



OXFAM
South Africa

THE RIGHT TO DIGNIFIED HEALTHCARE WORK IS A RIGHT TO DIGNIFIED HEALTH CARE FOR ALL

1 The Structure
of South
African
Healthcare

2 Public
Spending,
Profits and
Undignified
Work

3 Financial
Analysis of
Private Health
Care facilities

4 Policy
Gaps

5 Conclusion and
recommendations

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RESEARCH AND CAMPAIGN PROCESS

Step 1



Draft concept note



Step 2



OZA workshops draft concept note with its strategic partner Young Nurses Indaba Trade Union members who are nurses and CHWs. A report of the workshop compiled.



Step 3



The report from the workshop is used to develop terms of references of the research. Researchers are identified to carry out research.



Step 4



Researchers conduct desk top research using information in the public domain. First draft report is produced.



Step 8



A series of campaign workshops are held with allies to shape the campaign



Step 7



Report is reviewed externally by seven academics specialising in fiscal policy, working conditions for nurses, working conditions for CHWs, healthcare outcomes in South Africa.



Step 6



Comments are taken to produce second draft which is structurally edited by Oxfam team and copy edited.



Step 5



First draft is reviewed by research reference group made up of reps from YNITU, OZA, OGB and external reviewer



Step 9



Send Opportunity to Comment letter three major private healthcare companies.



Step 10



Response from Opportunity to Comment integrated.



Step 11



Launch of the report and campaign

FOREWORDS



SIPHOKAZI MTHATHI
OXFAM SOUTH AFRICA
EXECUTIVE DIRECTOR

As Oxfam South Africa, we put womxn's rights at the heart of all we do - which is why it is our honour to stand in solidarity with and collaborate with Young Nurses Indaba Trade Union (YNITU), one of a few womxn lead healthcare workers' union in South Africa. Womxn are the backbone of the South African economy and yet our backs are being broken under the combined weight of an insatiable extractive financial system and a gender-blind austerity government. This reports shows clearly how black womxn; nurses and community healthcare workers (CHWs), serving as the majority of healthcare professionals, find themselves pushed to breaking point and let down by the very systems that should protect them.

We show that, from 2016 to 2019, Network Healthcare Holdings Limited (Netcare), Mediclinic International (Mediclinic South Africa) and Life Healthcare Group (Life) paid out more in dividends and buybacks than they made in profits. This profit-seeking private healthcare combined with an austerity government which is still falling short of its 15% health budget commitment, as enshrined in the 2001 Abuja Declaration, has driven the unfair practices in the healthcare sector that have compromised the quality of healthcare.

These same womxn are responsible for the unpaid care work that keeps economies moving: the cooking, cleaning, and caring for children and the elderly. Statistics South Africa's 2010 Time Use Survey showed that, in South Africa, more than 80% of men living with children under 7 years of age did not report having done any child care in the previous 24 hours. The same survey showed that household production is valued at ZAR749.9 billion, and almost three-quarters of this household production was contributed by womxn, equivalent to 27.3% of GDP in the same period. This report argues that:

Failing to recognise the crucial role that womxn play in carrying out reproductive or emotional labour means that nurses and CHWs are stretched to capacity. Nurses and CHWs receive little support or recognition from employers with regards to familial responsibilities. Only 5.8% of nurses have access to childcare facilities. This means that nurses and CHWs are forced to entrust childcare duties to expensive childcare facilities, further adding to their financial burdens.¹ Alternatively, nurses and CHWs are forced to rely on family members or friends. In such cases, parents must deliver their children to the care of others before their work shifts begin, as early as 5 am, which implies transport costs and a trade-off with downtime before and after shifts.² These effects are felt even more by single mothers, whose burden is heightened as the primary caregiver. However, these consequences not only impact on the personal lives of womxn, but on the wider health system (from page 30 below).

The burden that rests on these womxn is enormous as they are unquestionably asked to care for others but thus far have not received their dues. The ongoing COVID-19 pandemic has put into sharp focus and exacerbated a number of inequalities and fragilities that haunt the healthcare system and constrain it from delivering on its constitutional mandate. The gender blind austerity budgeting has led to chronic understaffing, with 38 000 vacant nursing posts in 2018. The result is an overworked, underpaid and underappreciated workforce. The poor treatment of our healthcare workers has compromised the quality of healthcare, resulting in a healthcare system ill prepared for shocks such as COVID-19.

In the wake of the crisis our research aims to amplify the call that YNITU; nurses and community healthcare workers have made for an end to the injustice and inequality directed at healthcare workers. YNITU's leadership on this issue shows that the link between poor working conditions for healthcare workers and the quality of healthcare available in the country cannot be ignored. **Nor can their voices be side-lined.** Access to health care is skewed and unequal across the population and the quality of health care is ultimately

compromised, and racially marked. The private system is built parasitically on the backs of the public system and yet available only to 16.4% of the population. Using an intersectional lens, we see that 72.9% of the white population has access to medical schemes compared to only 9.9% of the black population.

A progressive NHI gets us started on the redistribution of resources between the two, but ultimately, the call is for overall reform of the system for quality, universal health care - a system of care designed to care for the public itself and caring first and foremost for those who keep the system standing, in this case, nurses and CHWs.



**FIKILE
DIKLOMELA-LENGENE**
YOUNG NURSES INDABA
TRADE UNION DEPUTY
PRESIDENT

YNITU is amongst a few womxn lead trade unions that organise healthcare workers in the country. We aim to fight the unjust system in the health sector. Our mandate was clear that labour spaces had to be challenged through radical and innovative means so that there can be a meaningful impact on the lives of health workers in their working space.

This report is important to us as healthcare workers to debunk the misconception that nursing is an unimportant activity and not a profession. Caring is put at the forefront of the nursing profession and therefore people forget about the most crucial factor, which is that we use science on a daily basis. This misconception leads people to think that there is no need to put monetary value to this profession because it has the model of the care component embedded to it.

As womxn, mothers, daughters and heads of households, we carry the work of keeping our communities moving. We do this with pride; however, this gender disparity in time-use creates an enormous restriction on womxn's time and their ability to choose how and what to use it on. When we quantify this time, we can see that what may appear to be an individual or household issue is actually an enormous economic one. This year's Oxfam Davos Report, Time to Care, estimates the value of unpaid care work at US\$10.8 trillion dollars a year, or around 13% of the global GDP.

We know that over the years, people have experienced frustration at a healthcare system that is divided: on one hand, an elitist, expensive, private healthcare system, hard to access for the common person; on the other, an inadequately resourced, slow public health care system.

Nurses and community healthcare workers, who are the frontline of services, have borne the brunt of the public's frustration. There are those who think nurses and care workers are lazy, and that they deliberately procrastinate when it comes to attending patients. Yet structural understaffing and hiring freezes mean there are often far fewer of us nurses and care workers than is safe and required to provide quality care.

Those available are overworked; working hours are strenuous and physically tormenting especially because theatre sometimes demands 12-hour shifts with no breaks. Sometimes there are multi-vehicle accidents and a patient comes in with multiple fractures, and the severity of the accident requires us to be on our feet until all medical procedures are done, leaving no space for meals or even toilet breaks. Community healthcare workers too are put under enormous strain as they are often left without adequate protection equipment, susceptible to communicable diseases, which poses a problem for us because we are not insured for occupational hazards and we do not have medical aid; therefore our lives are in danger and in turn endangering the lives of the people we are working with.

However, none of this is inevitable. We nurses and community healthcare workers are saying no more to being an overworked, underpaid and underappreciated workforce. We are calling for an end to the racially marked, skewed and unequal access to health care across the population. We know that quality of healthcare rests on our shoulders, but we need the private sector and government to play their role. As a matter of urgency, there is a need for greater funding in the healthcare sector as a lack of funding affects the right to decent work and gender equality for all nurses and community healthcare workers. Through tackling the socio-economic determinants of health and channeling funds towards one single system of health provision, the vicious circle of poor health, high pressure on the system and inadequate services can be broken.



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The right to dignified healthcare work is a sobering account of the precarious work and appalling working conditions of front-line nurses and community health workers (CHWs) in South Africa, the majority of whom are black African womxn. The report draws on the theory of intersectionality and South Africa's rights-based constitution, and identifies the policy gaps, workplace practices and social conditions that shape the poor working conditions for nurses and CHWs in South Africa.

The report highlights the irony and disjuncture between low pay, insecure contracts, unsafe and strenuous working conditions, gender-based violence, resource constraints and an environment of disabling practice on the one hand, and the expectations and demands placed on these womxn to deliver compassionate, quality health care for all. A combination of neoliberal economic policies, insufficient investment in both the public health system and the health workforce, and poor implementation of existing labour legislation have created the perfect storm of inequities and fragility of the South African health system. This is exacerbated by the COVID-19 pandemic, which lays bare the inequities, injustice and fault lines of our society.

The report makes bold recommendations to deal with the identified problems. These are: a universal and resilient healthcare system, responsive to people's needs; ensuring decent work for nurses and CHWs; transparency and accountability, both in the health system, and from employers; legislative and policy changes to close loopholes that impact negatively on these health workers; and an end to gender-based violence.

Nurses and CHWs are at the heart of an efficient and well-functioning health system and of a comprehensive response to COVID-19. The implementation of the recommendations requires bold and ethical leadership to enable and empower nurses and CHWs to work and function to their full potential. Empowering and investing in these front-line health workers will have the additional benefit of accelerating progress towards the Sustainable Development Goals on health, quality education, gender equality and decent work and inclusive growth. Importantly, nurses and CHWs must be valued as a political and leadership choice.



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EXECUTIVE SUMMARY

Profit-seeking private healthcare entities combined with underinvestment from government have driven unfair practices in the healthcare sector. Salaries have stagnated, and jobs have gradually been stripped of security, predictability and benefits such as health care and a minimum number of guaranteed hours.

The poor treatment of healthcare workers has compromised the quality of health care, this has resulted in a healthcare system ill prepared for shocks such as COVID-19 (Coronavirus disease 2019). The ongoing COVID-19 pandemic has put into sharp focus, and exacerbated, a number of inequalities and fragilities that haunt the healthcare system and constrain it from delivering on its mandate in terms of the South African constitution and regional and international human rights' law in terms of the right to health.

One of these spectres is an irony of South Africa's post-apartheid dispensation: strengthened labour protections and the feminisation of work have been undermined by the side effects of neoliberal economic policies which have accelerated precarious forms of work. Issues of low pay, insecure contracts and outsourcing, lack of safety and transport, sexual harassment, extensive and intensive working hours, and lack of resources and equipment are some of the poor working conditions that nurses and community healthcare workers (CHW) face. Ignoring the wellbeing of healthcare workers has left a healthcare system on its knees, with front line workers stretched while in a battle to restore health and get us back to work without adequate resources. The link between poor working conditions for healthcare workers and the quality of health care available in the country cannot be ignored. Failure to ensure safe and adequate working conditions

for healthcare workers in South Africa also amounts to failure on the part of the South African government to realize its obligations in terms of the right to fair labour practices in the constitution and the right to work in terms of regional and international human rights' law.

Womxn are the majority of those providing care - paid and unpaid - and the majority of health workers. It is no accident that our healthcare workers and unpaid carers are predominantly black womxn. This is driven by social norms which mean care is considered a woman's natural role and a woman's duty to provide. The disproportionate impact on womxn, and black womxn in particular, potentially violates the right to equality in the South African constitution and the prohibition of discrimination in terms of regional and international human rights' law.

We take a look at South Africa's "dichotomised health system", consisting of a public sector which struggles to secure the investment necessary to provide adequate healthcare for all, due to a neoliberal macroeconomic framework, and a well-resourced high-cost private sector supporting the minority. Whilst the private healthcare sector accounts for almost half of South Africa's total healthcare expenditure, only 16.4% of the population are covered by private medical insurance. If we include those paying out of pocket those served by the private healthcare sector amounts to nearly 20% of the population. Government spending on health care steadily increased before 2012 but has been in steady decline since. The implications of fiscal austerity for working time and fair pay for nurses and CHWs cannot be overstated, and it is important to emphasise that the protection of critical posts in patient care is undermined by the practice of cutting non-critical posts.

A study of the total net income, dividends, share buybacks and executive remuneration from 2016 to 2019 for Network Healthcare Holdings Limited (Netcare), Mediclinic International (Mediclinic South Africa) and

Life Healthcare Group (Life) showed that the companies made R11.7 billion in profit and paid R19.7 billion to shareholders (dividends and share buybacks), an average of R92 million a week. During the same period, shareholder pay-outs increased by 96%. In addition, shareholders were paid out even when losses were made. This shareholder bonanza comes at a time when the macroeconomic situation of the country has deteriorated since the global financial crisis of 2008, putting structural constraints on healthcare facilities. The rise in unemployment has meant that fewer people are able to afford medical insurance, and by implication private healthcare. Some of the strategies employed by companies to make up for this structural constraint, in order to maintain the shareholders returns on investments, are shareholder buy backs to prop up share prices and extract cash for shareholders, and the use of agency work for cost containment.

In terms of the duty to protect the right to health of all in South Africa, the government has a duty to regulate the private health sector to ensure, amongst other things, the affordability of healthcare services. In addition, private entities operating for profit in the healthcare sector have at very least a responsibility to respect the right to health in terms of international human rights' law and may have a direct right to health obligations in terms of the South African constitution.

We offer some recommendations for these companies and the public healthcare system to improve their treatment of womxn workers in their operations, thereby improving the quality of care.

01 The need for a people-responsive, resilient healthcare system that recognises, values and fairly rewards healthcare workers and enables universal

access to a healthcare system that is responsive to the needs of communities, society, free at the point of use.

There is a need for greater transparency in the healthcare sector. The unavailability of data and information aids in continuing a healthcare system that works against the nurses and CHWs who keep it afloat.

02 It is imperative that the employers recognise and fairly reward work done by nurses and CHWs as inadequate remuneration misses important human rights obligations.

03 In addition, there is a need for security of contracts for all healthcare workers including CHWs, as outsourcing makes work precarious.

04 Importantly, reduce the total number of hours CHWs and nurses spend on unpaid care tasks and admin work. This is to recognize and respect the realities that nurses and CHWs face as womxn and as mothers who carry the double care burden of paid and unpaid care work in a violent society.



05

There needs to be implementation of workplace policies conducive for familial responsibilities and the wellbeing of nurses and CHWs through the provision of accessible, safe and affordable day care facilities, revision of working hours allowing for flexibility but not insecurity, and 24/7 canteen facilities.

06

As the move to gender equality is an ongoing struggle in all their places of work, nurses and care workers must be represented and empowered in the design of and decision making around all policies and operations that affect them.

07

There must be an uncatergorial commimment to end violence against women. In all workplaces there is a need to have clear policies that establish a zero-tolerance policy towards all forms of violence and sexual harassment and discrimination in the workplace.

Our recommendations aim to reduce the precarity of work for nurses and community healthcare workers, and improve their working conditions. Calling for a review of the role of private employment agencies deserves special attention, since they are an important instrument in the labour market for temporary workers. Whatever the role of the private sector in a future where there is publicly funded universal healthcare, there is a need for private sector actors to behave responsibly. This could include making an explicit commitment to respecting internationally recognized human rights standards – UN Guiding Principles on Business and Rights (UNGPs) – applying the principles in its supply chains and operations.



INTRODUCTION

Currently South Africa's healthcare sector faces a number of great challenges. High rates of poverty continue to cause an onslaught of poverty related diseases.³ Cuts in government spending continue to threaten the quality and standards of health care.⁴ Nursing understaffing caused by a myriad of factors such as migrating workers, an ageing workforce and, of course, restrictions on filling posts in nursing threaten the capacity of the healthcare sector.⁵ South Africa is also faced with a heavy burden of disease.

The country accounts for 17% of the world's HIV infection rates and is also home to one of the world's worst tuberculosis epidemics globally.⁶ Of course, we cannot ignore the ongoing COVID-19 pandemic which has delivered a sharp blow to the healthcare sector. At the time of this writing, South Africa has 23 615 confirmed cases of COVID-19,⁷ thereby disproportionately affecting the South African healthcare system.

At the centre of this crisis are the nurses and community health workers (CHWs) who make up the backbone of the healthcare sector. Nurses and CHWs are at the frontline of South Africa's health crisis, battling to protect and ensure the health of their fellow South Africans. CHW is an umbrella term used for a heterogeneous group of lay health workers whose responsibilities range from implementing biomedical interventions to acting as community agents of social change.⁸ This paper defines CHWs as 'any health worker delivering health care, trained in the context of the intervention, and having no formal professional, certificated or degreed tertiary education'.⁹ In this paper, the term nurses shall refer to the collective group of professional nurses and midwives, enrolled nurses, enrolled nursing auxiliaries and student nurses who make up the entire nursing workforce.

However, the importance of nurses and CHWs is not a new phenomenon. Nurses and community health workers have long since been instrumental to the South African healthcare sector. Nurses in South Africa make up the largest single group of healthcare providers. They play multiple roles in the health sector and often bridge the gap between communities or patients and healthcare facilities, especially in rural areas where physicians are reluctant to practice.¹⁰ Nurses have been recognised by the WHO as being instrumental in addressing the complex disease burden and improving the performance of weak health systems in African countries.¹¹ Historically, nurses played a prominent role in charity activities and the anti-apartheid struggle.¹² Similarly, community health workers were instrumental in providing healthcare to black populations under apartheid.¹³ CHWs have been key in improving access to health care and encouraging community participation in health care in peri-urban and rural areas¹⁴ and have helped significantly to reduce child mortality rates and the burden of TB and malaria. Yet despite their great importance in battling the current health crisis and their historic significance, nurses and CHWs do not get the protection or recognition that they deserve. This predominantly black and female workforce often suffers under poor working conditions, long working hours and work amidst a slew of other social issues that will be elaborated upon in later parts of this paper.

Recognising the disconnect between the importance of CHWs and nurses and their working conditions, this paper aims to identify and expose the policy gaps, workplace practices and social conditions that allow for the continuation of poor working conditions for nurses and CHWs in South Africa. This report draws upon Crenshaw's¹⁵ theory of intersectionality - which considers people's overlapping identities and experiences in order to understand the complexity of prejudices they face¹⁶ - to call attention to the importance of race and gender in simultaneously shaping the realities and experiences of South African nurses and CHWs in the healthcare sector. This shall be done in order to provide appropriate guidance and recommendations to policymakers, activists, healthcare actors, feminists

and all other actors as to how the conditions may be improved and adjusted to ensure that nurses and CHWs work in decent and dignified working conditions as defined by the International Labour Organisation (ILO) and entrenched in sections 10 and 23 of the South African Constitution as binding legal rights as well as in the International Covenant on Economic Social And Cultural Rights (Articles 6-8).

COVID-19 in South Africa

Coronavirus threatens us all. But it preys most on the vulnerable. It has exacerbated inequalities. Globally, the economic fallout from the coronavirus pandemic could push half a billion more people into poverty unless urgent action is taken to bail out developing countries. As the United Nations Committee on Economic, Social and Cultural Rights has noted:

*The COVID-19 pandemic is threatening to overwhelm public health care systems, and is having devastating impacts across the world on all spheres of life – the economy, social security, education and food production. Tens of thousands of lives have already been lost, including those of doctors and nurses providing front-line medical treatment. Jobs have been lost and livelihoods imperilled due to restrictions imposed to curb the transmission of the virus, such as “lockdowns”.*¹⁷

We know that gender-based violence increases during times of crisis. During community quarantines or lockdowns, the incidence of domestic violence, marital rape, and other forms of gender-based violence is likely to go up but womxn may find themselves trapped without any recourse to reporting and help. Lifeline reported that cases of GBV in SA rose by 500 percent since the lockdown began on 27 March 2020.¹⁸ In addition to the GBV in the household, healthcare workers are also the subject of violence at the workplace¹⁹

Crucially, COVID-19 also has serious health implications for healthcare workers. In the course of their duties, some of them have been infected with the virus and others have also died. At time of writing, the Department of Health had reported that over 500 healthcare workers had contracted the virus²⁰. The bulk of these infections were of nurses in private healthcare facilities²¹.

Feminization of the workplace and increase in precarious work

Over the past fifty years, we have seen a significant increase in womxn entering the workforce worldwide. Through a theory known as the feminization of the workplace, we discover that womxn are more highly represented in certain sectors than men, which simultaneously correlates with lower pay in these sectors than their male-dominated counterparts. This trend has caused seismic shifts across international labour markets. Special attention is given to the care work and nursing professions in which womxn are overrepresented. Indeed, according to the ILO, “womxn and girls are performing more than three-quarters of the total amount of unpaid care work and two thirds of care workers are womxn.” With such a high proportion of womxn in care work, it serves as fertile ground for examining the impact of feminization at work. The United Nations Committee on Economic, Social and Cultural Rights has acknowledged that, like all informal and formal workers, unpaid care workers have a right to “just and favourable conditions of work” and “should be protected by laws and policies on occupational safety and health, rest and leisure, and reasonable limitations on working hours, as well as social security”.²²

Womxn are the majority of those providing care, paid and unpaid, and the majority of health workers. It is no accident that our health and care workers and unpaid carers are predominantly womxn. This is driven by social norms which mean care is considered a woman’s natural role and a woman’s duty to provide. In this report, we will explore leading arguments in a debate about feminization of work, including the neoclassical, institutional and feminist perspectives.

This report aims to answer the following questions:

- 01 What are the **gaps in the present national policy and regulatory framework** that undermine the rights to decent work and gender equality for black womxn workers in South Africa’s healthcare sector?

02

How do **poor working conditions and ineffective legal protections** within South Africa's healthcare sector affect personal, professional and national health outcomes and the realization of the state's obligations in terms of the right to health?

03

What are the **trends and drivers of insecure work** within South Africa's public and private healthcare sector? Has the South African government adequately regulated the private healthcare sector in accordance with its obligations in terms of the right to health?

This report is split into three main sections.

1st

The first section will map out the South African healthcare sector and highlight the key gaps in government spending and policy that compromise the right to decent and dignified work for nurses and CHW's.

2nd

The second section will identify four major areas that disrupt the right to decent and dignified work for black female healthcare workers, namely working hours, low pay and social protection, gender based violence, and safety and labour broking.

3rd

Finally, the third section will synthesise the arguments made in this report and offer recommendations as to how the working and living conditions of CHWs and nurses may be improved in accordance with their rights in terms of the South African Constitution and regional/international human rights law.



CHAPTER 1:

THE STRUCTURE OF SOUTH AFRICAN HEALTHCARE

South Africa operates a “dichotomised health system”,²³ consisting of a public sector which struggles to provide the investment necessary to provide adequate healthcare for all while a well-resourced private sector supports the minority. Whilst the private industry accounts for almost half of South Africa’s total healthcare expenditure,²⁴ only 16.4% of the population are served by private healthcare facilities are covered by private medical insurance.²⁵

In a review of South Africa’s compliance with its human rights obligations, the United Nations Committee on Economic, Social and Cultural Rights noted that to fulfil these obligations, South Africa must:

*...address the large disparities between the public and private health-care systems, as well as between rural and urban areas, by securing a sufficient number of medical professionals, improving medical equipment and expanding the range and improving the quality of public health-care services, particularly in the primary and community health-care sectors and in rural areas.*²⁶

This is sharply divided along the lines of race: whilst 73% of Whites have medical coverage, this drops to only 10% for Black Africans²⁷. As such, the vast majority of South African citizens rely upon a public health sector that is not equitably resourced through general taxation in the ways realised within most global economies.²⁸

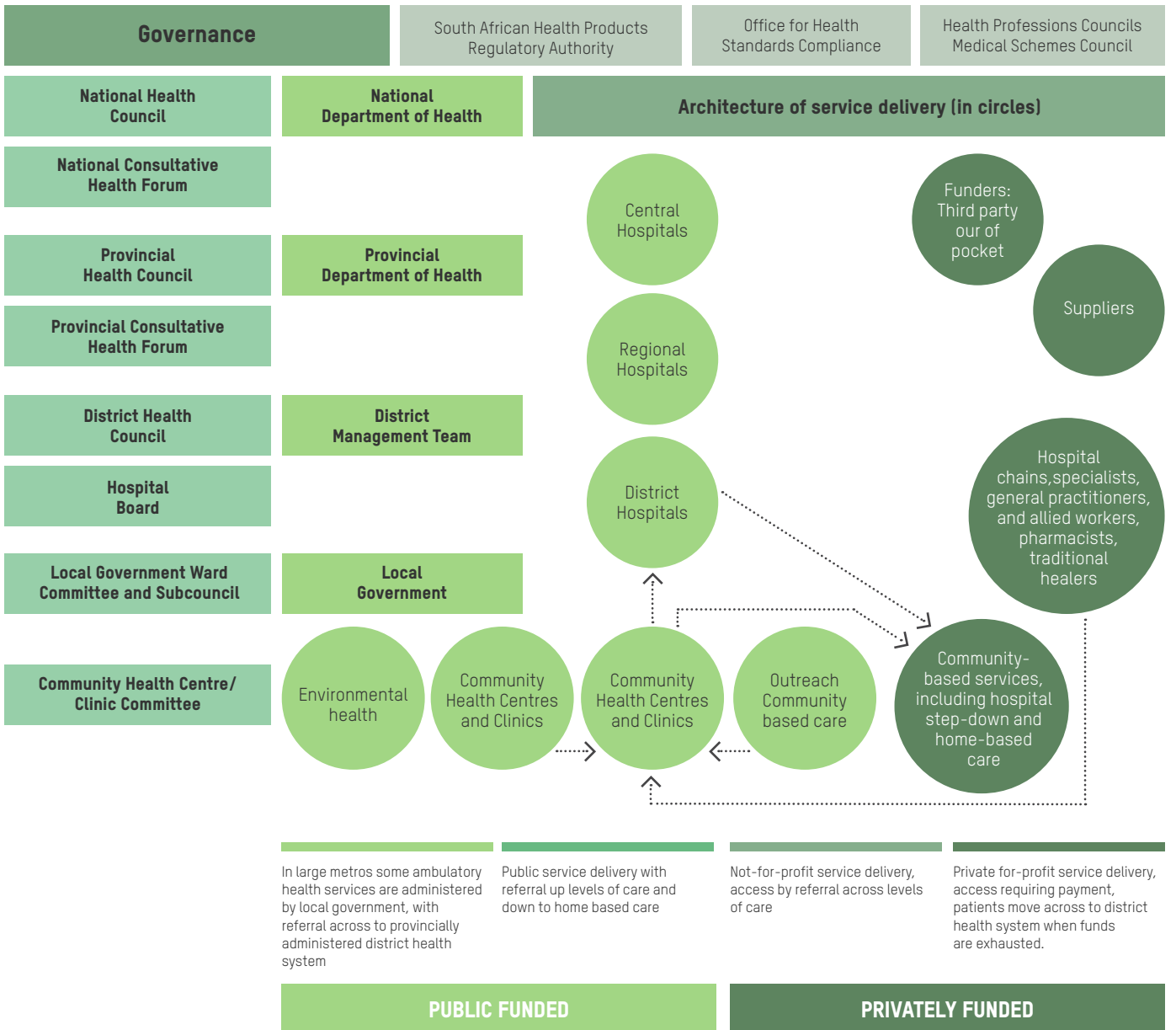
Combined with systemic issues such as nursing understaffing, low pay and inequitable labour distributions (38% of nurses and 59% of specialists work in the private sector),²⁹ South Africa currently exemplifies the inverse care law, whereby access to quality healthcare inversely relates to its population needs.³⁰

The financial strain placed upon the public health system is additionally compounded by South Africa’s “triple burden of disease”³¹, consisting of maternal and under-five mortality, communicable and non-communicable diseases, and violence-related injury³². These issues are disproportionately concentrated in marginalised communities,³³ reflecting the legacies of colonialism and apartheid on South Africa’s adverse health outcomes.³⁴

Building on this context, this section maps the structure, workforce profile and financing trends of South Africa’s public and private health sectors to provide context for the policy analysis. It shows that relative to demand, government health spending has been largely constrained and additional cost-containment strategies are exacerbating harsh working conditions for South Africa’s womxn-led frontline staff. The policy gaps preventing protection from these effects will be analysed in the next chapter.

1.1 OVERVIEW OF THE PUBLIC HEALTH SECTOR

Figure 1: Structure of the national health system



Source: McKenzie et al.³⁵

South Africa’s public health system is divided into three main layers of governance (see Figure 1). The National Department of Health is responsible for developing and co-ordinating policy frameworks, and the provincial sphere is responsible for implementation, including primary health care and the district health systems; the everyday management of public health facilities falls under the nine provincial departments of health.³⁶

In the organizational context, the Ministry of Health receives a budget from the annual government budget and allocates an amount for its own administration and a broad range of conditional grants (such as HIV, the National Treasury Services Grant, Health Professional Training and so on).The rest of the public health budget is allocated to primary, secondary and tertiary medical facilities that are located in and managed by



the provincial departments of health on a capitation basis. Public primary care units and public hospitals are expected to deliver care to all South Africans who have no other means of paying for care. Reimbursement comes almost entirely from tax-funded state and provincial budgets. Therefore, the provincial departments are the direct employers of the health workforce while the National Ministry of Health is responsible for policy development and coordination.

Healthcare delivery is built upon a nurse-based primary healthcare model (PHC), which aims to deliver free essential healthcare services at the point-of-use, supported by community participation³⁷. PHC is managed under the district health system and is comprised of approximately 3 500 local clinics,³⁸ whilst secondary and tertiary services (hospitals) are available by referral and require some form of payment.³⁹ The South African Nursing Council (SANC) is the main regulatory body for nurses in South Africa, which is responsible for maintaining standards of education and practice in line with the Nursing Act No.33 (2005).

Underpinning South Africa's PHC system is a complicated network of CHWs who deliver essential health promotion and home-based care to marginalised communities, and who often represent the first point-of-contact with the national health system.⁴⁰ In a drive to contain the spread of the COVID 19 virus, the Department of Health has deployed more than 28 000 CHWs to undertake door to door community screenings and testing.⁴¹ This crucial work helps to trace and monitor the virus as well ensure that suspected cases receive medical attention. Occupying an uncertain space between "employee" and "volunteer", the vast majority are precariously organised under sub-contracted NGOs⁴². However, an increasing number are being insourced by the provincial departments of health under South Africa's re-engineering PHC strategy, which aims to standardise, formalise and integrate their roles within the national health system.⁴³ In alignment with the context of externalizing PHC to NGOs and further reducing resources in the care-work sector,⁴⁴ CHW as a group remain unregulated and paid extremely low "stipends" even below the already low minimum wage levels, with little employment protection.⁴⁵ The United Nations Economic and Social argues that the minimum wage must be raised and be constantly adjusted to factor in the rising cost of living in order to meet adequate standards of living for all workers.⁴⁶



1.2 OVERVIEW OF THE PRIVATE HEALTH SECTOR

The for-profit private health care sector in South Africa consists of healthcare practitioners, medical insurance schemes and private health facilities⁴⁷.



Healthcare Practitioners

Healthcare is provided by healthcare practitioners that include general practitioners, specialists, nurses, pharmacists and other professionals.



Medical aid schemes

Medical aid schemes are non-profit organisations which provide health insurance to groups of people by setting premiums which are related to their ability to pay and number of dependents. According to the recent annual report published by Council for Medical Schemes, there are approximately 80 medical schemes in South Africa, which have 4.02 million registered members, serving a total of 8.87 million beneficiaries. Medical scheme membership is predominantly enlisted from the white population.



Private health facilities

There are currently 409 private healthcare facilities in comparison to 405 public healthcare facilities. The key players in the private healthcare industry are Netcare, Life Healthcare, and Mediclinic, who have a combined market share of more than 80%. We focus here on their actions as they collectively hold a significant part of the market. Members of a medical scheme or a private insurance plan are entitled to receive health care from private doctors and in private facilities.



1.3 WORKFORCE COMPOSITION

Representing 77% of the public sector's human resources for health,⁴⁸ nurses constitute the backbone of South Africa's national health system. The profession is separated into three main ranks depending on the level of training,⁴⁹ which consists of registered nurses (four years), enrolled/staff nurses (two years) and enrolled auxiliary nurses (one year).

According to the SANC's 2018 database, registered nurses are the most numerous category at 146 781 registrations, followed by enrolled/staff nurses (70 552) and enrolled auxiliary nurses (68 361). However, SANC's data does not reflect attrition through emigration, career changes or retirement, which will likely affect the numbers. The number of CHWs, crucial component in the public healthcare sector, is estimated to be 72 000.⁵⁰ Unfortunately demographic profile of CHWs is limited⁵¹.

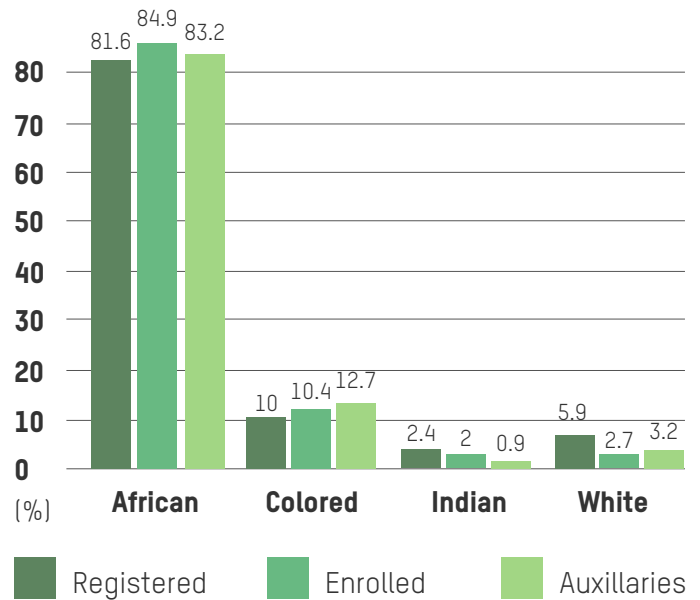
Gender

Nursing and CHWs professions are highly feminized. Womxn constitute approximately 90% of the workforce across the nurses' cadres⁵² and most CHWs are womxn too. The most recent statistics from the South African Nursing Council illustrate the disproportionate representation of womxn within South Africa's nursing proportion. In 2018 the number of womxn in the overall population was 51.2%, yet womxn made up 90.1% of nurses.⁵³ Interestingly, the ratio of womxn in training is slightly lower, which perhaps indicates a trend towards greater, albeit not equal, gender balance within the profession.

Race

The most recent updates about racial distribution of nursing staff in the public sector, Figure 2 illustrates that, in 2006, approximately 83% of public sector nurses of all categories were Black African. Unfortunately, there is no official data which is further disaggregated by social class.

Figure 2: Composition of public sector nursing workforce based on race (2016)



Source : Breier M, Wildschut A, and Mggqolozana T. Nursing in a new era: the profession and education of nurses in South Africa. Cape Town: HSRC Press (2009).

Age

There is much more variation around age. Nearly 45% of registered nurses are over 50, whereas the majority of enrolled/staff and enrolled auxiliary nurses fall into the 30-49 age bracket.⁵⁴

A common issue across all the ranks is the extremely small proportion of young nurses, with under-30s constituting only 7.6% of the profession, fitting the global pattern of an ageing nursing workforce.⁵⁵ This clearly presents challenges not only for future staff shortages, but also for the physical demands of round-the-clock shift work for those remaining in the profession. As there is no centralised regulatory body for CHWs, their workforce profile is largely missing from the public domain. However, a previous audit by the NDoH⁵⁶ estimated 72 000 CHWs to be working within South Africa. Numerous studies confirm that they have a similar profile to nurses, with the majority being Black African womxn and often single mothers.⁵⁷ Qualifications and experience are highly fragmented amongst these workers, ranging from experience-only to National Qualifications Framework (NQF) qualifications.⁵⁸

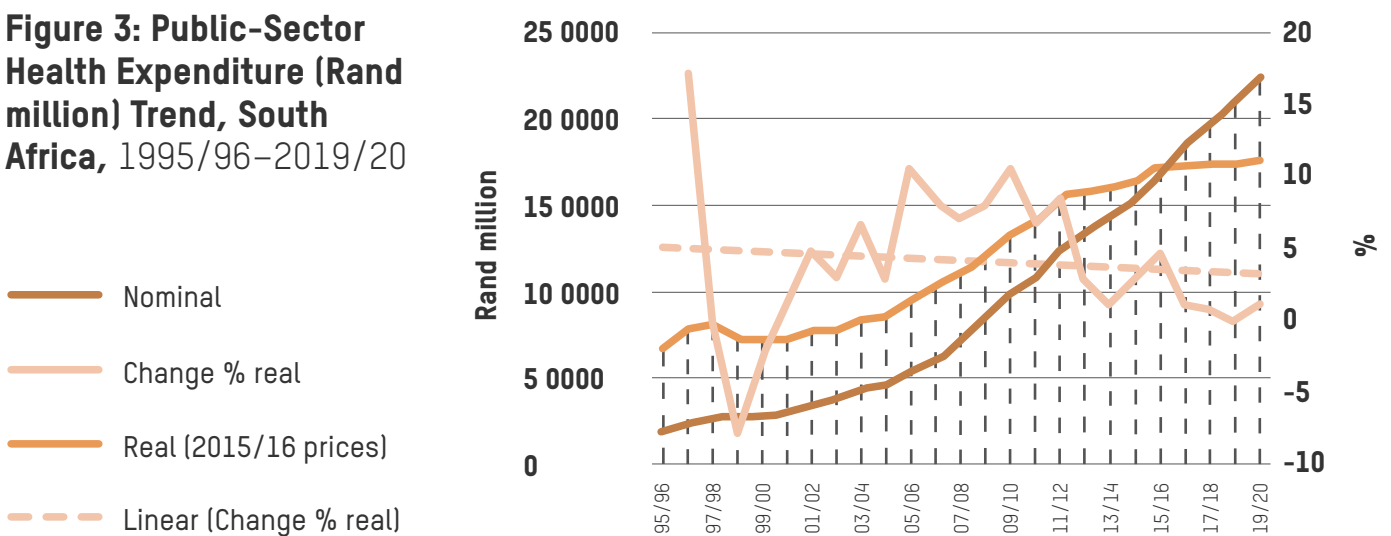
CHAPTER 2: PUBLIC SPENDING, PROFITS AND UNDIGNIFIED WORK

The World Health Organisation found that, two years into the Sustainable Development Goals era, global spending on health continues to rise. It was US\$ 7.8 trillion in 2017, or about 10% of GDP, and \$1 080 per capita – up from US\$ 7.6trillion in 2016. South Africa unfortunately bucks this trend, with a steady decline in public spending on healthcare. The importance of this lies in understanding that higher government spending on health is associated with lower inequality and a decline in preventable deaths.

Trends in Health Spending

Figure 3 illustrates the pattern of government health spending in South Africa over the last two decades. It shows that, after a sharp drop in health expenditure following the adoption of the Growth, Employment and Redistribution (GEAR) strategy,⁵⁹ government health spending increased faster than inflation for the majority of the 2000s, doubling from R72 731 million in 2000/01 to R157 547 in 2012/13. Blecher et al.⁶⁰ note that key drivers of this increase include the implementation of South Africa’s HIV/AIDS programme, large-scale public sector recruitment, increased CPI costs of imported medicines and the sizeable increase of the public sector wage bill due to the 2007 Occupational Specific Dispensation (OSD)⁶¹ agreement.

Figure 3: Public-Sector Health Expenditure (Rand million) Trend, South Africa, 1995/96–2019/20



Note: 2018/19 and 2019/20 figures are medium term estimates.

Source: Blecher et al., "Health spending at a time"



However, the year 2012/13 marks a clear turning point in this trend, where we can see growth in the health budget contract and even fall below inflation after 2015/16 marking a decisive policy shift into fiscal austerity.

Figure 4: South Africa’s domestic government health expenditure (DGHE) as a percentage of general government health expenditure (GGE) to understand health’s priority within the national budget. As shown, this has steadily increased from 10.9% in 2000 and has levelled out across recent years at approximately 13.3 percent. As highlighted by Ataguba and McIntyre,⁶² South Africa is therefore still falling short of its 15% health budget commitment, as enshrined in the 2001 Abuja Declaration.⁶³

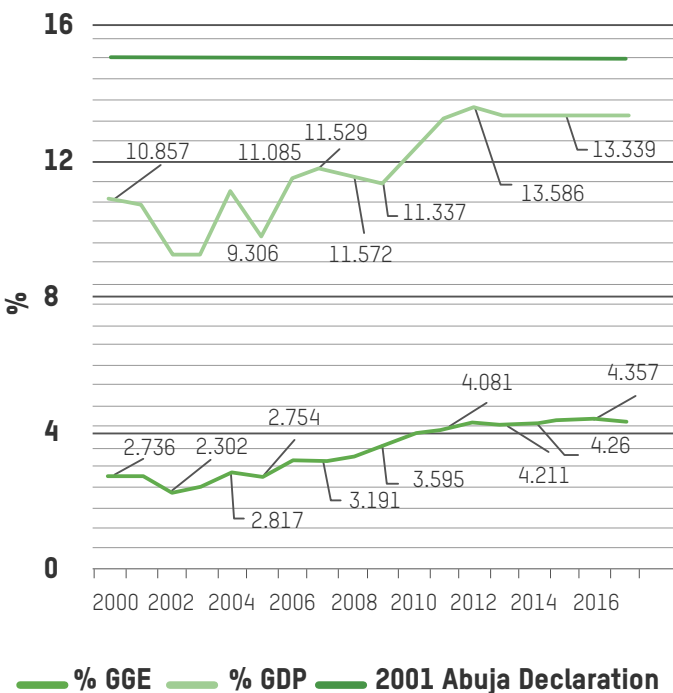


Figure 4 tracks South Africa’s domestic government health expenditure (DGHE) as a percentage of its general government health expenditure (GGE) to understand health’s priority within the national budget. As shown, this has steadily increased from 10.9% in 2000 and has levelled out across recent years at approximately 13.3 percent. As highlighted by Ataguba and McIntyre,⁶² South Africa is therefore still falling short of its 15% health budget commitment, as enshrined in the 2001 Abuja Declaration.⁶³

Moreover, such “austerity measures” have been noted by the United Nations Committee on Economic, Social and Cultural Rights. The committee indicates that in order to ensure the realization of South Africa’s legally binding human rights commitments, South Africa must “increase the level of funding in the areas of social security, **health** and education”.⁶⁴ Any decreases in real public spending on healthcare amount to “retrogressive” measures in violation of South Africa’s domestic and international human rights obligations in terms of the right to health.⁶⁵

Prioritisation of healthcare spending

Table 1 below illustrates the current and projected prioritisation of health within South Africa’s national budget. At 12.5% of the total budget in the 2018/19 fiscal year, healthcare is the third largest recipient of resources, below Learning and Culture (21.3%) and Social Development (15.4%).

Table 1: Consolidated government expenditure by function, 2018/19-2021/22

R billion	2018/19	2019/20	2020/21	2021/22	2018/19 - 2021/22
	Revised estimated	Medium-term estimates			Average Annual Growth
Learning and culture	354.8	386.4	415.2	442.6	7.6%
% budget	21.3%	21.2%	21.3%	21.2	
Health	208.8	222.6	238.8	255.5	7.0%
% budget	12.5%	12.2%	12.3%	12.2%	
Social development	256.9	278.4	298.9	317.1	7.3%
% budget	15.4%	15.2%	15.3%	15.2%	
Community development	186.4	208.5	225.1	243.7	9.3%
% budget	11.2%	11.4%	11.6%	11.7%	
Economic development	192.4	209.2	219.9	235.9	7.0%
% budget	11.6%	11.5%	11.3%	11.3%	
Peace and security	203.5	211	222.9	233	4.6%
% budget	12.2%	11.6%	11.4%	11.2%	
General public services	65	65.3	67.6	76.9	5.8%
% budget	3.9%	3.6%	3.5%	3.7%	
Payments for financial assets	15.5	29.8	30.4	30.9	
% budget	0.9%	1.6%	1.6%	1.5%	
Allocated expenditure	1,483	1,611	1,719	1,836	7.4%
% budget	89.1%	88.2%	88.2%	87.9%	
Debt-service costs	182.2	202.2	224.1	247.4	10.7%
% budget	10.9%	11.1%	11.5%	11.8%	
Contingency reserve		13	6	6	
Consolidated Expenditure	1,665	1,827	1,949	2,089	7.8%

Source: PwC South Africa. "The National Treasury Budget 2020 highlights" (2020).

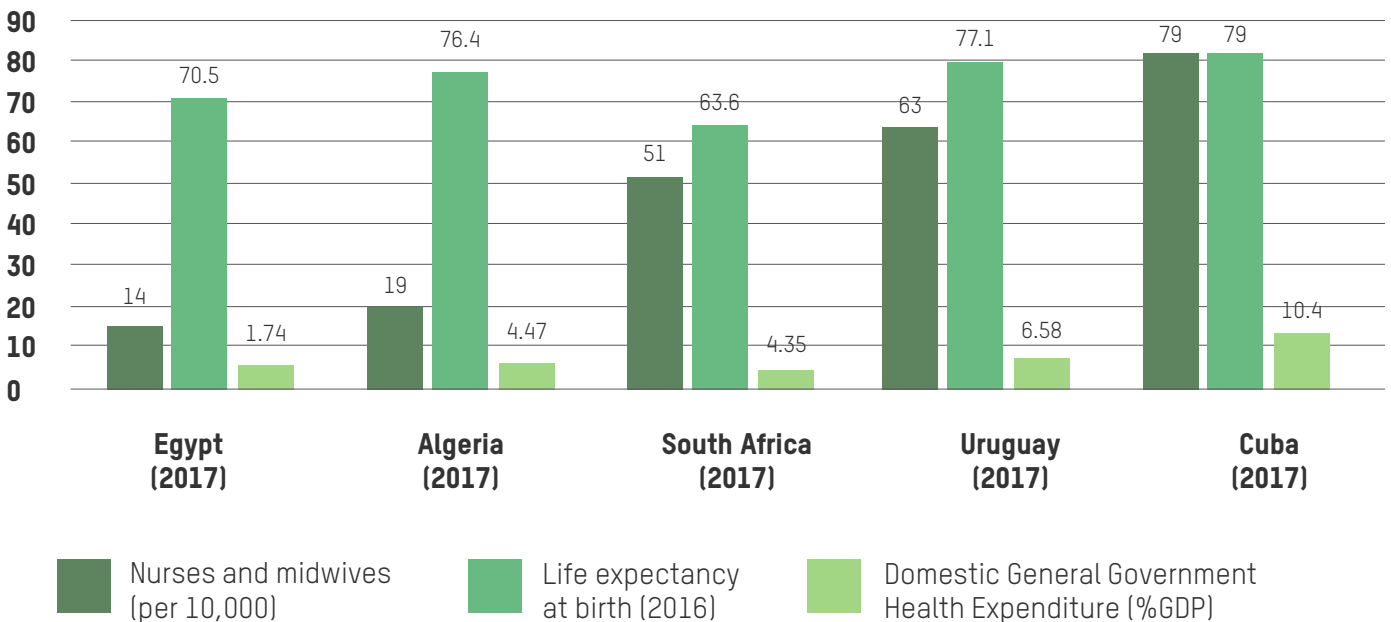
However, the medium-term budget estimates indicate that healthcare is becoming less of a priority. By 2020/21, the share of health funding is set to decline by 0.3% from the 2018/19 baseline, a trend in line with both Learning and Culture (-0.1%) and Social Development (-0.2%). As such, the social service sectors appears to be deprioritised in upcoming years.

By contrast, the main winners of the projected budget are Community Development (+0.5%) and payments for financial assets (+0.6%). Until the COVID-19 pandemic hit, the overall proportion of allocated public expenditure was decreasing. The budget for 2020/21 was set to be 1.2% lower than 2018/19. This appears to make room for greater increases in debt-service costs, which are set to grow at a nominal rate of 10.7% annually. Prior to the

COVID-19 pandemic, estimates were that by 2020/21, the proportion of government spending on debt would increase +0.9%. As such, South Africa’s budget reflected an overall squeeze on non-interest public spending.

Similarly, South Africa’s DGHE as a percentage of GDP has remained relatively consistent at approximately 3-4% (Figure 4). Whilst this compares favourably across comparable middle-income countries, as illustrated in Figure 5 below, South Africa also has the lowest life expectancy amongst the group, reflecting its triple burden of disease, inequitable resource distribution and inadequacies in healthcare delivery.⁶⁶ As a result, the level of government health expenditure in South Africa is not commensurate with the country’s need.

Figure 5 : Nurse to population ratios, life expectancy at birth, and domestic general government health expenditure as a percent of GDP) for selected middle income countries



Source: World Health Organisation Global Observatory Data Repository 2018, 2019; World Health Organisation Global Health Expenditure database, 2020.



Fiscal austerity and restricting filled posts

Together with increasing fiscal austerity, one of the greatest ironies with regard to dignified work in the public healthcare sector is that fairer wages, to be attained through the introduction of Occupational Specific Dispensation (OSD), have been coupled with the deterioration of working conditions. Blecher et al.⁶⁷ demonstrate that following its implementation in 2007, compensation expenditure increased by R28.4 billion against inflation by 2012, and an additional R13.3 billion between 2010 and 2016.

Across the decade, the average annual cost of each filled post rose by more than 4%. To control these personnel costs against a narrowing health budget after 2012, provincial departments of health have increasingly implemented tight restrictions on filling posts. For example, research by the Rural Health Advocacy Project⁶⁸ found that official staff-wide freezes and strict staffing controls had been implemented in KwaZulu-Natal, the Eastern Cape, North West, the Free State and Mpumalanga. Demonstrating this impact on the nursing supply, fewer than half the number of professional nurses in the period 2006 to 2012 were hired between 2012 and 2016.⁶⁹

Even now when critical posts are supposedly protected, the annual reports of the provincial departments of health consistently emphasise budget pressures as a key driver of acute understaffing, which have been recorded as high as 35% and 17% for professional nurses in Limpopo⁷⁰ and North West⁷¹ respectively. Ironically, delays in filling nursing posts have also been linked to nursing agency fees in the Western Cape, suggesting that short-term staffing needs are creating a vicious cycle for sustainable recruitment.⁷² Most provinces were either freezing or abolishing non-critical roles to reduce their spending on compensation, as seen, for example, in North West,⁷³ Mpumalanga⁷⁴ and Western Cape.⁷⁵ It was also apparent that this was being used as a strategy to meet the 8% vacancy target without hiring more permanent staff. For example, KwaZulu-Natal eliminated 5 138 non-critical posts in 2017, which reduced their vacancy rate from 12% to 8%.⁷⁶ The blanket cutting of all unfunded posts in Northern Cape allowed the same outcome.⁷⁷

The implications on working time for nurses cannot be overstated and will be explored in depth later. Here, it is imperative to emphasise that the protection of critical posts in patient care is undermined by the practice of cutting non-critical posts. For example, in 2015, an investigation into nine public and private hospitals across Free State and Gauteng found that nursing managers only spent a quarter of their day on patient duties, whereas 30% of their time was spent on administration. On average, the nurses reported completing 36 tasks each hour, the majority of which were unexpected.⁷⁸ As such, critical and non-critical posts (such as administration) need to be analysed in conjunction.

DESKILLING OF SUPERVISION

Finally, the downward pressure on staffing costs due to budget strains has also led to the deskilling of nurse supervision within the public healthcare system, an issue widely cited by nurses themselves.⁷⁹ For example, the 2014/15 Financial Report of Eastern Cape's Department of Health⁸⁰ states that service provision was remodelled in order to generate cost-savings within clinics. This included changing the ratio of registered nurses to enrolled nurses and enrolled auxiliary nurses to lean more on the latter categories. As such, this means that nursing is being carried out at very low pay and without adequate training, risking the safety of both the patients and the workers. Against the acute understaffing in the public sector, this is likely to be more dangerous, where tight management is not possible.

Similar patterns are also sanctioned within South Africa's PHC Re-engineering Strategy. Whilst the 2011 *Provincial Guidelines for CHW Integration* stipulate that each PHC outreach team must be overseen by a registered nurse,⁸¹ the National Health Council has approved the downgrading of supervision to an enrolled nurse in the revised 2018/19 to 2023/4 policy framework.⁸² This is predominately framed in the language of cost-containment, emphasising the lower training required alongside job creation.⁸³ This is particularly problematic given that lack of adequate supervision is raised as a key concern by both CHWs and enrolled nurses.⁸⁴

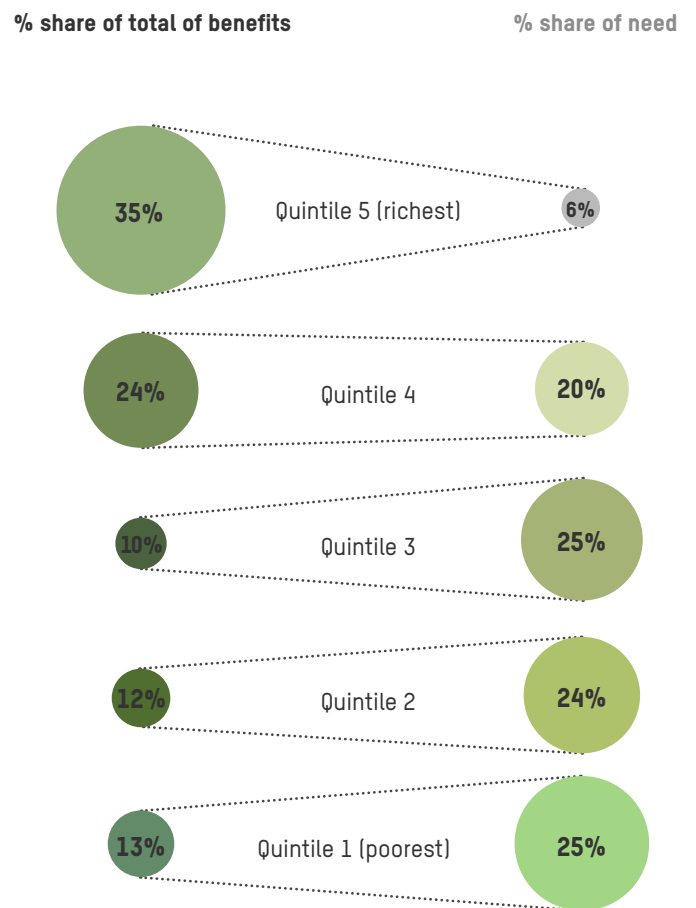
CHAPTER 3: FINANCIAL ANALYSIS OF PRIVATE HEALTH CARE FACILITIES

South Africa’s private healthcare sector operates to serve a minority of the population. This is because access is limited to those that have a paying job that affords them medical aid. This means that millions of South Africans are excluded, as many are either unemployed or in precarious jobs that do not afford them medical aid. Access to private healthcare intersects at the levels of class, race and location.

One out of ten households headed by a Black person has medical aid whereas seven out of ten households headed by a White person has medical aid. Moreover, nearly three out of ten urban households have medical aid whereas fewer than one out of ten rural households have medical aid. A household survey points out that the poorest quintile was the most likely to use public primary health care facilities (68.8%), while approximately 60.8% of the richest quintile use private health.⁸⁵

Ironically, while the wealthy and the middle class can afford medical aid, they also have the fewest healthcare needs, in comparison to the poor majority who cannot afford medical aid, yet have the most healthcare needs (Figure 6). The impoverished members of our society have 25% of the healthcare needs but only have 13% of the benefits, whereas the wealthy have 6% of the healthcare needs but a total of 35% of the benefits.

Figure 6: Distribution of Health Benefits



Source: Ataguba and McIntyre, “The incidence of health financing”.

Further inequalities are demonstrated by inequalities in resource distribution between the private healthcare sector and the public healthcare sector. The public healthcare sector is staffed by 30% of the doctors in the country and serves 84% of the population (40 million people) who are uninsured. However, the private healthcare sector is staffed by 70% of the country's doctors, who serve 16% (8 million people) who work full time.⁸⁶

Reports of the country's healthcare sector's readiness to respond to COVID-19 further illustrated these inequalities. The private healthcare sector has double the ventilators, double the critical bed capacity and nearly triple the existing bed capacity in the public sector, as Table 3 shows.

Table 3: Resources in public and private hospitals

Sector	Critical care beds	Pads / Neonatal beds	High care beds	Existing bed capacity	Current ventilator available	Projected ventilator (excluding ORs)	Additional ventilator requirement
Public	1178	252	1082	1769	1111	2333	1223
Private	2140	896	1640	3139	2105	4667	2561
Total	3318	1148	2722	4909	3216	7000	3784

Source: DHIS, Facility Readiness Team. Presentation to Portfolio Committee on Health, COVID-19 Public Response. 10 April (2020)

Subsidy to the Private Healthcare Sector

Crucially, this well-resourced private healthcare sector that serves a rich minority of the population is subsidised by the fiscus. The private healthcare sector accounts for half of the country's healthcare expenditure. Much of this expenditure is subsidised by medical tax credit. Medical fees of high-income earners are subsidised via salary benefits and tax rebates, while many poor families cannot benefit from such preferential regimes because they have no taxable income from which this rebate can be deducted. **Instead of giving R35.4 billion medical tax credits to wealthy taxpayers and the private healthcare sector, the government could increase the budget allocated to the public healthcare system by more than 60%.** The government is obliged in terms of international human rights law to use the "maximum" of its available resources to ensure the realization of the right to health.⁸⁷ The United Nations Committee on Economic, Social and Cultural Rights has emphasized "equality of access to health care and health services" noting that "[s]tates have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities".⁸⁸ It has warned that "inappropriate health resource allocation can lead

to discrimination that may not be overt", giving the example of resource investments and allocations that:

...disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population".

Shareholder Bonanza for Private Healthcare Facilities

Shockingly, the subsidy also subsidises shareholders and senior management of the private healthcare facilities, because without the subsidy, many would find themselves excluded from private healthcare because of its high cost. In addition, the high cost of care should not be mistaken for quality care. The Competition Commissions Private Healthcare Market Inquiry found that the sector has been unscrupulous in overcharging patients at scales that do not match the care needs, putting profits over patients⁸⁹. Further our analysis of dividends, buybacks and CEO pay of the three largest private healthcare companies in South Africa shows the extent to which private healthcare is prioritising shareholders and executives

Definitions

Dividend: The distribution of a portion (or share) of a company’s earnings to shareholders

Buyback: When a company buys its own shares from the market, reducing the supply of shares, which inflates the share price. It is another method of paying cash to shareholders.

Net profit: The company’s profit after all expenses have been paid, including tax and wages.

Shareholder pay-out ratio: For the purpose of this report, the proportion of net profit paid to shareholders (dividend + buyback/net profit)

Executive remuneration: For the purpose of this research, the executive’s base salary plus all bonuses and benefits.

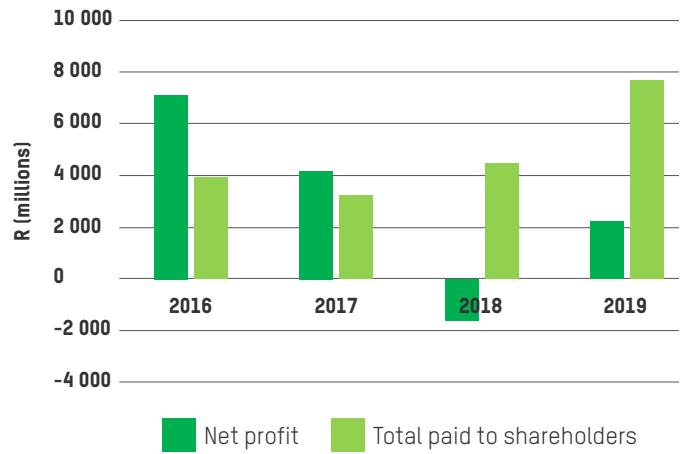
From 2016 to 2019, Netcare, Mediclinic and the Lifecare Group made a combined R11.7 billion in net income and combined paid R19.2 to billion to shareholders in dividends and share buybacks . Cash to shareholders exceeded profit, with a shareholder pay-out ratio of 163%. Over the four-year period cash paid to shareholders increased by 96%.

This shareholder bonanza comes at a time when the macroeconomic situation of the country has deteriorated since the global financial crisis of 2008, putting structural constraints on the healthcare facilities. The rise in unemployment has meant that fewer people are able to afford medical insurance and, by implication, private healthcare. To make up for this structural constraint in order to maintain the shareholders’ returns on investments, companies employ strategies such as shareholder buybacks to prop up the share price and extract cash for shareholders, and the use of agency work for cost containment (discussed in chapter 4).

Extreme inequality in South Africa means that it is the richest 1%, who own more than 95% of bonds and corporate shares,⁹⁰ who are the main beneficiaries of dividends and buybacks, with the richest 0.01% owning 62.7%⁹¹.

As shown in Figure 7 below, between 2018 and 2019 the companies paid increasing amounts to shareholders - in the case of Life Healthcare Group, despite posting a net loss in 2018.

Figure 7: All companies, total paid to shareholders vs. net profit



Source: Netcare, Lifecare and Mediclinic Annual Reports.

In addition, CEOs on average earned R11 million a year while registered nurses earn R170 000 per year.⁹² It would take a nurse 65 years to earn what a CEO takes home in a year. In just five days, a CEO earns more than a healthcare worker will earn all year.⁹²

⁹²Netcare's response to these figures is that "The comparison of measuring the quantum of dividends paid against annual profits does not take into account a number of other relevant factors that Boards would ordinarily consider when declaring dividends. Notwithstanding this shortcoming, a review of your table reflects that 2017 is the only year in which Netcare’s dividend payment exceeded the profit attributable to shareholders. It should be pointed out that the 2017 results included certain non-cash adjustments of R5.5 bn (being the impairment of assets and goodwill, and the recognition of onerous lease provisions - all related to the UK business that we subsequently exited in March 2018), which did not affect Netcare’s ability to pay dividends as the losses were non-cash in nature". Indeed, the quoted figures show that combined all three companies paid out more to shareholders combined than they made in profits. In fact, the data reveals that shareholders were paid more than what the company made in profits in 2017 and in 2019. In 2017, the company made a loss yet still managed to pay out R 1.2 billion to shareholders, a choice it made in spite of other competing needs such as paying workers a fair wage.

These findings, alongside Oxfam South Africa's research into wages and working conditions for healthcare workers, demonstrate the extent to which these companies are willing to put shareholder interests above other workers and society reliant on these services. Just a small proportion of the R19.2 billion paid to shareholders could mean better wages and working conditions for staff and contract workers and improved services for the excluded. Put simply, these companies could afford to pay decent wages, provide dignified working conditions (in line with the employees' right to decent work) and service the excluded millions, but they choose to prioritise shareholders instead.

The analysis finds a significant disconnect between net profit and the amount paid to shareholders and suggests that they can expect consistent returns regardless of profitability. This finding challenges the theory that shareholders are exposed to the greatest risk of all business stakeholders and so justifies putting shareholder interests first. It also challenges companies' rejection of proposed wage increases as unaffordable, as they appear to be able to afford shareholder pay-outs.

How lack of disclosure in any sector can enable corporate tax abuse

From the distribution of profits and the prevalence of corporate tax abuse to unfair labour and wage practices, business behaviour in any sector can affect inequality trends in both direct and indirect ways. Around the world, corporate tax avoidance is contributing to inequality⁹³. However, to tackle inequality, governments need sufficient and continuous revenue streams, of which taxation is a major one, to fund essential public services, including healthcare and education, for their poorest and most vulnerable citizens, and to pay for the public infrastructure needed to raise living standards, increase gender equality and build well-functioning and stable economies. These investments also directly benefit companies⁹⁴.

Even when not acting illegally, corporations can use sophisticated tax planning to take advantage of a broken system that allows multinational corporations from many different industries to get away with avoiding paying their fair share of taxes. Multinational

corporations may avoid paying their fair share of taxes by setting up a complex structure of companies across many jurisdictions, avoiding tax obligations in some jurisdictions and taking advantage of tax benefits in others.

Traditionally, multinational corporations establish a multi-tiered structure, with a parent company at the top, subsidiaries that engage in real economic activity at the bottom, and a multitude of *largely invisible* intermediaries in between. These intermediaries are often shell companies with no employees or actual economic activity, located in jurisdictions that are known as tax havens, with the single objective of reducing tax payments in multiple countries.

Netcare's presence in tax havens

Due to lack of transparency around taxation, researchers around the world rely on identifying patterns of practice, use of financial transactions, and establishment of subsidiaries in known tax havens as clues that strongly suggest tax avoidance is underway. In 2015, the British trade union Unite published an investigative report, entitled "Unite investigates: Tax Avoiders buying up the NHS and how TTIP could lock in tax avoidance", that investigated a number of private healthcare providers operating in the United Kingdom, focusing on behaviour related to tax avoidance⁹⁵.

Among other companies, the report analyses the corporate structure of the General Healthcare Group (GHG), one of the biggest for-profit care providers in the UK. Since 2006, Netcare has had a 50.1% controlling stake in GHG, which at the time of the report owned 47 hospitals across the UK. The research demonstrated that each of the 47 hospitals owned by GHG was owned by a separate company, which were all incorporated in the British Virgin Islands – a notorious tax haven jurisdiction⁹⁶. While the companies were registered in the UK for tax purposes, they were still British Virgin Islands companies. As such, Netcare owned GHG through a corporate structure with a strong presence in a tax haven.

This means that each hospital was initially owned by a UK company, but in every case those UK companies were in turn owned by a British Virgin

Islands company, which was then in turn owned by a South African company. Along this line, it's possible to see that Netcare employed a structure for the ownership of GHG that would enable tax avoidance, raising questions about the motives for such a costly, complicated structure. The report surmised: *"What the structure of many of these businesses shows is that tax planning is at the very core of their activities. This is the wrong priority for companies working in the state funded NHS [National Health Service] where the tax contribution everyone makes, including from those who supply NHS services, is vital to the continuing health of the nation."*

While this report was published five years ago, it is unclear what Netcare has done to date to correct this.

We did not find a similar investigation and finding on Mediclinic and Life tax practices, but there is a limited inference that there will be parallels.

Lack of transparency on business structures, relationships, and practices is one of the chief enablers of tax avoidance. Fundamentally, lack of disclosure by corporations is necessary to guarantee the opacity needed to mask their transactions and the total amount of taxes they avoid. Because lack of disclosure is so essential to tax avoidance, it can actually be considered an indicator as well. Full transparency is essential so all stakeholders - not just shareholders, but employees, civil society and governments - can properly scrutinize the activities of corporate multinationals. Ideally, all companies in all sectors should publish their activities, taxes paid and financial transfers for each jurisdiction where it is present. Known as "country-by-country" reporting, multinational corporations already provide this information to tax administrations in the countries where they operate. However, the publication of such information would represent an important advance on transparency and democratic accountability by large corporations.

Slow progress on Gender and Racial Equality

Finally, the analysis sheds light on the gross lack of transformation in these companies. Despite the spirit of the Employment Equity Act and the B-BBEE Act, progress towards gender equality for black

womxn in the healthcare sector appears to be slow and incremental. Black womxn are still highly underrepresented at senior management levels across all three of the private healthcare firms. Mediclinic had no black womxn represented at senior management level until the appointment of Gale Shabangu as our Chief Transformation Officer. Netcare performs better but remains inadequate. Lifecare's lack of disclosure is a cause for concern.

Rapid increases in the B-BBEE ratings across all three companies appear to be largely driven by the Enterprise and Supplier Development Programme. As such, there is a concern that B-BBEE initiatives are targeting "easy-wins" that offload responsibility onto their suppliers. This is especially salient given the disproportionate weighting in the ratings of the suppliers' pillar (which counts for 44 points), as opposed to, for example to managerial control (19 points).



CHAPTER 4:

POLICY GAPS

Recent global policy initiatives have highlighted the critical role in sustainable development of investments in health and the health workforce, pointing to the integrative power of strengthening the health sector by addressing simultaneously various Sustainable Development Goals (SDGs). The SDGs recognize decent work as a central factor in ensuring inclusive economic growth and its contribution to social progress.

Importantly, South Africa also has legally binding obligations in terms of the right to decent work entrenched in the International Covenant on Economic, Social and Cultural Rights (ICESCR) and extrapolated in the General Comments of the UN Committee on Economic, Social and Cultural Rights.⁹⁷ ICESCR also explicitly requires “fair wages and equal remuneration for work of equal value without distinction of any kind,

in particular womxn being guaranteed conditions of work not inferior to those enjoyed by men, with equal pay for equal work” in Article 7(a)(i).

Pursuing full and productive employment and decent work for all womxn and men is an integral part of SDG 8 that also underlines protection of workers’ rights. Regarding the health sector, SDG 8 links directly to the call for increasing the recruitment, development, training and retention of the health workforce as part of SDG 3 to ensure healthy lives for all. Health and decent work are essential for social cohesion, human development and inclusive economic growth.

Decent work in the health sector is fundamental to ensuring effective and resilient health systems, a prerequisite for addressing health workforce understaffing, and for achieving the goal of equal access to quality health care. The health sector is essentially about people; without health workers there can be no health care. This, in turn, makes decent work for healthcare workers central to South Africa’s execution of its legally binding mandate to respect, protect, promote and fulfil the right to health as required by the South African Constitution⁹⁸ and regional and international human rights law.⁹⁹

POLICY GAP 1: EXCLUSIONS IN WORKING HOUR REGULATIONS

In the context of unequal resources between the private and public sector, understaffing and the triple burden of disease, a significant barrier to achieving a **balanced distribution of work, family and personal life** and a **safe and healthy work environment** for healthcare workers in South Africa is weak and poorly controlled working time regulations. This situation has resulted in the normalisation of long and unprotected working hours and a lower quality of life. This section will critically analyse the national regulatory framework regarding working time in South Africa, alongside its legal implications for healthcare workers. Public and private health sector trends in working time arrangements will be examined, before outlining the personal consequences of understaffing.

At the outset it should be noted that the South African government has an obligation to regulate the working conditions of all workers in terms of its duty to protect the right to work in regional and international law and the right to fair labour practices for all workers, entrenched in Section 23 of the Constitution. These legislative enactments, and their application to healthcare workers, should be assessed and measured against standards set by the right to work.¹⁰⁰

Working time is regulated in Chapter 2 of the *Basic Conditions of Employment Act (BCEA) No.75 (1997)*, which stipulates the following:

- Employees are to work a maximum of **45 hours per week**;
- Employees are to work a maximum of **nine hours daily** for a working week of five days or less and a maximum of **8 hours daily** for a working week of 5 days or more;
- Maximum working hours may be extended by up to **15 minutes daily** to allow for employees serving the general public to finish their duties, but no more than 60 minutes weekly;
- **Compressed working week agreement:** Employees can work up to **12 hours of normal work on any day** without receiving overtime pay. But the employees may still **not** work more than **45 normal hours per week** and may not work on more than 5 days in a week;
- All workers are entitled to a **daily rest period of 12 consecutive hours** between the last and next working shift. A weekly rest period of **at least 36 consecutive hours** is required for all workers;
- No employee is permitted to work **more than 10 hours per week overtime** for which they are to be compensated by at least 1.5 their normal wage rate.

As per Section 7, these legislative standards must be implemented with due respect to the employee's health and safety, alongside their family responsibilities. It therefore carries particular relevance to nurses and CHWs given the highly feminised status of both professions. These provisions are supplemented by the **Code of Good Practice on the Arrangement of Working Time as per Section 87**, which contains specific measures employers must consider when designing rotational shift patterns. Whilst the Code does not carry the same legal weight as the statutory regulations, in the case of disputes, employers must demonstrate that they have taken its contents into account.

These regulations remain in broad alignment with the **ILO's Hours of Work (Industry) Convention No.1 (1919)** and the standards set in terms of international human rights law as detailed by the United Nations Committee on Economic, Social and Cultural Rights in General Comment 23. However, we identify five key challenges and legal exclusions that prevent the realisation of dignified work within the healthcare sector (two of these five challenges in South Africa's regulations represent problematic departures from ILO standards and the standards set in terms of international human rights law).



1. Compressed working weeks

In accordance with the BCEA's stipulations around compressed working weeks, nurses tend to formally work 12-hour shifts starting at either 07h00 or 19h00¹⁰². These shifts are scheduled to include weekends and add up to approximately 160 hours a month (40 hours a week). Ordinarily, a three-shift week (33 hours) is followed by a four-shift week (44 hours) to achieve this average.¹⁰³ This pattern is also present for CHWs, who normally work 12-hour shifts between 07h00-19h00, albeit without weekend working.¹⁰⁴

The normalisation of compressed working weeks within a predominantly female workforce greatly disregards the double burden of carrying out both productive and reproductive labour¹⁰⁵ especially where womxn are single parents. In actuality, in order to fulfil reproductive care duties to children and other family members, prepare for work and travel to hospitals, nurses may wake up as early as 04h30 in the morning,¹⁰⁶ thus making their working time much longer than the hours accounted for in the compressed working week. Failing to recognise the crucial role that womxn play in carrying out reproductive or emotional labour means that nurses and CHWs are stretched to capacity. Nurses and CHWs receive little support or recognition from employers with regards to familial responsibilities. Only 5.8% of nurses have access to childcare facilities. This means that nurses and CHWs are forced to entrust childcare duties to expensive childcare facilities, further adding to their financial burdens.¹⁰⁷ Alternatively, nurses and CHWs are forced to rely on family members or friends. In such cases, parents must deliver their children to the care of others before their work shifts begin, as early as 5 am, which implies transport costs and a trade-off with downtime before and after shifts.¹⁰⁸ These effects are felt even more by single mothers, whose burden is heightened as the primary caregiver. However, these consequences not only impact on the personal lives of womxn, but on the wider health system. Geiger-Brown et al.¹⁰⁹ found that nurses who worked 12-hour shifts provided lower quality patient care than those who worked 8-hour shifts. There is thus a greater need to better enforce the *Code of Good Practice on the Arrangement of Working Time* to produce more beneficial outcomes for all and ensure compliance with international human rights standards.



2. "Emergency" work

The ILO Hours of Work (Industry) Convention (No.1)¹¹⁰ excludes emergency work, supervisors and management from work-time labour protections. Healthcare workers at all levels are more susceptible to emergency work than most professions. Therefore, the ILO Nursing Personnel Convention (No.149)¹¹¹ was developed in partnership with the World Health Organisation to close the loophole in the Hours of Work Convention to ensure adequate protection by promoting work-life balance within the healthcare sector. The enjoyment of hours equal to those of other industry workers is significant, particularly given the exemption clause for urgent work within the ILO convention.

In terms of section 6(2) of the BCEA, emergency work is excluded from working-time protections. Emergency work is defined as, "Work which is required to be done without delay owing to circumstances for which the employer could not reasonably be expected to make provision and which cannot be performed by employees during their ordinary hours of work." Due to factors such as emergency patient care needs, understaffing and the triple burden of disease in South Africa, this is a key loophole that risks being abused and misappropriated within the healthcare system. Indeed, research by the ILO concludes that nurses frequently work over this amount of time, with longer than 24 hours not being uncommon¹¹².

The impact of this workload cannot be overstated. A study by Khamisa et al.¹¹³ revealed that 60% of nurses experienced poor general health related to anxiety and insomnia. The study found that nurses consistently report higher levels of stress than other professions in South Africa, which, in turn, affects their quality of work, mental health and physical wellbeing. Studies by Oginska-Bulik and Tomik and Tomik showed that nurses are at higher risk of suffering from mental health problems because they work nights or irregular shifts more than others.¹¹⁴



3. Meal breaks

Though the BCEA states that employees are to be granted a one-hour meal break after every five hours of work, Section 14(2) contains a caveat which states that the right to breaks can be overridden in circumstances where the employee's "duties cannot be left unattended and cannot be performed by another employee". Given the acute nursing understaffing in South Africa, this conditionality is a glaring weakness that permits employers to curtail break times for nurses. Unfortunately, this is often the reality particularly for theatre staff whose break is often reduced to 30 minutes due to the nature of their work.¹¹⁵

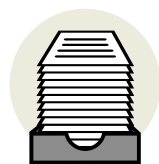
Translated into practice, nurses have reported only having one large meal daily as they are unsure of when they would be able to eat again.¹¹⁶ Nurses are not able to access healthy options in hospital cafeterias which has also left nurses open to the threat of diseases such as obesity and hypertension.¹¹⁷ Phiri et al.¹¹⁸ demonstrated that nurses experienced a lack of time to prepare healthy meals due to long working hours and being overtired after work as barriers to leading a healthy lifestyle, thus making diabetes and hypertension a key health concern for both day and night shift workers. Accounts from nurses reveal that this loophole has also meant that nurses will often be on their feet for hours without so much as time for a bathroom break, thus leaving them at risk of illnesses such as urinary tract infections, and several musculoskeletal disorders such as lower back pain, shoulder pain and neck pain.¹¹⁹ CHWs might eat at home and skip meals while at work because they might be on their way to assist a client. Thus this is time that is often ignored.

Needless to say, seen as a whole and understood in their full context, these conditions violate the ILO's "decent work" standard and the right to decent work in terms of international human rights law, which are both premised on dignified working conditions and worker's rights to "just and favourable conditions". This situation reveals that in caring for the public and their families, nurses have been forced to forfeit the time to take care of themselves in even the most basic ways, which arguably compromises their constitutional right to human dignity (Section 10 of the Constitution).



4. BCEA threshold exclusions

Outside of temporary loopholes, more blanket legal exclusions are contained within Section 6, which stipulates that statutory working time protections do not apply to senior managers, employees working less than 24 hours a month and those who earn over the BCEA earnings threshold, which currently stands at R205 433.30.¹²⁰ Based on the 2018/19 public sector salary scales,¹²¹ the threshold thus excludes ranks above Staff Nurse Grade 3 from being able to *legally demand* statutory working time protections. Problematically, these gaps in legal protection have also not been substituted by collective bargaining arrangements, with our review of the resolutions from the PSCBC (Public Services Coordinating Bargaining Council) and the PHSDSBC (Public Health and Social Development Sectoral Bargaining Council) revealing no ceiling on working hour determinations. This means that as Occupational Specific Dispensation (OSD) increases annual wages,¹²² more nursing categories will be pushed outside of the legal safety net if the BCEA earnings threshold is not adjusted accordingly. This will also be the case for salary adjustments within the private health sector. Its stagnation for nearly six years is currently a key point of contention between the Labour Minister and the United National Transport Union, and therefore we recommend mobilising around this issue to help mitigate ever-widening inequalities between pay and legal working time protection.



5. Unrealistic scope of work

Particular attention needs to be paid to the alignment of working hours' regulations with the job descriptions of CHWs, whose job security is interlinked with performance management criteria that includes serving a required number of households.¹²³ Here, previous estimates by the Valley Trust have cited a maximum of two home visits each day, based on geographical and time constraints and physical capabilities.¹²⁴ At this time, an evaluation of a CHW programme in rural KwaZulu-Natal funded by

the DoH instead found five visits to be routine practice, with over 92% of staff reporting exhaustion.¹²⁵ Despite this occurring at a ratio of one CHW per 101 households, South Africa's national strategy and policy framework for 2018/19-2023/24 currently recommends a ratio of one CHW per 150 to 250 households, depending on the level of need.¹²⁶ This is still substantially above what has been identified as unmanageable. As the work of CHWs is also built upon strong trust and relationships with their communities,¹²⁷ there is also a high risk that extended working hours become normalised to accommodate the community's needs.

RECOMMENDATIONS FOR POLICY GAP 1

01

Raise awareness amongst healthcare workers (in particular nurses and CHWs), administrators and officials about the right to decent work in terms of domestic, regional and international human rights law;

02

Ensure that healthcare workers (in particular nurses and CHWs) have effective avenues for complaint where their rights have been violated;

03

Raise awareness of the personnel and health system effects of poor working regulations within the healthcare system, and their contradiction with Section 7 of the BCEA regarding the safeguarding of employee health and safety;

04

Promote the implementation of workplace policies conducive to the gender and working time needs of staff, such as in-house childcare facilities and 24/7 canteen facilities in line with the *Code of Good Practice on the Arrangement of Working Time*;

05

Amend Section 6(2), Section 14(2) of the BCEA to remove the loopholes that lead to work overload and exhaustion for health care workers, such as blanket exclusions for certain categories of healthcare professionals from work-time protection (contained in Section 6(2)); a caveat making provision for meal breaks that are shorter than an hour (contained in Section 14(2); and a compressed work week.

06

Advocate for the removal of the BCEA earnings threshold;

07

Promote more realistic staffing ratios within the national CHW programme to avoid extended working hours outside of working time regulations to meet the job description.

POLICY GAP 2: INSECURE WORK

This section will critically evaluate South Africa's national policy framework with regard to temporary agency workers. It will do so by comparing its legal compliance with the international norms set out in the ILO's Private Employment Agencies Convention (No.181) 1997 and the standards set by the International Covenant on Economic, Social and Cultural Rights. It will do so in comparison to the regulatory context of Namibia. Trends regarding agency work within the public and private healthcare sectors will be examined, before discussing the personal consequences of casualised nursing and CHW practices within South Africa.



1. Summary of legal comparison

Namibia's regulatory regime of agency work is far more progressive than that of South Africa. Namibia's agency work is regulated by Section 128(4)(a) of the Labour Relations Act 11, 2007 and South Africa's is regulated by Section 198(A) of the Labour Relations Act, 1995. In 2007, Namibia's high court outwardly banned labour broking on the premise that the employment relationship is between two parties only.¹²⁸ However, this was overruled by the Namibian Supreme Court of Appeal in the case *Africa Personnel Services v Government of Namibia and Others (SA 51/2008)*, which stipulated that denying the right to economic freedom is unconstitutional.

South Africa's and Namibia's regulations of agency work are similar in that both provide for the equal treatment principle (ETP). This means that an agency worker must have protections and benefits equal to those of a permanently employed worker. Key differences between the regulation of agency work in both countries are located in the qualifying period and its exclusions. South Africa allows the agency worker to be employed by the client for three months before equal terms and conditions are required. This may simply create an additional issue of rotational schemes to avoid compliance. In Namibia's case, the ETP operates from day one of employment, thereby strengthening agency worker protections.

Table 4: Summary of legal comparison in labour brokering legislation

	South Africa	Namibia
ETP or equivalent?	✓	✓
From when?	3 months	Day 1
Exclusions?	>R205,433.30	X

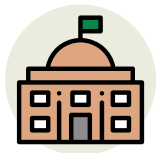
The second key difference within South Africa's labour brokering regulations is the implementation of the R205 433.33 annual threshold. While this stipulation is intended to support the most vulnerable workers, such as CHWs, it also denies equal treatment for agency workers who earn more than this amount, regardless of whether the client has employed them for more than three months. Moreover, many nurses whose salary adjustments increase their salaries from below the threshold to above the threshold run the risk of losing their labour protections. As such, it does not solve the issue of agency workers being used on a long-term basis to undercut company welfare provisions for permanent staff.

Finally, even the most stringent application of the ETP does not fundamentally solve the insecurity of work associated with atypical employment. Equal pay and working conditions may, when sufficiently regulated, go some way to alleviating income disparities associated with temporary work. However, the short-term nature of agency work itself means that secure and stable employment is still not realised.

International human rights law protects "the right to just and favourable conditions of work" of "everyone" without "distinction of any kind". The United Nations Committee on Economic, Social and Cultural Rights has explained that:

*The reference to "everyone" highlights the fact that the right applies to all workers in all settings, regardless of gender, as well as young and older workers, workers with disabilities, workers in the informal sector, migrant workers, workers from ethnic and other minorities, domestic workers, self-employed workers, agricultural workers, refugee workers and unpaid workers.*¹²⁹

On the face of it this protection applies equally to so-called “temporary workers”. In addition, Section 23 of the South African Constitution indicates that “everyone” has the right to fair labour practices, and by using the phrase “worker” it avoids “employee” – a definition that is most often used to exclude temporary workers from legal protections. To the extent that labour legislation designates some temporary workers out of the protection of labour law by excluding them from the definition of employee, such legislation arguable conflict with Section 23 of the Constitution and international human rights law.

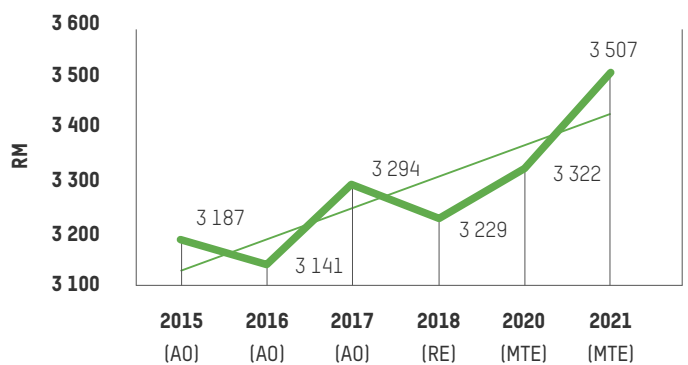


2. Public sector trends – agency work

Figure 8 and Table 5 illustrate the most recent and projected trends in total agency and outsourcing expenditure by South Africa’s public healthcare sector. During the 2015 to 2017 outcomes audit, South Africa’s

combined provincial health spend on agencies was R3 207 million on average. Based on the medium-term estimates of South Africa’s budgets, this looks set to rise to R3 322 million and R3 507 million respectively across the years 2020 and 2021.

Figure 8: Trends in total agency expenditure by the South African public healthcare sector, 2015-21



Source: own calculations from SA Treasury, Estimated Provincial Expenditure. Pretoria: Republic of South Africa.

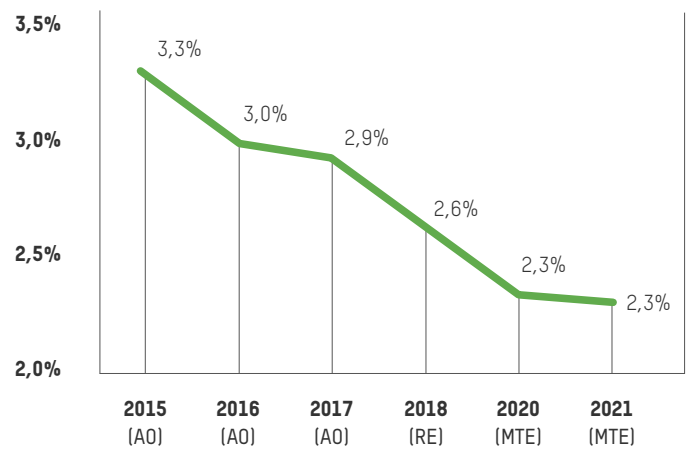
Table 5: Agency and outsourcing expenditure by provincial health department

Province	2015 (AO)	2016 (AO)	2017 (AO)	2018 (RE)	2020 (MTE)	2021 (MTE)
Eastern Cape	549	501	238	233	273	252
Free State	246	292	332	238	330	338
Gauteng	289	217	256	234	259	273
KwaZulu-Natal	1,106	1,037	1,235	1,180	1,135	1,198
Limpopo	128	128	121	78	122	130
Mpumalanga	92	118	74	115	106	102
North West	252	304	478	487	477	553
Northern Cape	93	116	90	189	131	144
Western Cape	431	427	471	475	488	517
Total	3,187	3,141	3,294	3,229	3,322	3,507

Source: own calculations via SA Treasury, Estimated Provincial Expenditure.

Figure 9 and Table 6 below illustrate agency and outsourcing expenditure as a percentage of total employee compensation spend, at both national and provincial level. As illustrated, the 2018 revised estimate places the percentage of agency expenditure against total compensation spend at approximately 2.9%, albeit it is declining slightly year-on-year. Provincial disaggregation reveals marked differences amongst agency expenditure as a percentage of total compensation spending. Whilst Gauteng and Mpumalanga spent approximately 1% on agency staff during the 2017 audited outcome, this rises to 7.5% in North West.

Figure 9: Agency and outsourcing expenditure as % of compensation expenditure



Source: own calculations via SA Treasury, Estimated Provincial Expenditure.

Table 6: Agency and outsourcing expenditure as a percent of total compensation spending, by province

Province	2015 (AO)	2016 (AO)	2017 (AO)	2018 (RE)	2020 (MTE)	2021 (MTE)
Eastern Cape	4.4%	3.7%	1.6%	1.4%	1.5%	1.3%
Free State	4.4%	5.0%	5.3%	3.6%	4.2%	4.1%
Gauteng	1.4%	0.9%	1.0%	0.9%	0.8%	0.8%
KwaZulu-Natal	5.1%	4.4%	5.0%	4.4%	3.6%	3.6%
Limpopo	1.1%	1.1%	0.9%	0.5%	0.7%	0.7%
Mpumalanga	1.5%	1.8%	1.0%	1.5%	1.2%	1.1%
North West	4.5%	5.0%	7.5%	6.8%	5.7%	6.2%
Northern Cape	4.3%	5.0%	3.5%	6.6%	3.9%	4.0%
Western Cape	3.9%	3.6%	3.7%	3.5%	3.1%	3.1%
GRAND TOTAL	3.3%	3.0%	2.9%	2.6%	2.3%	2.3%

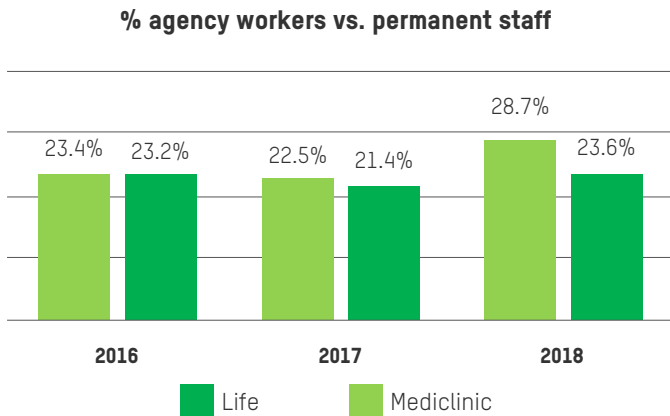
Source: own calculations via SA Treasury, Estimated Provincial Expenditure.



3. Private sector trends – agency work

Across the three largest private health providers (Netcare, Life Healthcare and Mediclinic), granular data regarding the ratio of permanent staff to agency workers is unsurprisingly limited and inconsistent. For example, Netcare does not report the percentage of agency workers within its organisation at all. By contrast, Life Healthcare and Mediclinic do regularly report their agency ratios, albeit only at aggregate level. Consequently, the specific use of nursing personnel versus other occupational roles (such as administration support) is opaque. Figure 10 illustrates the available agency data taken from their Annual Integration Reports. As shown, the industry standard percentage of agency staff floats around 22% to 24%, although a significant increase was witnessed in 2018 by Life Healthcare.

Figure 10: Private sector trends in agency usage



Source: own calculations via SA Treasury, Estimated Provincial Expenditure.



4. Effects of low paid agency work

There is extensive literature proving that the inadequate levels of remuneration in the healthcare sector greatly affects nurses and CHWs. Overall, nurses and

CHWs feel that they are not sufficiently rewarded and acknowledged for their work.¹³⁰ This causes challenges to their psychological and physical wellbeing as they report feeling underappreciated and thus unmotivated to come to work.¹³¹

A study by Mabuda¹³² shows that these low-income levels have also led to high levels of debt amongst nurses and CHWs. Professional nurses and CHWs average household expenditure exceeds average income¹³³ showing that nurses are living beyond their means due to low levels of pay. This has exposed nurses and CHWs to the dangers of loan sharks in particular townships and regions,¹³⁴ but can also have adverse effects on mental health as the weight of repaying debts increases pressure on nurses and CHWs.

Apart from their own incomes, high poverty rates in South Africa affect nurses and CHWs¹³⁵ as they are sometimes forced to overstep their professional boundaries by using their own money to assist patients that lack food. This is illustrated through interviews with nurses by Dlamini and Visser:

I once came across a patient who had just found out he was HIV positive and needed to start his treatment. This was an elderly patient, who stayed alone and did not even receive pension money. As I was explaining to the patient about the healthy diet, he stopped me and said "Even at this very moment I haven't eaten, I am hungry". I made him the free government porridge, but that small meal was not enough, and I ended up sharing my food with this man.¹³⁶

Furthermore, the low levels of pay that nurses and CHWs receive have resulted in many seeking additional sources of income. This is primarily done through agency nursing and moonlighting¹³⁷. Studies by Rispel and Blauuw¹³⁸ show that "moonlighting" is more widespread amongst private hospital nurses (58%) than those in working in the public sector (28.4%). This same study evidenced that moonlighting caused feelings of tiredness at work and a loss of concentration, and that nurses who moonlighted were more likely to take sick leave when not actually sick and to argue with colleagues.¹³⁹

RECOMMENDATIONS FOR POLICY GAP 2

01

Amend Section 198A(3)(b) of the LRA to remove the earnings threshold for qualification of workers who are covered by the BCEA so that nobody is excluded from fair working conditions; because in Oxfam South Africa's view, it is contrary to the Constitution and International Human Rights standards.

02

Amend Section 198A(3)(b) of the LRA so that the equal treatment principle operates from day one of employment, thereby strengthening agency worker protections; because in Oxfam South Africa's view, it is contrary to the Constitution and International Human Rights standards.

POLICY GAP 3: PAY AND SOCIAL PROTECTION

Overall, nurses and CHWs feel that they are not sufficiently rewarded or acknowledged for the work they do, impacting not only on their pride in their profession but also their ability to make ends meet, particularly as many HCWs are the primary source of their households' incomes.¹⁴⁰



1. The care penalty and equal pay for work of equal value

In the public healthcare sector, intense protracted strikes and negotiations for fairer wages in the 2000s, particularly mobilised by DENOSA (the Democratic Nursing Union of South Africa), accelerated the implementation of the landmark Occupational Specific Dispensation (OSD) agreement.¹⁴¹ Aiming to attract and retain skilled health professionals against acute nursing understaffing and high attrition to other countries, the remuneration structure substantially increased public sector pay based on qualifications and experience, and now includes annual pay progression in line with PSBC collective negotiations.¹⁴²

Table 7 provides average public sector care worker salaries for the 2019 period. It is important to note that these wages include in-kind benefits, which are approximately a third of the overall TCE package.¹⁴³ As a result, we can estimate the average take-home pay to be much lower, at approximately R304 761 (professional nurse), R196 302 (enrolled nurse) and R150 457 (enrolled nursing assistant) per year. As raised by Kisting et al.,¹⁴⁴ while in-kind benefits are favourable to these workers, their net cash wages - essential for day-to-day living - still remain low, especially in comparison to their workloads and contribution.



Table 7: Average public sector salaries for selected health professionals

Health worker category	Average 2019 public sector wage
Professional Nurses	R 461 759
Enrolled Nurses	R 297 428
Nursing Assistants	R 227 965
Community Health Workers	R 42 000
Pharmacists	R 773 730
Medical Practitioners	R 981 843
Pharmaceutical Assistants	R 253 427

Source: Department of Health (not published)

The failure to provide fair pay most acutely apparent when reviewing the salaries of CHWs, which are nearly 5.5 times lower than the next ranking category (nursing assistants). This is despite CHWs being trained to carry out key tasks, whose official job description includes health assessments, treatment and patient rehabilitation.¹⁴⁵ Their treatment as a secondary, deprofessionalised category is further reflected in their precarious employment status within the public health system, which is currently built on 12-month contracts that are often erratically renewed¹⁴⁶ and compensated by a flat minimum wage of R3 500. This not only falls significantly below a decent living wage,¹⁴⁷ but also provides little prospect of stable career progression.¹⁴⁸

Moreover, the Committee on Economic, Social and Cultural Rights has noted the inadequacy of the level of the national minimum wage in South Africa. It recommended that, in order to ensure compliance with South Africa's legally binding international human rights obligations, South Africa should"

(b) Raise the national minimum wage and regularly adjust it to the cost of living so as to ensure an adequate standard of living for workers and their families;

(c) Ensure full compliance with the minimum wage ... This presupposes that the State party will design a

composite index to regularly assess the cost of living, in order to support its efforts to guarantee that wages provide workers with a decent standard of living for themselves and their families...¹⁴⁹

Similarly, the short-term and temporary nature of the contract means that CHWs are excluded from the benefits provided to permanent public sector employees, such as paid maternity leave and medical insurance. This leaves CHWs highly vulnerable to the occupational hazards faced on the job, especially given that medical supplies and adequate PPE are often undersupplied due to budgetary strains.¹⁵⁰ Problematically, in a draft contract of employment annexed to the 2011 *Provincial guidelines for PHC re-engineering*,¹⁵¹ a 37% pay allowance in lieu of such benefits was already built into the R2500 stipend, whilst travel expenses incurred through daily house visits are to be paid out of pocket and later reimbursed. This is a highly disturbing contract arrangement - given that CHWs often experience the same economic hardships as the communities they live within and serve¹⁵² - especially where budgetary strains risk delayed payment. It is important to emphasise that the poor terms and conditions of employment offered by the Department of Health ironically constitute the most favourable available to CHWs. The vast majority still remain precariously linked to outsourced NGOs,¹⁵³ who are either unpaid or receive stipends (often delayed) far below South Africa's national minimum wage of R3500.¹⁵⁴



2. Health system consequences of low nursing and CHWs pay: moonlighting

Faced with inadequate pay¹⁵⁵ and often high levels of debt,¹⁵⁶ the financial pressure experienced by nurses and CHWs¹⁵⁷ to make ends meet has contributed to the widespread practice of moonlighting in South Africa's healthcare system.¹⁵⁸ In 2015, a self-survey of 3784 nurses in 80 public and private sector hospitals found that nearly 30% had reported moonlighting within the previous year, with the odds approximately 1.5 times higher for mothers.¹⁵⁹ Moonlighting was also higher for private (40.6%) as opposed to public (24.2%) sector nurses, potentially reflecting pay inequalities across both sectors - although it is also likely that nurses in

the public sector would be less inclined to disclose this practice. The study further revealed that 51.5% of moonlighting nurses felt too tired to work, 12% experienced reduced concentration whilst on nursing duty and 10.9% had reported taking sick leave without being unwell.¹⁶⁰ CHWs use moonlighting as well as child grant as survival strategies to supplement their low pay¹⁶¹. Therefore, this not only affects the personal welfare of nurses and CHWs, but also their ability to provide safe patient care when on duty. Against the backdrop of severe understaffing in the public sector, this is likely to be particularly dangerous given that tight supervision is less possible. In this way, the failure to ensure the protection of nurses' rights at work has a knock on effect, potentially compromising the right to health of users of the public healthcare sector.



3. Poor social protection for precarious and informal workers

The vulnerability experienced by informal and precarious workers in South Africa's health system is further heightened by their exclusion or disadvantage from social security mechanisms. Under the current legal framework, only workers who are formally recognised as "employees" are able to pay in and withdraw from the Unemployment Insurance Fund (UIF),¹⁶² as stipulated by the Unemployment Insurance Act No.63 (2001) and the Unemployment Insurance Contributions Act No.4 (2002). As a result, CHWs are completely excluded from receiving any financial support during maternity leave and illness or after contracts are terminated.

Similarly, withdrawals from the UIF itself are calculated from the number of credit days accrued during previous employment when contributions were made to the UIF. As this is based on one credit day per six days of employment, it significantly reduces the extent of social security for those in part-time or contracted forms of work.¹⁶³ In the case of maternity leave, for example, this means that mothers (particularly lone parents) have to return to work much earlier.¹⁶⁴

The United Nations Committee on Economic, Social and Cultural Rights has indicated that, in order to ensure decent work, national minimum wages should be calculated taking into account various factors including "the cost of living, social security contributions and benefits, and relative living standards".¹⁶⁵ It has also indicates that states could "establish non-contributory

social security programmes" for certain categories of vulnerable workers.¹⁶⁶ Finally, in a direct recommendation to South Africa, the committee indicated that in order to execute its obligations in terms of the right to social security, South Africa must "expand the coverage of the Unemployment Insurance Fund benefits to all workers, regardless of their status".¹⁶⁷

The heavy labour involved in CHWs' work exposes them to occupational hazards. The work of CHWs is physically exhausting as they often have to lift and carry patients in and out of beds and assist wheelchair patients.¹⁶⁸ This results in muscle cramps, excessive burnout, headaches and fatigue.¹⁶⁹ In spite of their exposure to occupational hazards, CHWs are not able to make claims on the state for injuries incurred during the course of their work as provided for by the Compensation for Occupational Injuries and Disease Act. This is because of the informality of their contracts.

RECOMMENDATIONS FOR POLICY GAP 3

01

CHWs should be recognised for their vital contribution to South Africa's PHC system and all of them should be integrated into the Department of Health with living wages and permanent status, as many remain employed by NGOs.

02

Enhanced transparency in the private health sector to promote accountability over fair pay.

03

Advocate for informal workers to be recognised under the Unemployment Insurance Fund to promote equitable social protection.

POLICY GAP 4: SAFETY DURING WORK-RELATED TRAVEL

As recognised within Oxfam's 2019 **Dignified Work for Womxn** framework, incidents of violence at work are not limited to the physical setting but encompass all spaces where womxn must travel to fulfil their professional requirements. This is particularly relevant for nurses and CHWs, a highly feminised labour force which routinely navigates **night commuting and mobile services – increasing their potential exposure to crime**. Slow progress in redressing the spatial irregularities produced by the Group Areas Act of 1950 during apartheid has intensified these risks, with poor transport links making work-related travel prolonged, fragmented, expensive and dangerous.¹⁷⁰ As a result, **nurses and CHWs in South Africa have reported attacks becoming increasingly frequent, particularly as their uniforms increase the likelihood of being robbed for medical supplies**.¹⁷¹ Against this context, we identify two key gaps in the legislation.



1. Weak employer accountability for night transport safety

Section 17 of the BCEA No.75 (1997) regulates the use of night work, defined as “work performed after 18h00 and before 06h00 the next day” (A1). As 12-hour shifts starting at either 07h00 or 19h00 are routine for nurses and CHWs,¹⁷² the vast majority will therefore fall under this scope. Under Article 2b, employers are required to ensure “transportation is available between the employee’s place of residence and the workplace at the commencement and conclusion of the employee’s shift”. As employers in the public and private health sectors rarely provide shuttle services,¹⁷³ the ambiguity of the term “**availability**” is problematic as it provides no clarity regarding the acceptable distance to public transport, the safety of the walking route, nor the regularity of public transport itself.

The Code of Good Practice on the Arrangement of Working Time does outline the need to consider the “**personal security of the employee when commuting**” during shift design.¹⁷⁴ However, this does not carry the same power as statutory provisions, and the testimonies of HCWs suggest this is rarely prioritised in practice.¹⁷⁵

The United Nations Committee on Economic, Social and Cultural Rights has indicated that “freedom from violence and harassment” falls within the ambit of the right to just and favourable working conditions.¹⁷⁶



2. No safety protection for on-the-job travel

The Occupational Health and Safety Act (OHSA) No.85 (1993:8) defines the “workplace” as “any premises or place where a person *performs* work in the course of his or her employment”. By restricting its scope to traditional ideas of the “physical” workplace, this act artificially constructs boundaries about when and where job-related activities commence and finish,¹⁷⁷ limiting the employers’ obligations to welfare.¹⁷⁸ This is clearly a key legal gap for CHWs, where multiple daily house visits constitute a core part of their job description.¹⁷⁹

Moreover, CHWs are exposed to a range of threats of violence during their daily house consultations. They live in fear of being followed by *nyaope* (street drug) addicts as they walk long distances to see patients. As a CHW, Lungile, expressed it:

*We do not have UIF, we don't have pension, we are not paid properly, our job is not taken seriously. We just work because we love the job and need the money. This job is very important, but are not seen as important... sometimes it's quiet on the street - everyone will be at work, only a few people on the street; some of these corners are dangers because of the nyaope boys. You see what can happen, they can follow us and do anything they want to do... it's not safe. We are a small group of womxn, the nyaope boys can sit and plan for us because they know what time we come in, what time we come out - we get scared (31 May 2018).*¹⁸⁰

RECOMMENDATIONS FOR POLICY GAP 4

01 Engage with relevant trade unions and employers to advance negotiations on workable solutions for transport safety, particularly at night.

02 Request health facilities to disclose relevant measures undertaken to promote the “personal security of the employee when commuting” as per the *Code of Good Practice on the Arrangement of Working Time*.

03 Advocate for broader conceptualisations on what constitutes “work” within the OHS Act (1993) to extend the protection of healthcare workers within the full scope of their professional requirements. A notable example of national best practice is Zambia’s Occupational Health and Safety Act No.36 (2010), which extends employer welfare obligations to “any place where the employees work or are likely to work, or which they frequent or are likely to frequent in the course of their employment or incidental to it”.

04 Promote South Africa’s ratification of the recent Violence and Harassment Convention No.190 (2019), which stipulates specific worker protections when “commuting to and from work” (A3). This is already being pushed by the Commission for Employment Equity¹⁸¹ and so greater organising around this issue may accelerate this.

POLICY GAP 5: GENDER BASED VIOLENCE

Nurses are greatly affected by the social issues that South Africa currently faces. One such issue is the crisis of **gender-based violence (GBV)**. GBV is widespread in South Africa with a femicide rate five times higher than the global rate¹⁸² and the fourth-highest female interpersonal violence death rate in recent years.¹⁸³ A study by Jewkes et al.¹⁸⁴ found that 1 in 4 womxn in South Africa have experienced physical abuse in their lifetime and that black womxn were more susceptible to acts of GBV. Thus, as a predominantly black female workforce, nurses, CHWs and other care workers are especially vulnerable to threats of GBV both at home and in the workplace.

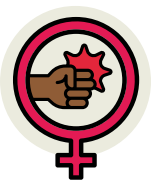
Violence in the workplace violates the right to a safe working environment as outlined by the ILO and the International Covenant on Economic, Social and Cultural Rights. In addition the United Nations Committee on the Elimination of All Forms of Discrimination Against Womxn has indicated that states are required to develop and implement “protocols and procedures addressing all forms of gender-based violence that may occur in the workplace or affect womxn workers”.¹⁸⁵ Moreover, as

with all other violence against womxn, such violence impinges on various constitutional rights including the rights to dignity (section 10), equality (section 9) and security of person (section 12).

As the South African Constitutional Court has noted more generally on gender-based violence:

Sexual violence and the threat of sexual violence goes to the core of womxn's subordination in society. It is the single greatest threat to the self-determination of South African womxn.' . . . South Africa also has a duty under international law to prohibit all gender-based discrimination that has the effect or purpose of impairing the enjoyment by womxn of fundamental rights and freedoms and to take reasonable and appropriate measures to prevent the violation of those rights.¹⁸⁶

In addition to having similarly devastating effects on survivors' human rights, the occurrence of violence outside of the workplace contradicts Oxfam's framework of dignified work, which highlights the right for womxn to be free from any kind of violence.



Normalisation of workplace violence against nurses and CHWs

Owing to daily interactions with patients in distress, the risk of violence within the healthcare sector is particularly acute. For example, Kajee-Adams & Khalil¹⁸⁷ found that 78% of nurses at general hospitals and 86% of nurses working in community health centres reported verbal abuse. The South African constitution specifically entrenches a right to "bodily and psychological integrity" (Section 12).

Though the levels of physical violence are much lower, this type of violence has been on the increase in both general and psychiatric hospitals.¹⁸⁸ For example, Madzhadz et al.¹⁸⁹ interviewed 300 nurses working in one regional and two district hospitals in Thulamela, and found that 85% had experienced workplace violence in the previous year. Groups particularly at-risk appear to be psychiatric nurses, who have reported being raped and physically attacked by unstable

patients, including those with criminal backgrounds, as they are not permitted to medicate incoming patients for the first 72 hours after admission.¹⁹⁰ Instances of workplace violence are especially pronounced where poor staffing ratios leave nurses at greater risk of being physically overwhelmed by patients. As such, legislative enactments such as the *Occupational Health & Safety Act (1993)* should address and properly enforce the need for a minimum number of trained staff within an area where threats of violence are commonplace.

Unfortunately, despite their frequency, cultures of silence regarding work-related violence appear to be widespread. According to Zuzelo, Curran and Zeserman,¹⁹¹ only 25% of nurses seek professional help to cope with workplace violence. This could cause serious psychological effects, including frustration and low job control.¹⁹² GBV affects both the individual and their families as it often leads to arguments and confrontations on the home front.¹⁹³ Gender-sensitive and confidential support for all victims of domestic and workplace violence should be made a priority in the health sector.

The *Code of Good Practice on the Handling of Sexual Harassment in the Workplace* of 2008 states that employers should create an environment where complainants do not fear reprisals. While commendable, this does not go far enough to consider how difficult it might be for nurses and CHWs to continue working after experiencing acts of violence at work. Thus, more than the fear of reprisal, the code could make provision for the needs of victims of abuse at work, such as provisions for psychiatric help, paid leave and so on.

Evidently, the prevalence of GBV in South Africa is affecting and threatening the safety of all womxn, and by extension the predominantly female population of nurses and CHWs. Nurses and CHWs shouldn't experience threats to their life inside and outside of their workplace, especially when they dedicate their lives to protecting the health and safety of all South Africans. Gaps in policy around GBV affect all womxn and should therefore be a primary concern for the government. Setting boundaries around acceptable patient behaviour may limit verbal and physical violence in the workplace¹⁹⁴ and therefore reduce violence related stress.

RECOMMENDATIONS FOR POLICY GAP 5

01 Government should **invest in programmes which educate the public** about the dangers of GBV and to change harmful cultural beliefs and practices which lead to continued danger for womxn.

02 Violence in the workplace for CHWs and nurses should be **formally recognised as a violation of dignified work** so that nurses can seek legal action against these acts of violence.

03 **Increased funding and support for victim support** rooms and courts so that victims are able to access protections against GBV quickly and easily.

04 Draw attention to the fact that **poor staffing ratios place nurses at greater risk** of patient violence.

05 **Challenge the normalisation of violence** against nurses and CHWs as simply “part-of-the-job”.

06

The *Code of Good Practice on the Handling of Sexual Harassment in the Workplace* and the Protection from Harassment Act **should be amended** to expound upon the realities and needs of nurses and CHWs who experience violence at work. Thus it must include measures sensitive to the needs of victims of abuse at work, such as provisions for psychiatric help, paid leave and so on. The Occupational Health & Safety Act (1993) should address and properly enforce the need for a minimum number of trained staff within an area where threats of violence are commonplace.

POLICY GAP 6: TOWARDS QUALITY UNIVERSAL ACCESS TO HEALTH CARE, FREE AT THE POINT OF USE

As part of the Sustainable Development Goals, world leaders signed up to achieve universal health coverage by 2030¹⁹⁵. Oxfam believes that a world in which we achieve the Global Goals, end poverty and leave no one behind is a world in which there is a quality, universal, people-centred, resilient healthcare system that is responsive to the needs of communities, society and healthcare workers and free at the point of access.

The Constitution of South Africa¹⁹⁶ states that “Everyone has the right to health services...including reproductive health care...no person may be refused emergency treatment. Government must take reasonable legislative and other measures, within its available resources, to achieve progressive realisation”. In order to meet its mandate, government has proposed establishing an: “integrated, prepayment-based health financing system that effectively promotes the progressive realisation of the right to health care for all”. In December 2015, a White Paper on a National Health Insurance (NHI) was released, starting the process of building universal health cover. Consequently, an NHI Fund (NHIF) is to be established as a single purchaser and single payer of healthcare services in South Africa.

The NHIF would pay public and private providers to deliver the service to the public. The NHIF would be funded through progressive taxation: high earners would contribute more while the wealthiest would pay the biggest portion. Currently this cross-subsidization does not occur in South Africa because almost half of total spending on health is done through private medical schemes, which only benefit the private sector which serves 16% of the population. The majority of that 16% happens to be also healthier than the rest of the population. Cross-subsidization is the key pillar of social solidarity and would create more equity as it is based on the principle that health is a public good and a fundamental human right for everyone, not just the wealthy.

However, NHI, as it is currently debated, is insufficient to meet this vision as it is based on a public purchaser and private provider model which remains crippled by profit seeking and cost containment. “Public funding, even if expanding over time, cannot satisfy the profit motive of the private providers while maintaining other expenditures necessary to provide healthcare”; thus cuts will follow on those pivotal expenditures such as labour¹⁹⁷. The proposition of cross subsidisation, which will be central to universal health care, risks being undermined by the private-public mix where health remains a commodity to be sold in the market. This is perhaps due to the influence of the private sector lobby which is evident in the advisory structures set up by the Department of Health to bring about NHI: large corporate firms operating in the health sector enjoy strong representation in those structures and advise government on financing mechanisms.

RECOMMENDATIONS FOR POLICY GAP 6

01

Ultimately, quality and sustainable healthcare can only be achieved through decommodification of services: public investment in infrastructure and in the health labour force to guarantee staffing levels, living-wages, and decent working conditions.

02

Government should strengthen frontline health workers and their physical and emotional ability to carry out their tasks¹⁹⁸. for a successful strategy for the future of South African health care, and responsiveness to pandemics.

03

Investment in the health sector should not be motivated by profit-seeking for a tiny minority but by health outcomes and by the needs of the majority of the population, made up of working-class patients and black womxn health workers, specifically nurses and CHWs.

CHAPTER 5:

CONCLUSION AND RECOMMENDATIONS

This report has identified and uncovered five gaps in policy and implementation that compromise the right to decent and dignified work for nurses and CHWs in South Africa today. To begin with, this report provided an overview of the South African healthcare sector. This was done to highlight key issues currently plaguing the sector, specifically an extractive profit-driven private healthcare sector and underspending associated with the restriction of filled posts which has had far-reaching effects on the public healthcare sector.

The report then identified five major areas that undermine decent work, gender equality for black female workers in South Africa's healthcare sector; and undermine health outcomes for society at large and dual healthcare. The areas are working hours, low pay and social protection, GBV and safety, labour broking and dual healthcare system. This section revealed that nurses and CHWs are overworked and poorly remunerated.

This has led to high levels of stress, burnout, and high levels of financial debt for many nurses and CHWs. A focus on labour broking within the healthcare sector revealed that nurses and CHWs are increasingly taking up agency work. Yet due to poor regulation and insecure working contracts in the labour broking sector, nurses suffer under poor working conditions and are paid abysmally. Finally, an examination of the crisis of GBV in South Africa demonstrated that as a workforce of predominantly black womxn, nurses and CHWs are susceptible to violence inside and outside the workplace. Underpinning this reality is that as of yet there is insufficient protection in existing legislation around these major issues.

In order to ensure that CHWs and nurses are able to work in decent and dignified conditions, it is crucial to recognize and consider the race and gender of this predominantly black female workforce when drafting policies and protections. As this report has shown, these intersecting identities have great implications for how CHWs and nurses experience work in the healthcare sector, especially with regards to issues of gender based violence and safety.

The following recommendations have been drafted with these main findings in mind. These recommendations aim to condense the ways in which decent and dignified working conditions may be achieved for nurses and CHWs in South Africa.

RECOMMENDATIONS



Transparent and accountable health system

There is a need for greater transparency in the healthcare sector. The unavailability of data and information aids in continuation of a healthcare system that works against the nurses and CHWs that keep it afloat. As such, there needs to be greater transparency of data around workforce compositions, pay scales and so on from both private and public healthcare actors. Companies must pay proper taxes, disclose payments and advocate publicly for tax regimes that reduce inequality. Oxfam and its allies have outlined a proposal on how companies can begin to engage positively on tax issues in a report, *Getting to Good: Towards Responsible Corporate Tax Behaviour*.¹⁹⁹



Increasing government public spending on healthcare.

As a matter of urgency there is a need for greater funding in the healthcare sector, as a lack of funding restricts rights to decent work and gender equality for all nurses and CHWs, which in turn negatively affect the quality of care for patients. Importantly, SA's austerity measures in social security, health and education have been noted by the United Nations Committee on Economic, Social and Cultural Rights to be in contravention of its legally binding human rights' commitments.²⁰⁰ Any decreases in real public spending on healthcare amount to "retrogressive" measures in violation of South Africa's domestic and international human rights obligations in terms of the right to health.²⁰¹ Through tackling the socio-economic determinants of health and channeling funds towards one single system of health provision, the vicious circle of poor health, high pressure on the system and inadequate services can be broken.



Create conditions for decent work and work towards a living wage.

Pivotal to a well-functioning health system is a healthy workforce, sufficient in numbers to meet evidence-based clinical needs of the population. Both the private and the public healthcare sectors must improve the working conditions for nurses and CHWs. This includes paying all a living wage as agreed in the Occupational Salary Dispensation for Nurses Resolution taken in 2018; and no less than R12 500 per month for CHWs. The public and private sector must ensure opportunities for professional development and promotion. In all cases this includes committing to publish and reduce the gender wage pay gap²⁰². There must be a commitment to publish and reduce executive-worker average pay ratios that include outsourced workers, and in the interim to offer insurance to health workers and their families as well as employee benefits (including but not limited to medical care, sickness benefits, unemployment benefits, old-age benefits, employment injury benefits, family benefits, maternity benefits, invalid benefits and survivors' benefit and death benefit for family) – complementing, rather than substituting for or undermining the fact these will be unified under the new legislation²⁰³.



Reduce inhumane working hours for healthcare workers

There are various loopholes in the Basic Conditions of Employment Act that may be exploited by healthcare employers to create inhumane working hours for health care workers given the crisis of understaffing. It is not uncommon for healthcare workers to be working for 24 hours, which compromises both their health and the quality of care. Therefore, there is a need for an

amendment to Section 6(2) and Section 14(2) of the BCEA so these loopholes that lead to work overload and exhaustion for healthcare workers are removed – such as: blanket exclusions for certain categories of healthcare professionals from work-time protection (contained in Section 6(2)); provisions that make meal breaks shorter than an hour (contained in Section 14(2)); and the compressed work week.



Secure contracts

There is a need for security of contracts for all healthcare workers including CHWs, and to work to remove temporary and outsourced work, as outsourcing makes work precarious, causing workers to live with insecurity and worry. Precarious work is a major concern because people who are fearful of losing their jobs are unlikely to speak out or assert their rights²⁰⁴. Section 198A(3) of the LRA must be amended to remove the arbitrary threshold of R205 433.30 (nurses earning above Grade 3) that disqualifies workers earning above that amount from secure contracts. An amendment of Section 198A(3)(b) of the LRA is needed so that labour-brokered workers obtain the same labour protections as permanently employed workers from day one of employment through the agency, instead of waiting for three months. The three-month delay creates an additional issue of rotational schemes to avoid compliance.

In particular there is a need for CHWs to be recognized as formal sector employees, and thus benefit from all labour policies, regulations and laws, including the BCEA and LRA. The crucial role that CHWs play should be reflected in the way that they are treated and remunerated. As formal sector employees, they would be able to receive benefits such as medical aid, UIF, maternity leave and pensions to ensure that they are able to cope with their personal and financial needs. In order to protect CHWs from unfair and unfavorable working conditions, they should be provided with strong full-time employment contracts, which will shield them from exploitative practices and conditions, especially in the labour-broking industry. Training opportunities

for professional promotion need to be offered. The elaboration of realistic staffing ratios within CHW programmes is necessary if CHWs are to stop being overburdened in their work.



End discrimination against womxn

For both the public and private sector much more needs to be done to take cognizance of the fact that the healthcare workforce is predominantly – 90%²⁰⁵ – black and female nurses and CHWs make up the backbone of the healthcare sector yet suffer under poor working conditions and are undervalued because they are black womxn. Therefore, there is a need to *implement* the UN Womxn's Empowerment Principles²⁰⁶. It is important to embed the principle of gender equality in policies and processes across the public and private sectors, extending this to governing bodies and throughout operations, including recruitment, remuneration/benefits, training, promotion, and development reviews, paying equal remuneration, including benefits, for work of equal value²⁰⁷. In-company gender equality should be reviewed, including contract status, regularly and corrective action taken where needed to improve the gender balance amongst employees and executive management. Partnering with relevant public and private stakeholders, such as labor unions and NGOs, to advance gender equality in the workplace, marketplace and community.



Recognize the burden of unpaid care work

Womxn's unpaid care work has a monetary value of \$10.8 trillion a year – three times the size of the world's tech industry²⁰⁸. Across the world, womxn do an average of more than three times the unpaid care work of men, with the difference rising to more than five times in poor, rural areas²⁰⁹. There needs to be implementation of workplace

policies conducive for familial responsibilities and the wellbeing of nurses and CHWs through the provision of accessible, safe and affordable day care facilities, revision of working hours allowing for flexibility but not insecurity, and 24/7 canteen facilities in line with the *Code of Good Practice on the Arrangement of Working Time*, along with innovating in order to reduce hours that nurses spend doing admin work and employing support staff. In addition, it is important to ensure that maternity and paternity leave is available and that its existence is socialized so all employees are encouraged to use it. Employers need to play their role in challenging harmful norms and sexist beliefs that see care work as the responsibility of womxn and girls and perpetuate economic and gender inequality.



End violence against womxn

In all workplaces there is a need to have clear policies that establish a zero-tolerance policy towards all forms of violence in the workplace and for preventing sexual harassment. It is important these policies are publicly disclosed, provided to a workforce socialized within the workplace so that staff know their rights. It is important that there are policies, procedures, grievance mechanisms and support structures for employees or suppliers to anonymously report incidents or suspected incidents of violence, exploitation or harassment, and that protection is in place for whistleblowers so that persons feel able to report without fear of retribution.

The safety concerns that nurses and CHWs face as womxn travelling at night or in dangerous places to reach patients, and dealing with violent patients, should be recognized and addressed through specific policies and acts and through implementation of commitments which should include provision of dedicated transport for night shift workers. The issue of housing and transport of health workers have to be addressed in ways that reduce or eliminate instances of attacks for health workers commuting from house to work. South Africa needs to step up and ratify the *Violence and Harassment Convention* No.190 (2019), which stipulates specific worker protections when “commuting to

and from work”, and in addition, through the Code of Practice, address and properly enforce the need for a minimum number of trained staff within an area where threats of violence are commonplace²¹⁰.



Represent and empower healthcare workers

In all their places of work, nurses and care workers must be represented and empowered in the design of and decision making around all policies and operations that affect them. Moreover, they must be empowered in the form of continuous learning and training at all levels so that they are upskilled. CHWs must receive training such that there is career progression. Government must commit to involve CHWs and nurses in the design of policies, including the National Health Insurance.



Commit to doing business responsibly

Whatever the role of the private sector in a future where there is publicly funded universal healthcare, there is a need for private sector actors to behave responsibly. This could include making an explicit commitment to respecting internationally recognized human rights standards – UN Guiding Principles on Business and Rights (UNGPs) – applying the principles in its supply chains and operations. This must be complemented with human rights impact assessments and followed up by public reporting. Importantly, to deal with skewed financial incentives, implement reporting that assesses the distribution of economic value across stakeholder groups (employee wages and benefits, payments to providers of capital, payments to government by country, and community investments), in accordance with Global Reporting Initiative (GRI) indicator 201²¹¹. How a company shares the economic value created reflects how they are increasing or reducing financial inequalities.

CONCLUSION

If implemented, these recommendations stand to address the key barriers to decent work that female healthcare workers face. This is crucial as this will not only improve the lives of millions of womxn working in the healthcare sector, but will lead to better and higher quality healthcare in South Africa. The challenges that the South African healthcare system faces are by no means unique to it. Nursing understaffing, cuts in health spending and the casualisation of labour affect almost every healthcare system worldwide. Yet, in being at the forefront of addressing these issues and fighting for the rights of its workers, South Africa could have a far-reaching impact on the lives of millions of healthcare workers within its borders and beyond. All healthcare workers deserve the right to decent and dignified work. Black South African womxn and nurses have dedicated their time and efforts towards protecting and ensuring the health and safety of others. Now, it is time for us to do the same for them.

METHODOLOGY NOTE FINANCIAL ANALYSIS

Methodology notes

The analysis for this paper aimed to provide an aggregate picture of a set of 3 companies Network Healthcare Holdings Limited ("Netcare"), Mediclinic International ("Mediclinic South Africa"), and/or Life Healthcare Group ("Life"), private healthcare providers labour rights engagements It did not aim to assess individual companies' performance (or to compare them with each other). We assessed companies' engagements based on the latest available publicly available information. The main data sources were company websites.

Data Source

- Company financial data is based on company filings between 2016 – 2019.
- Average nurse wages were sourced from payscale.com.

Data collection

- The data was collected by research consultants with expertise in gender, corporate sustainability, public and private health care policy.

Company selection

- Company selection focused on 3 companies that hold 80% of the market. We consider this to be significant holding giving these companies significant influence over working conditions and health outcomes in the sector. The tables 1, 2 and 3 are the data points extracted from company filings

Table 1. Mediclinic Net Profits and payouts to shareholders and executives, in millions except for Executive pay 2016-2019

	2016	2017	2018	2019	TOTAL	AVERAGE	SOURCE
Net profit	3748	3848	-8166	-2835	-3,405	-851	Company filings
Dividend	1016	1042	963	1108	4,128	1,032	Company filings
Buyback	21				21	21	Company filings
Total paid to shareholders	1038	1042	963	1108	4,150	1,037	Company filings
Highest paid executive	1672791	17289427	18687696	11264113		12,228,507	Company filings

Table 2. Netcare Net Profits and payouts to shareholders and executives, in millions except for Executive pay 2016-2019

NETCARE In millions (except salaries)	2015	2016	2017	2018	2019	TOTAL	AVERAGE	SOURCE
Net profit	2461	1719	-493	4940	2447	8,613	2,153	Company filings
Dividend	1166	1250	1296	1388	1996	5,930	1,483	Company filings
Buyback		141			458	599	300	Company filings
Total paid to shareholders	1166	1391	1296	1388	2454	6,529	1,632	Company filings
Shareholder pay-out ratio	0	1	-3	0	1	1		Company filings
Highest paid executive	14052000	14288000	14435000	12136000	9826000		12,671,250	Company filings

Table 3. Life Net Profits and payouts to shareholders and executives, in millions except for Executive pay 2016-2019

	2015	2016	2017	2018	2019	TOTAL	AVERAGE	SOURCE
Net profit	1866	1616	814	1575	2569	6,574	1,644	Company filings
Dividend	1520	1087	765	758	1321	3,931	983	Company filings
Repurchase of Common Stock	119	61	125	72	72	330	83	Company filings
Repurchase of Preferred Stock		320		1250	2700			Company filings
Buyback	119	381	125	1322	2772			Company filings
Total paid to shareholders	1639	1468	890	2080	4093	8,531	2,133	Company filings
Shareholder pay-out ratio	0.88	0.91	1.09	1.32	1.59			Company filings
CEO remuneration	7794000	9171000	5891000	7642000	9513000		8,054,250	Company filings

Data Analysis

The data points from the table 4 were sourced from company filings or calculated by the authors. An explanation of how net profit, percentage increase between 2016 and 2019 in total paid to shareholders, shareholder pay-out ratio and cash paid out to shareholder ratio were calculated by the authors. An explanation of the formula used follows below.

Table 4. Shareholder payout ratio and cash paid out ratio 2016-2019

Totals across all three companies	2016	2017	2018	2019	TOTAL	Percentage increase from 2016-2019	
Net profit	7,083	4,169	-1,651	2,181	11,782.30	-0.69	
Total paid to shareholders	3,897	3,228	4,431	7,655	19,209.50	0.96	Cash paid out
Ratio	0.550141891	0.774270156	-2.684398667	3.50935265	1.630369283	shareholder payout ratio	
CEO salary Ave. across 3 companies	8,377,264	12,538,476	12,821,899	10,201,038	10,984,669	0.22	

Formulas for table 4

- Total paid to shareholder figures are the sum of dividends and buybacks (share repurchase) between 2016-2019.
- To calculate C.E.O pay, Oxfam South Africa used the reported remuneration figure which is the sum of all compensation components which include: salary, stock options and other forms of compensation and reward.
- Net Profit is the sum of the annual profits made by each company between 2016-2019
- Shareholder pay-out ratio is the ratio of the sum of the total paid out to shareholders in the three

companies between 2016 and 2019 to the sum of profits earned in the three companies over the same period multiplied by 100.

- Cash paid out: first we take the total sum of dividends and buybacks paid to shareholders annually between 2016-2019. Then the cash paid out is calculated using percentage change of total paid to shareholders between 2016 and 2019

Formula for table 5.

- Years for a registered nurse to earn what a CEO takes home in a 1 year is calculated using the average of the sum of all compensation components of the three companies in a particular year, divided by the average of the sum of nurse wage in the same year.

Table 5: Years for a registered nurse to earn what a CEO takes home in a 1 year

	Local currency
CEO annual wage	10,984,669
Worker annual wage	169,807
Ratio	65

Formulas for table 6

Table 6: Days it takes for CEO earn more than what a healthcare worker earns in one year

	Local currency
CEO annual wage	10984668.92
Worker annual wage	169807.3333
Day	33388.05142
How many days it takes for CEO to earn what worker earns in the entire year	5.085871326

- For calculating the number of working days of a CEO, it was assumed that 'CEOs work 12 hours a day, including three out of every four weekends, and take fewer than 10 days' holiday per year.
- CEO daily salary was calculated using annual CEO wage divided by number of working days for a CEO
- Average nurse wages were sourced from payscale.com and calculated using the average of the sum of all three companies' nurses' salaries in a given year.
- How many days it takes for a CEO to earn what a nurse earns an entire year was calculated using the worker annual wage and dividing it by daily pay of a CEO.

NOTES

1. Mabuda, T.B., Aspirations, Economic And Social Well-Being
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ABBREVIATIONS

B-BBEE: Broad-based black economic empowerment

BCEA: Basic Conditions of Employment Act

CHW: community health worker

CPI: Consumer Price Index

ETP: equal treatment principle

GBV: gender based violence

ICESCR: International Covenant on Economic, Social and Cultural Rights

ILO: International Labour Organisation

LRA: Labour Relations Act

NDoh: National Department of Health

OSD: Occupational Specific Dispensation

PHC: primary health care

PPE: personal protective equipment

SANC: the South African Nursing Council

SDGs: Sustainable Development Goals





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In an era where health care workers are finally recognised for the essential workers they are, this report positions the exploitation of care workers within a systemic analysis of the healthcare sector. It highlights how low wages, poor working conditions, and precarious employment contracts in the private sector are matched by high corporate profits, alongside an under-funded public healthcare sector that shifts the burden of care onto the poorly-paid and unpaid. Congrats to the Oxfam South Africa team on this timely intervention.



Dr Gilad Isaacs: Institute of Economic Justice and University of Witwatersrand



The publication of this book is timely. South Africa and rest of the world are grappling with the COVID-19 pandemic, which has had a direct and immediate impact on the healthcare system and on all healthcare workers. The book shows that the South African state has been implementing austerity measures, leading to poor healthcare services and the undermining of the rights and interests of nurses and community health care workers, who are predominantly black women. On the other hand, private healthcare serves a tiny minority, and resources of the state support it at the expense of working class and marginalised citizens.



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South Africa spends a significant amount of money on health services, but health outcomes are not reflecting the share of the country's GDP devoted to health services. The country has a quadruple burden of disease including HIV/TB, injuries, communicable and non-communicable diseases. Unfortunately, the recent COVID-19 pandemic may further compound health inequalities and exacerbate the quadruple burden of disease. The vital role of healthcare workers, including all cadres, has become even pronounced in the wake of the COVID-19 pandemic. Healthcare workers are the first line of defence for, among other things, managing severe coronavirus cases that cannot be managed away from a health facility. This report that highlights the longstanding plights of many healthcare workers, especially female health care workers, is timely. The report points out the challenges that healthcare workers face, especially those that can be addressed through effective policy. Although not peculiar to the health sector, the report calls on those in power to ensure among other things, dignified working conditions for healthcare workers as this contributes to improving health outcomes. It concludes that failure to internalise the gendered nature of the healthcare workforce through gender-responsive policy and improve the working conditions of healthcare workers may exacerbate the country's disease burden and deepen the social and economic crisis.



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