to day basis. However, the form of representation and degree of engagement of the parties in the different committees differed markedly from the other studies, as did the support provided by the administrators, with implications for the outcome which are explored later in this chapter.

An industry is also not a monolith, particularly a marginal industry such as clothing, which is highly sensitive to external factors such as shifts in government policy on tariffs and protection, as well as to elasticity in demand, which in the case of clothing is directly related to general economic conditions. Most significant were the differences resulting from the two year time lapse between the projects in the Cape and in Natal.¹ The clothing industry in Natal was substantially smaller than in the Cape, but with the same pattern of an overwhelmingly female workforce in scattered workplaces, many of them small. More significantly, employment levels were very unstable in the period of the study and afterwards. In 1994, membership of the NCIC Sick Fund hovered around the 33,000 mark, after a period of contraction, in which there had been retrenchments, factory closures and widespread short-time working. The resultant insecurity (for both employers and workers) was compounded by the

¹ Though the NCIC project was first mooted in late 1992, it did not get under way until early 1994.

prospect of reduced tariff protection. Employers felt threatened and defensive and this coloured their approach towards change.

The time lapse also situated the project squarely in the middle of fundamental political change. Natal (now KwaZulu-Natal) was (and remains) the most politically riven of South Africa's provinces. It was the power base of Chief Mangosuthu Buthelezi's Inkatha (subsequently the Inkatha Freedom Party - IFP), radically (and indeed violently) opposed to the ANC and any organisations associated with it, including COSATU-affiliated unions. Given the power exerted by the IFP, union activism in COSATU-affiliated unions took on an especially dangerous edge in Natal. This was particularly the case for African workers, given the IFP's strength in African residential areas and their hold over the rural areas, where many workers' families lived.² Nevertheless, trade unionists were heavily involved in political work in the lead-up to South Africa's first democratic election (Buhlungu 1994a). The approach of the election exacerbated tensions in Natal, which was swept by a tide of violence (Lesufi et al. 1995; Sitas 1995; Clark 1996). This small project struggled to gain a foothold in the eye of the storm, and failed.

² Many amenities were linked to IFP membership, including access to housing and pensions. As a result, many people took out membership, even when they supported the ANC. The IFP created its own union, the United Workers' Union of South Africa (UWUSA). With the IFP, UWUSA was linked to many violent incidents against members of COSATU-affiliated unions (Baskin 1991: 70-72; 126; 327-342).

2. Another province, another union

The Sick Fund project in the Cape was part of a broader process whereby a new leadership transformed the union, while in Natal the established leadership was securely rooted in a militant tradition and did not have to prove itself by transforming the institutions within which it operated. In short, the Sick Fund in Natal held neither symbolic resonance nor challenge for the union leadership.¹ Nevertheless, the CCIC and NICLI projects both had ripple effects on the Natal region of SACTWU. The single Council policy was extensively discussed at high levels in the union in the early 1990s and the process included detailed comparison of the various agreements and their associated funds and benefits, in order to facilitate amalgamation. Union leaders (both officials and shop stewards) in other regions and in the third sector, textiles, heard about Sick Fund developments in national forums. Nevertheless, knowledge about the CCIC and NICLI developments was neither detailed nor accurate in the union at large. This vagueness allowed a dangerous unreality to develop, especially about the costs of change, as well as an unspoken assumption that research alone would accomplish change and that the model developed in the Cape could simply be imported into Natal. Union officials directly involved in the other projects were not infected by this unreality, but they were thin on the ground.

¹ The dismissive attitude of Natal leadership is clear in the following comment: 'According to Copelyn [then General Secretary of ACTWUSA], the GWU(WP) has an obsession with beauty contests and benefits ... which detracts from what a trade union is all about' (Markham 1987). Traces of this attitude are still discernible in the Natal branch.

The industry

Durban was the centre for cheaper clothing, which heightened the local industry's dependence on protection from imports (Netshitomboni 1995). The industry started to expand again in 1995, with membership of the Fund growing to 37,000 by mid-year, but subsequently shrunk quite dramatically, to a low of 29,000 in January 1997.⁴ This instability confirmed the conservatism of employers, concerned about their own survival in a threatened industry and nervous about any new financial commitments. The shrinking of the industry reduced both the income and the expenditure of the Fund, though not proportionally, given the fixed costs involved in running the clinics and administering the Fund. In addition, the rules allowed free access to certain benefits for contributors who became unemployed, which was a significant potential burden for a poor Fund in times of large scale redundancies.⁵

Wage levels were similar to those in the Cape, differentials between Councils having narrowed in the last few years.⁶ The workforce was and remains predominantly female, as in all areas in the clothing industry. In Natal, there was a majority of Indian workers, with the rest made up largely of African workers, with very few coloured workers and a minuscule number of white workers.⁷ By general consensus, the

⁴ Interview with B. Harrison (Secretary of the Industrial Council) and B. Nyager (SAC(TWU) official), Durban, 23 January 1997.

⁵ The entitlement was free medical services for a period of 6 weeks for 1 year's service, up to a maximum of 24 weeks for 10 years service. Members with 20 years service who retired due to ill-health or old age, were entitled to free medical service for life.

⁶ In 1994, there was only R2.50 difference in the cash wage between the Cape (R263 per week) and Natal (R265.50) (South African Labour Bulletin 1994).

⁷ Registrations with the Industrial Council in 1993: Indian workers 66%, African workers 31%, coloured workers 3% and white workers less than 1% (total 23) (Letter from Dr Mall, March 1993).

proportion of African workers in the industry was growing.⁸ These demographic patterns had implications for planning. As in the Cape, the predominance of women highlighted the need to develop services to tackle women's health problems.⁹ The large number of Indian workers was pertinent because of the high rate of diabetes in the South African Indian population.¹⁰ The entry of African workers into the industry is accompanied by a shift in the pattern of dependant residence, as a proportion of African families continue to live in the rural areas while the primary member works in town.

Unfortunately, while there was anecdotal evidence about the demography of the Fund, it was not supported by reliable data. The Council started the process of computerising its records only shortly before this study was undertaken and was unable to provide reliable information on such factors as age, sex, number of dependants and residence (of primary members or dependants).¹¹ The only reliable geographical information related to the distribution of workers by factories, which were clustered in the central Durban area. The Council was supposedly in the process of updating its records, via the Provident Fund (which also needed dependant names and addresses, as beneficiaries).

⁸ This trend was commented on by all parties, but could not be verified by reference to systematic records.

⁹ It was clear from the Cape study that it was important not to limit 'women's services' to contraception and pregnancy-related services. Many older women complained that they were forgotten once they stopped bearing children.

¹⁰ Dr Mall confirmed this pattern in the clinic population, but was unable to provide measurable data, given the manual record-keeping system.

¹¹ When workers first entered the industry, their addresses were registered with the Council, but there was no reason to update these records unless they left the industry and then re-entered. Given the length of service of many workers, there was a strong likelihood that addresses were out of date.

The union

The impetus for the NCIC project came from a union official fully aware of the dangers of a simplistic approach. Mike Murphy had also made the initial approach about the leather fund. At this stage, I was heavily involved in the implementation of the recommendations of the leather study, and in compiling the Cape Clothing Sick Fund Report, so I had a great deal of contact with the union in all centres and at all levels.¹² He was aware of membership dissatisfaction with the Fund and concerned about the way the union had responded, specifically the way that Sick Fund-related demands had been added to the annual list of demands for negotiations without serious consideration, and as easily dropped from the list at the first check in negotiations. He had first hand experience of the SFMC and identified union neglect as one of the fundamental problems with the Fund, along with ineffectual management and reluctance on the part of both employers and workers to increase contributions, which he attributed to ignorance of the real costs of health care and of the tight constraints under which Dr Mall (the Principal Medical Officer of the Sick Fund) had been running the medical services. He argued that Natal needed its own Sick Fund investigation, in order to develop realistic plans. In his view, the project needed bilateral backing from the SFMC to lend it legitimacy and should include a survey of dependants, in order to provide reliable data, which would hopefully deflate employer perceptions of the size of black families (and the consequent cost of cover), involve a

¹² This section is based on my notes of a series of informal discussions with Mike Murphy during 1992.

broader group of union officials and give them a stake in the project, and connect with the membership.

The lack of broad involvement in Sick Fund matters by trade union officials and leaders was mirrored, to a degree, in the membership. A number of factors combined to alienate members. In the first place, there had been a great deal of confusion after the wage negotiations of 1992. The union had gone into these negotiations with demands for a new maternity benefit and sick fund benefits for children, influenced at least in part by developments in the Cape. It was a tough year for negotiations and the eventual deal was a maternity benefit and agreement on the *principle* of dependant benefits (Keet 1993; Von Holdt 1993b). It suited both employers and union to allow a certain vagueness on this issue, the employers claiming generosity and the union a victory on the list of demands. Not unnaturally, many workers understood this as agreement to include dependants immediately, especially given the concurrent contribution increase.¹⁵ The fact that the maternity benefit was being largely funded from reserves (and therefore could not survive indefinitely without additional funding, requiring a further contribution increase) was also glossed over. The unfortunate legacy was serious dissatisfaction from workers, unrealistic expectations and reluctance to stomach any further increases.

This was the background to my early involvement with the Sick Fund. At the request of Mike Murphy, I prepared an outline of the proposed research, which was

¹⁵ The system changed from a flat rate to a percentage (0.7%) of the wage. For machinists this meant an increase from R1.10 to R1.54. The increase was generally viewed as very large and quoted in percentage terms. However, the base was extremely low and the new rate was still cheaper than a packet of cigarettes.

submitted to the SFMC in April 1993 and subsequently expanded at their request to a Draft Proposal in June 1993. In the event, the research was delayed for a further six months because of the outcome of the wage negotiations in mid-1993. Mike Murphy recognised explicitly that the project would face the obstacle of undoing some of the problems of the past, especially the unrealistic ideas about the costs of extended cover. At the beginning of the process, I met with hostility when I spoke to mass meetings about the financial situation of the Fund and the contribution levels that would be necessary to fund better benefits for members and coverage of their dependants. Resentment continued even after Mel Clark (who took over when Mike Murphy moved from the Sick Fund) tackled the issue head on and publicly accepted that the union was responsible for this problem, having not come clean about the financial implications of the agreement struck around the maternity benefit.¹⁴

Unfortunately, the residual membership dissatisfaction and suspicion was sparked into new life by an incident during the project, when the membership survey described in Section 6 below was administered by Industrial Council staff.¹⁵ In addition, the process of investigation of the scheme was shorter and more concentrated, with less time for members to absorb the issues and take on a leadership role in the changes. The lack of a survey was not balanced, as happened in the leather study, by extensive (and relatively unconstrained) contact with the membership. It was

¹⁴ The delay between the Draft Proposal and the beginning of the formal project meant that Mike Murphy was no longer directly involved in the Sick Fund, having moved full time into national rather than regional union work.

¹⁵ By comparison, the CCIC survey was administered by researchers with the co-operation of the union, rather than by Council staff.

very difficult to establish anything like the degree of contact with members that I had developed in both the CCIC and the NICLI projects. Although I developed a relationship with the shop stewards' council and, particularly, with the task group appointed to assist in the Sick Fund project, conditions around the time of the election resulted in severe disruption of normal union activities (Buhlungu 1994a; 1994b; Sitas 1995).

When Mel Clark became involved (from March 1993), he took a particular interest in the issue and was the guiding union figure and my major contact. However, this was only one of his responsibilities: his job description was fluid in the extreme, with new tasks added to his remit throughout the period of this project.¹⁶ While other union officials expressed friendly interest in the process, few became actively involved. Clearly, the Sick Fund was neither a high priority nor an attractive involvement, especially in comparison with the mainstream political issues of the time. There was also a great deal of confusion concerning 'nationalisation' of health care, with a number of officials sharing the widespread belief amongst workers that health care (read 'private health care') would be 'free' after an ANC victory, in which case energy spent on reforming the Sick Fund would be wasted.

¹⁶ Mel Clark's abilities were obvious in the decision by union leadership to assign him several full time responsibilities at once, despite his relative newness to the union. For example, he had the overall responsibility for recruitment, organisation and co-ordination of monthly paid workers. The union was on a drive to increase its membership amongst this group of workers, who were particularly demanding of organisers. The responsibility he was given did not, however, translate into backing by the leadership for his activities in another sphere, namely the Sick Fund. He came into the union from university, moved to the Trade Union Research Project at the University of Natal and then to the KwaZulu-Natal Regional Economic Forum.

3. *The Industrial Council: bargaining and administrative structure*

The NCIC Sick Fund was not established in terms of a separate legal agreement (as in the CCIC and NICLI), but was a part of the main Industrial Council agreement. This dependent status is mirrored in the organisation of meetings: Provident and Sick Fund meetings were scheduled to follow one another on the same afternoon, which resulted in rushed meetings. There was minimal employer engagement in the SFMC and this was mirrored in the research process, during which contact with employers was limited to a number of brief contacts with the secretary of the Natal Clothing Manufacturers' Association (NCMA) and attendance by a broader group of employers at the workshop at which the recommendations were presented and discussed. Dr Mall sat on the SFMC, but did not have a vote. The employers were generally proud of the 'economy' of their Fund, expressing the view that this was one area where they outdid the otherwise stronger Cape Clothing Industry. The regional employer organisations were made increasingly aware of the developments in other areas as a consequence of their regular meetings in connection with negotiations. By this stage, SACTWU had made some progress towards its aim of a single national Industrial Council for the clothing industry. The clothing ICs now combined for negotiations, though the separate councils remained. The union operated with a single negotiating team, composed of regional representatives and national officials, while the employers caucused together but did not field a single team.¹⁷

¹⁷ Each union region drew up demands, which were combined into one national set of demands. The settlement was an overall offer for the whole country, divided slightly differently in each region. A

The Natal employers' belief in their Fund's 'economy' was founded on Dr Mall's efforts to hold costs to a minimum.¹⁸ He, in turn, believed that his success in containing costs would incline the Committee to agree to his proposals to expand certain benefits.¹⁹ However, far from recognising his efforts, the chairman of the employers' association believed that there was still some 'fat' in the system and urged me to seek additional savings on the drug bill.²⁰ Ironically, the task of restructuring would have been easier had Dr Mall been less successful in keeping costs down in the past: contributions would have continued to rise with wages and there would have been savings to make, which could have been applied to improvement, offsetting part of the total cost of the restructured benefits.

The Fund was poorly managed, with particularly weak financial and statistical information systems. There were serious problems with the extent and accuracy of Sick Fund documentation, other than that obtained from the medical director (see below). The medical information was not computerised - in fact, little of it was processed, given the nature of record-keeping in the clinics. (Much of the information was provided in the form of handwritten notes.) This made for difficulty in analysis, particularly in terms of tracking trends over time. The Secretary of the NCIC was a particularly problematic figure. He was unreliable on deadlines and slow in responding to requests for information or assistance, failing to carry through certain crucial agreed

region might decide to put more of the increase towards the provident fund or sick fund, to reduce the gap between itself and the 'leading' region.

¹⁸ Interview with Len Smart, director of the NCMA, Durban, 1 April 1993.

¹⁹ For example, Dr Mall had submitted a proposal to improve the lamentable dental benefit, which was ignored.

²⁰ Interview with Len Smart, director of the NCMA, Durban, 1 April 1993.

tasks. His position was under threat throughout this period, particularly from the union, and his insecurity expressed itself in unco-operativeness.²¹ This created great difficulties during the research process, especially given my Cape Town base.²² A more fundamental problem only emerged after he left the Fund in mid-1995, when it was discovered that he had grossly overestimated real income.²³ He had premised all budgets on 100% collection of contributions, though the collection rate was only 50-60%.²⁴ In addition, he failed to take account of short-time (relatively widespread during this period) and employment records were seriously out of date which, in a shrinking industry, resulted in a major over-estimation of income due. As a result, the budgets made no sense at all and the likelihood of implementation of the recommendations of the Report dwindled.

The production and presentation of information is key to decision-making by the SFMC. The CCIC and NICLI produced substantial agenda documentation, including standard reports on utilisation and exception reports, and detailed financial reports (comprising monthly and year to date actual expenditure against budget, revised projections and cash flow analyses). They also produced semi-verbatim

²¹ For example, in a crucial research trip to Durban in February 1994, he was repeatedly unavailable to meet with me, though the trip was planned in advance and lasted a week. He spent the final day at a cricket match.

²² Distance is not in itself an insuperable problem, as was obvious in the NICLI study. The leather IC is based in Port Elizabeth, some 750km from Cape Town and the study also involved work in Durban, Pietermaritzburg, Johannesburg and Great Brak.

²³ He resigned from the Council, under some pressure, particularly from the union. (Interview with Berlin Nyager, Durban, 23 January 1997)

²⁴ The low collection rate was a further indicator of poor administration. All ICs have trouble recovering fees due, especially from small companies, but this recovery rate was so low as to cripple the Fund.

minutes.²⁵ The custom in Natal was to run a series of meetings on the same day, dealing with Sick Fund, Provident Fund and other issues. (For a while, the union proposed merging all the committees, but settled on a policy of using the same delegation to all the committees.) As a result, there was a palpable time pressure. The NCIC documentation was extremely skimpy, with no regular financial reporting of actual expenditure. Minutes were short, recording decisions only, without record of debate.²⁶ Meetings too were short, considering the importance of the issues, and were frequently postponed or cancelled.²⁷ In a well-run Fund, minimal documentation and short meetings might have indicated streamlined efficiency, in a weak Fund they hinted at lack of knowledge and control.²⁸

An active Sick Fund Management Committee (SFMC) would have identified the Secretary's administrative weakness and taken steps to counteract it. But neither party engaged sufficiently: the history of union neglect has been described above and the employers on the management committee, though managers themselves, appeared to focus exclusively on authorising and tracking expenditure to the exclusion of other management issues, including even the basic one of checking income.

²⁵ The meetings were taped and verbatim records called up in times of disagreement.

²⁶ The new Secretary, Mr Harrison, expressed satisfaction at his 'efficiency' compared with the ponderous procedures of the other Councils, citing the brevity of his minutes and agenda documentation (Interview with Mr WH Harrison, Durban, 23 January 1997).

²⁷ Anecdotal reports from union officials about the brevity of SFMC meetings was confirmed when Mr Harrison became involved in August 1995 and instituted a system of recording meeting times. Most meetings were completed in less than an hour, at a time of major financial crisis for the Fund. (Minutes of SFMC meetings, 1995 and 1996.)

²⁸ The other Funds were probably over-documented, though this was, of course, immensely helpful to a researcher. The standardised nature of reporting, in particular, facilitated analysis.

The mandate for this study was to investigate the extension of medical benefits to the dependent children of members. While the union (or more specifically, the union leaders who spearheaded the project) wanted a fundamental examination of the whole benefit structure, the employers had insisted on the narrow remit which became my formal brief. I attempted to manage this conflict by blandly assuming consensus on the statement that recommendations for cover could not be made in isolation: while the primary focus was on provision of cover for dependent children, the framework would be the existing provision for primary members and this would inevitably be subject to analysis and, where appropriate, recommendations for re-structuring. With hindsight, this was a serious mistake: avoidance of the underlying conflict did not dissolve it and it came back to haunt the project. Employer resistance compounded with worker resentment to form a potent barrier to change.

4. *A summary of the project*

The introduction of the unfunded maternity benefit after the 1992 wage negotiations depleted the Fund's reserves to such an extent that other developments were rendered unfeasible without major re-structuring.²⁹ In the 1993 wage negotiations, the Sick Fund once again lost out to other demands. The only

²⁹ The deficit was more than R700,000 in 1992 and more than R900,000 in 1993.

development was a further contribution increase.³⁰ This heightened the resentment of the membership, who believed that they had already paid for improved benefits and even dependant cover and were now being further burdened, while the promised improvements seemed as far away as ever. Unfortunately, the increase was nowhere near large enough to fund improvements. In fact, it was not even sufficient to restore the reserves, slashed by 70% in one year. Once again the project was deferred, this time by six months. The formal study was completed in the period January to June 1994 and the Report was submitted in time for the mid-year wage negotiations.

From the start, the raw material of this project was unpromising. The benefit structure was similar to that of the other IC Funds, with a few features which exacerbated the difficulty of transformation, especially the payment system for panel doctors described below. The financial constraints were stark: a very low contribution base, shrinking reserves and unrealistic expectations from both members (expecting major improvements with no further increases) and employers (expecting further savings from a very lean fund). Given the financial position of the Sick Fund, the hope of cost-free change of a positive nature was unrealistic in the extreme. Like the other Sick Funds, it operated on a low funding base but it also had certain peculiar problems. Contributions had not been increased for a number of years, thus losing ground against inflation. The NCIC faced the prospect of re-structuring with shrinking reserves, unlike the CCIC which had the useful buffer of the Dependants' Fund.

³⁰ The 1993 increase was from 0.7% to 0.95% of the weekly wage (from R1.54 to R2.28 pw for machinists).

To make matters worse, two other sources of finance were also ruled out. First, it was still locked into paying sick pay.¹¹ In the Cape, moving to BCEA sick pay had released substantial funds for redirection, at the cost of a negotiated reduction in the wage increase for one year. A similar deal was ruled out in the NCIC, because of employer resistance (fuelled by reports from Cape employers of the inflationary impact of the change to BCEA sick pay) and economic conditions, which rendered unlikely a wage increase large enough to make a once-off reduction (in return for the changeover in sick pay system) acceptable to workers.

Second, the nature of the panel contracts in the NCIC meant that there was no potential to save by moving patients to clinics. Like the CCIC, the NCIC operated two clinics alongside a panel system. Members had to register with either a specific panel doctor or a clinic.¹² Some 13,000 of the total membership of 33,000 chose to register with one of the 14 panel doctors who were contracted by the Fund at the time of the study. The NCIC panel was paid on a capitation basis (a fixed fee per member per month, regardless of usage), whereas the CCIC and NICLI funds paid their panel doctors on a contracted fee for service basis and could make substantial savings by moving to clinics. Moving NCIC panel patients to clinics, while it could improve quality of care, would actually be an extra cost rather than a saving. Nearly half the

¹¹ Sick leave conditions fell between the CCIC and NICLI, paying 50% of wages for 40 days a year. The first two days were not paid, even in a longer illness. Sick pay accounted for 36.4% of Fund expenditure in 1992 and 28.2% in 1993, total payout falling by 13%. The decrease was probably largely related to a drop in employment during this period and reluctance to take sick leave in times of high retrenchment. Though retrenchment procedures are negotiated, worker anxiety persists and there is a tendency to avoid being conspicuous in any way.

¹² In the Cape Clothing and Leather Funds members could consult any of the panel doctors and/or the clinics.

membership were serviced by private doctors at a remarkably low rate. Unlike the panel doctors in the CCIC and NICLI, doctors could not become rich from this Fund. The limited number of doctors on the Natal panel (14 compared with 96 in the CCIC and 325 in NICLI, which had a similar membership) was due in part to Dr Mall's close management of the system but rather more to the financial arrangements (the CCIC and NICLI had a constant stream of applications from doctors wishing to join their panels).⁴³ On the other hand, their risk was limited (as the Sick Fund supplied drugs to them directly for dispensing) and quantifiable (as they controlled access to their own patient lists). They had, on the whole, been persuaded into joining and remaining on the panel through religious connections, as a charitable gesture.⁴⁴ The payment system and level had both negative and positive spin-offs: though the artificial cheapness of the system meant that switching to a clinic system would increase rather than reduce costs, the Natal doctors were highly unlikely to undermine the re-structuring process, as it posed no threat to them but rather relieved them of the burden of charity. Unfortunately, the Sick Fund was built on the basis of this uneconomic model, which had enabled contributions to be held at unrealistically low levels for many years.

⁴³ In the CCIC, the highest earning panel doctor made R44,000 from the Sick Fund for October 1992 (Cornell 1993). In the NICLI, the panel doctor in Great Brak earned R280,000 from the Sick Fund in an 18 month period from January 1991, 85% more than the total contribution income from the 650 workers on his list (Cornell 1992).

⁴⁴ The SMO is a devout Muslim and confirmed to me in discussion that he approached doctors on the basis of community duty.

The methodology for this study was constrained by time limits, a limited research budget, access to reliable data and distance.³⁵ Trips to Durban had to be carefully scheduled and were relatively inflexible, which made postponement or curtailment of meetings (markedly more frequent in the time around the election) more problematic. This also increased my reliance on the Secretary, unfortunate in terms of his efficiency and reliability. The problems of administration were highlighted in the ill-fated dependant survey, undertaken when the Council's updating of Provident Fund records was delayed indefinitely. Instead, a sample survey was planned, and failed spectacularly. Because of time and budgetary constraints, the survey had to be designed to be administered by Council staff, who normally visited factories in the course of their duties. The process was simplified to reduce the possibility of error. A briefing was provided for the Council agents, together with a list of factories to visit, stressing particularly that they must involve the shop stewards in each factory and explain the purpose of the exercise to workers in order to gain their co-operation. The Secretary was responsible for informing employers, briefing the agents, keeping them to an agreed timetable, and overseeing data entry. However, Council staff ignored instructions to involve shop stewards in administering the questionnaire, a vital condition given the history of member dissatisfaction with the Sick Fund and a prevalent reluctance to provide personal information to sources regarded as official.³⁶

³⁵ There was a great deal of pressure to complete the Report before the 1994 negotiations (mid-year). This was the only project in which a cost limit was imposed from the start. This would have been an even more serious constraint had donor funding for the HRCG not subsidised the consultancy fee.

³⁶ Suspicion of official questioning goes far beyond the Sick Fund: the South African census has always suffered in accuracy as a result.

As a result, the process aroused hostility and suspicion amongst members (which was fuelled by rumours that current contributions would be multiplied by the number of dependants), and the apparently straightforward aim of gathering information on dependants and residence was frustrated. Mel Clark embarked on a damage-limitation exercise, issuing a series of explanatory pamphlets, a poster and a letter to accompany the questionnaires to each factory.¹⁷ The issue was also discussed in a number of union fora, in order to dispel misunderstanding amongst the membership, and a task group was appointed, with one shop steward from each local branch, to assist in the process. Despite this involvement, the membership survey could not be rescued and the information it yielded revealed a number of flaws, which meant that it could not be used to project dependant patterns to the membership as a whole. As a result, a survey of tax records was undertaken in four large companies and this was used as the basis for calculation of dependant numbers. Progress was also impeded by the crudity of the record-keeping systems employed (with no computer records at all for the period leading up to the project), the paucity of information from the Council (and some doubts about the quality of such information as was available) and the lack of backup from the Council itself (in direct contrast to the attitudes of the CCIC and especially the NICLI administrators).

¹⁷ The letter addressed the fears of members, explaining the need for the information and ending in classic union style: 'Forward to treatment for the children!!! Forward to a better Sick Fund for all!!! Long live SACTWU, Long live!!!' (Circular letter to members, SACTWU, Durban, February 1994.)

Despite the problems of the research, a Report was produced and presented to the Industrial Council for consideration (Cornell and Lewis 1994). The central recommendations were:

- upgrading of the existing clinics
- establishment of a network of neighbourhood clinics
- retention of a limited panel system
- incorporation of dependants into the clinic system

It was six months before a joint employer-union workshop was held to discuss the recommendations in the Report, in December 1994. By this time, another round of wage negotiations had been completed, again without agreeing an increase in contributions sufficient to fund any real improvements. At the workshop, the employer response could be described as polite stonewalling: they approved the approach in broad outline but referred all decisions with cost implications to wage negotiations. As wage negotiations happened mid-year, this put implementation on the back burner again. This was a time of shrinking employment in the sector, which inevitably compounded a reluctance to change, which was then further justified by reference to uncertainty about state policy on health care and its funding (Dobson 1996; Rossouw 1997). The only issue on which there was some progress was moving the clinic downstairs: Dr Mall was instructed to investigate the costs in detail. It was clear that the employers saw no further role for me: I had completed the investigation and implementation was not my concern, an assumption which was not forcefully

challenged by the union. Though I had further informal contact with the union and Dr Mall, it was clear that the process had ground to a halt.

This impression was confirmed by a follow-up visit in January 1997, when I interviewed the new Secretary of the Council and the union official who had taken over responsibility for the Sick Fund from Mel Clark. There had been very little progress in the intervening two years. The Gale Street clinic had moved downstairs into expanded and upgraded premises, though these were not fully used, due to lack of funds. For example, there was now an well-equipped dental surgery, including facilities for an oral hygienist, but the dentist was still employed on a sessional basis, offering an unchanged limited service, and the oral hygiene surgery had never been used. The proposal to move the Lorne Street clinic to a residential area had died a slow death. Dr Mall was clearly trapped in an unchanged position: all the work of administration of the clinics fell on him, but his role was still undervalued. The new secretary spoke slightly of him as being 'overpaid'. This was an interesting perception, as Dr Mall was being paid less for a full-time clinical and managerial role than the Secretary was making in a part-time contract post. The new Secretary had been appointed to modernise the Council's operation and, in the case of the Sick Fund, to stage a rescue operation. However, under his management, the Sick Fund had not only wiped out all its reserves but accumulated a debt of R3 million. His response was to present a rescue scheme to the SFMC meeting in November 1996. This 'management plan' contained a number of recommendations, designed to improve income and curb expenditure.

The recommendations were, in summary:

- improvement of collections (R750,000 was owed)
- marketing of services to other Sick Funds (for example, the leather and laundry industries)
- shelving dependant cover (cost projections had now risen to R3.8m)
- limiting the maternity benefit
- limiting or eliminating chronic medicines
- further restricting sick pay
- restricting or eliminating free care for retirees
- imposing a levy for medicines (R5)
- considering closing the Lorne Street clinic and retrenching staff

Though he proposed suspension of the maternity benefit for six months, the Secretary calculated that it would take at least two years to repay the debt (during which time there could be no improvement in benefits) and he assumed that the suspension would be permanent. It was clear that the paralysis which afflicted the Fund had continued and worsened. Instead of expanding, the Fund was considering contracting and cutting benefits, even the maternity benefit. Though this drastic step was not taken, it was startling that it was even suggested, in a largely female industry. The Secretary put a figure to usage, saying that 'only' 3.7% of the membership drew maternity benefit in a year, and used this to back his argument that this was the most sensible target for economy. The SMO had always been somewhat ambivalent about

the maternity benefit, arguing that it was too expensive, absorbing resources which could better have been applied to improving the dental and other benefits for all members.³⁸

Minutes of SFMC meetings in 1996 reveal the employer representatives distancing themselves from responsibility for the state of the Fund or attempts to rescue it. In February, 'It was noted again that the economics of an extension of Sick Fund services were to be established and considered for inclusion on the agenda for annual negotiations.' (SFMC Minutes February 1996) Given the history of Sick Fund demands in negotiations, this was likely to result in no action at all. In March, the employers reiterated their support for extension of services, but on condition that these were 'self-funding as much as possible' (SFMC Minutes March 1996). This was an entirely new proposal and out of place in a joint structure: if workers were to fund the benefit extensions alone, employers clearly had no right to be involved in decisions about benefit structure. There were no meetings of the SFMC between March and August, largely because of an industry-wide wage strike.³⁹ When meetings resumed in August, the employers once again urged that a decision be taken once and for all, but only on a self-funding basis. The union was understandably reluctant to follow this route and, in the event, the question became irrelevant in the face of the financial crisis, which was considered seriously for the first time. It is unclear why it took so long,

³⁸ He expressed particular resentment at the fact that he had motivated his staff to accept low salary increases on the basis that the increased reserves would be used to establish a new clinic in the residential area of Clairwood and these reserves had been 'blown' on maternity pay. (Notes of meeting with Dr Mall, Durban, 2 April 1993)

³⁹ The union settled for 8.5% on wages and 0.5% on bonus, plus an increase of 1% in the employer contribution to the provident fund (Collins 1996).

given the fact that the fund had been losing steadily for the past 6 years. The new Secretary had been in office for more than a year at this stage, sufficient time to uncover the real financial situation. Against this background, it was highly inappropriate for the union to take sole responsibility for rescuing the Fund.

7. Assessment

Delays and shifts in the timing of research are standard in union-generated projects, but in this instance they had particularly negative effects. In the Cape, the major delay (in implementing the change to statutory sick pay, via the BCEA) had been balanced by the establishment of the Dependants' Fund, which massively strengthened the Sick Fund's financial viability and capacity to accommodate change. In Natal, the delay was due to the impact of the unfunded maternity benefit, which drained reserves and significantly weakened the Fund's viability. All the while, members' unrealistic expectations, undamped by the union, fuelled a growing dissatisfaction. Most significantly, the delay shifted the study into 1994, with political change looming.

The political climate influenced this study in marked ways. The imminence of the first democratic election, set for April 1994, had a pervasive effect: big change both overshadowed and threatened little change. In the face of galvanic national political change, it was difficult to engage officials, shop stewards or workers in the process of re-structuring something as small-scale as a simple sick fund. While the

CCIC study had its roots in the apartheid era, when the state's reluctance to upgrade health services for working class people challenged the union and presented it with a clear field for action, the NCIC study began in a radically different time. By early 1994, with a new government in the offing, worker expectations were at a high pitch, but they were focused on government for once, rather than the union (Ginsburg et al. 1995; Torres 1995; Isaacs 1995). At the same time, employer fears about the electoral alliance of the ANC, COSATU and the SACP and its influence on the economic policies of a future government reinforced their caution about any change with financial implications. This caution was underlined in relation to the Sick Fund by a belief (shared with union leaders) that the new government was likely to impose some new legal requirements in terms of health care for workers - National Health Insurance was often mentioned by employers and unionists - and employers were reluctant to commit themselves to expansion until they knew what government would impose on them.

The election period was particularly complex and extended in Natal, where the levels of violence were such that predictions of full-scale civil war did not seem exaggerated. In the end, the election had to be postponed in this province and there were widescale reports of intimidation and fraud, alongside the endemic violence. The union had extensive commitments in the run-up to elections, with some leaders seconded to the Independent Electoral Commission, and a great many officials and shop stewards involved in programs associated with the elections (Buhlungu 1994a).⁴⁰

⁴⁰ John Copelyn, long-time general secretary of SACTWU (and previously of NUTW) was one of the COSATU 'list' of official trade union candidates, submitted to the ANC as part of the electoral

This meant that meetings were more erratic than usual, and a number of key figures were absent. The absence of key worker leaders had a ripple effect - not only were they not drawn in as a conduit to and from workers, but when they did return to union life from election activities, some were suspicious about processes which had gone on in their absence. The meetings which did occur were infected with the uncertainty, anxiety and excitement of the time and it is not surprising that the Sick Fund issue failed to ignite widescale commitment, or even interest.

This chapter underscores the significance of the genesis of a project. The contrast with the way the Cape Clothing Industrial Council (CCIC) project arose is particularly marked: that project was grounded in years of work and discussion inside SACTWU and its precursors, before a formal study was ever undertaken. Though the same union was involved, the Natal Sick Fund lacked the historical and political significance that the Cape Sick Fund exerted in relation to union role. As a result, action to restructure it was less powerfully motivated, more narrowly focused and more easily derailed. Despite the energy and involvement of at least two key union officials, the Fund failed to engage the interest of a broader group of union officials in Natal. The legacy of worker disillusionment and dissatisfaction made the Sick Fund an unpopular issue, without powerful supporters among the union leadership at the branch level. As a result, though Sick Fund-related issues were placed on the list of

alliance deal. In addition, many other unionists (both officials and workers) stood for election on the general party list. In the process, the union movement lost a cadre of experienced leaders to government, a process which has continued since the election. Voter education was a particular priority for the union. The electorate was expanding from whites only to the whole adult population, so there was a massive group of first time voters, including SACTWU's entire membership. To add to the task, the voting format hammered out in negotiations was complex.

demands for bargaining every year, they were the first to be sacrificed when the horse-trading began. The lack of interest at negotiation time was a mirror of the discontinuity of responsibility for Sick Fund issues within the union and the low level of involvement in SFMC meetings. The SFMC system was cumbersome, but it offered some potential to exert influence (if not absolute control) over finances and the nature of services provided. The union did not use the potential powers of the SFMC structure, leaving financial management to the Secretary of the Council and medical management to the medical director of the Fund.⁴¹

This study also highlights the way in which research relationships impact on the outcome. In comparison with the CCIC and NICLI studies, my involvement with this Fund was very limited. There was minimal contact prior to the study itself and during the study there were major problems with both the extent and the regularity of contact at different levels in the union. These factors combined to produce a significant divergence between the stated purpose of the study and the realistic scope for intervention. The notional task was to meet the expectations of both workers and employers for dependant cover and better benefits for existing members without further increases in the base contributions. Realistically, the most that could be hoped for was to restore financial viability to the Sick Fund in its present form and to persuade the parties that substantial change would require real increases in contributions and real involvement in managing the affairs of the Sick Fund. In the event, the project failed to meet even this scaled-down aim. There was a model,

⁴¹ For example, the union had failed to examine financial statements critically, assess the standard reports presented to the committee, or respond to Dr Mall's proposals and pleas.

developed and refined by experience, and the project was backed by at least two committed union officials but it was not grounded in the relationship between union leaders and members. Though there were external reasons for failure (including the timing and style of the research process, the state of the industry and events on the national political stage), and internal reasons (including the structure, staffing and financial basis of the NCIC and the Sick Fund), the crucial flaw was in the union's relationship with the project.⁴²

The final study in the next chapter examines the issues of joint management in the context of a far more complex situation, in which ten very different unions are drawn into a Board of Trustees to save a much larger and more elaborate scheme from disaster.

⁴² Continuing problems of political violence and economic restructuring face the trade union movement, which has also been weakened by the ongoing leadership brain drain. See for example Buhlungu (1994b), Sitas (1995), Lesufi et al. (1995) and Clark (1996).

Chapter 7. Transmed

1. *Introduction*

This chapter reports on a study of a trade union project in which both process and outcome were coloured by a complex and shifting balance between ten very different trade unions. The project of restructuring a medical scheme was one of the arenas in which a much broader struggle between unions played itself out. Inter-union relationships were characterised by a tension between solidarity and sectionalism, giving rise to strategic alliances, fragile truces and significant silences. This study raises questions about the implications of union involvement in a multi-union context where the workforce is very diverse, and reveals the possibility that union solidarity may mask and even compound inequality. It also draws attention to the attenuated relationships that may develop between leaders and members on an issue like health care.

The project was the restructuring of Transmed, the in-house medical scheme of Transnet, the state-owned transport conglomerate.¹ The company (previously the South African Transport Services - SATS) had commercialised in 1990, as a first step towards corporatising on the basis of divisions, and the longer term aim of privatising (SALB 1992c; Makgetla 1995; Ray 1997). The company had no history of bargaining about health care, and the creation of a structure in

¹ Transnet incorporates Portnet (harbours), Spoornet (all rail services except local passenger services), Autonet (road freight from ports), PX (parcel express), Transwerk (maintenance), Petronet (oil transportation), Metro (local passenger rail services) and Transtel (cellular communications).

which to tackle the issue was an integral part of the project. The Transnet workforce was extremely diverse, as was the range of trade unions operating in the company. There were thirteen unions in all, ten of which had representation on the Board of Control (the others were very small). At one end of the spectrum was a union for pilots; at the other a union whose membership base was largely manual labourers. There were major differences in organisational style and resources, bargaining style and skills, and political affiliation within the range of unions. Though all ten unions declared themselves non-racial, in practice membership broke down roughly on a racial basis reflecting the division of labour prevalent in South Africa prior to the change in government: three unions organised largely unskilled and semi-skilled workers (two with overwhelmingly African membership and the third with a largely coloured and Indian membership); the other seven unions organised the rest of the workforce and had overwhelmingly white memberships. I was drawn into the project by SARHWU, the largest union in Transnet. SARHWU's membership was larger than all the white unions combined. Recognition by the company followed two bitter and bloody strikes in the 1980s, which established the union as the radical voice of black workers, in contrast with the compliant unions which had previously been recognised for the purposes of negotiations (Baskin 1991; Green 1986).

On the whole, the unions operated within natural constituencies, with little overlap.² The competition between them was not for members but for resources. Transnet, as a commercialised state company, was facing conflicting demands. On

² The white unions had agreed on a delineation of recruitment and membership and did not overlap with each other at all. SARHWU's base was unskilled workers, but it had started to recruit across skills levels and business units as employment practices shifted in the company and black workers started to enter other areas of work.

the one hand, the centrality of transport to economic development meant that there was great pressure from government to streamline the company, increase efficiency and cut costs. These were also seen as necessary steps towards privatisation, for which Transnet was being seriously considered (Wackernagel 1997). On the other hand, as a state-owned company under a new government it was under pressure to shake off its racist past and redress the deep-rooted inequalities which characterised its labour practices. The provision of health care benefits for its employees and ex-employees was one of the areas of discrimination: current employees were in five different medical 'Plans' with very different benefits and some 25,000 current employees, almost all black, had no cover at all. Discrimination amongst pensioners was even more extreme: while some 50,000 white pensioners enjoyed sophisticated full benefit medical aid funded by the company, at least 14,000 black pensioners had no cover at all.¹

This study opens up a number of crucial and uncomfortable questions about the differential uses and effects of union solidarity. Where there are significant material differences between union constituencies, it may be counter-productive to submerge sectional interests (especially those of the least advantaged group) too soon or too completely. The contrast with the leather project is striking: though that was also a multi-union situation, the workforce was homogeneous and there was a single medical scheme with uniform benefits for all workers and union solidarity benefited all workers equally. This was not the case in Transnet, where the different unions represented constituencies with very different wages and

¹ Pensioners who retired before 1991, when the company was commercialised, were funded 100% by the company, with the exception of a voluntary top-up plan ('re-insurance').

conditions, who had access by virtue of their income to very different health care arrangements. Given the economic constraints, developments which improved the situation of the lowest paid workers threatened the position of unions whose members had enjoyed more elaborate benefits. These unions invoked union solidarity to block changes which threatened to erode their position, thus preserving an unjust situation and effectively pursuing a sectional agenda.

The themes of threatened loss and need to redress injustice which characterise this project echo the larger project of national restructuring in South Africa. The Transnet workforce (present and past) is a microcosm of South Africa's heterogeneous population, with all its class divisions, coloured by a history of complex racial distinctions. As in the national process, this project involved restructuring health service provision in the context of a financial deficit and redistribution between groups, concurrent with the development of new structures for decision-making and involvement of the users of health services. Unlike the Industrial Council studies, there was no pre-existing structure for decision-making: a new structure had to be developed to accommodate a far more complex set of employer-union relationships and this had to be done rapidly, given the major financial implications of delay.

The project faced difficulties of a different order from those of the relatively simpler Industrial Council studies, with their limited and uniform benefits and modest budgets. The IC projects involved improvement of benefits from a very low base, working 'upwards' as it were, while the Transmed project involved, in essence, a narrowing of choice for members: those who had 'lost' were aggrieved and those whose access to benefits had improved were also not satisfied while

differentials remained. The suspicion was heightened by the re-design of benefits, which made precise comparisons of entitlement between the old and new scheme difficult and added uncertainty to the sense of loss experienced particularly in the white unions.

Transmed, with its multiple tiers of benefit and mix of private and public sector health care, mirrored the problems facing the Department of Health in developing a strategy for the country as a whole. The sheer size of the problem in Transmed was daunting: with 151,000 principal members and nearly half a million beneficiaries in total, this is one of the biggest medical schemes in the country, even before incorporating the substantial group without cover. The scheme's income for January to September 1996 was R636 million. While the Board of Trustees struggled to come to grips with the problems involved in restructuring both benefits and contributions, *monthly* losses rose as high as R20 million a month, three times the *annual* income of the Natal Clothing Sick Fund. The enormous difficulty of restructuring one element of welfare provision in one company (albeit a large national company in a sector central to the economy) highlights the complexity of nationwide change and the problem of generating and implementing a model to suit all situations, while retaining union involvement.

2. Background

History cast a long shadow over this project. There were two previous eras of medical benefits in Transnet. In the first, differentiation was on explicitly racial grounds. Medical benefits were originally introduced as part of a policy of

protecting white labour. The railways was one of the last enclaves of protection for the white working class (mining was another), and was characterised by low wages, but job security and good benefits for retirement, disability and illness. White workers' families were included in the social security net and the railways had a tradition of family employment which still survives. The medical scheme provided for these workers initially bore some resemblances to the Industrial Council schemes, with relatively simple benefits and - crucially - a panel of doctors. Over time, these limitations were removed and the scheme developed into a full-scale medical aid scheme, with no direct provision of services with the exception of the network of 57 Transnet pharmacies. However, though the white scheme was developed, the scheme offered to black workers (the so-called 'blue card' system) remained crude. The blue card entitled black workers to very limited benefits, basically consultations with contracted 'railway' doctors and simple medicines dispensed by them. Workers' families were excluded from even this simple benefit, revealing clearly the institutional racism which permeated the transport sector, especially the railways.

The second era of benefits was ushered in when Transnet was commercialised in 1990. This time explicit racial differentiation was abolished and replaced by economic differentiation. Transmed 'modernised' the design of the scheme, introducing five different benefit options ('Plans') to replace the earlier stark division between the 'white' and 'black' schemes. The five Plans varied dramatically in the kinds of benefits offered, financial limits on coverage and contribution levels. Plan 1 was the lowest level, in its initial form incorporating

only primary care benefits and no hospitalisation. It was intended as an equivalent benefit to the 'blue card' system. Plan 2 was slightly broader and more generous in limits. Plans 3 to 5 became progressively more generous and elaborate.⁴ Though the five Plans were open to all, affordability created a barrier to access to the higher benefit schemes which was almost as impermeable as the racial barrier of the past.

When the five new Plans were introduced in 1992, all employees were asked to nominate their choice of Plan. The vast majority of black workers did not do so by the deadline. In an attempt to force their hand, Transmed threatened to close down the 'blue card' system and transfer all members who had not nominated a choice to Plan 1. This move aroused considerable dissatisfaction and deepened the suspicion with which black workers and their unions regarded the medical scheme. At this stage, the South African Railways and Harbour Workers' Union (SARHWU) asked me to assist in negotiations with Transmed. They also drew into the process the two other black unions, the Black Labourers and Allied Trades' Union (BLATU) and Transport and Allied Trades' Union (TATU).⁵ In the end, it was impossible to design a rational scheme from first principles (because of lack of information and company attitude), so we fell back on a compromise, using union muscle (the company was nervous of another strike) to force through some basic design changes in Plan 1.⁶ There was a deadlock on the question of equity,

⁴ Members of plans 3 to 5 could opt for 're-insurance': in return for a set monthly fee per family, certain limits on benefits were removed.

⁵ SARHWU involved the other unions for both practical and political reasons: practical, because many of their members were also in the 'blue card' system, political, to strengthen alliances with the other unions (with which they hoped to amalgamate).

⁶ In the event, we could have been far more radical, given this nervousness and their remarkable lack of figures to back their costings, but I advised against driving contributions lower on the

with Transmed management arguing with remarkable naiveté that the new design was equitable because all the schemes were open to all employees. The black unions, on the other hand, saw that whites had a long history of very highly subsidised generous medical aid coverage in a single scheme and that at the moment when membership was opened to all workers there were suddenly five Plans with very different costs and benefits. For a price close to that of the old white scheme, they were now offered far lower benefits. The resentment engendered by this unfairness coloured the attitude of union leadership towards the scheme. Though SARWHU managed to head off the Transmed proposal to transfer all 'blue card' holders to Plan 1, by default, members clearly indicated their dissatisfaction and distrust by staying out of the medical scheme in large numbers. This background is important, compounding as it did the general suspicion on the part of the black unions towards the operation of Transmed.

The white unions were also dissatisfied with the Transmed Plans and showed this by taking legal action to prevent Transmed raising contributions 'unilaterally'. There was an existing structure for collective bargaining in the Transnet Industrial Council, established in 1991 after a period of bitter industrial strife. However, instead of referring the Transmed issue to the bargaining structure, the company decided to establish a new and different joint body and assigned a senior manager in the Finance Department of Transnet, Jacques Schindehutte, the task of writing a constitution for a joint employer-union Board of Trustees for Transmed. The legal injunction lent urgency to the process as the

grounds that at some stage they would have to be made more realistic, and this would then involve a larger and more unpalatable increase for members.

scheme could not survive without some mechanism to implement member contribution increases.⁷ However, the prospect of drawing together in a decision-making structure ten very diverse trade unions, management representatives from a company in the process of dramatic restructuring and medical scheme administrators unaccustomed to accountability, was a daunting one. I was engaged as a consultant to this process, formally as a consultant to the employer and all the unions, but with an understanding that my primary connection was with labour.⁸

3. *The interested parties and their agendas*

The trade unions

Transnet was a multi-union employer and all the unions operating in the company, with the exception of the South African Railways and Harbour Workers' Union (SARHWU) were company-specific.⁹ The unions largely recruited from different groups, though there were some minor overlaps.¹⁰ The result was a very complex inter-union relationship, with a shifting balance of common and conflicting interests. The relationships of the different unions with the employer shifted dramatically in the period of the study: black unions' access to management

⁷ As the 'employer' contribution was a percentage of wages it increased automatically with salaries and wages.

⁸ My role is discussed in some detail in the methodology appendix.

⁹ SARHWU organised workers in two domestic airlines aside from SAA and in the Airports Company. An impending merger with the Transport and General Workers' Union (TGWU), set for early 1998, will bring together public and private sector transport in one union (Interview with Tsidiso Moshao, London, 21 September 1997).

¹⁰ This is markedly different from the leather industry, where the three unions competed for members.

increased, as did movement of black employees (sometimes trade unionists) into management, creating an interestingly nuanced set of relationships.¹¹

The unions involved in the medical scheme project were:

- SA Railways and Harbour Workers' Union (SARHWU), affiliated to COSATU, organising predominantly labourers, open to all but with a largely African membership base: 37,074 members¹²
- Black Labourers' and Allied Trades' Union (BLATU), affiliated to NACTU, organising predominantly labourers, with a largely African membership base: 7,076 members
- Transport and Allied Trades' Union (TATU), unaffiliated, organising mostly artisans, with a coloured and Indian membership base: 1,971 members

All of the following unions admitted black members, but were overwhelmingly white:

- Salaried Staff Association (Salstaff), affiliated to the Federation of Unions of South Africa (FEDUSA), organising mainly administrative workers and more recently middle managers: 10,253 members
- Tegniese Werkers Unie (Technical Workers' Union - TWU), affiliated to FEDUSA, organising mainly artisans: 11,122 members
- Voetplaat Werkers Unie (Footplate Workers' Union), affiliated to FEDUSA, organising train drivers: 7,933 members

¹¹ For example, the President of the union took a management position in the company during the course of the project.

¹² SARHWU had some white members (and at least one white official), but experienced the common problem of assimilating white members into union activities (Zikalala 1993a; 1993b).

- Engineering Union of South Africa (EUSA), affiliated to FEDUSA, organising the lowest skills levels among white workers: 5,037 members
- South African Airways Pilots' Association (SAAPA), unaffiliated: 142 members
- South African Airways Flight Engineers' Association (SAAFEA), unaffiliated: 1,909 members
- South African Airways Engineering and Artisans' Union (SAAEUA), unaffiliated: membership unknown¹³

My first task was to produce a commentary on the draft constitution for the unions. This commentary was circulated for responses, after which I ran a workshop for representatives from all the unions (attended by all except TATU) in which the issues were discussed, co-ordinated the responses into a single document and sent this as a labour response to the employer. The constitution went through many further adaptations, to accommodate changes in design, to meet the legal requirements of the Registrar of Medical Schemes and to fit with administrative procedures in the scheme.¹⁴ At this early stage, the principal issues from a union point of view related to:

- representation for unions: proportional or equal? (proportional representation would have favoured SARHWU and might have forced some of the smaller white unions to join forces for representation)

¹³ The SAA unions are not party to the IC. They operate a joint closed shop for the defined job categories and have their own bargaining forum. SARHWU has members in SAA and negotiates wages for these members in the IC, taking only division-specific issues like staffing levels to the SAA bargaining forum.

¹⁴ The final version was only signed in July 1996.

- division of the membership into different 'risk pools' and different Plans and consequent allocation of reserves and resources
- decision making: the nature of a quorum (simple majority or majority of each party) and decisions by simple majority or by larger majority for some issues
- the role and powers of 'experts' and of Transmed administrators on the Board of Trustees
- the powers of the Board, the Executive Committee and any sub-committees
- dispute resolution
- voluntary membership, withdrawal and re-joining
- definition of pensioner members

All ten unions had equal representation on the Board of Trustees. The minority (white) unions supported the position of the Transnet manager who drafted the constitution on this issue. Though his motivation was to establish the character of the Board as a non-bargaining forum, they clearly envisaged a bargaining forum and feared that proportional representation would weaken their position, given their size. Though SARHWU and the other black unions initially proposed proportional representation on the pattern of the Transnet IC, they eventually conceded. Like the white unions, they took their own agendas into the Board. Their fundamental scepticism about the medical scheme resulted in a conditional attitude towards the Board and they held in reserve the strategy of withdrawal if involvement did not produce tangible benefits for their members.

The white unions benefited from an undivided mandate: all their members belonged to the medical scheme, as did their ex-members. All had enjoyed high-

level benefits at very low direct cost and had no fundamental problems with the scheme as it was: their mandate was to retain existing benefits and hold contributions down.¹⁵ For the black unions, the situation was much more complicated and they operated with an unstable mandate. Unlike the white unions, their experience of the medical scheme was recent. A significant section of their membership had not opted for membership, was highly suspicious of Transmed as an institution and strongly opposed to any compulsion to join the scheme. On the other hand, union members who had opted for scheme membership were dissatisfied: the majority were in Plans 1 and 2 and were dissatisfied with the low level of benefits. The minority who had opted for Plan 3 were satisfied with the benefits but unhappy with the cost. The general mandate from black scheme members was not retention of the status quo, but rather return to the past (specifically to the highly subsidised, high benefit system previously open to whites only). The SARHWU leadership structures repeatedly questioned decisions of the Board, rejecting compromise and demanding that their trustees maintain a hard-line sectional position. This vastly complicated their task.

The employer representatives

One of the fundamental differences between the Transmed project and the Industrial Council projects was in the nature of employer involvement. In the IC projects, the employer representatives on the Sick Fund Management Committees had a direct economic interest in the outcome: some were factory owners, others

¹⁵ The majority of white employees and pensioners were in Plans 3-5, the high benefit plans. Plans 1 and 2 had very few white members.

managers directly answerable to owners. Those who came from the employer organisations were mandated by their members and answerable to them. In Transmed, on the other hand, the 'employer representatives' were simply employees themselves. Only one person from the employer group, the Chair, had more at stake, having effectively staked his personal prestige and perhaps his future with the company on the 'success' of the project: securing a deal, holding the unions to it and getting Transmed onto a sound financial footing.¹⁶ The real power on the employer side lay outside the Board of Trustees, at the most senior management level in the company, which was going through dramatic shifts in the period of the project. The change of government in 1994 had accelerated the pace of a process of change already begun in Transnet. At the most overt level, this involved a program of affirmative action in appointments and promotion in a company whose major section (the railways) had been a bastion of 'civilised' (white) labour. Less obviously, it resulted in a shift in company culture, with a great stress on 'transparency' and inclusiveness.¹⁷ Industrial relations had been professionalised relatively recently and experience of the new system was restricted on the employer side, with a residue of distrust and discomfort among the non-IR managers around the style and tactics of bargaining. During 1996, the management structure of Transnet was revamped. A new layer of executive directors (six black appointees, mostly from outside the company) was created, with responsibility for divisions and some overarching functions, such as finance.

¹⁶ He is no longer Chair of the Board of Trustees, a rotating position which has passed to the General Secretary of the SAA union. He has recently been appointed Principal Officer of Transmed, reporting to a new Chief Executive.

¹⁷ The company took some time to shake off the old culture of secrecy: in 1992, acting for SARHWU, my difficulty in extracting routine information from Transmed was only overcome by

Some of these appointees were uncomfortable with the structural implications of their position in management, especially in relation to the black unions.¹⁸ During the course of this project the position of the managing director changed fundamentally: at the beginning, he was still in power and was approached directly by the Board with a request for financial assistance, later, though he retained nominal power, real power shifted to the heir apparent to whom subsequent requests were directed. The company was committed to a policy of affirmative action, attempting to transform a traditional white-dominated structure to a 'rainbow nation' workforce. These changes were visible to some extent in the choice of employer representatives for the Board of Trustees, including a number of black managers. However, there was some distance between the new management and the Board members supposed to represent them, which manifested itself at several decisive moments, described below. The employer representatives were chosen for a range of reasons, including experience in fields regarded as relevant to the business of the Board (for example, legal and accounting expertise). They were neither formally mandated with an employer position, nor did they report back to management structures. In effect, they acted in their individual capacities. The imbalance in power and accountability between union and employer representatives was a repeated source of frustration to the unions.¹⁹

the intervention of the head of the IR department. In 1996, information was often equally difficult to obtain, even with the authority of the Board of Trustees.

¹⁸ Most of the new black managers would have been ANC supporters. This, and a shared experience of racial segregation, made the black unions closer to them.

¹⁹ The lack of employer mandate continues to be a problem, raised explicitly on the Board. The ex-Chair has suggested that employer representatives should confer with the Executive Director (Finance) for their mandate (Interview, Tsidiso Moshao, London, October 1997).

The administrators

In the past, the medical scheme had been part of the larger bureaucracy of a government Department, the South African Transport Services (SATS). When the company was commercialised in 1990, Transmed was defined as a separate division and required to function as a commercial company. The separation was, in fact, more notional than real, as the ties and overlaps between Transmed and the rest of the company survived, along with the operational style of the past. Technically, the administration company could have been replaced by a commercial administrator (many of whom offered lower rates), but practically, the change posed enormous difficulties. In addition, the staff of Transmed were organised by the unions which operated in the rest of the company, who were consequently torn between their desire for competent and competitive administration and the need to protect members' jobs.

Rumour and alarm were quite as powerful and disruptive amongst Transmed staff as in the scheme's membership. It was a large organisation with an extensive hierarchy. In the course of the project, there were a number of meetings and workshops with staff. The company policy of affirmative action was far less obvious in Transmed than in some other divisions and it retained the traditional white Afrikaner-dominated staff pattern well into the project. Towards the end of my involvement, there were some changes, including the appointment of a black woman as chief executive and the promotion of black staff in a few key positions.

The lack of engagement in, and enthusiasm for, the project was problematic, given the major administrative tasks involved in a fundamental change

in benefit design. Lack of commitment went to the top of the organisation, with the Executive Manager announcing his resignation and rapid departure two months before the launch of the new scheme.²⁰ An exception to this lacklustre rule was the computer division, which seized on the challenges with relish.

Outsiders at the table

The analysis and re-structuring of the Fund necessitated expert actuarial consultants. The process of appointment prefigured the joint operations of the Board (which had not yet been constituted). The manager who had drafted the constitution proposed a company with which Transnet had an existing consultancy relationship. The unions were suspicious of this relationship and questioned the consultants' independence. In the end, several consultants were put through a joint vetting process, at the end of which Old Mutual Actuaries and Consultants (OMAC) were appointed, with Heather McLeod, an actuary specialising in health care, as principal consultant.

As in the IC projects, my involvement in this project was rooted in a longer term relationship with a trade union, then extended to include a broader group of unions and a parallel relationship with the employer party and, in this case, with other consultants. However, my role was substantially different: I was a watchdog, interpreter and mediator, while OMAC did all the analysis and produced designs and costings. This project was notable for the complexity of the Board's relationships with 'experts'. Unlike the IC projects with their simpler parallel

²⁰ Ironically, he left to take up a post in managed care for the largest medical scheme administrator in the country. His departure was something of a relief, but did nothing for staff morale.

relationships (formal with both parties via the SFMC, informal with the union outside this structure), Transmed could more easily be characterised as a web. Besides the relationships between OMAC and the various parties, and myself and the parties, there were other more shadowy experts around, in the form of consultants drawn on by the white unions at various points, or flourished by different (white) pensioner groups.²¹ OMAC's task was, in the first instance, to unravel the workings of the administrator, in order to track income, utilisation of benefits and expenditure by each of the five Plans. Usage and expenditure was then broken down further by age, income and family size, and by category of expenditure. All of this information fed into the design of a new benefit structure and proposals for restructured contribution tables.

The Working Group

A Working Group was tasked with the ongoing work of restructuring, meeting as necessary and reporting to the Board. The core group consisted of Jacques Schindehutte, Heather McLeod from OMAC and me (to represent labour) and others were drawn in as necessary.²² In the course of the project, we met about once a week on average, with the intensity and frequency of meetings gaining momentum as the implementation date for the new scheme approached. Alongside these meetings, there was a process of contact and work with the administrators, the pharmacy network, the Registrar of Medical Schemes, the

²¹ In addition, it emerged in time that the Chairman had engaged the consultant he originally nominated on a retainer basis, for additional advice.

²² Others who attended the Working Group meetings from time to time included, for example, other OMAC and Transnet staff, accountants, legal experts and so on, as well as the Transmed Executive Manager and computer staff.

national Department of Health, lawyers, managed care companies and other suppliers, in which I was involved. In addition, OMAC staff were engaged in ongoing analysis, design, projections and costings, which had to be constantly adjusted as the problems in the data supplied by Transmed emerged. I reported on developments in the working group to the labour caucus which became accepted as a standard feature, preceding each Board meeting. Labour caucuses were also called during Board meetings, when issues became explosive. On one crucial occasion, exasperated by contradictory opinions from employer Trustees, labour insisted on an employer caucus.²¹

3. The Task

In 1996, the new Board assumed responsibility for a discriminatory scheme, running at a deficit which the poor financial systems made it hard to estimate accurately. It was, however, clear that the scheme, with no reserves, could not survive without additional income. The Board's first task was to put together a rescue package to keep the scheme afloat, a task which tested its fragile equilibrium and revealed some of the tensions which would bedevil the whole process. The difficulty of the decision was exacerbated by the knowledge that this was merely a first step, to shore up the scheme while it was re-designed from scratch. The knowledge of fundamental change to come hardened the resistance of the white unions to any increase in contributions, which they saw as the first step in

²¹ This met with puzzlement and initial resistance from the Chair. I left the room with labour and the other consultants but was called back in (and cheerfully dispatched by the unionists) to assist in clearing the line.

the dilution of their benefits. In the longer term, the unions were faced with the inevitability of fundamental change in benefit design and the likelihood of change in the structure and size of the employer subsidy. In crude terms, this meant that at least some members would probably pay more for less. The basic options for funding were stark: either new resources had to be found or existing resources would have to be redistributed. The first option was unlikely, considering the cost of extending to the whole workforce the very high levels of subsidy afforded to white workers in the past. The new government wanted a leaner transport sector which would be attractive to private buyers and was concerned about the ripple effects of increases in transport costs. The second option - redistribution - fundamentally threatened the security of the membership base of the white unions. It was met with strong resentment, heightened by the company's history of non-market related salaries, which had been justified to workers on the grounds of compensatory security of employment and good benefits. A sense of frustrated entitlement and broken promises permeated the white unions' responses throughout the project.

The black unions also called up the past, in their case to highlight the extent of the company's historical debt to them resulting from low wages and minimal benefits, as well as broader discrimination on issues such as training and promotion. They also resented the cheapening of the medical benefit, precisely when they finally had access to it: what they wanted was what whites had had in the past, not a diluted and devalued version. Their constant theme was a need for positive discrimination to redress past injustices. The background of threats of

privatisation (either wholesale or by division) and additional downsizing raised the temperature and the stakes even higher.

The tasks that faced the Board were: devising an interim rescue package to keep the scheme afloat pending fundamental change; creating a viable and equitable benefit structure for the future; and accurately costing the benefits, taking into account company policy on subsidy and possible changes in the future.

Membership

The medical scheme had four categories of members: current employees of Transnet; Transnet pensioners (retired after company formation); South African Transport Services (SATS) pensioners (retired before company formation); private members (previously employed by divisions of SATS/Transnet, lost in the process of rationalisation).²⁴ The table below indicates the spread of membership.

Table 2: Transmed membership (December 1995)

Category	Total membership	%
membership		
Working members	89,969	58%
Transnet pensioners	13,961	9%
SATS pensioners	49,638	32%
Private members	1,551	1%
Total:	155,119	100%

²⁴ SATS: the pre-commercialisation name.

This table reveals several of the underlying problems in Transmed. At 41%, the proportion of pensioner members is strikingly high, largely as a result of downsizing (which sheds current employees, but not pensioners). Also, there were two categories of pensioners, SATS (retired before the company commercialised) and Transnet (retired after commercialisation). The subsidies were very different for these two categories, with SATS pensioners subsidised 100%. All of these pensioners were white.

Though all Plans were notionally open to any employee, the costs of contributions combined with the employment pattern in the company (especially when the project began) to produce a clear racial gradient in membership. The overwhelming majority of black members were in Plans 1 and 2, which had very few white members. Equally Plans 4 and 5 were almost exclusively white, while Plan 3, which had the largest membership, was predominantly white, with a small proportion of black members. Approximately 25,000 current employees (almost all black) had not opted for membership and approximately 14,000 black SATS pensioners did not have cover, because they retired while the 'blue card' system was in operation. In addition, a smaller number of black Transnet pensioners also had no cover, because they had not opted for membership before retirement.²⁵

Data

One of the major problems throughout this project was the quality of data from the administrators. At the time when the project started, the Fund's accounts

²⁵ Very few black workers joined the scheme when they were close to retirement age.

were opaque in the extreme. As the medical scheme of a state enterprise, Transmed was exempt from the requirements of the Medical Schemes Act. This had far reaching effects on the scheme, particularly in two respects: first, it was not required to report to the Registrar of Medical Schemes and, as a result, an accounting system had developed which caused great difficulties in the process of restructuring the scheme; second, it was not required to hold financial reserves and, as a result, it was vulnerable as soon as the state ceased to act as unofficial guarantor of losses

Accustomed to functioning in a non-commercial environment, the Fund managers were not geared to many of the routine operations of a commercial administrator, such as projecting the use of various benefits and costing benefit packages accordingly. They were initially bewildered by requests for a clear statement of the financial situation of each of the Plans. Indeed, it emerged that they did not keep separate accounts, but simply combined the income and expenditure figures of all Plans. A basic principle of legislation governing medical schemes in South Africa is that benefit options should be accounted for separately, so as to avoid cross-subsidisation between options (particularly in cases where members of a low benefit option subsidise a high benefit option, whose benefits are barred to them).

The style of accounting practised in Transmed had specific effects on the project: because the schemes were all combined, the contribution tables were not directly related to benefit costs. Even if no fundamental re-structuring were undertaken, the pricing of schemes would have to go through a major shake-up,

with some schemes becoming cheaper and others more expensive. There had been no contribution increase for 18 months when this project began and would be none until the unions agreed, with the result that the Fund was plunging into the red, with some schemes losing far more than others and only the lowest benefit schemes (Plans 1 and 2) breaking even. The 're-insurance' was grossly underpriced, resulting in massive losses (and cross-subsidisation by the surplus-making Plans). To re-structure on top of this unstable base was to attempt to build in an earthquake zone.

Subsidy

Adding to the problems caused by the opaque accounting, there was an extremely complicated subsidy system. Conventionally, contribution tables for medical schemes have two variables, income and number of dependants, and employers pay either a percentage of the total contribution, or a fixed amount towards it. The Transmed contribution tables showed only the member share of the contributions. Member contribution did not vary by income and the variation by number of dependants was unusually small. The company subsidy was unrelated to the contribution table and did not vary according to the number of dependants. Rather it was related to wage: 9% of (basic) wage up to a ceiling level.²⁶ The company subsidy was invisible to ordinary members: it did not appear either on their pay slips or on the medical scheme contribution tables. As a result, they were unaware of the real cost of their coverage. In practice, the company

²⁶ The subsidy ranged from R126 (on the minimum wage of R1,400) to R325 pm. If an employee chose not to take up the option of medical cover (only possible for black employees) s/he lost the subsidy.

subsidy worked out at 60-80% of the total cost, compared with a market norm of 50-66%. The white unions, in particular, argued that the company owed this to workers (and by extension, pensioners) because of the non-market related salaries of the past, which had been justified by job security and good benefits. Security had already been eroded by down-sizing, and erosion of benefits was simply unacceptable to the trade unions.

It was clear that in the longer run, the contribution table would have to be re-designed to show the full cost of membership of each Plan (leaving the *division* of the cost to negotiation) and to allocate the costs reasonably between family sizes.²⁷ The basic principle was that cross-subsidies should be relatively transparent and acceptable to those whose contributions were loaded. This shift could not be made in one move, especially on top of a general increase.

The situation was made more complex by questions of tax structuring. Under South African law, employers may offset contributions to medical schemes against tax, a concession not available to employees. Some companies pay the whole contribution pre-tax, on a salary sacrifice basis, and Transnet was prepared to do this, especially in order to soften the impact of contribution increases. The company was, however, concerned that this would lead to cost inflation by further blurring members' consciousness of the real cost of medical cover. In addition, the tax treatment of medical scheme contributions was likely to change within the next

²⁷ Dependant contributions were fixed in an eccentric fashion, charging the same rate for adult (spouse) and child dependants and setting this at the very low rate of 25% of the principal member contribution (compared with an industry norm of 90-100% for an adult and 30-50% for a child). This extra payment applied only to the member contribution resulting in radically insufficient funding for dependants.

couple of years.²⁸ However gradual the change of tax treatment, there would be an inevitable impact on members, resulting in a demand that the company make good the difference. Management, in the process of introducing bargaining based on 'total cost of employment' (TCE), frequently responded that the division between employer and member contribution was artificial, as the so-called 'employer subsidy' was merely a part of the overall wage package. This argument was received with stubborn scepticism by most unions, who continually referred to their historical rights.²⁹

The opacity of accounting and the disparity between the price and the real cost of medical benefits was a recurring problem in the project. The unreliability of the figures produced by the administrators, especially relating to the calculation of losses (which varied wildly from one Board meeting to the next), was particularly problematic. Both parties were unsettled by this uncertainty, which exacerbated an already difficult task and constantly eroded hard-won ground.

4. Multi-unionism in action

This project became a series of leadership negotiations at Board level. Members were not active participants, either on or off the Board. All the unions included senior national officials among their representatives and when members were also representatives, they tended not to be very quiet in Board meetings. The

²⁸ The loss to the fiscus occasioned by the tax deductibility of contributions for private health care cover is estimated at approximately R1.5 to R2 billion per annum (Price et al. 1996).

²⁹ The one exception was the pilots' union which had negotiated a separate salary deal with a range of salary sacrifice options. As the highest paid unionised group, they stood to gain most by reducing taxable income.

Board of Trustees was technically a non-negotiating body. Though trustees were elected/nominated by specific constituencies, once on the Board they were expected to act impartially, in the interests of the stability and survival of the scheme as a whole. The constitution limited the Board's remit to deciding on benefit structure and approving appropriate contribution tables. The conflictual task of dividing the costs between the parties was to be left to existing negotiating forums. The fundamental flaws in this notion rapidly revealed themselves. In the first place, there was an imbalance between the expectations of union and employer representatives. The union leaderships were expected to bind their members to (often unpopular) decisions, while the employer representatives, with the exception of the Chair, had no power to commit the company to any action. Their responses were inconsistent: sometimes they took the 'larger' view (by arguing for measures necessary to the survival of the scheme) and sometimes they responded simply in terms of their own scheme membership (reacting to perceived threats in the proposed changes). This made for some unexpected alliances, generally, but not always, on racial lines.

A second flaw was in the notion of common interest. In fact, there was a direct conflict of interest on two levels. First, between the union leaderships, whose members had very different benefits. Given the context of limited resources, unions could only defend the status quo (in the case of the white unions) or advance their members' benefits (in the case of the black unions) at the cost of other worker groups. Part of the 'depoliticising' of the Board had been the insistence on equal rather than proportional representation for unions. This rendered the white unions disproportionately powerful in relation to their numbers,

though there were some checks on this power: inter-union relationships in other fora, some of which had proportional representation (for example, wage bargaining) constrained the degree to which the white union leaderships could disregard the impact of their actions on black unions, as did the climate of company change which made overt racism unacceptable. The other conflict of interest was the fundamental one between the employer and the unions (in terms of apportioning the cost of cover and responsibility for the deficit). The lack of power of the 'employer' trustees meant that this could not be tackled directly. The Board's decisions were rendered conditional and there was a real disequilibrium. Removing the employer-union conflict from the ambit of the Board unnaturally highlighted the inter-union conflict, which could not be kept consistently private, despite the use of caucuses. When union tensions erupted, the 'employer' trustees were turned into spectators, with little at stake, watching with interest. This was a source of some irritation to the union trustees.

The third flaw was in the notion that division of the costs could be left out of the Board's ambit. In fact, this was impossible. It was naive to believe that benefits could be designed in isolation, without consideration of budgetary constraints and the impact of increases in benefit funding on the amounts available for wage bargaining.⁴⁰ Two questions hovered: first, the amount which the employer would make available against the deficit (the estimated size of which varied wildly from time to time), and second, the financial implications of the extension of benefits to the substantial number of employees (present and past)

⁴⁰ The impossibility of insulating the Board from the rough and tumble of negotiations was clearly experienced in the wage negotiating season in 1997. It was a hard year for bargaining and the bitterness infected Board meetings and made it particularly difficult to get decisions (Dobson 1996).

without cover. It was a case of cutting a coat for a body of uncertain proportions according to a cloth of unknown size. The process was exhaustive and extensive.

The Board

The first formal meeting of the Board of Trustees followed directly on the Trustee training. The training was one of OMAC's first tasks and was done in a peculiarly South African setting, a private game park, to which 45 people retired for a week.¹¹ This was a difficult period. OMAC were unused to the industrial relations context and to worker education, as was the leader of the employer group (who was also Chair of the Board). OMAC's major problem at this early stage was an inability to read the nature of the Board correctly. In their view, the fact that trustees were drawn from union or management ranks was a technical question which fell away once the Board was constituted. The Chair shared this view and was consequently initially reluctant to allow caucuses, which he feared would shift the Board towards industrial relations-style negotiations. The unions fiercely opposed both OMAC and the Chair, whom they suspected of wanting to use them to rubber-stamp contribution increases and other unpalatable changes to the Scheme.

OMAC were, indeed, desperate to reach a point by the end of the training where the Trustees would approve what was, in their view, a 'reasonable' increase in members' contributions: one that would keep the Scheme solvent during the process of re-structuring. OMAC's task was greatly complicated by the Byzantine

¹¹ The group included the members of the Board, a number of people from the administration company (Transmed), a group from OMAC and myself.

ineptitude of the accounts. The unions used this confusion as an additional reason to oppose increases, arguing that it was impossible to motivate their members to pay increases to cover a deficit whose size was still uncertain. At this stage, the process almost broke down completely. After extended labour caucuses, a compromise labour position was hammered out: labour agreed to the closing of Plan 5 because of the scale of its losses and offered an increased co-payment (30% instead of 25%) for members of Plans 2-4 until such time as the re-structuring was complete.³² Even this concession was delicately balanced, with serious opposition from two of the unions to any change whatsoever. In return, the unions demanded a commitment from the employer to a cash injection to stabilise the fund, to match the projected income from the increased co-payment.

The Chair was unhappy but eventually persuaded that the only way to maintain labour involvement in the Board was to accept the outcome of a fragile labour truce. OMAC was very unhappy and inclined to persist with arguments about 'reasonableness' until this line was sharply cut off.³³ The question of employer response raised clearly for the first time the recurrent problem of the imbalance of expectations: the employer trustees had no power to make a reciprocal offer and the financial request had to be referred to management channels outside the Board.

³² Plan 1 had no co-payments, as a result of the 1992 negotiations between the black unions and Transmed.

³³ By me, on behalf of the labour caucus, backed by the Chair, who agreed to the compromise for the sake of progress.

Meeting the MD

The second example highlights the myth of common interest. On two occasions, the Board sent joint delegations to top management to request cash injections from the company to stabilise the medical scheme during the process of restructuring. The long-established (white) MD agreed to an amount of R40 million. Then the delay in implementation of the new schemes opened up a further deficit. The new demand was for a further R70 million. This time a larger delegation met with the new (black) MD. SARHWU and BLATU were deliberately lukewarm in the meeting, which led to angry accusations of lack of solidarity from the white union leaderships in the next Board meeting. Given the fact that the cash injections went to wipe out the losses of plans with overwhelmingly white memberships, this was an attempt to employ union solidarity for sectional purposes.

The MD's final offer was strategically constructed: the company offered R70 million, held the subsidy cap and raised the minimum subsidy, substantially narrowing the gap.¹⁴ This was a powerful compromise: the black unions had pushed for equal subsidy at the higher rate immediately (but settled for a major increase in the minimum and an explicit commitment to narrow the gap further in subsequent years); the white unions had pushed for removal of the cap and did not win this demand (but on the other hand, were the major beneficiaries of the R70 million).

¹⁴ The minimum subsidy was R223 p.m. (up from R126) and the cap was held at R325 p.m.

The way forward

The Board faced a major problem in terms of the way forward: the scheme was structurally flawed as well as underfunded. In order to function in the future, it was not sufficient to tinker with the benefits and increase the contributions. The scheme had to be fundamentally restructured. This was very threatening to many trustees, who regarded the changes as interference with their freedom of choice, feared a drop in quality and clung to the benefits they knew. Rumours of change were widespread in the company, resulting in considerable pressure on union trustees from their members. The task was made more difficult by the timing - the newly constituted Board was immediately faced with financial crisis (had indeed been established because of this crisis) and asked to take unpalatable decisions. There was no gentle run-in, giving trustees a chance to explore their roles in a routine situation.

The options for change were complex. The initial training of Board members was fleshed out as the months went by, by extensive exposure to issues in both Board and sub-committee meetings. This centralised knowledge in them, with contradictory effects: on the one hand, they were 'empowered', on the other, they were drawn into a level which alienated them from their members. They were uncomfortable with the speed of decisions, which reduced the possibility of taking decisions back to members for ratification - or challenge. Even the most sophisticated of the unions expressed some concern about their ability to explain issues accurately to their members. As a result, they were unusually dependent on outsiders to communicate with their members: OMAC was largely responsible for the education sessions in the regions at which members were introduced to the new

scheme and the choices which they had to make, and produced the video and other media for use in this campaign. Interestingly, several unions asked the Chair of the Board to write for their newsletters. There was a pervasive sense that they were being drawn into an operating style at odds with their usual practices. The problem was intensified by the scattered nature of the Transnet workforce, particularly in the railways. The Trustees tended to come from the head offices of unions, which were mostly in Johannesburg. A few unions elected representatives from other regions, but given the limited numbers, this could not result in anything like regional representation. As many trustees were also national officers, with many other responsibilities, the problem of feedback and contact with members was acute.

5. Outcome

After nearly a year's intensive work, the new Fund came into operation in October 1996. Members had a choice between three benefit options, the primary difference between them being in the facilities for hospitalisation (and consequently cost). The first (and cheapest) option allowed access to state hospitals, the second to a network of contracted private hospitals and the third (and most expensive) to all private hospitals. All hospital care, except for emergencies, had to be pre-authorised.¹⁵ As the network contained almost all private hospitals in the country, the 'own choice' option was included only in order to allay (exaggerated) fears of

¹⁵ In the state Plan, members were subject to the state referral system. In the other options, treatment was subject to pre-authorisation by a managed care company contracted to Transmed.

restriction on the part of some trustees.¹⁶ The new minimum employer subsidy brought membership of the state scheme well within range of the group currently outside the scheme, 25,000 low income members, but did not make the next step (from the state package to the network package) possible to significant numbers.¹⁷

Non-hospital benefits were divided into two: chronic medicine (on a pooled basis) and day to day primary care (on an individual basis). Medicine for chronic conditions, often expensive, was available to all members from Transmed pharmacies, with a smaller co-payment. Like hospitalisation, this was subject to monitoring and approval by an external medicine care manager, contracted to Transmed. The chronic medicine benefit was of particular importance to members of the 'state package', giving them access to a significant new benefit. All other care had to be covered from a 'personal medical savings account', to which part of the monthly contribution was directed. The amount available varied according to the hospital option chosen and the number of dependants. Members submitted accounts and were refunded at 70% of the agreed tariff.¹⁸

The Fund also included a further benefit, available free to all members: personal health care information from an audio health library and nurse helpline. This was intended to assist members in using their personal accounts optimally and

¹⁶ Members of the 'own choice' Plan were responsible for the difference between the actual fees charged by the 'own choice' hospitals and the tariff of reduced fees negotiated with the network hospitals. The expectation was that in time this option might wither away, as members observed the network in action and lost their fear of it.

¹⁷ Only workers earning below R2,300 per month benefited from the increased minimum subsidy: single people in this group might choose to pay extra for the higher level of cover (R100-150 per month, depending on income), but few with families could afford the additional amount (R156-407, depending on income and family size).

¹⁸ In 1997, the Board decided, after extended wrangling, to change the rules to allow refund at 100% of tariff. The black unions in particular had objected to the co-payment, which disadvantaged members who did not have the cash in hand when they needed treatment (personal communication, Geetesh Solanki, 1997).

reducing unnecessary consultations with doctors. (They were also reminded that they had access by right to clinics in the national health system. Though it was highly unlikely that members of the private hospital options would make use of this facility, members of the state hospital option were likely to have had more experience of the clinics in the past and to be prepared to use them if and when their personal accounts ran out.)

The involvement of two external managed care companies (for the hospital and chronic medicine benefits) was one of the most contentious issues in the Board. Many members (both employer and union representatives) feared their intervention and a great deal of time was spent exploring extreme scenarios. The administrators were also unenthusiastic, claiming that they could undertake these functions in-house (for an additional fee).⁹⁹ The Board was unconvinced, given the difficulties experienced with routine administration, but agreed to relatively short-term contracts with the managed care companies as an incentive to Transmed to improve its efficiency. (The terms also put the companies on their mettle, particularly as they had to gear up to accommodate a scheme as large as Transmed.)

Two additional elements were added to the major medical services immediately prior to implementation of the new scheme, in order to break a deadlock on the Board. Considerable unease had been expressed about members' ability to fund dental and optical expenses from their 'personal medical savings account'. Extra limits were allowed for these, at one stroke increasing the day to

⁹⁹ Contracting managed care operators has cost implications, though in each case the size of Transmed served as a useful lever in negotiating charges well below the quoted levels. Contracts specified monitoring of savings to the scheme and renewal was made subject to satisfaction with the level of service and of savings effected.

day account by half over the first year of operation, without any increase in contributions. This move illustrated clearly the non-neutral nature of the Board. It did not make financial sense to add extra benefits to a carefully costed package without increasing contributions. It was a decision made to break a deadlock and induce the unions to agree to implementation of the package. The unions held one invaluable weapon: each month's delay meant an increase of approximately R20 million in the deficit. The Chair considered it expedient to concede in order to avoid costly delay.⁴⁰

The question of subsidy for Transnet pensioners and for SATS pensioners was still undecided when I left the project. It was raised at certain strategic moments by the white unions, particularly when sabre-rattling was called for. Two factors intensified feelings on this issue: some of the unionists were close to retirement or anticipated taking retrenchment packages in the event of further down-sizing, and many Board members, including the Chair, had parents or other family who were SATS pensioners. Nevertheless, there was a tacit acknowledgement that decisions would be deferred until the new scheme was in operation.

Once the scheme was designed, agreed and costed, it had to be explained to members, so that they could make their choice of option. For a substantial number, there was no real choice involved: there was a predictable split between the state Plan and the others along income lines, and in general only the highest income members (for example, pilots) chose the 'own choice' Plan. Given the size

⁴⁰ In the event, this concession proved expensive: at the time of the January 1997 meeting, the new Fund showed a deficit very similar to the extra amount allowed for dental and optical benefits.

of the company and the nature of its operations, the process of publicising the new schemes was a daunting operation. Existing media such as the in-house radio station and newsletters were used, in addition to a video, posters, mailouts to scheme members and special member packs on the new schemes. The trustees and other union nominees were trained to take part in the publicity process to facilitate contact and trust. Another, implicit but powerful, reason for their involvement was in order to identify them with the new design and remove the potential for them to undercut the changes by disassociating themselves from the process.

Links with state

This project managed to develop a highly significant relationship with the state health sector. This was achieved against some odds, given the uncertainty of policy (with Social Health Insurance pending). Transmed was a medical aid scheme (rather than a Sick Fund), at a time when the Department of Health tended to see medical aid schemes as the preserve of the privileged. The challenge for the Transmed team was to persuade the Department to accept a more nuanced approach, differentiating public hospital fees according to the income levels of scheme members. Initial discussions were held with the Chief Director responsible for pharmacy in the national office, exploring the potential for linking the Transmed pharmacies in to the state tendering system for buying pharmaceutical products and/or for developing an agreement on chronic drugs, along the lines of the CCIC agreement in the Cape. At the time, the drug policy of the Department was in a state of flux, as proposals in the NHI Commission Report had been routed by the pharmaceutical industry (Sidley 1996). The Chief Director was sympathetic and

interested in exploring options for co-operation, particularly if the Transmed pharmacies could be made accessible to non-Transmed members. Discussions are still ongoing at the time of writing.

Progress on the hospital question was more concrete. The process started with a number of discussions with key people in the national Department, who agreed with the general approach.⁴¹ Because of the structure of the health sector, the national Department could not impose a policy on hospital fees on the provinces, so the proposals had to be negotiated separately in each of the nine provinces before they could be implemented. There were strong arguments for the proposals. First, the income level of the members of the State Plan was low. Outside a medical scheme, they would be entitled to use state services at very low tariffs. Now Transmed was proposing to pay the State for them at a negotiated rate between these tariffs and the higher 'medical aid scheme' tariff. Second, Transmed guaranteed payment (a significant incentive given the history of low fee recovery rates in the state sector). Consolidated billing to a scheme was also administratively simpler - and therefore cheaper. Third, the scheme aimed to extend cover to some 25,000 workers (and their dependants) previously without cover (and thus dependent on state services for all their health care).

The problem of undifferentiated rates is that they are a disincentive to schemes to provide hospital cover for the low-paid, or indeed to include the low-paid at all. Given the stresses under which the public sector was operating, we argued that it would be useful and productive to develop an approach which encouraged extension of hospital cover to as many employed people as possible,

⁴¹ This aspect of the project was taken over and expanded by Geetesh Solanki after I left.

located this provision in the public sector and recovered its costs on a rational basis.

Implementation

In January 1997, I returned to South Africa briefly. After four months, progress was palpable. Contrary to expectation, the new schemes had been implemented for current employees and Transnet pensioners in October 1996 without disaster.⁴² Fine tuning and dealing with teething problems had occupied the Board and the sub-committees (dealing respectively with finances, service providers and applications for ex gratia assistance) in the interim. OMAC continued to be heavily involved in the process and their contract was renewed for a further year. The major areas of involvement for OMAC outlined at the January 1997 meeting were the introduction of the new scheme for SATS pensioners and the tightening up of Transmed administration. Others not mentioned, but equally important, would include the revamping of the Transmed pharmacy system and exploration of links with the state in the area of pharmacy. These were the responsibility of Geetesh Solanki, who had recently joined OMAC. He had a background of health sector activism and had recently returned from studying in the U.S. When I left the project to come to the U.K., I had discussed his role with the unions, tentatively exploring whether they would use him as a labour resource, but was roundly told that they would make their own decisions about replacing me. By the January meeting, it was clear that he had developed good working relationships with the unions.

⁴² The vexed issue of SATS pensioners remained unresolved and is likely to put inter-union relationships under acute strain when it is finally addressed.

Attendance at Board meetings was good and consistent, with few changes in representation since I had left. Involvement was intense and demanding (two day monthly Board meetings and one day fortnightly sub-committee meetings), particularly as many of the trustees were senior union officials with a range of other responsibilities. This was clear evidence of the priority of the issue for the unions concerned (in direct comparison with the last study). In the case of the white unions there was a strong sense of the need to defend their members' benefits from erosion and worse, and on the part of the black unions a sense that the demand for equity was finally on the table, with a real possibility of improving their members' benefits at last.

6. Assessment

The political context in which the project evolved differed from the IC studies, most markedly from the CCIC and NICLI studies, as this project happened only after the South African election of 1994 and the installation of the new government. It would be an understatement to say that this project unfolded in a politicised environment, which coloured both the nature of the process and the technical possibilities of the project.⁴³ The characteristics of the industry, the nature of industrial relations, the scope of the project and the issues raised contrast strongly with the earlier work, especially the central study of the CCIC.

⁴³ My role was also fundamentally different from the one I had played in the IC studies, a shift which may be definitive in the future, highlighting potential new directions for a non-governmental organisation like the IHRG in a new political dispensation.

Unlike the IC studies (especially the Cape study), involvement in the Transmed project offered unions a poisoned chalice: the potential gains were neither obvious nor unmixed. Most of the union leaderships were involved in order to minimise potential losses for their members. To complicate matters further, they could potentially lose ground both to the employer and, more insidiously, to fellow unions. The first danger evoked union solidarity, the second stimulated sectionalism. Involvement in the Board of Trustees also involved a potential loss of face with members, through identification with an unpopular product (the new scheme) and accusations of softness or closeness to the employer. When the white union leaderships invoked union solidarity, they did so for sectional ends: they wanted a united front for a demand that the employer carry the deficit accumulated in the scheme. As this had been accumulated almost entirely by white scheme members enjoying superior benefits, the black union leaderships were understandably reluctant to respond.

SARHWU was hampered by the representational basis of the Board and by the style of its operation, which diluted two of its traditional weapons: the size and militancy of its membership. Even so, the black unions could have been much more demanding, in terms of the inequity of the past, but restricted mention of this to certain key moments when the white unions were being intransigent and blocking progress (usually by insisting that the company 'owed' them and should take all responsibility for the debts of the scheme and the increases necessary to run without loss). At moments like this, Tsidiso Moshao (the SARHWU assistant general secretary and a fine diplomat) would mildly mention the historic debt owed black workers and leave the implication of the impact of correcting the inequity

hanging in the air. Faced with the potential of sharing the existing benefit with a much larger group, or - more frighteningly - requiring the group which had accumulated the losses in the scheme (predominantly whites) to repay those losses by way of loaded contributions, the white unions would subside.

The union leaders had common cause in their mistrust of the administrators, though for different reasons: the black unions perceived them as tainted by racist habits and attitudes, some of the white unions thought they could find more efficient (and cheaper) administration in the commercial market. The tensions between solidarity and sectionalism persist, exhibiting most clearly in recurrent proposals by different groups to pull out of Transmed altogether. The most serious proposals came from the two poles of the union grouping: on the one hand, the South African Airways group of unions, whose members are the most highly paid of the unionised workforce, were consistently frustrated by the limits imposed on their members' consumption of expensive health care, which they could afford; on the other hand, SARHWU was constrained by association with the white unions, a relationship which had not produced much to show a membership distrustful of Transmed and vocal in demands for a medical scheme to meet the high (though vague) demands aroused by the new political dispensation. Both groups, though they participated in the joint project, held in reserve the possibility of withdrawal to advance sectional interests.

One of the central issues arising from this study is the meaning of equity. The current and past workforce of Transnet is divided into three groups, with different health care benefits. Theoretically, there is freedom of choice: in practice, this is severely constrained by income and subsidy level. In the end, the workforce

is still divided roughly according to income and the question is whether the project has simply reinforced a class-based differentiation in access to health care, whose lines were blurred by the appeal to trade union solidarity. Frank admission of the material base for the sectional interests of the different unions and their history of privilege, though it would have impeded progress in the Board of Trustees, would have been both more honest and more productive.

Chapter 8. Implications for trade unions

1. Introduction

The studies in this thesis highlight certain features of the form and practice of trade unionism, which are explored in terms of their influence on the process and evolution of the studies and the implementation of the recommendations which flowed from them. Some features are specific to South Africa, such as the complex interrelationship of racial and class oppression, others apply to any society in transition to democracy, yet others are more general, such as the gender composition of the unions and their leaderships and the nature of the relationships with employers.

2. Members

One of the fundamental differences between the studies was in the composition of the groups involved. It emerged that one of the pre-requisites for success was relative homogeneity in class terms, a narrow income range and a marked degree of shared experience. The Industrial Council schemes met these criteria, most notably in the Cape clothing case. They were compulsory, with uniform benefits for all members, so all workers had experienced the same system (though their actual use of the benefits would, of course, have varied). Income differentials were low, with the overwhelming majority of workers in each Council in the machinist/operator category, on a single

wage. In two of the schemes (Cape and Natal clothing), all workers were members of one union.

This uniformity was tempered by two factors: the racial and gender composition of the memberships. Segregation drew lines not only between white and black, but also between different groups within the black population. African workers lived in separate areas, often separated from their families (many of whom remained in the rural areas). Schools separated African children from coloured and Indian children. The labour market was stratified, with African workers on the bottom of the pile, even after the formal removal of job reservation in the late 1970s. Influx control, until its removal in 1986, subjected African workers to stringent controls on their right to seek and take urban employment. Coloured and Indian workers were not subject to influx control, and had indeed been advantaged by it in the past, especially in Cape Town, which formalised this advantage in the 'Coloured Labour Preference Policy'. These factors, of separation and relative advantage, made for some unease within the union, especially after the merger into SACTWU, which brought relatively a-political coloured and Indian workers from the unions which merged to form GAWU (whose experience of active and militant unionism was very recent) into contact with highly militant African textile workers from the NUTW wing of the merger. At the project level, this unease did not manifest strongly, perhaps because the proportion of African workers in the clothing industry was, though growing, still small.

The gender composition of the IC studies certainly influenced their outcome. Maternity benefits and family cover evoked a powerful response from the

overwhelmingly female membership in the clothing sector. Typically, it is women who stay away from work to care for sick children and take them to doctors or clinics. They bear the brunt of children's illness and have the most to gain from easier access to affordable services - and from reform of the sick leave system, which penalised one day absences by paying nothing for them, but nevertheless insisting on medical certificates. (The statutory sick pay system has a provision for self-certification for one or two day illnesses, which gives some leeway for taking time off for children's illnesses. Though this is technically termed abuse, it must surely be classified as both understandable and socially necessary.)¹

Interestingly, in the leather study, though there was vocal support for family benefits, there was also a great deal more concern about the issue of funding them, and a clear discomfort with the basic principle of cross-subsidisation, which would favour those with larger families, or sicker dependants. Some dissent also emerged on a cross-generational basis in all three studies, with the solidarity of older women distinctly tinged with resentment for the lack of support that had characterised their own child-rearing years.

The gender composition of the clothing and leather workforces is sometimes identified as one reason for their relative quiescence (compared with greater militancy in the male-dominated unions such as SARHWU), given the barriers to union

¹ SACTWU has managed to negotiate a breakthrough agreement in the Cape Clothing Fund in terms of which workers may draw on their sick leave to care for sick children (personal communication, Ronald Bernickow, October 1997).

involvement for women.² Other commentators focus on the racial question, claiming a gradient in militancy from coloured and Indian to African workers (Amra 1993; Coetzee 1993; Valodia 1993; Zikalala 1993a). The fact that racial tensions in the trade union movement and in the progressive arm of the political movement tend to have been unexpressed does not diminish their potency and disruptive effects. All COSATU unions espouse the fundamental principle of non-racialism, but it is a monumental task to develop a practice consistently based on that principle in a country scarred and deformed by institutional racism.

The Transmed project was at the opposite pole: there was absolute heterogeneity in class terms, a vast income range and minimal common experience, even of health care. There were many unions (some of which had overlapping constituencies), from very different traditions of unionism and political affiliation. A rare feature of the project was the presence of the (embattled) white working class. There was an uneasy, partial and conditional alliance across racial lines on the simple class divide between worker and employer, which blurred but did not erase the racial lines, with all their attendant history of privilege, exclusion and repression. It had taken two of the bloodiest strikes in South African history to force the company to recognise a non-puppet union for black workers, only five years before this project began. New, inclusive structures and policies of 'transformation' had not yet dissolved the basic distrust with which the membership of SARHwu regarded both

² See, for example, Baskin (1991 58; 354-7; 369-83; 457), September (1992) and Nyman (1996) on women in COSATU. Nyman (1996, 32) notes that nine years after the issue of women's participation was put on the agenda at COSATU's first congress in 1985 there was still no progress.

the management (which was not visibly altered until late in the project) and the unions which had been party to the old structures, acceptable to the old management and (with the exception of the two token black unions, one for coloureds and Indians, the other for Africans) in the same camp in terms of racial privilege.

The lack of common social experience was underlined by the range of health care experience. SARHWU had members outside and inside the medical scheme, with those inside spread across three Plans. As a result, SARHWU trustees had to operate throughout the project with an insecure and shifting support base, subject to contradictory pressures from different groups of members. The problem was exacerbated by the attitude of the union's National Executive, which was dubious about the scheme and the Board, and suspicious of all agreements resulting from it. Interestingly, the fact that members who moved from the 'blue card' system could include their dependants for the first time had made little impression. This may have been because this advance weighed little against the negative comparison with the higher Plans, which were unaffordable. The gender composition, with its very high proportion of men, may also have had something to do with it. Clearly unions with minimal female membership are more likely to overlook their perspective when priorities are ranked.

The regional schemes were at an advantage over the national schemes in the degree of contact between members and their physical closeness to the administration of the scheme. The Cape study had a concentrated population, which facilitated broad involvement in the project. Though developments were gradual, there were visible

changes in the central clinic, which were witnessed by a fairly broad circle of members, including those who visited the building for reasons not related to the Sick Fund, such as attending union meetings. This had a ripple effect, as shopstewards spoke to fellow workers back in their factories. The Sick Fund decision-making structures were deliberately linked to broader union structures, with worker representatives reporting to shop steward council meetings on developments. A few key members, such as Miss Jasmine Abrahams (universally and respectfully known as Auntie Minnie) gave the project their stamp of approval, which was an important feature in worker acceptance, especially among older workers. Some workers heard about the Sick Fund project in union education courses and others through the weekly union newspaper *Clothes Line*, which regularly raised issues about the Sick Fund from as early as 1989.³ Support was consolidated through the membership survey, which reached beyond activist members, taking the project into the factories and interviewing randomly selected workers, who then went back to the floor and talked about the experience. There is strong anecdotal evidence about social networks in the clothing industry: many workers stay in the industry for life, moving between factories, taking time out for childbirth and rearing. Many have family members and neighbours in the industry, often in the same factory.⁴ Word of changes would also spread via these social networks. The multiple and

³ *Clothes Line* ran a series of features in June 1989, with the instruction 'Members must discuss the following proposals at factory general meetings, and at all local meetings.' The union proposals for a health centre-based Sick Fund were outlined, along with five steps to achieve these objectives (GAWU 1989).

⁴ Given the importance of the clothing industry in the Western Cape economy, it is not surprising that many people have some link to it: the national Minister of Finance, Trevor Manuel, is the son of a clothing worker, as is the Western Cape Minister of Health, Ebrahim Rasool.

overlapping routes of contact gradually developed a web of support for the Sick Fund proposals and the demands which had to be made in negotiations to secure them.

The same should have been true of the Natal clothing project, which involved a similar scheme and a similarly concentrated membership. Its failure was due to a number of factors, including the different relationships between union leaders and members, the timing of the project and consequent disruption by election activities, and the narrower range of contact with members. The Sick Fund structure was not tied in to other union structures and there was no flow of information from the Management Committee back to union leaders, let alone workers. Worker members of the Sick Fund Management Committee attended erratically, participated minimally and had no special attachment to the Fund. Membership disaffection with benefits was compounded by disappointment when contribution increases failed to result in improvements and dependant cover. Most of the planned contacts with members were problematic: a shop steward council angry about the fact that a contribution increase had not resulted in delivery of *all* the Sick Fund demands (maternity pay, improved medical benefits, coverage for families); other councils so occupied with election-related crises that the Sick Fund item was cut to a gabbled report; and the disastrous mal-administration of the simple member survey, which re-sparked the smouldering suspicion and resentment among members. The only successful contact with members was with a small focus group of leading shop stewards, who came together to assist in the rescue operation.

In the leather study, involvement of the membership in the research process weakened the opposition of officials of one union and bolstered it in another. In the NULW, far from confirming the line taken by their leaders in SFMC meetings, members supported the idea of clinics with enthusiasm and a curiosity which implied that it was new to many of them. In TLATIU, only a few workers were brave enough to venture tentative support for clinics, a position immediately and forcefully repudiated by the General Secretary. The real feelings of the membership remain a mystery.

The problem of a dispersed national membership was even more acute in Transmed than in the leather industry. Though there were some concentrations of members in urban areas, others were scattered throughout the rest of the country, in every tiny town with a railway station. To make matters more difficult, some members, in rail and road transport, were constantly on the move. It was almost impossible to reach members consistently. The major contact with workers came *after* the scheme was designed and negotiated, when OMAC, the Board and management put together a national roadshow, explaining the new scheme and the options to groups of workers around the country, so that they could make their choice. Before then, there was no direct route to members for the project team. The union trustees were the conduit for worker views: if unions could not, or did not choose to, consult with their members, there was no way to bypass them and contact members directly. In the case of SARHWU, my primary union relationship in this project, there was a slightly different problem. The union had grown very fast (see Chapter 1) and battled

to consolidate its growth. It operated from a spartan rented head office in Johannesburg, with minimal resources and equipment. The Cape Town and Durban offices, the only other ones I visited, were equally minimalist. None of them had large meeting spaces, unlike SACTWU, which owned substantial buildings in Cape Town and Durban. If contact was difficult for SARHWU officials, especially national officials trying to reach members throughout the country, it was near impossible for me. I never bumped into a worker (other than the President) in a SARHWU office and have met only a handful either in specially organised meetings or on the Board (two of the three SARHWU trustees were workers).

3. *Leaders/officials*

The most successful of the studies involved a new leadership committed to transforming union structures and practices to reflect principles of worker control and democratic accountability. When the project started, it was essentially a regional union, and the leaders were local people, strongly rooted in the area. They were young, many with a background in youth and student activism. During the project, more worker leaders moved into full-time official positions. Of the two key union figures supporting the project, one was an ex-youth activist, Ronald Bernickow, the other an ex-worker, Wayne van der Rhee, who had started out as a shop steward at one of the biggest Cape Town factories, then became a full-time official ('organiser' in

South African parlance) and later Regional Secretary.⁵ Their involvement consolidated the sense that this was a 'union' project, though it was organised through the bilateral Industrial Council, and their association with this issue both increased its credibility and linked theirs to its success: this was certainly a factor in their tenacious support for Sick Fund demands in internal union battles during wage negotiations.⁶

In the leather study, there were three key figures in SACTWU. Mike Murphy, who initiated both this project and the Natal clothing project, was based in SACTWU's head office, with broad responsibilities. Mark Bennett was the major representative on the SFMC and central to the strategic development of the project and steering the union caucus through negotiations. He was also based in head office in Durban, but as head of collective bargaining had wide national responsibilities and travelled constantly. Kevin Perumal, a regional official from the Pietermaritzburg branch, was centrally involved in implementing the proposals in Pietermaritzburg. The leather project had both strategic support from the union leadership at a national level and grounded local backing from regional leadership. It is clear that this form of leadership is a condition for success, perhaps particularly in a national project, administered by a distant head office. None of the other regions has thrown up an official or worker leader in the leather sector with similar commitment to the project, which has been a crucial factor in the continued development of the Fund in KwaZulu-Natal in particular.

⁵ Support from other worker leaders, such as Connie September, a clothing worker who is now Vice-President of COSATU, was also important (Gabriels 1991; Barrett 1993; Collins 1996).

⁶ Ronald Bernickow is now Labour Affairs Manager for the Clothing Industry Bargaining Council.

The NULW had a centralised structure, which concentrated power in the hands of officials, who represented the union in all structures. The officials were supported by a substantial administration. The task of organising the project meetings fell largely to the administration and was efficiently performed. As a result, a broad swathe of shop stewards had the opportunity to connect with the project directly, rather than through a remote leadership. Though never openly expressed, there was some competition between the NULW and SACTWU about the size of the separate regional union meetings called as part of the project. The NULW drew larger numbers, whose response diverged markedly from their leaders' line in SFMC meetings. This same divergence was clear in the attitudes of regional officials in both Pietermaritzburg and Durban, a factor in the decision to devolve implementation to local sub-committees. The third and smallest union, TLATIU, exhibited the tightest control on members, facilitated by the fact that it only operated in one region. The General Secretary actively controlled the meeting with shop stewards and was the only TLATIU representative I ever heard speak on the SFMC.

One of the many reasons for the failure of the Natal clothing project was lack of leadership support. Despite the early involvement of Mike Murphy and the energy and commitment of Mel Clark, who took over responsibility, the issue never attracted support from a broader group of full-time officials. Few officials wanted to be associated with an unpopular issue, especially at a time when the election period offered far more exciting options for involvement.

The leadership of SARHWU was drawn from different sources, with a strong emphasis on worker leadership. The Assistant General Secretary, Tsidiso Moshao, who was my major union contact in this study, had returned from exile to join the trade union movement and was a skilled negotiator, courteous and strategic. He was also tough, though he only revealed this on rare occasions: when he did, the Board was electrified and deadlocks rapidly broken. For more than a year, he was engaged for at least a day a week on average on medical scheme matters. The union's decision to commit such a senior official to this task is indicative of both the suspicion in which the SARHWU executive held the Board, the administrators and the management, and the shortage of skilled negotiators in SARHWU. The executive was particularly dubious about involvement with other unions in the process, believing that this would compromise their own demands. They saw Moshao's role as being a watchdog for their interests and that they failed to understand that his presence inevitably required him to participate and that a totally uncompromising attitude was impossible in the circumstances. Their attitude added an extra complication to the strategic role he played on the Board.

Interestingly, all of the key union officials in the four projects were men. This is largely due to the very small proportion of women in leadership roles in South African unions. Though 36% of COSATU members were women in 1996, only 8% of national office bearers were women, a position unchanged since 1994 (Filita 1997). At regional level, there was more change, with the proportion growing from 8% to 15% over the same period (*ibid.*). With an overwhelmingly male membership, it is

unsurprising that there are virtually no women leaders in SARHWU (3, all at regional level).⁷ However, this argument cannot hold for SACTWU, with its predominance of women members but a minority of women leaders.⁸ Male leaders responded to 'women's issues' in different ways. In the Cape study, the new young officials appealed to female members, first by securing a new maternity benefit and then by articulating a demand for family health care. Given the high proportion of women-headed households, this was a sure vote-winner. In the Natal study, the leaders failed to ensure that the maternity benefit was properly funded, which resulted in deficits in the Sick Fund and hampered further developments.

4. *Inter-union relationships*

The studies reveal that it is simpler to work with only one union in a union health care project. Where there was more than one union, the inter-union dimension sometimes cut across and complicated the primary union-employer relationship. The problem was markedly more acute when the unions organised very different groups who were in direct competition with each other for resources, as in Transmed, rather than for members, as in the leather case.

In the leather study, the major conflict was between SACTWU, the new entrant to the industry, and the NULW, the established majority union. The third

⁷ Interestingly, the SARHWU team on the Board of Trustees always contained a woman worker. For a while, this was a white woman, one of the small group of white SARHWU members.

⁸ In 1996, women comprised 30% of regional leadership and 13% of national leadership (Filita 1997).

union was rarely a factor and the other two unions easily agreed to de-prioritise changes in the Transvaal region to placate the Transvaal union. Because the membership was highly homogeneous, the unions were not competing for resources. Any improvement to the Sick Fund would benefit all members, rather than one group at the cost of another. The only element of competition was for the political credit of the advances. SACTWU drove the process, but could not be seen to be doing so, for fear of consolidating resistance from the other two unions. This required strategic work in the union caucus, resulting in a higher profile for the NULW in the SFMC and the occasional impression of ventriloquism: it was the NULW representative who formally proposed my appointment, for example, though SACTWU had first mooted me as their private consultant.

The SACTWU negotiators' strategic skills were also obvious in their support for the Transvaal union's insistence that the process of investigation include separate regional meetings for each union, to avoid bias. SACTWU officials realised that the 'clinic option' had become associated with SACTWU. The separate union meetings would allow this option to be raised in a neutral fashion (by me, as the 'researcher' from outside), without the accusation of domination by SACTWU. The meetings would also give me access to ordinary members' views, rather than merely the official version.

The multi-unionism of the Transmed case was far more problematic, with competition for resources as well as for status. There was a distinct tension between solidarity and sectionalism, which played itself out in different ways. The white union

leaders made constant appeals to union solidarity, directed specifically at the black unions. Demands were carefully couched in terms other than racial, but they were nonetheless sectional and would result in a continuation of white privilege at further cost to the black majority in the company. The black union leaders, entirely aware of this process, nevertheless had been building a working relationship with the white unions, particularly in the central negotiating forum of the Industrial Council. Open antagonism was largely avoided. On the surface, relations were polite, often amicable, but underlaid by a solid core of mistrust. Alliances formed and shifted according to the issues involved. The basic division was racial, with SARHWU and BLATU firmly in one camp, the white unions in the other and TATU (with coloured and Indian membership) rather tentatively based in the black camp. TATU representatives were notably uninvolved, attended more erratically and very seldom spoke in meetings. Both BLATU and TATU were in merger talks with SARHWU, but there was little progress with TATU, while BLATU and SARHWU drew closer over the period of the project.⁹ On occasion, there was evidence of a tenuous alliance which cut across the racial division, when the black unions and the white unions organising artisans would unite in defence of low paid workers, to defeat a proposal by the airways unions. This was easily done (given their combined strength) and as easily shrugged off by the airways unions, engaged in separate consultations with the company outside of the Board, with a view to creating either an independent scheme or a dedicated option within Transmed to suit their members. Ironically, the unions at the two extremes

⁹ The merger between SARHWU and BLATU is expected to be completed by the end of 1997. (Interview with Tsidiso Moshao, London, 21 September 1997.)

(SARHWU/BLATU and the SAA unions) were similarly semi-detached from the process: it was the unions of the (white) middle ground which had the most to lose and were therefore most defensive and embattled. Various groupings of unions caucused and had their own advisers outside of the Board. The white union leaderships also had private lines of contact with Transnet management and the Transmed administrators, which were disrupted in the course of the project when the new (black) executive directors were appointed, and the (white) managing director was replaced. In a sudden inversion, it was the black union leaderships who had privileged access to senior management and the whites who felt excluded and threatened.

Though SARHWU had the same number of seats as other unions, it had a great deal more power, when it chose to use it. The ultimate weapon was the threat to pull out of the process, which would have undermined the credibility of the Board, probably fatally, given the company's commitment to 'transformation', in terms of which a whites-only Board and medical scheme was an unthinkable option. The flip side of this power was the credibility which SARHWU's presence lent to the Board and the process of restructuring the medical scheme and, from SARHWU's point of view, the association of the union with an outcome which was likely to be a compromise and unpopular with their members. The tension between abstention and involvement was a constant feature of the process. Ultimately, I believe that SARHWU gave more than it gained by the process. Whether it can build on the limited gains and manage to check the demands of the white unions, so that in time the

gap disappears and there can be one scheme for all Transnet employees and ex-employees, remains to be seen.

5. Unions and employers

The three Industrial Council projects were in private sector manufacturing industries. The last project was in the service sector, in a publicly owned company. All of the projects took place in the context of institutionalised relationships between unions and employers, long established in the case of the Industrial Councils and much more recent in the case of Transnet. In the Industrial Council projects, the relationship took the same form as the primary relationship: it was a bargaining relationship. The Sick Fund Management Committees were subordinate to the ICs, to which major decisions had to be submitted for ratification. In the Transmed project, the relationship was fundamentally different. The medical scheme was removed from the sphere of negotiations in the Industrial Council (in itself a relatively new structure, set up only in 1991) to a Board of Trustees (brand new, set up in 1996), which was explicitly not a bargaining structure. In addition, the employer representation was constituted in a very different way from the representation on the ICs.

Employers in the clothing and leather industries belong to various employer bodies. Each of the regional clothing councils had one or more corresponding employer bodies. The dominant employer body in the Cape, the CCMA, represented large and medium-sized employers and was well-resourced. The newer and smaller GMA represented small enterprises, generally so-called 'cut-make-trim' operations at

the most marginal end of the industry, highly sensitive to increases in the cost of labour and with highly personalised labour relations. The NCMA was similar to the CCMA. Up to 1991, regional wage negotiations were held entirely separately. In 1992, at SACTWU's initiative, as part of the union's drive to create a single national Council, negotiations were held together for the first time (SALB 1992b). The union fielded one negotiating team, with representatives from each region, while the employers had separate teams. By the time of the third project, in Natal, the employer side was more unified, though some rivalry remained, as evident in the NCMA's explicit pride in the 'economy' of their Sick Fund, compared with the Cape Fund. On the whole, the CCMA was better organised. They had taken some convincing of the need to change the Sick Fund, but had had much longer to get used to the idea, from first sight of union proposals in 1989 to the start of the research process in 1992. Their involvement in Sick Fund management was more rigorous than in Natal, where mismanagement of the Fund was not picked up by employer representatives on the SFMC. This would not have happened in the Cape, where accounts were far more closely scrutinised and questioned, and nor would the introduction of an unfunded maternity benefit. The Natal employers' lack of engagement with the Fund and failure to invest in the process of its restructuring mirrored and compounded the union's disengagement in this region.

The threat to the clothing industry posed by the reduction of tariff protection drew the employer organisations and union into a tripartite forum with government, to develop a strategic plan for the industry. The plan involved phased reduction of

protection, alongside 'supply-side measures' to protect against job loss (SACTWU 1993, 30; Altman 1994). In the event, this proposal was rejected by government, which gave the unions some cause for concern about the efficacy of tripartite institutions (Collins 1996, 17).

In the leather industry, there were three employer organisations, the Footwear Manufacturers' Federation (FMF) being the most powerful, with a full-time secretariat based in Port Elizabeth, near the Industrial Council head office. FMF members (and especially their secretary) dominated the employer side in the SFMC. Interestingly, the other two sub-sectors (tanning and general goods) were represented on the SFMC by non-members of their industry, with very different results. The tanning representative (from the local Chamber of Industry and Commerce) was highly biased by his own position in a large local medical aid scheme and was generally scornful of the modest proposals for the Sick Fund. It was generally accepted that his interventions were neither mandated by the tanners nor likely to be acceptable to them. His obstructiveness was alleviated only by the fact that the exasperation he provoked in employer and union representatives alike precipitated decisions. The general goods section of the industry contracted an industrial relations consultant, Theo Heffer, to represent them on the SFMC. His interventions were independent and often enlightened.¹⁰ His opinions were probably also at variance with those of the

¹⁰ Theo Heffer had an interesting history, having defended the unions' right to take up political issues in the volatile climate of the Eastern Cape in the 1980s: 'Are there any non-political unions?' he asked 'Is a union that wants to preserve the status quo less political than one which want to change it?' (Friedman 1987, 237).

manufacturers he represented (often struggling small companies) but they were far more positive than those of the tanners' representative.

The 'employer' trustees on the Transmed Board should more accurately be described as 'non-union'. They were individuals from the ranks of management, nominated to serve on the Board. They did not caucus, and were neither mandated by nor answerable to top management. They attended more erratically than union representatives, which caused problems with quorums for decisions and sparked accusations from the unions that management did not take the issue seriously. The Chairman was the only person from management with any power, though this was eroded in the course of the project, as his own position as a manager in Transnet came under threat precisely because of his links with the white establishment. In the early days of the project, he had a direct line to the managing director and his privileged knowledge put him in an anomalous position as a supposedly 'neutral' Chairman. The unions rapidly sensed that he knew more than he made public and resented this.

6. *Unions and politics*

The development of the South African trade union movement in a highly politicised context was outlined briefly at the beginning of this thesis. The connection between shopfloor issues and political issues operated in both directions. Focusing on the studies, the two-way influence between trade unionism and politics is seen in a number of ways. The Cape study started in the period of political transition, after the

release of Nelson Mandela and other political prisoners, continuing through the period of constitutional negotiations. The implementation process was well under way before the elections of 1994, with the first new clinics opening just three weeks before the election. The leather study happened in the same period, spanning 1992-1994. The leather Sick Fund managed to maintain the momentum of developments, establishing three clinics in Natal by the end of 1994, because planning was well under way before the election period and the initial research and meetings with members had been completed in 1992. The only direct impact of the election on this project was the relative difficulty of organising meetings, given the political commitments of trade union officials, and the decision to close the Pietermaritzburg clinic early in the evenings because of the danger of violence to staff and patients, travelling after dark. Both the Cape and Natal projects benefited, ironically, from falling in this period under the old regime, when the general hostility of the state to workers was somewhat tempered by the approaching change, but remained sufficiently institutionalised to leave unchallenged the union's role as protector of its members in the absence of a reliable welfare safety net.

The stasis in institutions and policy direction had dissolved by early 1994, the time of the third study, which was subject to a powerful combination of political uncertainty, economic instability and violence. In the circumstances, it is hardly surprising that it was impossible to ground and develop a new project in health care.

The Transmed study was permeated by the lingering after effects of apartheid. This project laboured under a major difficulty in trying to restructure and redistribute

at once. Though it started nearly two years after the election, health policy was still by no means clear. This had a real impact on the acceptability of the new 'State package' in Transmed, designed to link in to State hospitals at negotiated tariffs, in order to make hospital cover affordable for the lowest paid workers in the company.

The structure of the Fund, in which bipartite control is premised on joint funding, raises the question of ownership. As the Industrial Councils increasingly moved towards global bargaining, the notion of joint funding (and consequently right to control) became increasingly hollow. In global bargaining, all wage related costs are included in the equation and agreement is reached on the total amount available. Though some ground rules may be agreed (for example, the total cannot be taken in cash wage, without deductions for social security benefits), in this system the union has far greater control over the eventual distribution of the increase. Contributions to benefits such as the Sick Fund or Provident Fund are not optional extras, negotiated in isolation from wages, but an intrinsic part of the deal. It is arguable in this context that formal joint control of the benefit Funds is no longer appropriate and that unions ought to assume sole responsibility for the management of benefits which are part of the social wage. However, the prospect of increased responsibility is unlikely to attract the union in Natal, given its lack of engagement in the past. In the aftermath of unpopular decisions, joint structures allow a face-saving shift of blame, used by both parties in the course of the project and - to a startling degree - by the employers at a later stage, as revealed in the follow-up visit. In the leather industry, the involvement of the employer party shifts the focus away from inter-union rivalry and, on occasion,

serves as a spur to union unity. It is only in the Cape, where there is a reasonably sound financial basis and development is fairly advanced, that the advantages of assuming solo control and therefore responsibility for the management of the Sick Fund might outweigh the dangers for the union.

The projects had very different results, with a number of factors interacting to influence the outcome. One thread runs through all: the relations between union leaderships and memberships. Leaders can be involved in a health care project without taking their members with them into the process. This can be because they have little interest in the issue themselves, as was the case with some of the union representatives in the Natal Clothing Sick Fund. Sometimes the structures make it difficult to relate to the members on the issue, as in the Transmed case, where meetings were so frequent as to make it difficult to report back to members and impossible to represent them on a properly mandated basis impossible. A certain gritty persistence on the part of key leaders is vital, as in the KwaZulu-Natal region of the leather scheme, which has far outstripped the other regions, despite regional characteristics which daunted the Natal clothing fund.

The next chapter moves on to consider implications for health care, arising out of the studies. It is important for unionists involved in health care projects to keep abreast of developments in health policy, in order both to ensure that union experience is taken in to account in policy formulation and to develop a strong interface between union-supported medical schemes and the public sector.

Chapter 9. Implications for health care

1. Introduction

This chapter focuses on health care as a prism through which to reflect on the relationship between trade unions and politics. The influence of the political context on the outcome of these studies has been referred to in previous chapters. The focus here is narrowly on the implications for health care. In the last years of the apartheid regime, health policy had been generally directed at de-regulation of the private sector and 'encouragement' to the employed to use private sector facilities, leaving the public facilities for the unemployed, elderly and indigent (Naylor 1988; Price 1988a; 1988b; Price and de Beer 1988). Black membership of medical schemes grew dramatically, though from a low base, as trade unions moved beyond recognition battles and wage bargaining, into the arena of conditions of work and benefits. While private sector expenditure expanded, public sector expenditure was relatively static, especially considering the fact that, despite the growth in black membership of medical schemes, the vast majority of the population (including many in employment) were dependent on public sector services.

It was clear that the government was not going to make the kind of investment in the public sector that would result in acceptable services. This concentrated the minds of union leaders, obliged to take the initiative. The early stages of political change opened a gap to secure deals with sympathetic officials in the state health

bureaucracy (as seen in the Cape and Leather studies). The disruptive violence and policy uncertainty of the election period closed this gap, with disastrous effect in the Natal study. After the election, the new government's understandable concentration on building up the public sector, along with a long-drawn out confusion about policy direction on the private sector, NHI and the public-private connection, bedevilled the process of changing Transmed and poses ongoing problems for undertaking the restructuring of any further schemes.

2. What do the studies show?

Specialisation

Workers were increasingly distanced from the process of change in the *private health sector*. This tendency is obvious in the studies, most starkly in a comparison of the Cape Clothing and Transmed projects. Increasing complexity, financial scope and deficit size lend urgency to the need for change and increase the dependence on professional assistance (Broomberg et al. 1991; Broomberg 1991). There is a burgeoning market for health care consultancy in South Africa, as more and more schemes are hit by levels of medical inflation which threaten their membership base in the short-term and their survival in the longer term. Alongside this growth, there has been a growth in companies specialising in various interventions aimed at curtailing both the unit costs of various health services and the underlying problem of ongoing increases in utilisation of health care. These interventions go by the collective name of

'managed care' and are being heavily sold to medical schemes (Broomberg et al. 1991; Veliotes et al. 1993; Kinghorn 1994).

'Managed care' introduces new professionals to the process of restructuring, with their own vested interests, increasing the pressure on trade unionists, required to assimilate new systems, rules and jargon and to choose between competing companies with little track record. Most unionists feel uneasy about explaining managed care operations to their members and this compounds their reliance on the professionals (the health care consultants and the scheme administrators) for member information and education. The entry of managed care has also antagonised existing vested interests, particularly the medical profession, who may use their direct influence with members to foment resistance to new measures, and may go so far as to refuse to treat members.

The process of change in the *public health sector* has equally excluded trade unions. There is no mechanism to involve trade unions, as the largest organisations of health care users, in the process of decision-making and policy development. The two major commissions on health financing were made up of members chosen on the basis of their individual expertise, not as representatives of particular constituencies. This was a problematic formulation, not least because there were unionists with a particular expertise in the management and development of schemes for low-income members, whose experience would have been valuable, given the low coverage of this group.

Degrees of success

There is a clear gradient in the 'success' of the studies, with the later studies less successful than the earlier ones, judging success by not just the extent of implementation but also the degree of involvement of unions and their members. This gradient was unexpected, given growing experience with the model, and national political change, which might have been expected to ease the problems and increase the chances of success. A number of factors interacted in complex and sometimes contradictory ways to produce the different outcomes. At the most basic level, the raw material of the studies differed markedly, especially their financial soundness. The Cape Clothing Fund had strong reserves relative to its size and scope and these had been markedly strengthened by the Dependants' Fund, which served as a buffer against the uncertainty of change, diluting employer resistance and enabling the union to push through major developments. The Leather Fund had diminishing reserves and a serious problem with over-expenditure in some regions, notably Durban and Pietermaritzburg, but was able to cross-subsidise these areas from other 'profitable' regions. More significantly, the parties recognised the crisis in the Fund and were prepared to take the step of increasing contributions fairly dramatically in percentage terms (though from a low base) in order to stabilise it, pending restructuring. The increase was softened by the national scope of the Fund, as it was spread across 'loss' and 'profit' areas. Resistance from the major 'profit' area, the Transvaal, was diluted by the fact that it came from the smallest union, which had no presence in any of the

other areas. The Natal Clothing Fund was seriously underfunded, with diminishing reserves, inaccurate budgets and income forecasts, and resistance from both employers and the union to the increases necessary to stabilise it, before expansion could be considered. Transmed had the same problem, on a massive scale. With no reserves at all, the scheme was battling to contain a mounting deficit, pending major restructuring of both benefits and contributions.

All three IC schemes had a clear subsidy policy, with matching contributions from employers and workers, which created a certain parity about financial decisions, as they were equally funded by the two parties. Transmed, however, had a fixed contribution from the employer, which was related to the wage level, rather than the actual cost of the benefit. This contribution rose only with wage inflation, which is substantially lower than medical inflation. Consequently, the impact of any increase in medical scheme costs above wage inflation was felt only by the members. This was particularly problematic in a situation where the benefits had been substantially underfunded and there had been no contribution increase for a year and a half. Restructuring of the benefits and of the subsidy range (with no increase in the maximum subsidy) added further uncertainty. The resultant imbalance mirrored the imbalance in responsibility on the Board of Trustees.

Transmed also differed from the three IC schemes in containing multiple options, raising complex questions of equity. This case highlighted the problem of attempting to design a health scheme to meet health 'needs'. It is complex enough to reach a definition of 'needs' when there is no pre-existing scheme, but the existence of

a scheme of any sort inevitably influences and often distorts the process. This is less problematic in simple schemes like the IC schemes, which build from a low base of benefits. In the Transmed case, however, the existence of five different Plans clouded all consideration of the issue of needs. Those in the lower Plans wanted the benefits of Plan 5, and those in Plan 5 saw the closure of their option as an attack on their health. (High) cost was equated with (high) quality and freedom of choice (of scheme and provider) with democracy. Attempts to reduce the unit costs of care were regarded as inherently dangerous and anti-democratic, an assault on the health of the members. The classic uncertainty of need compounded the difficulty: healthy people may be overtaken by accident or dread disease at any time. It was never possible to disentangle a discussion of health need from this tangle of emotion and history.

3. *Issues for unions*

If unions want to assure access to good and affordable health care for their members, they have to address a number of issues, which emerged in the course of the studies.

Worker distrust of the public sector

The first of these issues is the widespread distrust of the public health sector amongst workers and its corollary of exaggerated respect for the private sector.¹ The distrust of the public sector is based partly on direct experience in the apartheid era. Services were under-resourced, resulting in overcrowding, long queues and shortages of staff, equipment and supplies. The association with the apartheid state lingers and has not been successfully overturned by the new government. The Transmed study in particular revealed a sense from workers, shared by many of their leaders, that public sector health care was part of the past, which they thought the 'New South Africa' had moved beyond. Interestingly, the advance envisaged was movement out of the public sector and into the private sector, rather than the reclaiming and strengthening of the public sector and redistribution of resources between groups and regions inside it, which was the thrust of education reform.

The impetus to move out of the public sector was strengthened in situations where there was a racial gradient in access to health care within a company or sector, so it is markedly stronger in Transmed (with its multiple Plans) than in the Cape Clothing Fund (with its single scheme). Exposure to differential benefits focuses aspirations on achieving the most expensive benefits, short-circuiting a more fundamental process of examination and comparative ranking of health and other

¹ This phenomenon is by no means unique to South Africa and has been described in many countries, including both developed countries (Calnan et al. 1993) and less developed countries (Banda and Walt 1995).

needs. I would stress that this is independent of the question of how the costs are met: a decision to aim for a lower cost benefit is not a union failure, provided negotiating energy is directed to ensure that the putative increase is not lost but redirected to improvement of the cash wage or other elements of the social wage.

However, it is unrealistic to imagine that members will change their attitude towards the public sector on order. This will not happen unless and until there are visible changes in public sector services, which need to achieve a dramatic shift in image. The use of public sector services by high profile personalities, especially (but not only) from the political sphere, would assist in raising the credibility of these services, as would the involvement and backing of union leaders. There is a curious anomaly in the fact that the staff of public sector health services, some of whom are unionised, belong to medical schemes and use primarily private sector health care. If those who provide the health care in the public sector are seen to go elsewhere for their own health care, it is not surprising that workers would prefer to follow their example. Equally, it is strange that unions which are strongly opposed to privatisation, on political as well as economic grounds, have failed to make the link with health policy.

The challenge of solidarity

The design of benefits and contribution tables throws up a series of issues for unions, related particularly to the problem of giving practical effect to the long-established union principle of solidarity, the old slogan of 'An injury to one is an injury

to all' taking on literal force in this instance. All medical schemes are systems of social solidarity, the degree to which they embody this principle depending on the balance achieved between different groups. All contribution tables are built on the principle of cross-subsidisation: if all members paid exactly what was spent on their behalf for health care, there would be no need for a scheme. On the other hand, the degree of subsidisation has to be balanced by the need for reasonable consensus. Some kinds of cross-subsidy are more generally acceptable than others, most notably subsidy of the sick by the healthy, since there is a reasonable chance that sickness may strike anyone. Subsidies of the old(er) by the young(er), of women by men, or of the poor(er) by the rich(er), are contentious, and may well be resisted by the potentially affected group. Since young men (sometimes also relatively richer, by virtue of their placing in the skills hierarchy) are often amongst the most vocal and active of union members, union officials have to exert considerable moral authority to avoid their interests dominating (especially as they are more likely than not to be young men themselves). The broader the group, the more marked are the problems of cross-subsidy: thus Transmed, with its very wide income range, experienced the problem in a far more acute fashion than the IC Funds.

The problem of gender emerges also in the design of benefits and the attitude towards women-only benefits. Is a gynaecological clinic a sectional benefit because men get no use from it? Is maternity leave an even more narrowly sectional benefit, because only certain women draw on it? Confronting these questions presents a

challenge to male-dominated union leaderships, particularly at times of financial crisis, when the pressure to cut costs tests the firmness of commitment.

The problem of limits and controls

All medical schemes confront the problem of meeting a virtually limitless need with limited resources. Different schemes met the need to ration health care in different ways. The Cape Clothing Fund imposed no limits to consultations with general practitioners. Dental, optical and gynaecological benefits were rationed by means of an appointment system. The Leather Fund imposed consultation limits in the course of the project, in an attempt (only partially successful) to curb runaway use in certain areas. The Natal Clothing Fund imposed no limits to consultations, though the capitation system of payment for panel doctors had a built-in incentive to doctors to discourage frequent consultations (which had more impact on the doctor than on the Fund, whose doctor costs were fixed). Transmed had limits in almost all benefit categories under the old Plan system. The new scheme removed most of these, subject to agreement by an intermediary (one of the managed care companies). The notable exception, the limit in the 'Personal Medical Savings Account' which had to cover all elective care, was the source of major dissatisfaction.

One of the problems with limits is that they easily transmute in members' minds into entitlements. Those who do not use a particular benefit 'to the limit' are often left with a sense that they have lost out, regardless of their objective need. This gives rise to the common pattern of a run on benefits (especially elective benefits such as

dentistry and optometry) close to the end of the benefit year. The creation of a limit also serves to focus fearful attention on what lies beyond the limit, and much time was spent during the Transmed project discussing hypothetical cases.

One of the clearest points to emerge from the studies is the difficulty of containing costs in systems which are located in the open private sector. Direct delivery of services through primary care clinics, staffed and financed by the schemes themselves (as in the IC schemes), facilitates monitoring of both cost and quality, though it does not automatically assure them.² Care delivered via contracted panel doctors is less satisfactory, particularly in terms of quality of care, but does enable some degree of monitoring of cost. The free choice system operating in most commercial medical aid schemes, and in Transmed, is the most problematic of all. The assumption is that the quality of care is higher than from panel doctors but there is no necessary causal link between high fees and high quality. Transmed concentrated its cost containment initiative on medicine and hospitalisation in the first instance, leaving members to 'manage' their own primary care from the 'personal medical savings account'. This approach failed, as many members ran through the amount available, and doctors began to demand cash up front, for fear that the savings accounts were empty and they would not be paid. Dealing with this problem is one of the many challenges remaining for the Transmed trustees.

The relationship between benefit design and utilisation levels on the one hand, and contribution tables and increases on the other, is generally obscure not only to

² Quality of care in health is notoriously difficult to measure. On this issue, see for example Zwarenstein (1995).

union members but also to their representatives on management structures.

Contribution increases only achieve some degree of acceptance if union representatives trust and understand the accounts and projections on which they are based and are prepared to sell them to the members. Member acceptance depends on the degree of trust they accord the leaders involved. In the Natal study, the undermining of trust resulted in resistance and resentment.

Though nobody likes contribution increases, most are accustomed to a steady annual increase. Unusual increases (larger or at more frequent intervals) meet with greater resistance. In general, people are not prepared to pay them unless and until they are sure they will get their money's worth: they want to see before they buy. This is manageable for a scheme with healthy reserves but hard for schemes which depend on the increased income to pay for the improvements. Hardest of all is the situation of a Fund (like the Natal Clothing Fund or Transmed) which needs an increase simply to meet a past deficit, and can offer no increase in benefit in return.

The pace of change

It is clear from all the studies that changing health care arrangements is a slow process and that democracy slows the pace, while greatly enhancing the potential for successful implementation of changes in medical schemes. There is a natural tendency toward conservatism around health care practices. If people are used to choosing their general practitioner, they will resent restrictions on choice. If accustomed to pink pills from the pharmacist for hypertension, they may well be suspicious of white pills from a

clinic. Resentment is intensified if there is a perception that the changes are imposed and are not compensated by obvious advances in benefit. Even when there is broad agreement with the direction of change, habits die hard and the transition period from the old benefit arrangement to the new is likely to be troubled, requiring careful management.

The slow development of the Cape Clothing project was definitely a factor in its success: members and officials had time to absorb the proposals, discuss them and respond to them. The issue was discussed inside the union for four years before the formal project began in 1992: implementation of dependant cover and the new clinics took two more years. Another factor was that the change in the Cape Fund was an advance. Members had access to the brand new benefit of dependant coverage. They were not being asked to make changes in their own health care arrangements. Rather, they were positively encouraged not to change from panel doctors to the clinics, which were prioritised in the first phase for dependants. The anticipated effect occurred: members who took their children to the Fund's clinics observed and approved, and began to agitate for access. As new clinics opened, members gained access. The panel remains, but is gradually shrinking, especially in the vicinity of clinics.

The Leather Fund did not have the luxury of time and financial resilience and was obliged to act more rapidly to stem losses, which it did by imposing a limit on consultations. This aroused strong reaction, particularly from the NULW, and diverted the broader process of addressing the problems of the scheme into crude demands for higher limits. Resentment of the limits showed in some areas, where

certain members ran through their limits within the first few months of the benefit year and union officials reported defiant responses to the new rules. The teething problems of the new clinics in Pietermaritzburg, in particular, highlight the barriers to successful implementation, which included the attitude of the doctor employed. The Natal Clothing Fund tried to short-circuit the process of change, which proved to be distinctly problematic. The time limit on the formal project was less than six months, in a troubled time which severely limited the extent of contact with members.

In the Transmed project, the deadline for implementation was extended by three months when it became obvious that the six month deadline could not realistically be met. Even nine months was absurdly short for a project of this size and scope and the effect was obvious, especially amongst members. The Board of Trustees has spent the year since the new scheme was implemented in damage control, attempting to placate angry providers, negotiating with state health authorities and adjusting benefit design to accommodate member concerns, at the same time as overseeing the rationalisation of the problematic financial systems of the administrator. All of these are tasks which should ideally have been accomplished before implementation. The Transmed case underlines the point, which emerges in all the studies, that the process is never complete and that monitoring the system is at least as important as designing and implementing it.

Is this a 'model'?

Though there were similar elements to the proposals in all three Industrial Council cases, there is not a mechanistic model, which can be transplanted to different groups of workers and implemented simply and quickly. This was abundantly clear in the Natal Clothing project. There was a great deal of contact between SACTWU leaders from the different regions and sectors of the union, and developments in one region were scrutinised by and discussed with others. This happened both informally and formally: informally, around meetings for other union business; formally, in preparations for national wage negotiations. There was also an explicit long term plan to create uniform conditions in the different Sick Funds, raising others to the level of the Cape Clothing Fund (see Chapter 4).

There is an important distinction between an instructive example and a model. The specifics of the existing scheme have to be taken into account in modifying the elements of the proposals: for example, the different panel payment system in the Natal Clothing Fund meant that conversion to clinics for all members would be an added expense, rather than a saving. If this was a desired move, it would have to be implemented over a period, to cushion the impact on contributions. More generally, the negotiating environment has to be accurately assessed, identifying the indicators for wage bargaining and the status of other non-wage demands, as medical scheme demands are more likely to lose out when wages are under pressure. This links to the most important factor: struggle is part of the model. There will inevitably be

disagreement and dispute about solutions to health care problems. Most changes have cost implications and the division of the costs is the most basic site of struggle. But the struggle does not end there, even cost-free changes or those which may indeed save money, may spark resistance. None of the outcomes will have universal approval - their success depends on answering the felt needs of a sufficiently large group, accommodating sectional concerns and neutralising resentment or opposition.

4. Conclusion

For the unions, involvement in health care is part of a broader concern for members' welfare. Of the options available, the model which concentrates on primary care allows unions to manage the situation in which the majority of contacts between members and health services occur, to monitor cost and quality and design the services for maximum convenience in terms of sites and opening hours. Primary care is the gateway to the other levels of care and it is an advantage to members to be referred into other levels with monitoring and follow-up care from their own services. Public sector hospital care is far more affordable, whether members pay out of pocket or the scheme includes hospital care in the benefit package and negotiates prices with the public sector.

There are distinct advantages to the state in this kind of scheme. They are relieved of responsibility for the primary care of large groups of workers and sometimes their families. Referral to secondary and tertiary care is managed via

agreed protocols, as is follow-up care back at the primary level. Administration of fees is markedly simplified: fee levels can be negotiated with the Fund according to the income levels of the member groups and a consolidated account issued to the Fund. This is likely to be more productive than the labour intensive system of individual billing.

The active encouragement of links between the public and private sectors in schemes like these would assist in breaking down the notion that it is the fact of employment which marks the divide between the sectors. The political support of the trade union movement would strengthen the Department of Health in inter-departmental battles over the allocation of state funding. It is certainly arguable that organised workers, because they have structures for the articulation of complaints and problems, would constitute a more critical and vocal constituency for public services than the unemployed and elderly, putting pressure on services to raise quality. This would have a ripple effect on disadvantaged groups. The Department of Health is committed to increasing participation of citizens at the level of the District Health Authority. The trade unions in these studies tried to do something very similar in the health schemes to which their members belonged. Their experience has resonance for others who are moving in the same direction.

The final chapter draws together the themes of the thesis, looking particularly towards the future of union health care initiatives in the light of broader health care developments in South Africa.

Chapter 10. Conclusions

The narrative of this thesis follows restructuring projects in a series of medical schemes for workers and their families. The purpose of the thesis, as distinct from the projects, is to analyse the role of trade unions in these projects in the past, consider whether they have a role relating to health care in a changed political dispensation and, if so, the conditions under which that role can be sustained and expanded in the future.

Political transformation was more than the backdrop to, and framework for, the studies. It loomed over them, intruded into them at crucial moments and shaped their progress. Health policy for post-apartheid South Africa is still in the process of formulation and I believe that it is important that the experience of trade unions feeds into the project of expanding, improving and democratising the delivery of health services to South Africa's people. The thesis arose out of engagement with this problem and its purpose was not restricted to retrospective reflection and analysis, but intended also to inform a renewal of that engagement. I did not so much choose a thesis topic, as find it emerging out of my work of the last ten years and more. The focus expanded along the way. Though a tightly focused study of a single scheme would have been neater and easier to manage, it would have been misleadingly narrow. Had the thesis been, as planned, a study of the Cape Clothing Sick Fund, it would have focused on a success. Expanding the focus to include projects which resulted in degrees of failure opened up far more challenging questions about the conditions for

success and the limits on replicability which are, I believe, of significance in the national project of health system reconstruction and development.

The four medical schemes at the centre of the thesis each faced problems with the funding and delivery of medical care at affordable cost for their members, especially low-income members. The schemes varied in size, geographic scope, benefit design and financial stability and the projects varied in the degree of trade union involvement, the organisational form of that involvement and the expectations of members. They also differed in the extent and style of my involvement. I was not an observer, but an actor. I was not documenting and analysing processes taking place apart from me, but centrally involved in those processes and with strong views about the direction in which trade unions should be moving. This adds a dimension to the process of thesis writing, requiring me not only to examine the projects and their outcomes, but also to apply the same rigour to reflection on my own views, and my relations with unions and workers. To what extent had I imposed my own agenda on the projects? To what extent had I honestly followed the principles of democracy which I believed were essential within unions, in my own relations with them and in the processes of research and implementation? In short, I have had to reflect on my working life and my politics and, in the light of that reflection, decide how to direct my work in the future. The thesis is for me a starting point for a new involvement in policy formulation on health care both within the union movement and in engagement with government.

1. *The argument*

The central argument of this thesis is that, under certain conditions, trade unions can transform existing arrangements for health care for their members, imprinting a trade union character on both the services and their management. I argue that struggle and the bargaining process are crucial to a successful outcome in projects which attempt to transform working class health care. The studies reveal the complex reasons which motivated certain unions to take up the issue of health care and to locate that issue in the context of collective bargaining, dealing with employers rather than directly with the state. Unions are faced with multiple demands on their time and energy, and there is a constant process of redefining their agendas and shuffling their priorities. The motivation for taking up a new issue is important, as it strongly influences the commitment and resources which will be devoted to the issue and the staying power of those involved. Basically, unions consider: first, whether they *should* take up a particular issue? (is it a union function or does the responsibility lie elsewhere, with the state, employers or members themselves?); second, whether they *can* take it up? (do they have the necessary resources and skills?); third, what the consequences of success or failure would be.

New issues challenge the capacity and skill of unions. Wage bargaining is a core union function and members grow to understand that their negotiators will have varying degrees of success with it, but unions taking up health care are assuming

responsibility for an area previously outside their scope. This has the potential for garnering both credit and blame. In either outcome, the union is identified with the scheme and this affects members' ideas of union purpose and operation: what unions are for, what they do and how they do it. Failures and shortcomings of the health care scheme will be blamed on the union, while successes may increase respect for the union but may also stimulate new demands and deflect attention from government failure to provide adequately in the field of health care.

Spurs to leadership action on a new issue may include strong dissatisfaction from members, an assessment that the issue is winnable, personal interest and strategic vision. There are elements of all these in the Cape Clothing study, where a new young leadership challenged the old leadership's claim of caring for members, in the first instance by questioning the quality and value of the benefit provided, and then by articulating the aim of improving benefits, extending them to dependants and wresting control from bureaucrats and doctors. The 'family' benefit was of particular significance in establishing the responsible nature of the cadre of new young leaders (many of them single and childless at the time).

The project would not have caught fire had there not been a basis of member dissatisfaction with the scheme: union leaders generally respond to dissatisfaction, rather than stimulate it. In the Natal study, though there was member dissatisfaction, this had not caught the attention of the leadership, which did not need to reclaim the benefit to establish its own legitimacy, as in the Cape. The project was adopted second-hand in Natal, rather than conceived with enthusiasm. The leather study falls

between the two clothing schemes in this respect. Impetus to examine the Sick Fund initially came from national leaders in SACTWU as part of their strategy for increasing their power in an industry in which theirs was a minority union. Unions became involved in the Transmed project because they had no choice. They were reactive rather than pro-active. The white unions had to engage when the representation they had demanded was offered and in the process they were associated with decisions unpopular with their memberships. The black unions had also responded reactively (but separately) in the past. The new style of joint union bargaining inevitably drew them into the process, carrying a separate agenda of their own: to redress the inequalities of the past.

Once unions decide to take up the issue of health care, the conditions for success include commitment from union leadership, membership support and involvement, efficient administration and financial stability within the health care funding mechanism. The projects are most successful when key leadership figures are prepared to invest time in the process of change, not merely rubber-stamping it, but prepared to fight for health care demands in the bargaining process against other and equally pressing demands. Continuity of involvement by such leaders gradually lends their credibility to the process of change, but the changes will not succeed if they do not answer member needs and attract member support. Few union leaders will involve themselves in issues which are unpopular with members and plans imposed from above, however objectively necessary or even 'good', will not work. At best, members will not understand them; at worst, they may actively subvert them. Poor

management of schemes limits the possibility of change: poor financial and data management increase the area of uncertainty and consequently confirm conservative tendencies and unwillingness to change on the part of both members and leaders.

Uncertainty is a good excuse for inertia, as seen repeatedly in the Transmed study when the unions (especially the white unions) used the unreliability and variance of the financial reports issuing from the administrators as a reason to defer decisions. In financial terms, stability is more important than size, also abundantly clear in the Transmed study. Despite its enormous size and financial flows, it was dangerously unstable, with no reserves and ongoing confusion about its actual financial status.

I believe that the thesis has demonstrated that by direct involvement, trade unions can improve the health care provided for their members. They do not need to regard this as an area to be left to the medical and planning experts who generally monopolise the design of health services. These experts have their place, but they should develop a relationship with those who will use the services they design. Union leaders bring an expertise of their own to dialogue with specialists: they are experts in the representation of their members' interests and in bargaining to advance those interests. The devil is in the detail and union leaders can feed into the planning process the detail required to adapt a model to the particular circumstances of their members in this place at this time.

The trajectory of the studies underlines the danger of simplistic model-making. There were very real achievements in the projects, which have changed the nature of the health care accessible to members, but these were hard-won and slowly

implemented. They were bargained, emerging gradually out of a process of extended struggle. This struggle is a fundamental feature of the studies and without it, the 'model' is lost. The process of struggle and bargaining embeds the issue, confirming the union's commitment to it as one chosen above others (which were, as a consequence, delayed or rejected), defended and argued for amongst leaders and members, and between unions in the multi-union schemes. In the multi-union schemes the inter-union caucus becomes a kind of rehearsal, an internal bargaining process before meeting the employer party in the collective bargaining process.

In the process of bargaining, commitment is tested again. Issues which have slid easily onto the agenda are as easily dropped. The Natal case is indicative of this problem. The issue of dependant benefits was repeatedly agreed 'in principle', raising expectations and then provoking resentment and distrust from members when the expectations were not fulfilled. In the leather scheme, by way of contrast, though dependant cover was a clearly expressed need, it was not the main issue in the mandate for the study. The result was that expectations were kept to more realistic levels, with a clear understanding that the first priority was to contain cost escalation as a necessary pre-condition to expansion of benefits.

The practice of bargaining assists in easing the stranglehold of the bureaucrats, medical professionals and medical business. Conventional medical schemes unilaterally raise contributions to cover utilisation of existing medical benefit structures, only restructuring benefits when contributions inflate to levels which threaten loss of members. The schemes in this thesis adopted a more radical approach,

taking account of the fact that 'need' is an elastic term in relation to health services and that demand for services grows continually. The only way to contain costs to affordable levels is to involve the users in a process of prioritising needs.

Bargaining around health care issues (other than employer subsidy level) takes place in different structures from wage bargaining. They may be sub-structures of the wage bargaining structures, as in the Sick Fund Management Committees of the Industrial Councils, or entirely separate, as in the Transmed Board of Trustees. There is a greater degree of common interest in health care than in wages, frequently marked by attempts by employers and medical administrators to 'de-politicise' the issue and divorce it from bargaining. The danger of this approach is demonstrated quite clearly in the Transmed study, in which health care issues were relegated to a body on which representation was not proportional to membership and where the employer party repeatedly attempted to avoid bargaining. This was unrealistic, given the impact of increases in the cost of the medical scheme on wage bargaining. The major increase in contributions, though decided in a non-bargaining body, was carried to the wage negotiations by trade unions determined to claw back in wages at least some of the contribution increase which their members had suffered. Equally, the tense atmosphere of wage negotiations infected the atmosphere of Transmed Board of Control meetings and exacerbated the difficulty of reaching agreement. In the Natal case, this infection was powerful enough to cause the cancellation of Sick Fund meetings throughout the period of the 1996 wage strike. The lesson is, I believe, that since it is impossible to avoid the element of bargaining about health care, it is

preferable to confront it directly and locate the issue in relation to bargaining structures. There is certainly a case to be made for separate structures for the management of Sick Funds: if Sick Fund management is simply one issue on the general agenda of the bargaining structures, there is an obvious risk that it will be squeezed by other urgent issues. However, the management structure should mirror the general bargaining structure in terms of representation, and should report to it, in order to maintain the link and the balance between health care demands and bargaining over wages and other benefits. Besides the bargaining process between employers and worker representatives, union-based schemes have used their experience of bargaining to good effect with other parties: with the state in all the cases; with managed care companies and suppliers, and even their own administrators, in the case of Transmed.

One of the major lessons of this thesis is that changing health care schemes is a very slow business. Short cuts do not work. The success of the Cape clothing project is in no small measure due to the slow percolation of the issue through the union and the deliberate pace of decision-making in Industrial Council structures. Frustrating though the challenges and delays are, the process of justification and cross-checking and further investigation tests the commitment of the parties and increases the chances of success. The slow pace in the Transmed project had more complex effects. While slowing the pace in the IC projects meant delaying new expenditure, in Transmed it meant increasing the deficit (by R20 million a month at the height of the problem) and compounding the inequities of the past by directing company rescue funds once again to schemes which largely benefited white employees. This project required (and

continues to require) a difficult balance between the (slow) pace of educating members about changes and the (rapid) pace needed to stem the financial collapse of the scheme.

The process of relating to members, gathering their responses to proposals, informing and educating them, is much more difficult in national schemes. The leather project was problematic enough but the difficulties were intensified in the Transmed project, in which members had to choose between options. In the end, there was minimal contact with scheme members, amounting to a series of meetings around the country *after the scheme had been designed*, explaining the new benefit options as a prelude to members making their choices.¹ Before this process, the views of members were presumed to be channelled through their representatives to the Board of Trustees. Equally, there was an assumption that the trustees were feeding in members' views and taking back to their members the discussions and decisions taken by the Board. This is a somewhat idealised conception of union functioning, given the competitive multi-union situation, the pressure for rapid decisions, the complexity of the issues and the stakes. The speed made it difficult to mesh with union structures, truncating the normal process of reporting back and receiving mandates and some of the trustees expressed insecurity about reporting back accurately on the complex issues and choices facing the Board. Also significant was an element of defensiveness especially among the white craft unions, who operated with a sense that they were

¹ I had already left on sabbatical at this stage, so missed the member meetings. The process was, by all accounts, gruelling.

defending their members' rights against overwhelming odds. They were reluctant to report back to members on the compromises they felt they were being forced into.

All the projects provide a sobering lesson for state health planners. Taking the Cape Clothing scheme as an example, if it takes this long to create a scheme for 50'000 families from a socially homogeneous group in one industry with minimal income differentials in a limited geographical area, on the basis of an existing scheme, then designing, planning and gaining public acceptance for a new scheme to incorporate either the whole working population or even simply those currently without medical cover, is a task of staggering magnitude.

2. *Complicated relationships*

It is important to recall that these are not union-only schemes: employers also have an interest in the schemes, which they jointly fund. This is an important feature, sometimes lost in the shorthand of referring to 'union schemes'. However, though the two parties share the funding, it would be wrong to view their interests as equal. The employers have a broad interest in the health of their workforces and an obvious preference for value for money via cost-efficiency within the schemes. The unions have an interest beyond the financial: their members use the services (along with their families in some cases), while employers do not. It is not surprising that interest in the actual services is keener on the union side, and that the process of change in the Sick Funds was in each case initiated by unions. Nevertheless, there were a number of

employer figures in the IC projects, especially in the leather study, who had a sustained interest in the developments and were involved in their implementation and the driving force in the Transmed project was a manager, who absorbed himself totally in the process. On the administrative side, commitment varied from the energetic involvement of the General Secretary of the Leather IC to the frank lack of interest and carelessness of the Secretary of the Natal Clothing IC and the incompetence and occasional resistance of some Transmed staff. Senior administrators tended to give the lead for their organisations and consequently working with NICLI was productive and enjoyable, despite the objective difficulties, whereas working with the NCIC was frustrating in the extreme, and with Transmed, a startling exposure to incompetence on a grand scale.

One of the more twisted threads running through the thesis is that of the complex relationships around health. It would be a romantic overstatement to say that these unions have equalised the power imbalance between workers and doctors. The shift of balance is slow and not accomplished once and for all. The relationships are ongoing and so must the union involvement be, if the balance is not to swing back towards the professionals. Therein lies the danger - that union leaders lose interest or energy after the initial engagement and allow old habits to reassert themselves. They also need to engage with members, to start to challenge their views on health care, to open the way to a more positive attitude, which does not simply equate quality with quantity (of drugs, tests, consultations and interventions) and the level of luxury in facilities. The other strand of this theme is the relationship between union leaders and

the new cadre of medical management appointed to give effect to the plans for development and to run the services on a day to day basis. The studies have proved how difficult it is to find and hold good medical managers and staff, and how easy it is to lose control. It is dangerous, but easy, to neglect the relationships with medical staff once they are employed, leaving them to get on with the job of providing health care to members. This is not simply a technical job, the same in all situations. The way in which providers interact with their patients is at the core of that care and it is extremely difficult to judge in the abstract or to monitor in practice. Qualifications can be scrutinised in the selection process, but care and respect are more difficult to measure outside of the provider-patient interaction, which is generally private. For this reason, the unions need to retain and strengthen mechanisms for members to relate their experiences in the Funds' health care centres, and they also need to provide a working environment which fosters and acknowledges good practice from health professionals. As employees of the Sick Funds, the medical staff have employment rights which should not be overlooked by trade unions when they become employers.

Joint management of health schemes is demanding, and potentially creates and entrenches a new group of 'specialists' in the management committees, distancing them from ordinary members. The task of transformation does not stop with the challenge to the old administrative bureaucracy, as a new bureaucracy, this time medical, is in danger of emerging. Joint management structures also tend to involve 'outsider experts' more directly than wage bargaining structures. Their role is complex: on the one hand, they can 'empower' worker (and employer) representatives

in relation to the bureaucrats, medical business (in the form of managed care operations) and professionals; on the other hand, they can substitute for those representatives, especially between management meetings. The most powerful of the Transmed sub-committees is the finance committee, which has trustee members, but in its first year was usually only attended by the Chair (a senior manager) and an actuarial consultant. The frequency of meetings is a serious barrier to the involvement of union representatives, most of whom have numerous responsibilities in addition to their Board duties. The Transmed study also provided vivid evidence of the difficulty of transforming relationships inside bureaucracies, especially large ones. Monitoring change is a difficult and continuing task, but the fact that the Cape Clothing Sick Fund recently survived a serious problem with its second medical director without impact on the ongoing development programme is an encouraging example of the robustness of joint management.²

The role of consultants and advisers in the transformation of schemes, and their relationships with the other parties, is a common thread in the four studies. In the first three, I carried this role alone, while in the last, I was only one player in a large cast. In chapter 2, I reflect on my role in some depth: here I would like merely to highlight certain structural features of the role of consultants or 'experts'. From a trade union point of view, the crucial issue is balancing the independence which experts need in order to function honestly and produce sound and useful work, and the control which the union needs in order to ensure that the work is directed towards ends in which the

² Dr Morar, the first medical director, who left the Fund to study further, has been re-appointed and returns to the Fund in November 1997.

union believes, and at a pace and cost appropriate to union capacity. Clearly the projects would not have developed as they did without the involvement of consultants, to provide information, alternative benefit designs, cost projections, detailed plans and so on. However, information is seldom value-free: consultants come with agendas, sometimes fixed ideas and biases, or models drawn from previous work. They are likely to align themselves more closely with one of the parties: whether this is problematic depends on the extent to which they manage to establish credibility with the others and develop a working relationship with them. Most important, in my view, is sensitivity to the industrial relations context. Functioning in this context requires adaptation to the notion that expertise will sometimes have to take a back seat to the exigencies of bargaining. Operating in a multi-union context poses a challenge to consultants, specially any with links to one of the unions.

In the Transmed study, the intensity and extent of the financial crisis, the multiplicity of options and the administrative chaos compounded a situation of dependence on the experts which was far greater than in the Sick Funds but, even with the benefit of hindsight, inescapable. The Sick Funds needed ongoing contact and support from me as their consultant, long after the formal research reports were submitted, but with the exception of the Natal Clothing Fund they took responsibility for implementation and later went on to extend the process independently. Transmed's dependence on consultants continues, though the joint management structure has developed in sophistication and confidence. At the most basic level, though, until the administrators prove that they have both the capacity and the will to

implement the Board's decisions efficiently, the Board will continue to depend on the consultants as watchdogs through the process of change.

3. *Economic and political conditions*

The timing of the projects was crucial and the studies present a chronology of changing political and economic contexts. The Cape Clothing and Leather projects started while the apartheid state was still in power, some years before the democratic elections of 1994. Though the roots of the Cape project were firmly planted in the old era, political change was in the air and cracks were opening in the previously impermeable facade of the state. The Cape clothing project, in particular, seized the opportunity to engage with the provincial health department to negotiate concessions on drug supplies. The leather project, while it successfully negotiated a concession with a regional health authority (in Great Brak), was unsuccessful in attempts to negotiate a drug and hospital deal with provincial health authorities in Natal and to get a clear ruling on the scope of clinical practice allowable by law for its clinic nurses. In an ironic sign of the changing times, panel doctors in Natal used the new vocabulary of democracy to defend and preserve their position (and income) at the expense of the Fund and its members. In some ways, things were simpler under the old regime: a hostile state was not going to take action for workers' health care, so the unions had to.

There was considerable uncertainty about how the electoral alliance between COSATU and the ANC would transmute into a new working relationship with government, and with the post-apartheid state. In the broad front politics which characterised the last period of the struggle for national liberation, class differences were submerged in the face of a common enemy. After the election, the ANC assumed power but as the senior partner in a Government of National Unity (GNU), sharing power (in terms of the negotiated settlement) with the National Party and Inkatha Freedom Party, despite its overwhelming electoral victory. This arrangement constrained rapid policy change, along with the fragile economy inherited from the National Party and pressure from business and the international community, including donor agencies. At an institutional level, the fact that the settlement had also guaranteed the jobs of civil servants slowed the transformation process within the state and often put a brake on progress. At the same time, the ANC was faced with high expectations from their alliance partners and their electoral base. 'Delivery' was the catchword of the day, formally enshrined in the Reconstruction and Development Programme.

The Natal clothing project, launched in the immediate run-up to the elections, was paralysed by a combination of heightened expectations of 'delivery', uncertainty about government policy and issue overload on the part of unions, which were heavily involved in the negotiations before settlement and in the run-up to the elections. The Transmed project started in late 1995, more than a year after the new government was elected. The euphoria had subsided and transformation was proceeding unevenly and

slowly. There was one visible effect of transformation in this project: as top management of Transnet changed, union access was inverted. For the first time, the black unions had privileged access to company and government decision-makers and they used it.

Economic conditions have a significant influence on the projects, firstly on unions' ability to take up health care as an issue at all and then on the degree of mobility they have in bargaining. Health care demands are weighed against wage increases and improvement of other benefits, and come under particular pressure in adverse conditions, though responses differ in relation to the union's degree of commitment to the health issue. In the Cape, the union agreed to a delay in the change-over to statutory sick pay, but exacted a special contribution (the Dependants' Fund) in return. In the event, this Fund was crucial in establishing the financial stability necessary to weather the uncertainty of major change. In the subsequent negotiations, the union had to face the difficult issue of offsetting the cost of the shift to employers by a once-off reduction in the wage increase. This would not have been possible in a bad year for the industry: workers would simply not have accepted it.

In the Natal study, tough economic conditions combined fatally with lack of commitment to the Sick Fund issue to ensure that it was the first demand dropped during bargaining. The influence of economic conditions took a particular spin in the Transmed project, given the knock-on effects of increases in transport costs on the economy as a whole. A number of state departments have interests, sometimes conflicting, in developments in Transmed. The company, Transnet, falls under the

jurisdiction of two ministries, Transport and Public Enterprises, an uncomfortable situation compounded by the concern of the Department of Trade and Industry and the Department of Finance. The threat of privatisation and company break up is a major concern for the unions and has direct implications for the medical scheme project. Medical scheme liability is a factor in the saleability of the component companies. Equally, substantial loss of membership would affect the medical scheme, shrinking the risk pool and upsetting financial projections. It would also affect the administrators, whose infrastructure is premised on the current membership and would be difficult to scale down in proportion to loss of membership. Most intractable is the pensioner problem. Transmed already has a very high pensioner load, due to downsizing in the past. Further downsizing will exacerbate the problem, as divisions which are sold take their current employees but not their pensioners. It is unlikely that all divisions will be sold, which raises the spectre of a small publicly owned remnant with an enormous pensioner load, to be carried in effect by the state. The financial problem would be further magnified by any action to extend benefits to black pensioners. This issue highlights the problems that the state as employer encounters in trying to balance the need for fiscal discipline and the need to redress the injustices of the past.

4. *Implications for health policy*

In all the extensive policy work on the issue of a new health system for South Africa, there has been little involvement of ordinary users of that system. Consultation

about policy tends to take place at high levels and is dominated by specialists, with commercial and professional interests well represented. The Sick Funds, on the other hand, are examples of bottom-up construction within tight budgetary constraints, and a degree of popular involvement in the processes of design, negotiation and management of a new system which is rare not only in South Africa, but also internationally.

The discussion so far assumes that the Sick Funds have important lessons for the architects of a new health system. A more fundamental issue is whether the lessons are historical only. Were the Sick Fund developments an offshoot of unusual times, made inappropriate by a new political dispensation? Should they wither away or be absorbed into a unified national health system? These questions raise a series of difficult issues for the trade unions. I have argued that one of the motivating features for union action in the early studies was state failure to provide for working class needs. The health care projects arose out of a form of trade unionism which defined its sphere of activity, responsibility and engagement far more broadly than the workplace, relations with employers and employment issues. Few issues were excluded from the agenda of the independent unions in the 1980s and early 1990s, but not all issues resulted in extensive action in the way that health did in certain unions. In general, health care was a fire-fighting issue in COSATU unions: union officials responded to demands or complaints from members when they reached a critical level, but few unions had comprehensive policies, strategic plans or negotiating programs on health care. A combination of factors combined to force health care onto the agendas

of certain union. These included rampant medical inflation in the private health sector, the decay of state facilities, member complaints and demands, rising real wages and the extension of bargaining beyond union recognition and wages as the independent unions became increasingly established and confident. Health care was not a popular issue with union negotiators with members in standard medical aid schemes, who tried to match the desires and expectations of their members and the realities of the commercial medical aid scheme market. The union officials who took up the health care issue with enthusiasm tended to be those with members in low level schemes, like the Sick Funds, or members with industry-delivered services, as on the mines. These simpler schemes had potential for growth, development, expansion and consequently gain for members, while action on the elaborate and expensive schemes was generally in the unpopular direction of simplification and cost-containment, likely to be experienced by members as loss of benefit.

This background explains the vagueness of health policy at a national level in COSATU. The Sick Funds in this study (and others in which unions are involved), were not taken seriously by most other unions as alternatives to medical aid schemes.¹ Many saw them as old-fashioned and second rate, suitable for low-paid workers who could not afford medical aid, but unsatisfactory for workers who had progressed beyond this level. In my experience the problem was more complex: there was a gap between the wage level of clothing or leather workers and the level at which medical aid was reasonably affordable and the vast majority of workers fell into this category.

¹ For example, the Foodworkers' Medical Benefit Fund and the South African Municipal Workers' Union Medical Benefit Fund, both Western Cape initiatives.

Even for workers who could technically afford medical aid, the costs were too high, relative to other calls on their income. Nevertheless, medical aid had high status and was seen as the pinnacle of aspiration under the old regime and as such easily became the focus of supporters' expectations of the new regime. Workers expected the new government to do something for them and this expectation all too easily translated into an expectation of 'free' care *in the private sector*.

The new Department of Health has made considerable advances, particularly in expanding access to primary health care. Its priority has been the unemployed, indigent and marginal, especially in the areas worst served under the old regime, and nobody could object to this priority. The problem is that the policy on working people is not sufficiently differentiated. All those in formal employment, with the exception of those below the tax cut-off, are lumped together without recognition of the working poor. I argue that the new Social Health Insurance proposal is little more than a tax on the poor, without significant redistribution. If introduced, it is likely to raise first expectations and then resentment. The proposal is for a form of Social Health Insurance (SHI) which would impose a 'legal obligation for formal sector employees earning above the income tax threshold to be insured against the costs of themselves and their dependants *for care in public hospitals*' (Department of Health 1997a, 4) (emphasis mine). The system covers only hospital care (primary care *in public facilities* is free at point of service) and is in essence simply a mechanism for increasing funding for the public hospital sector. The SHI legal obligation may be met either by direct membership of a new SHI scheme, incorporating all working people (above the

tax cut-off) who are not currently members of medical schemes, or indirect participation via registered medical schemes, which must reinsure for all care which their members receive in public hospitals. This would incorporate all current members of medical schemes. The cost of membership is as yet uncertain, but two possible contribution levels are proposed, either 2% or 4% of earnings, split equally between employer and worker.

In my view, this version of SHI is problematic. From the point of view of trade unions, the problems may be summarised as follows. It offers little to workers who *do not* have a scheme at present. At present they use state hospitals and pay little or nothing for them. Under the new scheme, they would be paying for what they used free in the past. It also offers nothing to workers who *do* have a scheme at present. Their medical schemes would simply be required to pay the real costs of any public hospital care used by their members. The contributions would increase the cost of labour, a serious concern in marginal sectors. The system does little in the way of redistribution: the richest are generally in medical aid schemes, most of which use public sector hospitals very little if at all. Consequently medical aid schemes would contribute very little to SHI, and the major income would be from non-scheme members, the working poor. In addition, the policy document does not recognise the fact that some medical schemes (especially Sick Funds and medical benefit schemes) have low-income members. A single hospital fee system for all schemes disadvantages these schemes and will result in higher contribution increases for their members.

5. *The future for unions*

It is important that trade unions do not retreat from the issue of health care. Health policy is in a crucial stage of formulation. If the SHI proposals are implemented, they will undermine the basic principle of the Sick Funds, which provide primary care but direct their members to the public sector for hospital care, which they receive at subsidised rates because of their low income. The SHI proposals envisage free primary care but hospital care at full cost, to be funded either by the Sick Fund or via SHI. Either way, low paid workers will no longer be subsidised for hospital care. If the Sick funds are to survive, they will have to negotiate a concession in this regard: bargaining for exemption from SHI or reduction in contributions, in return for relieving the state of the cost of primary care for their members. The radical alternative is to close down the Sick Fund primary services, re-directing members into the public sector for primary care. This is neither practical nor desirable. Public sector primary services are severely overstretched and cannot accommodate any additional load. Nor is there yet a mechanism for incorporating the clinics into the state health system. Realistically it would be difficult to hand over the clinics, not least because of the sense of ownership which they evoke in members and the particular sets of relations which have developed between workers, their union and those who work in the clinics. There is an uncomfortable truth in the fact that fighting to preserve these clinics is a sectional issue, because they are exclusive to workers in the industries concerned and there is little immediate likelihood of either incorporating them into the

public sector clinic network or opening the facilities to some kind of broader access. In response, I would argue (in part, of course, defensively) that it is inappropriate for low paid workers to carry the load of subsidising even lower paid workers or the unemployed, who should be carried by the working population as a whole, with taxation ensuring that the richer carry more of the load. I am reassured by the fact that advances for Sick Fund members are not won at the expense of other poor groups. Their precedent value is significant, as examples of affordable provision, with a degree of democratic involvement not yet seen in any state service. As examples of the difficulty and slowness of fundamental change in health service delivery, they also have cautionary value for health planners engaged in the project of change at a national level.

In the process of restructuring health care for their members, the unions involved were strengthening a form of unionism which accepts a broad responsibility for the social welfare of their memberships and members' families. This breadth of responsibility was partly related in South Africa to historic state neglect of working class health and welfare, which left a vacuum for unions to fill. The change in government did not change this situation overnight, but opened up the potential for active engagement with the state at different levels, feeding union experience into the national project of constructing a health service to meet South Africa's needs.

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