

**The disempowering faces of the flexible firm: a case study of
Gaborone Private Hospital**

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ABSTRACT

The purpose of the study was to investigate the ways in which the practice of the Flexible Firm Model (FFM) disempowered the non-citizen professional nurses at Gaborone Private Hospital (GPH) in Gaborone, Botswana. GPH is a member of the Life Healthcare group of private hospitals based in South Africa. This study sought to probe the manner in which the practice of FFM influenced the employment relationship for non-citizen professional nurses. It also sought to examine the impact of the nature of the employment relationship on career development and representation and participation. Both qualitative and quantitative research methodologies were applied. Questionnaires were used to collect quantitative data. Thirty-five questionnaires were issued out to professional nursing staff and thirty-three responses were received. The response rate was ninety-four per cent. The qualitative research data consisted of twelve in-depth interviews with professional nurses, the human resources manager, a professional nurse agency owner and a private clinic co-owner. Document analysis in the form of labour legislation, employee guides and employment contracts was used to validate data collected from the in-depth interviews. The results from the questionnaire revealed that an overwhelming majority of the professional nurses were Non-Citizens' dependent contractors. Although just under half of the participants held two or more previous contracts with GPH, an overwhelming majority had never been promoted. In addition, none of the participants were affiliated to the Botswana Nurses Association (BNA), the local equivalency of a professional nursing trade union. The in-depth interviews disclosed a sense of helplessness at their perceived disempowerment within the employment relationship, a poor career development and weak representation and participation. This study concluded that disempowerment at GPH was manifested through worker representation and participation and ineffective skill upgrade. These forms of disempowerment were made worse by the global professional nurse shortage and maladministration of available human resources. Effective use of human resources and continued education could be employed to circumvent the adverse results of disempowerment.

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ACRONYMS

APC	Acute Patient Care
BNA	Botswana Nurses' Association
BNMC	Botswana Nursing and Mid-Wifery Council
BOMAID	Botswana Medical Aid Society
BOPA	Botswana Press Agency
BPOMAS	Botswana Public Officers Medical Aid Scheme
BURS	Botswana Unified Revenue Service
CCF	Consultative Communication Forum
CEMAEF	Citizen Entrepreneur Mortgage Assistance Equity Fund
CSF	Critical Success Factors
FCC	Focus Care Centres
FFM	Flexible Firm Model
GPH	Gaborone Private Hospital
HR	Human Resources
HRM	Human Resource
HUMC	Hackensack University Medical Centre Management
ICU	Intensive Care Unit
IPP	Individual Performance Plan
JPM	Joint Performance Management
KPA	Key Performance Areas
MARS	Medical Air Rescue Services
NAB	Nurses Association of Botswana
NHS	National Health Service
VAT	Value Added Tax

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CHAPTER ONE

1.0 INTRODUCTION

The objective of the study is to examine the ways in which the practice of the Flexible Firm Model (FFM) disempowered the non-citizen professional nurses at Gaborone Private Hospital (GPH) in Gaborone, Botswana. GPH is a member of the Life Healthcare group of private hospitals based in South Africa. This study seeks to look into the way in which the practice of FFM has shaped the employment relationship for non-citizen professional nurses. It also seeks to examine the impact of the nature of the employment relationship on career development and representation and participation.

1.1 BACKGROUND CONTEXT OF GABORONE PRIVATE HOSPITAL

Gaborone Private Hospital (GPH) was opened in 1991. It had a bed capacity of 132, three theatres and four delivery suites. It became an affiliate of Afrox Health Care in 1994. In 2003 GPH became an affiliate of Life Healthcare. In the late 1990s it expanded its bed capacity by 66 units (Daily News, 1999). However, in 1998 GPH went through a highly publicized restructuring process that was characterized by the scaling down of its services. In 2003, it underwent a similar process that saw the closing of some wards and staff redundancy (Mooketsi, 2007). According to various press reports, GPH had encountered a financial crisis, which had come about because of a series of conflicts with medical aid scheme companies (BOPA, 2001; BOPA, 2003; Mmegi, 2003; Chwaane, 2006; Mooketsi, 2007).

In 2001, GPH unilaterally increased its tariffs by 10 per cent (BOPA, 2001). The then prominent medical aid scheme companies – namely, Botswana Medical Aid Society (BOMAID) and Botswana Public Officers Medical Aid Scheme (BPOMAS) – did not concur with the increment in tariffs. It is arguable that the tariff increment had been a measure to pre-empt the then highly publicized Value Added Tax (VAT), which the Botswana Unified Revenue Service (BURS) planned to introduce in 2002. VAT is described

as “an indirect tax levied on the supply of ... services consumed within Botswana. It is called consumption tax as the amount you pay is directly related to purchases you make. It is not a business expense as it is borne by the customer” (BURS, 2010). The standard rate of VAT was and continues to be ten per cent. Officially, VAT came into effect on 1 July 2002 (BURS, 2008).

In July 2003, GPH increased its tariffs again by 80 per cent to offset the delayed payments by medical aid scheme companies (Mmegi, 2003; Mooketsi, 2007). The services which faced an increment in their tariffs were in-patient and theatre. Outpatient, pharmacy and radiology services did not face any increments. In addition, BOMAID and BPOMAS patients had to pay for their medical fees upfront and claim their money back from their respective medical aid schemes (BOPA, 2003; Mmegi, 2003). Other factors that contributed to the tariff increment included a cumulative shortfall in revenue, the impact of VAT, the shortage of nurses, and the fact that GPH is a private hospital meant that it did not benefit from state subsidies (BOPA, 2003; Buchan, Hancock and Rafferty, 1997; Tuttas, 2003:226).

Although GPH management recognised that the major implication of a tariff increment would be a drop in demand, it argued that it would restructure accordingly (BOPA, 2003). As predicted, demand dropped drastically because medical aid schemes started referring their clientele to South African hospitals, which offered lower tariffs (BOPA, 2003; Mooketsi, 2007). GPH was forced to scale down its operations as is evidenced by the then General Manager, Mr. Ryan’s words: “we are restructuring the meet the patients’ demand” (BOPA, 2003). To carry out the restructuring exercise, 110 employees were retrenched to reduce running costs (BOPA, 2003). Just less than a quarter of the 110 employees were nurses and the rest were clerical and administrative staff. In addition, some wards were closed down (Mooketsi, 2007; 2009).

The on-going conflict with the medical aid schemes was resolved in 2007 (Mooketsi, 2007). Demand rose because the upfront payment of fees was reduced from 80 per cent to 10 per cent as the patients were expected to pay for VAT (Chwaane, 2006). This is evidenced by the fact that BPOMAS alone had 56000 principle members at the time (Chwaane, 2006). In addition, the tariffs offered by GPH matched those offered by South African hospitals. As a result, medical aid schemes started referring their clientele back to GPH (Chwaane, 2006). Yet again, the hospital had to restructure to match the patients’ demand for healthcare

services (BOPA, 2003). Operations were up scaled through staff increment, the re-opening of wards and purchasing of new equipment (Mooketsi, 2007).

1.2 RELEVANCE OF THE STUDY TO THE INDUSTRIAL SOCIOLOGICAL DISCIPLINE

The relevance of this study to the discipline of Industrial Sociology is that it adds to the body of knowledge that relates with changes in the employment relations and labour regulation. However, focus is centred on the implications of these changes. The managerial primary goal of improving productivity at low costs has spurred the changes in the employment relation and labour regulation. The practice of 'Flexible Firm Model' is a depiction of the changes in the employment relationship and labour regulation. The changes have been categorized into non-standard jobs and portfolio careers (Dickens, n.d.:2). Focus is placed on the midpoint between the two, which is characterised as 'dependent contractorship'. This study offers a research based critical analysis of the implications of the changes in relation to the nature of employment relationship, career development and the worker voice.

1.3 OUTLINE OF THESIS

The subsequent chapter (chapter two) provides a literature review with the primary aim of depicting a global and contemporary setting within which FFM came about and how it is practiced. Chapter two looks at three key issues; it identifies the practice of FFM as a root cause of worker disempowerment and, addresses issues that have influenced organisational restructuring in the private healthcare sector. Lastly, focus is placed on how the practice of FFM disempowers dependent contractors. In the process of addressing these key issues, important concepts like FFM, worker disempowerment and dependent contractor are identified, defined and contextualised to the study.

Chapter three proceeds to further contextualise the manner within which the practice of FFM along lines of citizenship came about. In doing so, a historical overview of Botswana's economy is carried out with the aim of identifying how the demand of non-citizen skilled labour was created. The professional nursing terrain in Botswana is then outlined to create a greater understanding of why and how FFM is practiced at GPH. Chapter three clearly sets

out the research objectives. Thereafter, it proceeds to expand on the case study nature of the research. Lastly, the manner in which data was collected and evaluated is described.

Chapter five identifies the root of worker disempowerment as an ambiguous employment relationship. It proceeds to justify the classification of non-citizen professional nurses at GPH as dependent contractors. In classifying the employment relationship as that of dependent contractorship, this chapter is able to identify its precarious traits which bring about worker disempowerment. In the development of the chapter, issues of functional and numerical flexibilities are addressed. Furthermore, the organisational changes that have come about as a result of organisational restructuring are also dealt with.

Chapter six highlights poor career progression as an outcome of the practice of FFM at GPH for non-citizen professional nurses. The nature of the employment relations is cited as the cause of poor career development. Performance Management is an illustration of how the precarious employment relationship has negatively influenced career development. Performance Management is comprised of Joint Performance Management (JPM) and Individual Development Plans (IPP). Quality evaluation also contributes towards Performance Management. The premise of disempowerment is compounded by wage restraint and a lack of transparency in the reward systems.

Chapter seven brings to light how the practice of FFM has led to a weakened worker voice among the non-citizen professional nurses at GPH. The worker voice is contextualised to mean representation and participation. The manner in which HRM is practiced is brought under scrutiny as it influences the types of worker representation and participation that are accessible to the non-citizen professional nurses. The lack of trade union representation for non-citizen professional nurses is identified. This is with the aim of further illustrating the precarious nature of the employment relationship. Chapter eight wraps up the study, by discussing the conclusions to the findings in the substantive chapters.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 THE FLEXIBLE FIRM AND WORKER DISEMPOWERMENT AS AN OUTCOME

The concept of disempowerment is associated with the act or process of taking away power. Relating it to the concept worker disempowerment, it will be highlighted through a critical analysis of the power dynamics in the employment relationship; career development and worker voice. So, for the purposes of this research worker disempowerment is multi-faceted. Worker disempowerment is for the purposes of this study defined as: a lack of worker self-determination within the employment relationship, career development and representation and participation in the labour process. This research recognises that the traditional employment relationship is disempowering. With organisational restructuring measures like FFM, the balance of power within the employment relationship has tilted further in favour of senior management. This chapter seeks to contextualize the ways in which the shift of power occurred.

2.1.1 The Flexible Firm and Organizational Restructuring

This section introduces FFM as a post-Fordist perspective and provides a brief background to the origins of this paradigm. The current changing global economic conditions are influenced by the steady uptake of free trade in a market economy regulated by market forces. This is where by the system of production, distribution and consumption of resources and goods is influenced by the interaction between their supply and demand. This phenomenon known as neo-liberalism can be traced back to the crisis of Fordism¹ as described by Gottfried (1999:2). Fordism² as a regime of production is discussed to depict

¹ Roobeek (1987:140) proposes that Fordism's most basic feature was the ability to match production with consumption. The failure in maintaining this basic feature led to the crisis of Fordism. This failure was manifested in various sub-crises.

² Fordism "constitutes a specific arrangement of the technical and social division of labour along Taylorist lines, which facilitates the production of standardized goods through the decomposition of tasks and task assignment to individual workers" (Clark, 1992:19).

the nature of the employment relationship within the organizational structure before the crisis of Fordism. The sub-crises of Fordism are analysed to illustrate the forces that catapulted organizational restructuring and changes within the employment relationship. The driving forces behind the sub-crises of Fordism were a shortage of resources coupled with inefficiency, which together resulted in loss of productivity and an increase in production costs (Roobeek, 1987:46). The change from a predominantly 'Fordist regime' of production was aimed at effective resource exploitation and increased efficiency thereby increasing productivity and reducing production costs (Jessop, 2001:45). Post-Fordism marked a new approach to production and the onset of the flexible era. This research puts forward the argument that FFM is one of the manifestations of the flexible era. The core elements of FFM are discussed to provide an understanding of its dynamics. Lastly, the changes that have occurred within the employment relationship are traced.

2.1.2 A Post-Fordism Stance on the Flexible Firm Model

The focus of this research is centred in the FFM and its applicability to a private hospital context. This section aims to contextualize the concept of FFM by rooting it in the post-Fordism paradigm. The key reason behind this study's stance is that post-Fordism acknowledges and recognises the validity of FFM, whereas the neo-Fordism stance does not (Pollert, 1991:11). The outcome of the 'crisis of Fordism' was the search for adaptability or 'flexibility' in the labour market and workplace (Howell and College, n.d.:1). The outcome was marked by the title of 'post-Fordism' by writers like Atkinson (1985:13; 1994:338) or 'neo-Fordism' by writers like Pollert (1991:11). Post-Fordism is defined as a break from Fordism in the sense that the changes that came about to adapt to the changing circumstances were radical (Atkinson, 1985:13; 1994:338). On the other hand, there is a body of literature, which argues neo-Fordism best identifies the changes (Pollert, 1991:11; Gottfried, 1999:4; 2000:237). This is attributed to how the changes are viewed as modifications rather than a radical break from Fordism. In the following sections, the concepts of flexibility and FFM will be unpacked.

This section aims to show the problematic nature of post-Fordism and neo-Fordism. The conflict between these two paradigms is grounded in the true nature of 'flexibility'. Post-Fordists like Atkinson (1985:13) argue that the search for 'flexibility' in the work place and

labour market is indicative of a break from Fordism. On the other hand, neo-Fordists like Pollert (1991:5) argue that the changes in the workplace and labour market were modification of Fordism. As a result, 'flexibility' is not a break from Fordism but rather term used to mix up and hide the true nature of change. This study puts forwards that the natures of post-Fordism and neo-Fordism are problematic and this is rooted in the nature of Fordism. The concept of Fordism cannot be universally applied; therefore neither can the concepts of post-Fordism and/or neo-Fordism (Pollert, 1991:6). Boyer (1988) carried out a case study of seven European countries to trace their transitions into labour market flexibility. Pollert (1991:6) finds fault in Boyer's study by stating

Boyer himself acknowledges that each country in his study volume illustrates major differences in the role of the state, of trade unions, of social security systems and of industrial and labour market heritages. The concept of 'Fordist growth' becomes very problematic both as a description of diverse social and economic experiences and as a general analytical device.

As a result models like the Flexible Firm offer guidance rather than a prescriptive value.

The concept of 'flexibility' is also an issue of contention because it has been labelled as one of the leading frameworks to explain the changes in the workplace and labour market in the epoch following Fordism (Smith, 1995:85). Issues ranging from its definition to its nature have been topics of numerous debates (Pollert, 1991:11). Loosely defined, flexibility is the ability to vary or change (Bucki and Pesqueux, 2000:62). However, flexibility has various interpretations that have often led to conflicting interpretations (Sushil, 2001:860). Sushil (2001:860) develops a more precise definition of flexibility;

In a systematic sense, flexibility is the dynamic interplay or synthesis across the range of options from thesis to antithesis by exercising the freedom of choice. The term flexibility is used at various levels, products, processes, people, management, organisation, strategy, systems, structure, nation, culture and frame of mind.

Sushil (2001:860) notes that flexibility is multi-dimensional as it has different meanings in different dimensions. In relation to FFM, the most relevant dimensions are those pertaining to the numerical and functional flexibilities.

As was previously mentioned, FFM is an ideal model. As a result it may not necessarily be reflected in reality. Even Atkinson (1985:15) notes that the FFM has not been implemented across the board uniformly. So, a firm may illustrate a hybrid of traits, it is plausible to find contexts which reflect elements of flexibility and rigidity. Atkinson (1985:15) argues that the FFM is but one of the manifestations of post-Fordism. Volberda (1999:1) describes the FFM as a summary of various mechanisms followed by businesses to gain and maintain flexibility and reduce rigidity. The concepts of flexibility and rigidity are existent in various aspects other than in the context of the employment relationship. However, for the context of this research, the employment relationship aspect is the focus. The FFM sought to contribute towards change within the organizational structure by reducing the levels of 'rigidity' and increasing those of 'flexibility' in terms of the employment relationship.

Rigidity is the difficulty with which workers may be engaged or disengaged from the organisation in response to market changes (Armstrong, 2006:323; Volberda, 1999:1; Hunter *et al*, 1993:383). On the other hand, flexibility is the ease with which workers may be engaged or disengaged from the organisation in response to market changes (Armstrong, 2006:323; Volberda, 1999:1; Hunter *et al*, 1993:383). The employment relationship makes up a very important aspect of the organizational structure. The employment relationship regulates how workers and management relate to each other in the fulfilment of the organizational goals. The general trend of organizational restructuring since the 1980s, according to some theorists, has been towards a FFM (Atkinson, 1985:13; Hunter *et al*, 1993:383; Vallas, 1999:68). The FFM as described by Atkinson (1985:13; 1994:338), illustrates new patterns of employment that facilitated 'organizational flexibility'.

Before delving into the details of the FFM, it is important to understand the context within which it came about. It was essentially a shift to increased reliance on the 'external labour market' (Cappelli, 2006:182). Cappelli (2006:182) defines the external labour market as "forces outside the firm that manage employees". Examples of such forces include labour legislation and policies, technological change and international competition (Heckscher, 2001:60). The FFM came about in Britain in the manufacturing industry context in the 1980s (Atkinson, 1994:338). Atkinson (1994:338) describes FFM as a cluster of 'radically' different employment policies. Employees are separated into two main groups: the core and the periphery (Atkinson, 1985:18; 1994:339; Pollert, 1994:343).

The core workforce has no distinct job description, as they are multi-skilled. Multi-skilling occurs when two distinct disciplines like engineering and management are merged (Mulholland, 2002:80). As a result, these workers have high employment security. Employment security is the assurance a worker has to acquire and maintain employability (Hillage and Pollard, 1998). Employment security for the purpose of this research is derived from the concept of employability. From a general perspective, employability is the ability to enter and maintain an employment relationship. However, employability encompasses several dimensions (Hillage and Pollard, 1998).

Firstly, key skills play a major role in influencing the quality of the employment. Quality of employment is in terms of conditions of employment like remuneration and tenure. In addition, key skills aid in obtaining and maintaining employability. Maintenance of employment is also about the ability to change functional roles within and between organisations. So, “employability is the capacity to move self-sufficiently within the labour market to realise sustainable employment” (Hillage and Pollard, 1998). As a result of their employability, core workers have the capacity to change their functional position within the organizational structure (Atkinson, 1994:339). Their conditions of employment facilitate ‘functional flexibility’ (Atkinson, 1985:18; 1994:339; Pollert, 1994:343). Functional flexibility is the organisation ability swiftly to match the labour to and between jobs (Atkinson, 1985:16; Thompson and McHugh, 1990:196; Rubery and Grimshaw, 2003:138).

Peripheral workers’ main role is to insulate core workers from the constantly changing market (Atkinson, 1985:18; 1994:339). They do so by serving an adjustable numerical role to overcome the unpredictable nature of market demand and/or technological change (Boyer, 1988:25). This is referred to as numerical flexibility (Atkinson, 1985:18; 1994:339; Pollert, 1994:343; Gannon and Nollen, 1997:111). It facilitates the organisation’s ability to adapt its headcount at short intervals to an ever-changing external environment. In addition, production costs are more ‘flexible’ through adjustable labour costs (Gannon and Nollen, 1997:111). Numerical flexibility is facilitated through the use of non-standard labour practices such as the individualisation of employment contracts, flexi-work and agency work (Mulholland, 2002:68; Kalleberg, 2001:479).

The peripheral group of worker experiences some level of job security rather than employment security. Job security is the assurance a worker has about the continuity of

gainful employment (Armstrong, 2006:233). The contextualisation of job security in this research is derived from the concept of a job. A job is defined a group of purposeful and related duties, responsibilities and tasks carried out by a worker with an employment relationship (Armstrong, 2006:327). Duties, responsibilities and tasks make up the performance elements. Performance elements within an employment relationship are defined as specific acts that can be accomplished, quantified, measured and rated. A job is a rigid construct because it is a fixed entity (Armstrong, 2006:327).

Peripheral workers experience job security instead of employment security because they carry out the firm's non-specific goals (Atkinson, 1985:17; 1994:399). An example of non-specific goals would include clerical and cleaning occupations in an engineering firm. Peripheral workers lack the ability to change their functional position within the organizational structure (Atkinson, 1994:339). For example, a cleaner cannot assume the role of a manager. Peripheral workers exist in clusters around the core (Armstrong, 2006:210). The clusters are divided according to their importance to the functioning of the organizational structure (Atkinson, 1985:17; 1994:399). The further away the cluster is from the core, the lower the opportunities for skill enhancement and career development. Workers who fall into the outer clusters have reduced chances of being multi-skilled or having work security in comparison to those closest to the core.

The core essence of this research is to focus on the group of workers that FFM overlooks, the 'contractors'. Contractors for the purposes of this research are defined as

...a person who contracts with a principal to supply labour or to carry out the whole or any part of any work undertaken by the principal in the course of or for the purposes of the principal's trade or business (s2 of The Employment Act of the Republic of Botswana).

Contractors are found in both the core and peripheral groups. However this research seeks to focus on 'contractors' within the core. Organisations will at times outsource some functions like security or project work to contractors to facilitate low labour costs (Armstrong, 2006: 286). Contractors located in the core compliment the core workers by carrying out firm specific duties. Contracting also allows for resources to be concentrated on core business activities like investing in skill development of the core. Like the peripheral workers contractors also insulate core workers from market demand and/or technological change

(Boyer, 1988:25). Technically contractors are not employees, as a result they are not eligible for company benefits like pension or skills upgrade. The costs and risks of skill development fall squarely on the contractor. Their tenure is dependent on an agreed time span within a contract which subject to managerial reviews, may or may not be renewed.

Contractors are excluded from public and private rights and duties which arise from an employer-employee relationship (Jacobs, 1953:23). This is attributed to how they are not considered to be employees and are assumed to play an entrepreneurial role (Jacobs, 1953-4:25). However, there are instances where a contractor may portray the traits of an employee and some labour law contexts like that of Botswana³ overlook such an instance. Such contractors have been identified as 'dependent contractors' in some labour law contexts like that of Canada (Saunders, 2003:8). Employees work for remuneration under direct supervision. 'Independent contractors' embark on a job for a price, they decide on how the work will be done (Jacobs, 1953:23). Usually, independent contractors hire other workers to do the work and at times own the materials used to carry out the job. 'Dependent contractors' on the other hand work for remuneration under direct supervision. They are economically dependent on their 'client' or employer (Saunders, 2003:8). This study seeks to focus on dependent contractors and how the practice of FFM affects them.

From Atkinson's (1994:338) perspective, what made FFM 'different' was the blatant intra-organizational labour market segmentation. Furthermore, with increased intra-organizational labour market segmentation "the labour force became increasingly peripheral ... and therefore 'numerically' flexible" (Atkinson, 1994:339). Decreasing the number of core workers into a skeletal structure and increasing the number of peripheral workers purportedly made the organizational structure more effective (Atkinson, 1985:18; 1994:338; Hunter *et al*, 1993:383). However, this meant placing clear boundaries between the core and peripheral workers. Segmenting the two groups of workers is facilitated by the nature of their employment contracts. The nature of the employment contract determines whether they fall into the core group of workers. Being in the core group of workers ensures eligibility for career opportunity development and growth (Atkinson, 1985:18; 1994:338 Hunter *et al*, 1993:383).

³ s2 of The Employment Act of the Republic of Botswana

To sum up, FFM according to Atkinson (1985:18) is one of the indications of the flexible era. It has brought about changes within the employment relationship with the aim of improving organizational efficiency. As a result, FFM plays a contributory role in organizational restructuring to accommodate the changes in the nature employment relationship. 'New' patterns of employment are emerging from the practice of FFM (1994:338). The next section sets out to show the post-Fordist organizational structure and how it influenced the nature of the employment relationship and its regulation.

2.1.3 The Post-Fordist Organizational Structure and its influenced the Employment Relationship

This section sets out a background to how the organizational structure influences the nature and regulation of the employment relationship. It is important to note that the organizational structure is but one of the factors which influence the nature and regulation of an employment relationship. This research aims to specifically focus on the influence of the organizational structure with the occasional acknowledgement of other factors like employment policies. With this in mind, the influence of the post-Fordism paradigm on the organizational structure will be initially analysed. Thereafter, this will be related to FFM and how the changes to the nature and regulation of the employment relationship played out. To conclude this section, this account of the post-Fordist organizational structure and its impact on the employment relations will be problematized. This is with the aim of revealing that organizational flexibility has not necessarily brought about a mutually beneficial relationship for dependent contractors.

An organizational structure is defined by Armstrong (2006:288) as

A framework for getting things done. It consists of units, functions, divisions, departments and normally constituted work teams into which activities related to particular processes, projects, products, markets, customers, geographical areas or professional disciplines are grouped together. The structure indicates who is accountable for directing, coordinating and carrying out these activities and defines management hierarchies – the 'chain of command' – thus spelling out, broadly, who is responsible to whom for what at each level in the organization.

In relation to this study, the grouping of professional disciplines using FFM is the core issue. Professional disciplines are specialized jobs like engineering and management. The post-

Fordist organizational structure was a reaction to the rigidities that the Fordist organizational structure presented. The rigidities identified in the employment relationship were illustrated by the failure to adapt the workforce to market changes. The failure to adapt was attributed to the nature of the bureaucratic organizational structure (Cappelli, 2006: 184).

The bureaucratic organizational structure heavily relied on the internal labour market (Cappelli, 2006: 184). The internal labour market is defined as “circumstances that helped created formal arrangements for managing employees within the firm” (Cappelli, 2006:182). Examples of such circumstances include collective agreements, permanent employment contracts and firm policies. The bureaucratic model facilitated low entry levels and on-the-job training. The creation of a clearly demarcated organizational hierarchy made this possible. In addition, the organizational hierarchy facilitated promotion features. Seniority and eligibility for promotion were shown by time spent in a position. Greater job security was afforded to positions higher up in the hierarchy (Cappelli, 2006: 184). However, workers received protection through collective representation. Seniority clearly played a valuable role in the governing of employment decisions. Jobs in the lower echelons of the hierarchy were narrowly specified, there was a sharp differentiation of tasks and this made training simple. Where job security is concerned, management had lifetime tenure with minimal performance requirements. Although, workers in the lower ranks of the hierarchy had life-time employment contracts, they were prone to periodical redundancies. Issues like wages, benefits and lay-offs were based on seniority.

The rigidities within the organizational structure presented themselves in the centralisation of decision making and vertical integration (Boyer and Durand, 1997:14). Translated to the context of the employment relations this led to four major problems (Boyer and Durand, 1997:16). The division of labour and extreme specialisation led to rigidity in task allocation which translated to increased cost of running the organisation. Secondly, the polarisation of skilled work in the managerial hierarchy led to the incapacity of workers in the lower levels to speedily adapt to new technology thus making them redundant. Thirdly, hierarchical control and financial incentives precipitated wage increments which led to conflictual employment relations. Lastly, the conflictual employment relations presented the most feasible solution to the other problems faced. On the other hand, they also inhibited the

development of “mutually advantageous solutions” like ‘flexicurity’⁴ (Boyer and Durand, 1997:16).

The post-Fordist paradigm reflects changes within the organizational structure which translated into more flexible employment relations. The decentralisation of decision making and a more ‘horizontal approach’ played a pivotal role in the organizational structure (Boyer and). FFM is one of the manifestations of the decentralisation of decision making. The division of labour was reorganised as is illustrated by the core and periphery (Atkinson, 1985:18; 1994:339; Pollert, 1994:343). Workers with firm specific skills irrespective of their skill levels are placed into the core group. Those whose skills are not firm specific are placed into the peripheral clusters. The core and periphery are complimented by subcontractors. Role revision, especially within the core, has encouraged a more horizontal form of integration (Boyer and Durand, 1997:16). This is evidenced by a skill level mixture rather than a polarisation of skilled workers into managerial positions (Boyer and Durand, 1997:16). Work practices like teamwork expose team members to on the job training and peer monitoring. Teamwork in turn increases worker skill competencies. As a result, task allocation becomes more ‘flexible’ because more functions can be merged through teamwork.

The dimension of contracting out some functions in the core and periphery was added to the employment relationship. Although contracting out some functions is not a new phenomenon, the context in which it is applied in the post-Fordism context is different. The individualisation of the employment relationship has increasingly facilitated the engagement of dependent contractors. The advantages of engaging dependent contractors especially within the core include increased numerical and functional flexibility at low costs (Hall, 2000:33; Armstrong, 2006:386). Contracting-out enables resources to be concentrated on core business activities (Armstrong, 2006:386). There are fewer costs in terms of skill development investment because this cost is borne by the contractor (Hall, 2000:30). Employment costs are reduced because contractors are not entitled to the same benefits [like pension and funded skill development] as permanent employees (Hall, 2000:33; Armstrong, 2006:386).

⁴ Flexicurity is defined as a “policy strategy that attempts, *synchronically* and in a *deliberate* way, to enhance the flexibility of labour markets, work organisation and labour relations on the one hand, and to enhance security – employment and social securities - notably for weaker groups in and outside the labour market” (Wilthagen and Tros, 2004:169)..

Teamwork also facilitates power decentralisation as some decision making powers are shifted from managers to the team. The hierarchical chain of command is shortened as a shift of power allows for a more autonomous labour process, decisions are made more speedily and output is improved. The quality of work is improved upon as team members also undergo Performance Management. It is defined as follows by Armstrong (2006: 495):

A systematic process for improving organizational performance by developing the performance of individuals and teams. It is a means of getting better results by understanding and managing performance within an agreed framework of planned goals, standards and competency requirements... It focuses people on doing the right things by clarifying their goals. It is owned and driven by line management.

Its purposes include assessment of actual performance against set targets, employee development, guide to job changes and remuneration increments (Armstrong, 2006:496). According to Armstrong (2006:496), Performance Management is a planned process built around key elements of consensus, measurement, feedback, positive reinforcement and dialogue. To ensure that the quality of production improves, Performance Management is practiced from organizational to departmental to individual levels. It is through Performance Management that a 'partnership' is formed. As a result, Performance Management is based on cooperation rather than coercion (Armstrong, 2006: 497). Another outcome of the dialogue is that the 'partners' are able to identify developmental needs from the quality of the output (Armstrong, 2006: 497). As a part of this 'mutually beneficial partnership', a long-term compromise between management and workers is illustrated by an exchange of competency and loyalty for employment security. This compromise is signified by the employment contract. This in essence secures 'harmonious employment relations' (Armstrong, 2006: 497).

This study questions the validity of the claim of a 'harmonious employment relationship'. In fact the next section looks at the problematic nature of flexible employment relations. This next section will argue that although flexibility in the employment relations has brought about improvement in the labour process, some aspects of the employment relationship like the unequal power relations have not changed. In fact the next section will argue that flexible employment relations have presented more opportunities to exploit some groups of workers.

2.1.4 The problematic nature of flexible employment relations

As was previously mentioned, the FFM is an ideal model and the same can be said for the account, given above of the impact of the post-Fordist organizational structure on employment relations. This account offers a prescriptive rather than a descriptive account. Organizational and employment flexibility have not been necessarily mutually beneficial for all of the 'partners' involved. This section aims to look at how the flexible employment relationship is not mutually beneficial. To fulfil this objective, the themes of reduced labour costs and worker representation and participation will be used.

In as much as some scholars like Boyer and Durand (1997:16) will argue that the practice of FFM translates into a mutually beneficial relationship, managerial objectives will play a big role in the relationship. The need to increase and improve productivity at reduced operating costs is at the key to managerial objectives (Kenny and Webster, 1999:218; Lee and Clarke, 1999). One of the methods of operational cost reduction has been the changing of the nature employment relationship. The employment relationship changed from life-time contracts to periodical contracts to attain numerical flexibility (Mpabanga, 2004:26). However, for some workers, this has resulted in a lack of employment security. The lack of security is more pronounced in the case of workers who are labelled as dependent contractors within the core (Pearce, 1998:32).

As was previously stated, the local legal definition of a contractor often in some cases may not offer workers protection from exploitation as it does not differentiate between dependent and independent contractors (Armstrong, 2006:386). As a result, dependent contractors are viewed in the same context as independent contractors (Jacobs, 1953-4:27). The direct implication of this is that the dependent contractor is excluded from the rights and duties that arise from the employer-employee relationship (Jacobs, 1953:27). For example, dependent contractors despite being economically dependent on the 'client' are not eligible for employer-funded skills upgrade (Hall, 2000:34). The relationship between the dependent contractor and employer is ambiguous, because a differentiation is not made between independent and dependent contractors. So, accuracy is traded for simplicity by wrongly labelling dependent contractors as independent contractors. What makes this mislabelling problematic is that there has been a marked increment of dependent contractors in contexts like Australia and the United States of America (Saunders, 2003:8). Therefore, a sizeable

workforce is left unprotected from exploitation. Also as a result of the mislabelling, employers are able to choose which rights and duties to fulfil because of the ambiguous nature of the relationship.

One of the consequences of the practice of FFM has been a change in the manner which the employment relationship is regulated. There has been a shift to the individual dimension of the employment relationship in contexts like Australia and the United States of America (Armstrong, 2006:215). The individual dimension is manifested by the employment contract between management and the worker. This individual dimension is more pronounced among dependent contractors. An emphasis on the individual dimension of the employment relationship has facilitated the practice of radically different employment policies for different groups of workers (Atkinson, 1994:338). This is evidenced by the earlier mentioned traits of the core and peripheral groups of workers and contractors. The shift to the individual dimension has undercut the collective dimension of the employment relationship. This is evidenced by a drop in trade union membership among the working population (Stewart, 1985: 156).

From the 1980s, especially in Britain, trade union membership has been on the decline (Voos, 1994: 2; Blanchflower and Bryson, 2008:1). A small core and a large peripheral workforce has left most groups of employees ineligible for trade union membership. 'Dependent contractors' are not eligible for trade union membership in contexts like Botswana because they are not employees according to section 21(1) of the Trade Unions and Employer Organisations Act.⁵ In addition, trade unions in sub-saharan Africa especially, are not in support of the engagement of contractors (Kenny and Webster, 1999:222). This is attributed to how contractors pose a threat to the more permanent workforce. The hiring of contracted workers may result in the management's failure to commit to the development of human resources. The ability to outsource specialised functions may result in little incentive for management to invest in training the permanent staff (Hall, 2000:34). The drop in trade union membership has a direct impact on worker representation and participation.

⁵ 21. Restrictions on membership of trade union.

(1) No person shall be admitted to membership of a trade union unless he is an employee in an industry with which the trade union is directly concerned.

Worker representation and participation is the means through which the worker voice may be heard (Armstrong, 2006:808). Armstrong (2006:807) defines the workers' voice as "the say employees have in matters of concern to them in their organization". Worker representation and participation are channels through which employees may participate in the operation of the organisation as well as offer constructive criticism (Armstrong, 2006:807). The types of worker representation and participation that this study will look at in the latter part of this chapter are direct representation, communicative involvement and work councils. Since dependent contractors are not employees, technically they are not entitled to worker representation and participation. This group of workers is shunned by the trade unions (Kenny and Webster, 1999:222). Therefore one is left to question the efficacy of any form of representation and participation to which this group of workers has access.

To sum it up, this section has shown how the practice of FFM is problematic. It has led to the mislabeling of dependent contractors as independent contractors. The mislabeling has been facilitated by the shift to the individual dimension of the employment relationship through periodic contracts. As a result of being mislabeled, dependent contractors have been disempowered in several ways. The very nature has of their 'employment relationship' has alienated them from worker supportive structures like trade unions.

2.2 THE FLEXIBLE FIRM AND THE 'DEPENDENT' CONTRACTOR

This section aims to identify workers who are most likely to become dependent contractors. Thereafter, the implications of the status of being a dependent contractor will be further developed. In relation to FFM, dependent contractors are seen as "labour without liability" (Hall, 2000:34). This section aims to show the nature of the dependent contractor makes them such. It will also go on to question the efficacy of seeing dependent contractors as "labour without liability" (Hall, 2000:34). Notably, focus is still placed on dependent contractors in the core although reference will be made to other groups of contractors⁶ as well. This is attributed to how in some instances as shall be cited below, the different groupings of contractors share similar experiences.

⁶ These include independent contractors and sub-contractors.

This study argues that economic migrant workers among others are most likely to be dependent contractors. Economic migrant workers

Are described as tending on average to be more able, ambitious, aggressive, entrepreneurial, or otherwise more favourably selected than similar individuals who choose to remain in their place of origin. Economic migrants are those who move from one place of work and residence to another, either within a country or across international boundaries, primarily because of their own economic opportunities. (Chiswick, 1999:181)

The engagement of migrant workers as dependent contractors is an example of FFM in practice. The employment policies in terms of benefits and regulation differ from other groups of workers. From the above description, migrant workers tend to be classified as independent rather than dependent contractors (Glader, 1990-1991:1455). By classifying migrant workers as independent contractors, employers are able to avoid expenses often associated with worker protectionist laws and policies (Glader, 1990-1991:1455). For instance, in South Africa mining employers were able to avoid the expenses associated with health and safety measures by outsourcing (Kenny and Webster, 1999:226). The protection afforded to miners by the Health and Safety Act of 1996 was not extended to sub-contracted miners⁷. This was until the National Union of Mineworkers took a stand and negotiated to have the Act extended to sub-contracted workers. In this case the National Union of Mineworkers argued that contracted miners qualified for protection under the Act⁸ because they were in a non-standard employment relationship with the company. So, contracted workers could still be considered to be employees. The example of the South African mining industry reveals that the ambiguous nature of the employment relationship was exploited by mine management to cut operational costs.

Another instance of employers avoiding the costs often associated with permanent employees is where liabilities of law suits are shifted to the dependent contractor. In the late 1980s, hospitals in the Baltimore area in the United States of America had taken to contracting out particular services to physicians (Classen, 1987:469). By labelling the physicians as 'independent' contractors the hospitals were able to avoid law suits. As an 'independent' contractor, the hospital has no supervisory authority over the physician thus freeing them from malpractice suits lodged against the hospital. However, the courts in the

⁷ These sub-contractors tended to be illegal economic migrants (Kenny and Webster, 1999:226)

⁸ The Health and Safety Act of 1996.

United States of America have taken to extending some responsibility to the hospital through the doctrine of 'vicarious liability'. Vicarious liability is essentially the extension of legal liability to management from any group of workers in any form of employment relationship (Classen, 1987:472).

The two examples discussed above reflect how contracted labour gives an illusion of being "labour without liability" (Hall, 2000:34). Hall cites (2000:29) that cost reduction is the most prominent argument for outsourcing. However, he (Hall, 2000:29) goes on to argue that this is not necessarily the case. Instead he argues that "outsourcing should be strategically focused" instead of being applied universally throughout the organisation (Hall, 2000:29). Hall's (2000:26) argument is based on two case studies in Australia where in one instance outsourcing the cleaning function cut costs. On the other hand the outsourcing of Information Technology functions proved to be more of an expense than a cost cutting measure. Hall (2000:34) argues that the long term effects of outsourcing include a rundown of skills and a failure on management's part to commit to the development of human resources. Other effects also include tension between permanent employees and contracted workers and the generation of a low trust environment. However, these are not the key focus of this study.

The misconception of migrant workers as independent contractors has left the vulnerable to exploitation. All sorts of liabilities traditionally shouldered by management like legal liability and skills upgrade have been shifted to the dependent contractor. But, moves have been made by trade unions and some legal systems to stop the shirking liability from employers to contractors. This goes to show that dependent contractors are not necessarily "labour without liability" (Hall, 2000: 34).

To conclude this section, FFM as a part of organizational restructuring has led to worker discrimination. Although the bases of discrimination are based on the search for organizational efficiency through flexibility, there have been negative side-effects on workers like 'disempowerment'. The next section seeks to contextualize the practice of FFM in the health sector. It seeks to see how FFM as a part of organizational restructuring has affected professional nurses. The reasons that focus has been placed on professional nurses are that they are the agents of change whenever a hospital undergoes restructuring. In

addition, within the health paradigm, non-citizen professional nurses are the group of workers that are mostly prone to being dependent contractors.

2.3 RESTRUCTURING IN THE HEALTH CARE SECTOR

The last section introduced the post-Fordist perspective of organizational restructuring. FFM is depicted as one of the means through which organizational flexibility is achieved. The practice FFM has brought about changes within the nature and regulation of the employment relationship. This section seeks to contextualize FFM in the health sector (Sekhar, 2008). The impact of organizational restructuring in private health care on professional nurses will be laid out. Lastly, the challenges faced by professional nurses will also be laid out. However before these aims are tackled the concept of the professional nurse will be contextualised.

2.3.1 The Nursing Profession

Nursing may be defined as a discipline and/or a profession (Parse, 1994:275). The discipline is built and improved upon through research (Parse, 1994:275). Whereas the profession is about the provision of healthcare services to people (Parse, 1994:275). The discipline and profession are not necessarily separate entities. In fact they are heavily interwoven as each informs the other. The profession provides a realm within which the discipline may be practiced. In turn, the discipline acts as an instrument used to evaluate and improve the profession (Parse, 1994:275; Henderson, 2006:21).

Broadly put, the nursing profession is made up of people educated in the discipline according to nationally set, regulated and monitored standards (Parse, 1994:275). These standards act as checks and balances on the profession to ensure safe healthcare for all members of society. For this reason, it is classified as an intimate and essential service (Henderson, 2006:21). However, it is still difficult to come up with a more precise definition of the nursing profession because professional nurses play different roles in different contexts (Henderson, 2006:21). For example, in a context where there is a high doctor-patient ratio, the professional nurses will have a bigger role to play, in comparison to a context where there is a low doctor-patient ratio (Henderson, 2006:21). Bearing this in mind

this research will adopt the definitions of the nursing profession given in section (2) of the Nurses and Midwives Act of 1995 of Botswana⁹. This Act recognises and acknowledges the different grades¹⁰ in nursing as well. The grades create a hierarchy within the profession that is based on levels of training.

The role of a professional nurse was broadly set out by Florence Nightingale (cited in Henderson, 2006:24) as follows:

It is often thought that medicine is the curative process. It is no such thing; medicine is the surgery of functions, as surgery proper is that of limbs and organs ... neither can cure; nature alone cures ... And what nursing has to do in either case is to put the patient in the best condition for nature to act upon

Although this statement dates back to the 1860, it is still relevant to the contemporary professional nursing context (Henderson, 2006:23). The contemporary professional nursing context is concerned with effective 'patient-care'. Henderson (2006:25) defines patient-care as "a process which ascertains the patients' immediate needs are met directly or indirectly". Although patient-care may have changed drastically from 1860 when Nightingale described it, it still remains the essence of the nursing profession.

2.3.2 The Link between Professional Nurses and Organizational Restructuring

A brief overview of the nursing process pre-organizational restructuring era reveals that it was guided by a product focused orientations (Ingersoll, 1996:121). This means that healthcare was focused on the services. Specific patient needs were not necessarily catered for. Such an approach to healthcare proved to be costly and inefficient. The main implication of a product focused orientation on the actual nursing process was greater individual autonomy over the work process (Hall, 2005:58). The concept of restructuring in the private health care sector "was adopted from the business world in the early 1990s", it is defined as "the fundamental rethinking and radical design of business processes to achieve dramatic improvements in the critical contemporary measure of performance like costs, quality service and speed" (Pillar and Jarjoura, 1999). The emergence of private hospitals has

⁹ "nurse" means a person who has completed a programme of basic, generalized nursing education and passed such examinations in the practice of nursing as may be determined by the Council; "Council" means the Nursing and Midwifery Council of Botswana established under section 3;

¹⁰ Section 2 of Nurses and Midwives Act of 1995 of Botswana

placed private healthcare within a very competitive environment (Sekhar, 2008:48). As a result, priority is given to the provision of high quality health care and profit generation. Hospital organizational structures are under pressure to constantly improve their strategies for the provision of quality health care and organizational survival (Sekhar, 2008:48). Restructuring in the private health care industry follows the most successful approaches and concepts such as the FFM used in the business world. A hospital's organizational structure is described by Sekhar (2008:48) as,

...Consisting of service facilities for out-patients, in-patients, general wards, emergency, special wards, Intensive Care Units, operation theatres, delivery suits and support services such as pharmacies, radiology...

Similar to Armstrong's (2006:288) definition of an organizational structure, Sekhar's description (2008:48) sets out a framework which implicitly also sets out the roles and functions of professional nurses.

Another key function of the organizational structure is that it shows the appropriate channels of communication (Sekhar, 2008:52). Clearly defined communication channels serve the role of facilitating implementation of changes throughout the organizational structure. The functional, divisional, corporate, matrix and parallel hospital organizational structures are identified (Sekhar, 2008:56-57). However, for the purposes of this research focus is placed on the corporate hospital organizational structure as this organizational structure is identified with private hospitals. The corporate hospital organizational structure has a governing body and top management (Sekhar, 2008:58). The governing body is made up of elected salaried directors, executives and a chairperson. Top management is made up of the chairperson, general managers and corporate staff who provide services in areas like human resources, legal issues and public relations. Within a corporate structure there is emphasis on a team approach to management and decentralisation of decision making.

However, organizational restructuring in the health sector does not necessarily match that of other business sectors. The nature of healthcare influences the organizational structure. For example, the nature of the work does not allow for vagueness or mistakes. Diagnoses and treatments must be precise so as not to endanger the patients' lives (Sekhar, 2008:48). Much of the work is urgent and cannot be postponed so, decision making powers are more spread

out especially among the professional nurses (Sekhar, 2008:48). Hospital personnel are more accountable to their profession than the organisation. For example, professional nurses can only practice if they are registered with the local nursing council. As a result, the implementation of FFM may differ within the hospital context.

Professional nurses are the largest group of employees at a hospital as well as the agents of change (Aiken, Sloane and Sochalski, 1998:222). As a result, they are the most affected group of workers by restructuring processes (Aiken *et al*, 1998:222). Restructuring processes like FFM affect their numbers, skill types and skill mix. Thornley (1996:162) states that FFM has been used as a contemporary tool to address the issue of skill mix through the categorisation of the core and periphery. However, De Ruyter (2004:62) argues that although FFM has been used in hospitals to restructure the workforce, it has not been implemented in the same manner as it would be in non-health sectors. He states that in Australia hospital management has been using dependent contractors for core functions (De Ruyter, 2004:62). So, the strict application of FFM has not been used in the private health sector. De Ruyter (2004:64) also notes that this practice is more prevalent in the private sector than in the public sector.

To sum up, this section has shown the link between professional nurses and organizational restructuring. Professional nurses are the agents of change within the hospital context. It is through professional nurses that changes are implemented in the delivery of healthcare. What sets professional nurses aside from other health professionals is that they make up the largest group of workers who deliver healthcare. The use of contracted professional nurses in core functions is a manifestation of FFM, although not in the strictest of senses. However, the implications of this will be built upon in a later section. The use of FFM is but one restructuring process, the next section looks at decentralisation and its facets within the hospital organizational restructure.

2.4 DECENTRALIZATION OF HEALTHCARE SERVICES

The link between decentralization and FFM is that they are both part of processes which aim to bring about increased organisational efficiency. For example, decentralization calls for role revision, in the process of which functions tend to be merged, as is the case with clinical

care teams. The clinical care team takes over some decision making functions like treatment and dietary plans. The use of clinical teams is reflective of functional and numerical flexibilities. So in this regard, decentralization and FFM complement each other.

The decentralisation of healthcare services has brought about changes in healthcare delivery. This section aims to look at the features of decentralisation and how they have changed healthcare delivery in Western Europe and the United States of America. This section will show that decentralisation of healthcare ranges from the labour process level right up to the organizational structure level. The causes of restructuring within the private healthcare sector are various. Firstly, the need to increase productivity at reduced operating costs; secondly, improved quality care and thirdly, the developments in clinical care (Lee and Clarke, 1999). At the root of these causes is constant “economic and technological development” and competition (Pillar and Jarjoura, 1999). All of these causes heavily influence the organisation of services, care providers and patient outcomes.

2.4.1 Care-Givers and Role Revision

The aim of increasing organizational efficiency may also lead to the creation of new roles for the employees (Lee and Clarke, 1999). Restructuring tends to bring about the addition of roles and the revision of current roles. An example of such a feature is the development of a clinical care team, which has rotation of the lead position within the team (Lee and Clarke, 1999; Pillar and Jarjoura, 1999). The creation of clinical care teams is a manifestation of the decentralisation of functions at a micro-level. Decentralisation ensures that services are planned and carried out in a cost-effective manner (Lee and Clarke, 1999). Such a strategy facilitates cross training to ensure organizational flexibility. Clinical care teams are made up of professional nurses of different skill levels and specialities. For example a team may be made up of enrolled¹¹ and specialist¹² registered¹³ professional nurses. The rotation of the

¹¹ "enrolled nurse" means a person who has completed such period of training in practical nursing, and passed such examinations in such courses of instruction as may be determined by the Council for enrolled nurses

¹² "nurse specialist" means a nurse who has also completed a programme of post-graduate training in a particular field of nursing and has passed such examinations as may be determined by the Council for nurse specialists;

¹³ "registered" means registered in the appropriate register referred to in section 8.

Section 8 Registers to be kept

The Council shall keep and maintain the following registers

(a) a register for general nurses;

(b) a register for midwives;

(c) a register for nurse specialists;

leadership positions plays the role of training the professional nurses in decision making (Pillar and Jarjoura, 1999). Cross-training occurs as a result of mixing managerial skills and medical skills.

Cross-training is an illustration of the aspirations to improve quality care. The devolution of decision making power to team leadership means that key decisions in patient care are made faster. The skill mix of teams illustrates multidisciplinary approach to patient care which ensures a speedier recovery of patients. Patients spend less time admitted in hospitals facilitating high patient turnover. So, the clinical care team is part of the movement to streamline healthcare.

2.4.2 Changes in the Organizational Structure: Focus Care Centres

The benefits of decentralisation are various, but for the purposes of this research, focus is placed on the development of Focus Care Centres (FCC) (Lee and Clarke, 1999). FCCs are defined as ‘mini-hospital organisations’ or clinics that serve specific patients and physician populations. Patients are assigned to them on the bases of their clinical care requirements. FCCs lower hospital costs because of effective ‘demand management’ and resource utilization (Pillar and Jarjoura, 1999). Effective demand management is manifested by how each FCC is operated as a separate business entity and has a director who is responsible for operations and business development. Cost efficiency is a result of close monitoring of financial performance of each unit. Resource utilization occurs because of how the right technology and skills are allocated to the right point of care.

FCCs reduce transport costs as they are located on site (Lee and Clarke, 1999). Secondly, because FCCs are run as separate business entities, aspects like co-ordination and communication are simplified as the organizational hierarchy is flattened (Lee and Clarke, 1999). Furthermore, the decentralisation of financial management means that accountability and transparency are enhanced. Lastly, there is better focus on customer needs through demand management. This, in turn, facilitates the creation of a well-informed multi-disciplinary team approach to service delivery (Pillar and Jarjoura, 1999). It is interesting to

(d) a register for enrolled nurses;

(e) a register for student nurses; and

(f) a register for student midwives.

note that the FCC portrays traits which are akin to the loosely coupled organisation: a skeletal staff and operating in a sub-contracting manner (Morgan, 1989: 67). The skeletal staff serves the roles of planning and support to sustain the network. However, key tasks are contracted out to external entities. Such a set-up allows the organisation to change at a rapid rate at the lowest possible costs. The organisation is thus described as a 'system of firms' rather than a single firm. The organisation is therefore open-ended as it has neither a clear-cut structure nor boundaries.

2.4.3 Changes in Service: Acute Patient Care

The changes in services are a part of the movement to streamline healthcare. As was previously mentioned, role revision in the form of clinical care teams has also changed the manner in which services are provided. Acute patient care is one such service that a clinical team facilitates. Acute patient care is essentially early discharge from the hospital with continued treatment from the patient's home (Coast, Richards, Peters, Gunnell, Darlow and Pounsford, 1998). The Emergency Room is an example of a department within the hospital organizational structure which offers acute patient care. In some cases, acute patient care is the only service offered by the hospital as such is the case of Life St. George in Port Elizabeth, South Africa (Life Healthcare, 2010). Patients are stabilized before they are discharged or moved to general wards. The rationale behind acute patient care has been marked by finding ways to control and reduce costs while improving quality service delivery (Pillar and Jarjoura, 1999; Sovie and Jawad, 2001:588).

2.4.4 Patient Outcomes: Improved Quality Care

A restructuring guideline serves the role of showing the trajectory of restructuring. In the healthcare sector restructuring is focused on improving service and reducing costs (Pillar and Jarjoura, 1999). For example, patients are no longer just patients, but are now also seen as customers who make up a target market (Lee and Clarke, 1999; Pillar and Jarjoura, 1999; Tuttas, 2003:226). Secondly, the target market contributes towards the specializations adopted by physicians and nurses, and the healthcare facilities offered by hospitals. Thirdly, the nurses are an essential component in bringing care to the patient (Pillar and Jarjoura, 1999). Fourthly, administrative restructuring is also targeted towards catering for the needs

of the target market and improving service delivery. For instance, FCCs are the spheres within which relevant technology and clinical specializations occur (Lee and Clarke, 1999; Pillar and Jarjoura, 1999).

Since the 1990s, hospitals, especially private hospitals, have been run like private corporations (Pillar and Jarjoura, 1999; Tuttas, 2003: 226; Lee and Clarke, 1999). Consequently, focus has shifted from quantity to the quality of services provided. For example, a target market is identified and is sufficiently catered for through FCCs. This allows for effective demand management. Hospital activities are periodically reviewed to test the extent to which they add value to the target market. In addition, with the creation of FCCs, there is need for a cost effective division of labour through clinical care teams. The changes in services that occur are determined by the needs of the customers (Lee and Clarke, 1999). For example, FCCs also facilitate the effective matching of customer needs and the caregivers' clinical skills (Lee and Clarke, 1999).

To ensure quality customer care is carried out effectively there has been the development of patient-care managers and care-teams to facilitate a co-ordinated customer service. As previously mentioned, a cost effective division of labour facilitates reduced territorial barriers in terms of the delivery of the correct specialized clinical diagnostic services (Lee and Clarke, 1999). Furthermore, communication improves through the various strategies. For example, the use of clinical teams allows for the delegation of some decision making powers to team leaders. The decentralisation of decision making powers shortens hierarchy in the administrative structure.

2.4.5 Performance Management

The focus of this research is on Performance Management at an individual level. Performance Management at an individual basis begins when the professional nurse is fully informed of his or her job responsibilities, performance standards and expected outcomes. Performance appraisals are carried out at the end of predetermined periods by the immediate supervisor (Mpabanga, 2004:29; Armstrong, 2006:496). Appraisals occur through various methods, which include rating scales, critical incidents, management objectives, employee competency and employee comparison (Mpabanga, 2004: 30).

Output is measured in the quality of service delivery in comparison to the set objectives (Armstrong, 2006: 496). An on-going dialogue between management and the respective professional nurse is established and cultivated through Performance Management. A partnership is formed through this dialogue. As a result, Performance Management appears to be based on cooperation rather than coercion (Armstrong, 2006: 497). Another outcome of the dialogue is that the 'partners' are able to identify developmental needs from the quality of the output (Armstrong, 2006: 497).

Another aspect of Performance Management is the reward system which comes in various forms but focus is placed on annual salary increments and periodical rewards. There are numerous motives behind reward systems but focus in this study is going to be placed on the following that have been cited by Armstrong (2006:624). These are the development of a performance culture and a fair, equitable and transparent system. Performance culture is defined as a belief system created and cultivated by senior management. It is set "in the importance of continuing improvement" within the labour process among workers (Armstrong, 2006:119). The labour process is continuously improved upon by senior management setting targets and middle management carrying out performance evaluation of workers to ensure that the targets are met.

As a part of performance cultures, a reward system is created to encourage positive attitudes towards continued improvement of the labour process. The motives behind the reward system are all aimed at developing a positive employment relation. As a result, rewards are based on worker contribution. In addition, the process through which the rewards are given out needs to be fair, equitable and transparent to build worker trust. Chapter Six will further develop the notions of Performance Management and the reward system within a hospital setting.

2.4.6 Development of Clinical Care

Clinical specialization is illustrated by the development of FCCs. According to Lee and Clarke (1999), decentralization has resulted in complex and fragmented operational service structures in the form of FCCs. As previously mentioned, within the functionally focused

departments there is the development of patient-care structures that facilitate more coordinated patient-care. These structures are manifested in the appointment of 'patient-care managers' and 'care-teams' (Lee and Clarke, 1999). The patient-care managers are responsible for about six to eight care teams. This improves patient-care continuity through patient care co-ordination. Care-teams with proper training and equipment give more consistent and continuous care. The patient-care managers and teams also form a collaborative relationship with the physician. Furthermore, 'care-paths' are formulated to enhance patient care and communication (Lee and Clarke, 1999). Care-paths are multi-disciplinary procedures drawn up to outline the standard of care. They also play the role in determining the various job descriptions and duty allocation of patient care.

Improved quality care is evidenced by the increased levels of direct patient-care through customer-focused redesigning (Lee and Clarke, 1999). An example of this is evidenced by the clinical care team whose aim is to deliver improved quality care. The creation of patient-care management has improved continuity of care with a less fragmented staff approach. Better communication channels are also a side effect of patient-care management. In addition, care-paths have improved patient care organisation. Better personnel retention is evidenced by a marked reduction in turnover and absenteeism because of reduced job stress and teamwork. Teamwork serves the role of worker empowerment and rotational leadership also serves a role in increased peer monitoring. Thirdly, increased market shares are an outcome of higher patient satisfaction. Organizational decentralisation into FCCs encourages each unit to be more responsive to the needs of specific patient care channels. Reduced length of stay in hospitals directly translates into operation cost reductions but higher patient turnover (Lee and Clarke, 1999). The implementation of care-management and care paths simplifies the processes. FCCs improve responsiveness to clinical care. As a result, the right medication and care is given to a condition resulting in a reduced stay in hospital. Decreased labour costs are a result of decentralisation. FCCs ensure that there is less time spent on travel and transportation.

From the discussion above on the decentralization of healthcare services, one gets the impression that restructuring is entirely positive for both management and medical staff. This study argues that restructuring especially in relation to the practice of FFM has not been necessarily a positive experience for 'dependent professional nurses'. The next section

seeks to set out a critical analysis of the impact of the practice of FFM on dependent professional nurses.

2.5 THE LABOUR PROCESS AS A CONTESTED TERRAIN

The above given description of organizational restructuring through decentralization appears to be that of a unitarist perspective (Armstrong, 2006:758). A unitarist perspective is one that depicts both management and workers as sharing common interests where the organizational effectiveness is concerned with management spearheading the process. The unitarist claim is not necessarily wrong, however, the motives behind the aspiration for organizational effectiveness differ. Management aspires to increase productivity at low costs to accrue profits (Edwards, 1979: viii; Hall, 2000:33; Armstrong, 2006:386). In contrast, workers aspire for more rights, benefits and remuneration. As a consequence of differing motives and interests, management and workers are often in conflict. The differing of motives and interests between management and workers forms the basis of pluralistic perspective (Armstrong, 2006:758). The labour process becomes the terrain through which the conflict between the two parties is played out. However, the employment relationship [which regulates how the labour process is carried out] is inherently unequal in terms of power relations. Edwards (1979: viii) attributed the unequal power relations to profit accrual. He argued that greater managerial power translated into greater control over the labour process and possible profit accrual. Workers also recognised the unequal power relations and counteract it through collective organisation (Armstrong, 2006:808). By banding together, workers have enough leverage to disrupt the labour process with the aim of pushing forward their interests. It is for this reason that the labour process is referred to as a contested terrain (Edwards, 1979:48; Armstrong, 2006:808).

Relating the contested terrain to the research, this study puts forward that the practice of FFM has facilitated the restructuring of the employment relationship by increasing managerial control over the labour process (Peck, 1996:136). Increased control had been achieved through the individualisation of the employment relationship, increased demand for functional flexibility and the use of non-standard labour like dependent contractors (Peck, 1996:123; Mulholland, 2002:68; Kalleberg, 2001:479). FFM has served the dual role of shifting more power to management and gradually eroding the labour movement

organisation. This is attributed to how FFM had led to increased polarization among workers of the same productivity. Permanent workers feel threatened by dependent contractors as they present a cheaper labour option (Kenny and Webster, 2003:222). On the other hand, non-standard workers are eager to seek more security by settling for fewer rights, benefits and less remuneration (Kenny and Webster, 2003:222). This polarization undermines the ability for workers to organize and contest managerial control.

2.6 THE IMPACT OF THE FLEXIBLE FIRM MODEL ON MIGRANT PROFESSIONAL NURSES

One of the main goals of this study is to investigate the impact of FFM on migrant professional nurses at GPH. This section aims to carry out a brief review of the impact of the practice of FFM on migrant professional nurses in other contexts. The main objective of restructuring is to improve healthcare services at low costs (Lee and Clarke, 1999). The practice of FFM in the corporation hospital organizational structure serves the role of reducing labour costs. This study argues that the practice of FFM within the corporation hospital structure has not been an entirely positive experience for vulnerable groups of workers like migrant professional nurses. This section aims to show how by being mislabeled as independent contractors, some professional nurses are left open to exploitation and 'disempowerment'.

Migrant professional nurses in contexts like Australia and Britain are contracted to fulfil core functions (De Ruyter, 2004:26). However, because contracted professional nurses are assumed to have an entrepreneurial relationship with the hospital, they are often seen as independent rather than dependent contractors (Chiswick, 1999:181). This study argues that contracted professional nurses are dependent contractors because they are hired independently from nursing agencies. Secondly, they work for remuneration under direct supervision and are economically dependent on the hospital (Saunders, 2003:8).

A global health workers shortage has necessitated the international recruitment of migrant professional nurses (Likupe, 2006:1214). Migrant professional nurses from Africa are mostly motivated leave their countries of origin for economic reasons and career development opportunities (Likupe, 2006:1214). This study argues that with the practice of FFM, economic enrichment and career development are not always possible for migrant

professional nurses. The practice of FFM facilitates the different treatment of professional nurses of similar productivity levels. The basis of outsourcing core functions is to pay a [dependent] contractor to fulfil a specified role. As a result, factors like qualifications and experience are not taken into consideration for work placements (Likupe, 2006:1215). In contrast, with a permanently employed, citizen professional nurse fulfilling a core function, qualifications and experience would have to be taken into consideration (Gerrish and Griffith, 2004:585). A South African professional nurse working in the United Kingdom is quoted to have said the following in relation to the lack of recognition of qualifications and experience;

What is hard for some nurses to swallow is being paid less while in training or supervised practice, but when their 15 years of experience is not taken into account in the grading system. So even if you have experience in your country of origin relevant to the job in this country you may have to start as D grade. There needs to be some recognition given to overseas experience. (Employability Forum 2003:4)

Beishon, Satnam and Hagell (1995) based on their study of 'ethnic'¹⁴ professional nurses revealed that in some instances 'disempowerment' was manifested by less access to skill upgrades and retarded career development. Although Beishon *et al* (1995) attribute such 'disempowerment' to racism, this study argues that the nature of the employment relationship between migrant professional nurses and their employers plays a contributory role. In a study intended to evaluate an adjustment programme for migrant professional nurses, numerous managers were unsure about the "employment status and rights to residency" of migrant professional nurses and perceived them as temporary workers (Gerrish and Griffith, 2004:583). The ambiguous status of migrant professional nurses may have negatively influenced their access to equal opportunities for skills upgrade and career development (Gerrish and Griffith, 2004:583). Not all migrant professional nurses have had a negative experience. For example, migrant professional nurses from the Filipino at Oxford Radcliffe Hospital NHS Trust in the United Kingdom have had positive experiences (Likupe, 2006:1216). However, the same group of professional nurses felt that they were initially undervalued in terms of recognition of their skills and abilities (Likupe, 2006:1215).

¹⁴ African and/or African descendents

To conclude this section, the impact of the practice of FFM on migrant professional nurses has been shown itself to be a negative one. The ambiguous nature of the migrant professional nurses' status has led to their undervaluing in terms of skills and experience. Also as a result of their ambiguous status, management appears to be reluctant to make long term investments into the migrant professional nurses' skill upgrades. This appears to have also negatively influenced their access to equal opportunities for skill upgrades and career development. This section dealt with how organizational restructuring has impacted on migrant professional nurses. The next section aims to review the challenges faced by the nursing profession in terms of poor labour supply and how hospitals have dealt with the shortages of professional nurses.

2.6.1 Professional Nurse Staffing Challenges and the Flexible Firm Model

A number of writers have stated that there is a global professional nurse shortage (Buchan, Hancock and Rafferty, 1997; Tuttas, 2003: 234; Cheung and Aiken, 2006:357). This shortage has made possible the migration of professional nurses to better paying contexts (Likupe, 2006:1214). The migration patterns have ranged from local regional to international contexts. African professional nurses are cited to have migrated to the United Kingdom, Australia and the United States (Padarath, Chamberlain, McCoy, Ntuli, Rowson, and Loewenson, 2003 16). Within sub-Saharan Africa, they have migrated to South Africa and Botswana (Padarath et al, 2003:15). Earlier on, this review cited professional nurses as the largest group of workers a hospital may employ (Aiken et al, 1998:222). This section aims to take into account the wider context in which professional nurses exist. Factors that will be taken into consideration in depicting the wider context are the global shortage of professional nurses, why there are shortages and how the global shortage influences labour costs. The role of the practice of FFM as a contributory solution towards the global shortage will also be considered.

Internationally, hospitals compete for nursing staff by offering the attractive salary and career development packages (Tuttas, 2003: 234; Cheung and Aiken, 2006:357). As a result, nurses tend to move to hospitals that offer the best packages. Hospitals that fail to compete are plagued by high employee turnover and high labour costs (Tuttas, 2003:227). Labour costs become accentuated by the costs of recruiting, hiring and orientation of new staff. All

of these costs culminate in nursing staff being identified as one of the most expensive operation cost (Sochalski, Aiken and Fagin, 1997; Tuttas, 2003:227). This accounts for why the retrenchment of nursing staff tends to be the first option taken by management in downscaling operations (Baumgart, 1997; Sochalski, Aiken and Fagin, 1997; White, 1997; Burke, 2003:99; Tuttas, 2003:229).

Nursing staff shortages are one of the causes of financial strain on health care organisations and hospitals (Buchan, Hancock and Rafferty, 1997; Tuttas, 2003: 226). Nursing staff shortages are characterised by a low nurse to patient ratio, complaints of a heavy workload and reduced levels in quality care (Sovie and Jawad, 2001:590). Supervision over 'nurse aids' has also been identified as a source of increased workload (Sovie and Jawad, 2001: 590; Tuttas, 2003:230). These shortages may present an obstruction in the delivery of customer service expectations in various ways (Tuttas, 2003:227). A drastic reduction in enrolment for nursing schools has been evidenced by an aging workforce in contexts like Western Europe and the United States of America (Buchan, Hancock and Rafferty, 1997; Tuttas, 2003:227). The aging workforce is evidence of fewer graduates filling available vacancies (Buchan, Hancock and Rafferty, 1997). In an attempt to deal with the global nursing skills shortage, hospitals have begun to outsource migrant professional nursing staff as a temporary strategy to alleviate this shortage (Tuttas, 2003:229). Migrant professional nurses are being hired on contract bases, and nursing agencies are being used to fill in the gaps. Notably, both strategies are merely short-term solutions for a long term problem (Bola, Driggers, Dunlan and Ebersole, 2003:39).

The contracting of migrant professional nurses has been in practice since World War Two in the United States of America and since 1948 in the United Kingdom (Bola et al, 2003:39; Likupe, 2006:1214). This goes to show that the shortage is not a new phenomenon and is a long term problem. However, as a result of staff shortages, it becomes difficult to develop long-term strategies (Tuttas, 2003: 228). The role of FFM in the face of the global shortage is to increase mainly numerical and functional flexibilities of professional nurses. However, this study argues that the practice of FFM only serves to increase and perpetuate the long term shortage. This study argues that the rationale behind outsourcing some functions to migrant professional nurses is to deal with the shortage issue at reduced labour costs. Migrant professional nurses are awarded short periodic contracts in the hosting hospitals. For example in the United Kingdom, hospitals offer contracts that range from six months to

two years (Hardill and MacDonald, 2000:684). Short term contracts coupled with the mislabeling migrant professional nurses as independent contractors greatly contributes towards their ambiguous employability status.

The ambiguous nature of the migrant professional nurse's employability status has had negative results. Firstly, their qualifications and experience are undervalued (Gerrish and Griffith, 2004:583; Likupe, 2006:1215). Secondly, management is reluctant to invest in their skill upgrades (Gerrish and Griffith, 2004:583; Likupe, 2006:1215). This reluctance translates into the implicit shift of liability [in terms of expenses] on to the migrant professional nurse (Hall, 2000:29). In addition, an increased workload and stress level is accentuated by pressures from managerial staff to deliver exceptional customer service (Burke, 2003: 100; Tuttas, 2003: 226). Pressure is also magnified by feedback from patients' satisfactory surveys (Sovie and Jawad, 2001:590). Although the accuracy of these surveys is questionable, they provide an insight into how well a service is being delivered. As a result, nurses are susceptible to failing to balance non-clinical essential customer services [like good inter-personal interactions] and the performance of clinical duties [like timely clinical assessments, planning, interventions and patient evaluation] (Tuttas, 2003:226).

This section has depicted the wider context within which the nursing profession exists. It has shown how FFM as an employment policy has not solved the global shortage of professional nurses. In fact it has led to the undervaluing, exploitation and disempowerment of migrant professional nurses. So as a solution to the long term problem of a global shortage it is ill-suited. The perceived failure of FFM coupled with poor working conditions presents a huge challenge to professional nurses and hospital management.

The section on restructuring in the healthcare sector has served the purpose of illustrating the changes that have occurred and the impacts of those changes on professional nurses. Restructuring of the hospital organizational structure has occurred under the umbrella term of decentralisation. Decentralisation has taken form from a micro level as is shown by the clinical care teams and at a macro level as is shown by FFCs. The shift to customer oriented healthcare provision has also highlighted the shift to improved quality care of patients. This section also has shown how organizational restructuring through the practice of FFM has not been positive for migrant professional nurses.

Migrant professional nurses were the group that this study has chosen to highlight. This is attributed to how the global shortage has made the occurrence of migrant professional nurses in hospitals a common phenomenon. The practice of FFM within the corporate hospital structure has led to rigidity rather than flexibility in terms of numerical and functional capacities. The mislabeling of migrant professional nurses as independent contractors and their short tenure has had negative implications. Their short tenure means that they offer a short term solution in relation to numerical flexibility. Management's perspective of migrant professional nurses translates into reluctance to invest in skill upgrade thus stunting functional flexibility. In addition, the manner in which work practices have been reengineered have led to professional nursing staff taking up new roles that lead to work intensification (Baumgart, 1997; Pillar and Jarjoura, 1999; Sovie, and Jawad, 2001:588). The direct consequence of which has been an increment in pressure from management to perform and longer working hours (Pillar and Jarjoura, 1999).

Through the first two sections, reference has been made to disempowerment. The next section aims to build on this theme by arguing that the practice of FFM has led to worker disempowerment. The concept of disempowerment will be considered in the contexts of career development and the worker voice. The next section will argue that the practice of FFM has contributed towards the weakening of the worker voice. Yet again the migrant worker voice will be taken into account by considering the wider context within which disempowerment occurs. Pertinent issues like nationalism and fair discrimination will be drawn on as well.

2.7 THE DEPENDENT CONTRACTORS' DISEMPOWERMENT WITHIN THE FLEXIBLE FIRM CONTEXT

The previous sections introduced the concept of FFM and went on to contextualise it in the healthcare sector. They also identified the problem of disempowerment that arises for dependent contractors through the practice of FFM. This section seeks to further develop the theme of disempowerment in dependent contractors by firstly, conceptualising the workers voice within the workplace. Focus is placed on worker representation and participation, and the regulation of the employment relationship. Secondly, the nature of the dependent contractors' worker voice will be problematized. Issues like non-unionism, representations and participation for dependent contractors will be discussed to show the disempowering

elements. Lastly, the external conditions which facilitate disempowerment in dependent contractors will also be identified. This is with the aim of understanding why practices like FFM are considered to be legally legitimate in facilitating 'horizontal labour market segmentation'. The following issues of nationalism, fair discrimination and economic nationalism will be unpacked to explain how horizontal labour market segmentation occurs.

2.7.1 Worker Voice within the Workplace

The worker voice is conceptualised as "a whole variety of processes and structures which enable, and sometimes empower employees, directly and indirectly, to contribute to decision-making in the firm" (Armstrong, 2006:807). Representation and participation facilitates workers to address issues that concern them within the workplace. Direct representation within the workplace is not feasible for all groups of workers as it is unmanageable. So, the workers elect a co-worker to stand for them in all worker interactions with management. Through the worker representative, workers have the opportunity to contribute towards issues that affect them and are open for discussion. Therefore it is through the representative that the 'worker voice' is heard by management. An example of such a representative is a shop steward.

According to Armstrong (2006:808), worker representation and participation is a managerial driven initiative. Armstrong (2006:810) cites four issues that influence managerial objectives. Firstly, how keenly management seeks to educate workers more fully about their objectives to obtain worker approval. Secondly, how actively management seeks out worker ideas and improve performance. Thirdly, how eagerly management seeks to resolve conflict by listening and considering worker perspectives. Lastly, how strongly management seeks to use representation and participation as "a mechanism for channelling employee anxieties and misgivings without their resorting to the disputes procedure and industrial action" (Armstrong, 2006:810). All of these factors will contribute towards the extent to which management will encourage or suppress the worker voice.

Representation and participation fulfils several purposes. Firstly, the "articulation of individual dissatisfaction" serves to maintain good relations between management and workers (Armstrong, 2006:808). Secondly, the "expression of collective organisation" acts

as a check on managerial authority (Armstrong, 2006:808). Thirdly, a “contribution to management’s decision making” also serves to maintain amicable relations with workers (Armstrong, 2006:808). Lastly, as a “demonstration of mutuality and cooperative relations” it contributes towards the long term survival of the organisation (Armstrong, 2006:808). The true nature of the noted will be questioned in relation to dependent contractors in a subsequent sub-section.

The worker voice is expressed through individual and collective dimensions (Armstrong, 2006:808). However, the extent to which the worker voice is expressed is dependent on a matrix of factors (Armstrong, 2006:809). The factors identified include, the nature of issues discussed, and the dimensions of expression. With regard to the nature of issues discussed, some issues like security are of common interest to management and workers. On the other hand, issues like wages and working hours tend to be contested between management and workers. Individual expression of the worker is often associated with worker victimisation. Therefore, contested issues tend to be expressed collectively rather than individually.

This study cites four types of worker representation and participation for the purposes of this study. These are direct, communicative involvement, indirect consultation and trade unionism forms of worker representation and participation (Gallie *et al* 1998:91). The mentioned forms of the worker voice will be expanded on in a later sub-section of this chapter. This section sought to briefly unpack the concept of the worker voice within the workplace and the contributing factors that will influence its efficacy. It has also outlined the different forms of worker voices found within the workplace. The following section will problematize the worker voice in relation to dependent contractors.

2.8 THE PROBLEMATIC NATURE OF DEPENDENT CONTRACTORS’ VOICE IN FLEXIBLE FIRMS

This next section aims to show challenges faced by dependent contractors in representation and participation. Firstly, this study argues that non-unionism is a reality for dependent contractors. The implications of non-unionism will also be discussed. Thereafter, other forms of representation and participation in a non-unionised workplace will be addressed. Lastly, the role of the employment relationship in the disempowerment of dependent contractors will be discussed.

2.8.1 Non-Unionism: a Reality for Dependent Contractors

Trade union representation and participation is characterised by personal membership and is external to the organizational structure (Gallie *et al*, 1998: 103; Bryson, Forth and Kirby, 2005:458). As a result, its influence is dependent on how well it can enforce legal worker support structures. However, from the 1980s, especially in Britain, trade union membership has been on the decline (Voos, 1994:2; Blanchflower and Bryson, 2008:1). This has often been linked to the changing nature of the employment relationship.

Union representation of dependent contractors in contexts like Botswana¹⁵ is challenging because their ambiguous employment relationship. On the one hand, dependent contractors are not considered to be employees. Yet on the other hand, they portray traits of employees. Within the Botswana context, dependent contractors cannot legitimately join trade unions as they are not employees. So, for dependent contractors in contexts like Botswana, non-unionism is a reality.

Non-unionism entails the lack of a trade union presence in the workplace (Dundon and Gollan, 2007:1184; Dundon and Rollinson, 2004:1). In line with the research, Dundon and Gallon (2007:1184) suggest a future trend of 'non-unionised' workplaces and that a non-union voice will eventually replace the traditional and collective employee relations in contexts like Britain.

It would appear that Dundon and Gallon's (2007:1194) suggestion is to some extent supported by the fact that the search for organizational flexibility has led to a decline in trade union membership. For example, there has been a decline in trade union membership in Britain within the last twenty years (Dundon, and Rollinson, 2004:4). Furthermore, it appears that the trade union movement's failure to adapt to organizational restructuring has led to its own decline (Dundon and Gollan, 2007:1182; Lewchuk and Wells, 2006:658). Management's response to the trade union movement has been in the form of either

¹⁵ According to s 21 (1) of the Trade Unions Act of Botswana no person shall be admitted to membership of a trade union unless he is an employee in an industry with which the trade union is directly concerned.

suppression and/or substitution in institutions such as IBM, HP and M&S¹⁶ (Dundon and Gollan, 2007:1189).

Suppression and substitution are characteristic of union avoidance (Dundon and Gollan, 2007: 1189). Overt suppression may entail non-recognition of trade unions by management to delegitimize trade union activity within the workplace. Covert suppression may entail the substitution of trade union functions through the introduction and implementation of various firm-based structures like flexible firm associations, work councils, joint consultation committees and quality circles (Hyman *et al*, 2003:4). The essence of these structures is that they all undermine the demand for union representation (Dundon and Gollan, 2007:1183; Lewchuk and Wells, 2006:655).

To entrench union substitution, management introduces and implements strategies that are aimed at acquiring and sustaining worker cooperation as is illustrated by Magna's HRM model (Lewchuk and Wells, 2006:655). These strategies all seem to have an underlying objective of making workers buy into managerial goals (Lewchuk and Wells, 2006:655). Examples of these strategies include the individualisation of the employment relationship, open door policies and employee entrepreneurship culture cultivation (Lewchuk and Wells, 2006:655).

The individualisation of the employment relationship facilitates 'pay-for-performance' systems. Open door policies are aimed at stabilizing the traditional adversarial management-worker relationship by opening up communication channels. Furthermore, the use of problem-solving groups for labour process disputes cultivates an employee entrepreneurship culture (Lewchuk and Wells, 2006:685). Using the Magna's HRM model as an example, all of the underlying threads that unite the previously-mentioned strategies are aimed at the legitimation of managerial goals (Lewchuk and Wells, 2006:656).

It is important to note that at times management has no direct hand in the absence of trade union activity in a firm. Hyman *et al* (2003:2) argue that there are structural factors, like size and sector, which influence the levels of trade union activity. Small to medium-sized firms

¹⁶ IBM, HP and M&S all have HR practices that reduce the demand for trade union representation. For example, employee involvement programs undercut the need for union representation. However, it is important to note that other motives non-union related motives like improved efficiency may be the drive behind employee involvement programs (Fiorito, 2001:335).

tend to be viewed as infertile ground for trade union activity because they do not offer big returns as compared to large firms (Hyman *et al*, 2003:4; Yates, 2006:580). As a result, a lack of trade union activities within the firm may not necessarily be the result of managerial suppression and/or substitution.

In the face of suppression and substitution, there has been evidence suggesting that HRM tends to be more effective in a unionised workforce in Britain (Bryson, Forth and Kirby, 2005:452). In the aftermath of the crisis of Fordism, there has been an upsurge in the need for organisations to maintain a competitive edge (Bryson *et al*, 2005:452). This calls for a review of the importance of a unionised workplace. According to Bryson *et al* (2005:435), trade unions in Britain have two key functions. The first is the ability to balance the unequal employment relationship. The ability to bargain collectively with management means that a union is able to contain the supply of labour without this monopolization bringing harm to the union members (Bryson *et al*, 2005:435). Of course, this is dependent on other variable like market conditions. For example, if there is a ready supply of non-unionised workers to replace the unionised workers, then the union's ability to bargain is impaired. The second key function is the effective channelling of the workers' voice to management. By having a non-threatening outlet to express concerns and ideas, worker turnover is likely to be greatly reduced.

To conclude, trade unionism is but one form of the worker voice. Therefore non-unionism does not necessarily mean a silencing of the worker voice. Other previously mentioned forms of the worker voice are direct, communicative involvement, indirect consultation representation and participation. These forms of the worker voice play a major role in the absence of trade unions. The next section will expand within different HRM styles presented by Dundon and Rollinson (2004:40).

2.8.2 Dependent Contractors' Representation and Participation in Non-unionised Firms

The changing nature of the organizational structure has led to a re-conceptualisation of the employment relationship and the managerially inspired methods to obtain worker cooperation (Dundon and Rollinson, 2004:27). Worker co-operation obtained through worker input is important for employee motivation and the acceptance of organizational

change. One of the ways in which input is acquired is through representation and participation (Gallie *et al*, 1998:91). Gallie *et al* (1998:91) put forward direct, communicative involvement, indirect consultative and trade union representations as the forms through which workers can make an input.

According to Armstrong (2006:14), Human Resources Management (HRM) is a “...senior management-driven strategic activity that is developed, owned and delivered by management as a whole to promote the interests of the organisation that they serve...”. The forms of representation and participation that dependent contractors have access to are therefore influenced by the style of HRM practiced within the organisation. A HRM spectrum has been borrowed from Dundon and Rollinson (2004:40). Its values run from an exploitative autocracy, to a restrained autocracy, to a manipulative autocracy, to a benevolent autocracy and sophisticated HRM. These styles are broken down into how management regards employees, trust levels within the employment relationship, levels of unity or concurrence on how the organisation should function and how the employment relationship should be regulated (Dundon and Rollinson, 2004:40). Although the spectrum presents clear-cut divisions between the styles, reality may not necessarily reflect the same clear divisions. In fact, within the FFM context, all styles may be present within a single organizational structure and there may also be blurred divisions between two HRM styles. This is reflected in the ways in which different groups of workers are treated according to their core or peripheral status.

Direct representation and participation is characterised by formal and informal procedures like inter-disciplinary teamwork meetings (Gallie *et al* 1998:90). This gives workers a direct contribution into their immediate environment and work process. Highly skilled workers in the core tend to be eligible for this type of representation and participation. This is attributed to their intimate knowledge of technology and work process (Atkinson and Gregory, 1986:13). A sophisticated HRM system is most likely to be used to regulate the employment relationship. A sophisticated HR has some aspects of joint regulation through a range of management-initiated employee voice mechanisms (Dundon and Rollinson, 2004:40). Employees are regarded as valued assets and this tends to pay off in high trust dynamics within the employment relationship. Furthermore, there are low levels of distrust between management and employees. Although there is high emphasis on informality, there is also the use of formal processes. Direct representation and participation is often associated with

several types of organizational structures to varying degrees. Examples of these are the loosely coupled, project based and matrix organizational structures (Morgan, 1989:67).

Communicative involvement is characterised by formal procedures for information sharing (Gallie *et al*, 1998:96). Examples of such procedures include meetings, notices and news letters. It is aimed at cultivating a strong sense of participation by sharing information with the employees so that they are aware of organizational developments (Gallie *et al*, 1998:96). However, communicative involvement does not entitle workers to influence their immediate environment and work process (Gallie *et al*, 1998:96). All groups of workers can be subjected to communicative involvement to differing degrees. A benevolent HRM system could be associated with communicative involvement. A benevolent HRM system is characterised by a façade of joint regulation by using a selected range of employee voice mechanisms (Dundon and Rollinson, 2004:40). Employees are regarded as a factor of production. Worker co-operation is based more on persuasion than coercion. Trust levels within such a relationship are contextual and, consequently, tend to fluctuate. A benevolent HRM system can be associated with a loosely structured bureaucratic organizational structure (Morgan, 1989:67).

Indirect consultative representation and participation is characterised by a body made up of elected representatives like work councils (Gallie *et al* 1998:99). Traditional forms of worker representation like trade union have come under pressure as a result of the crisis of Fordism (Rogers and Streeck, 1995:3). Work councils are defined as “institutionalised bodies for representative communication between management and the workforce of a single workplace.” (Rogers and Streeck, 1995:6). All workers irrespective of any trade union affiliations are represented by the work councils. Membership duration is based on the duration of employment at that specific workplace. It is important to note that in some contexts like Germany, work councils and trade unions are independent of each other even in cases where they co-exist in a workplace (Rogers and Streeck, 1995:6). However, there are contexts where the two tend to be merged as is the case in Italy (Rogers and Streeck, 1995:6).

Work councils provide representation outside formal collective bargaining structures (Rogers and Streeck, 1995:3). Although they may be a managerial initiative, their structure is not influenced by managerial objectives (Rogers and Streeck, 1995:8). It is for this reason

that workers whose views that oppose those of management cannot be targeted. Rogers and Streeck (1995:10) identify the paternalistic, consultative and representative councils as the three main types of work councils. Paternalistic work councils tend to be a managerial initiative to circumvent trade unionism in the workplace (Rogers and Streeck, 1995:10). Although representitvity may be allowed, the freedom of expression is curtailed. Consultative work councils are formed to “set up to improve communication between management and workers through exchange of informtion and through consultation, in order to facilitate cooperation in production and thereby enhance the competitve perfomance.” (Rogers and Streeck, 1995:10). Representative work councils tend to be estbalished through collective agreements or legislation (Rogers and Streeck, 1995:10). They facilitate the worker voice to be heard in issues that management would ordinarily overlook. Representation in collective bargaining issues has had a tendency to cast the work council and management into an adversarial context. Although representative work councils facilitate participation, they also smooth the progress of industrial democracy.

Unlike communicative involvement, workers have some form of direct input into the work process through their representitives (Rogers and Streeck, 1995:10). However they are not made fully aware of some organizational developments. Peripheral groups of workers tend to be subjected to this type of representation irrespective of their skill levels. These traits can be associated to restrained, manipulative and exploitative autocratic HRM systems to varying extents (Dundon and Rollinson, 2004:40). In all of these HRM systems, workers are considered to be factors of production. Management guards its regulatory prerogatives. The production process is then often the terrain on which managerial power is overtly or covertly challenged. As a result, there are low trust levels within all three HRM systems (Dundon and Rollinson, 2004:40). However, with the restrained and manipulative autocratic HRM systems, the trust levels within the employment relationship are dependent on contexts. As a result, unlike the total disunity in an exploitative autocratic HRM system, disunity levels flactuate according to the contexts.

In an exploitative autocracy, the employment relationship is regulated through informal processes in terms of interaction and rules (Dundon and Rollinson, 2004:40). In contrast to this, within a restrained autocracy employment relationship, the employment relationship is regulated by a superficial front of formality. Lastly, a benevolent autocracy employment relationship is regulated through a mixture of formal and informal means (Dundon and

Rollinson, 2004:40). The different types of worker representation available to dependent contractors have been presented within contexts they are most likely to be practised. The next section seeks to show the practice of FFM has led to dependent contractors becoming alienated from the organizational structure. This study argues that, as a result of alienation, the efficacy of the dependent contractors' voice is questionable.

2.8.3 Fairness and the Employment Relationship

The pursuit of numerical, functional and financial flexibilities has had an impact on the employment relationship (Atkinson, 1985:13; Gannon and Nollen, 1997:111). The practice of FFM has arguably alienated dependent contractors from the organizational structure. This means that their link to the organizational structure has been distorted to the extent of ambiguity by the nature of their employment relationship. In the United Kingdom, the ambiguous status of the dependent contractor professional nurses' employment relationship has had a negative impact on career development. This section argues that alienation has also had a negative impact on participation and representation for dependent contractors. To highlight issues of worker participation and representation, this section will review the nature of the employment relationship under the FFM lens.

The legal view, traditional industrial relations and social exchange theory are the three paradigms this study will use to understand the disempowering nature of the employment relationship (Dundon and Rollinson, 2004:16). A critical analysis of each paradigm reveals the disempowering qualities of the employment relationship. The legal conception of the employment relationship is manifested by a formal contract. This is purported to be the simplest of descriptions of an employment relationship. It may be contextualised to suit different systems of labour laws in different countries, but may be generally defined as "the concept of a contract service, which can be defined as an obligation to work or be available for work, for which payment is promised" (Dundon and Rollinson, 2004:17).

Within this contract, other factors like benefits and conditions and terms of employment are included. In contract law, three basic assumptions are often made (Dundon and Rollinson, 2004: 17). These are the individualised relationship between the parties, reciprocal rights and obligations between the parties and equal bargaining power. However, the employment relationship has been labelled as imbalanced in terms of bargaining power. This description

is evidenced by the presence of collective worker support structures like trade unions to attempt to balance out the power relations. Furthermore, economic factors often force people to enter work contracts which contain terms and conditions they do not necessarily fully agree with. In entering an employment contract, the worker gives away power in a sense by agreeing to be subordinate to managerial 'power, authority and status'.

The mainstream perspective of industrial relations is about "the making and administering of rules which regulate employment relationships; regardless of whether these are seen as formal or informal, structural or unstructured" (Bain and Clegg, 1974:95). The rules in question are often achieved through collective bargaining from national to firm levels. Focusing on the collective representation of workers, the need to be a collective is a manifestation of the unequal employment relationship (Dundon and Rollinson, 2004:18). In the absence of trade union representation, non-union firms' employees lack that equalizing factor and not enough attention is given to non-union firms by some industrial relation systems. Limited research on the employment relations in non-union firms leads to the misleading insinuation that non-union firms are a temporary or unimportant phenomenon. As a result, aspects (like job security, benefits and training facilities) of the employment relationship in non-union firms are not given much attention unless they pose a direct threat to unionised workers (Kenny and Webster, 2003:222).

The social exchange perspective takes into account the social contexts that influence the employment relationship (Dundon and Rollinson, 2004: 22). It recognises that the employment relationship is an evolutionary process as is evidenced by the practice of FFM. Five factors are used to study the employment relationship, especially in non-unionised firms. These are cost and benefits, fairness, unavoidable expectations and obligations, trust and unequal power (Dundon and Rollinson, 2004: 23).

With regard to cost and benefits, each party within the employment relationship has to give up something in order to gain. The worker gives up self-determination for remuneration and management gives up money for labour (Dundon and Rollinson, 2004:23). Fairness is achieved by weighing the benefit to the cost. For example, the purchase of new technology may render some workers redundant, thus the redundant workers become more of a cost than a benefit. The question of fairness reveals conflict and cooperation are inherent in the employment relationship (Dundon and Rollinson, 2004: 24). A failure to balance the costs

and benefits of the employment relationship results in fluctuations in the levels of conflict and cooperation. As a result, trust is important and is built as well as maintained by fulfilling obligations within the employment relationship (Dundon and Rollinson, 2004: 25). Unequal power relations often lead to mistrust between parties, thus the development of structures like trade unions place checks and balances on managerial powers and authority.

Looking at the premises of the FFM and linking them to the employment relationship, “employers increasingly demand more flexible and accommodative modes of production and service delivery from employees” (Dundon and Rollinson, 2004:15). This has had a major implication for the regulation of the employment relationship for dependent contractors. In contexts like Botswana there is more emphasis on individual employment relations as a consequence, dependent contractors do not qualify for trade union membership. The nature of the non-standard employment relationship has been a source of ‘additional’ disempowerment of the worker. Emphasis is placed on the word ‘additional’ disempowerment because the traditional or standard employment relationship itself has often been deemed as disempowering. Non-standard forms of employment are aimed at attaining functional and numerical flexibilities within a firm. Atypical employment relations can be defined as, “those that differ from the traditional model of the employment relationship ... that deviate from full time open-ended wage employment including part-time ... and informal work” (Delsen, 1995:1).

The different forms of non-standard employment render their regulation problematic. Regalia (2006:8) groups them into four main categories. These are short time but regular employment, closed-ended employment, labour brokering and non-plant based work. For the purposes of this study focus is placed on closed-ended employment. Closed-ended employment is aimed at fulfilling specific labour requirements for specific periods, for example, in times of temporary skills shortage. Such forms of employment are characterised by fixed-term contracts and seasonal work. An example of such a scenario is depicted by how African and Filipino professional nurses were contracted to carry out core functions by hospitals in the United Kingdom.

As revealed earlier, the formal contract is inherently unbalanced in favour of employers (Dundon and Rollinson, 2004:17). Relating this to worker representation and participations, workers who fall within the dependent contractor groups tend to be subjected to restrained,

manipulative and exploitative autocratic HRM systems (Dundon and Rollinson, 2004:40). These tend to disempower them further in various manners. For example, in all three systems, management guards its regulatory prerogatives. As a result, there may be an inadequate flow of information to workers. Inadequate flow of information, in terms of worker rights, means that workers are not fully aware of their rights. For this reason, one of the roles of worker support structures is fully to inform workers of their rights and obligations. In contrast, management tends to have specialists and lawyers to inform them of their rights and obligations (Dundon and Rollinson, 2004:18). By having good insight into their rights and obligations, management is able to manipulate the conditions of the employment relationship to suit their objectives. In addition, the manner in which information is disseminated [for example notices and newsletters] does not facilitate active interaction with management. As a result, there is no real platform on which workers can be fully informed on various issues that affect the organisation.

HRM, as an alternative to industrial relations, tends to side-line trade unions. Although there are various strands of HRM, they all appear to be rooted in the following four key but general traits. The first is the deep-rooted importance of planning for the maximum utilization of human resources. The second is formulation and implementation of logical employment policies that are underpinned by a distinctive set of business strategies. The third is the machinery of human resources activities matched clearly with a set of business strategies. The last is the perspective of employees as strategic resources for gaining competitive advantage. HRM, like most social phenomena, exists on a spectrum as was shown in the last section. HRM is often used as a vehicle to avoid and/or substitute trade unions. Depending on the HRM system practiced, workers in dependent contractor groups tend to be further disempowered through a lack of active representation and participation.

From a social exchange perspective, as a side effect of organizational restructuring, the employment relationship has been refashioned in a bid to increase production at the lowest possible costs (Armstrong, 2006:25). As evidenced in the analysis of the social exchange paradigm, the employment relationship is not fashioned in a fair manner. Checks and balances have been placed on management through legislation and policies, trade unions and collective worker support structures. The increased use of non-standard employment is seen as a way of circumventing these checks and balances on managerial power. The standard

employment relationship was fashioned in a manner that facilitated these checks and balances.

To sum it up, organizational restructuring through the FFM appears to have accentuated the power disparities between employers and workers and among workers. As a result of allocating workers to core and peripheral groups, a small minority of workers have gained power at the expense of the great majority of workers.

2.9 EXTERNAL CONDITIONS WHICH FACILITATE DISEMPOWERMENT

One of the central arguments of this research is that organizational restructuring has further disempowered dependent contractors through the weakening of worker support structures, strengthening of HRM practices, and increased labour market segmentation. This section argues that non-citizen workers have been ‘disempowered’ as a result of the practice of FFM in contexts like Botswana. This is based on how the practice of FFM leads to horizontal labour market segmentation along lines of nationality. Horizontal labour market segmentation is contextualized for the purposes of this research to mean “inequalities among workers who have similar levels of productivity” (Polavieja, 2002:2).

2.9.1 A Divided Workforce

There are four generations of labour market theories. However, for the purposes of this research, reference will be made to the first three generations and focus shall be placed on the third generation as it is the most relevant to this study. The first and second generations offer a historical perspective on labour market segmentation. The first generation was developed by Doeringer and Piore (1971), who proposed that the labour market was divided into primary and secondary sectors. The primary is reminiscent of the core and the secondary is reminiscent the peripheral work groups (Atkinson, 1985:17; Fine, 1998:120). The second generation was largely a reaction to the first generation (Fine, 1998:123). The labour process was presented as a ‘contested terrain’ between management and workers.

The main issue of contention is control over the labour process. In a bid to maintain control, management weakens worker solidarity by segmenting the labour market (Fine, 1998:123).

The first two generations have been dubbed as 'dualist models' because they focus on the demand side of labour and the job attributes rather than worker attributes (Fine, 1998:125). Labour demand is presented as employer strategies and economic forces of capitalist production, distribution and exchange (Fine, 1998:125). This means that labour demand is shaped by technology, work organisation, the product market, industrial organization and profitability (Fine, 1998:125).

The third generation theories hypothesize that the interaction between demand and supply leads to labour market segmentation. Labour market supply is presented as the terms and conditions under which workers are willing to sell their capacity to labour (Fine, 1998:125). Segmentation is based on a matrix of causes, both economic and non-economic (Fine, 1998:125; Jenkins, 2004:17). The economic factors include market forces, technology, industry and sector. Non-economic factors include social equity laws and worker rights. The interaction between demand and supply is viewed as being mutually embedded. This interaction is conditioned through economic and social forces (Fine, 1998:126). For example, worker organisation, which is a social occurrence within the workplace, plays a role in the shaping of economic issues like wages through collective bargaining. Focus will also be placed on the role of the state in the shaping of the demand and supply of the labour market through its institutions.

2.9.2 Labour Market Segmentation

The key function of the labour market is to "...allocate human resources among alternative users and distribute incomes [economic resources]. In the process labour markets should contribute to efficiency, equity, growth and social justice" (Barker, 2003: 13). This definition would be very possible in a perfectly competitive labour market. However, reality has shown that the labour market is not perfectly competitive (Barker, 2003:12). Peck (2000:220) argues against a self-equilibrating labour market. Instead she (Peck, 2000: 220) puts forward the labour market as a "complex and contradictory institutional structure".

The segmented labour market theories were put forward to offer a critical explanation of the labour market imperfections (Barker, 2003:22). Dualist labour market theorists argued that the labour market was made up of primary and secondary 'non-competing' labour markets.

This is reminiscent of the FFM's core and periphery work groups. For both the dual labour market model and FFM, "the rules governing the behaviour of one labour market differ from the one segment ... to the other" (Peck, 2000: 220). In addition both focus on job traits rather than worker traits. As a result, the labour market is viewed as an economic institution rather than a social one (Peck, 2000: 222).

The society in which these organisations occur, and its relation with these organisations, has been very little studied. To the extent that the outside world does not impinge on the structure and functioning of organisations, it is conceptualised not in terms of interests, values, class loyalties, ideologies, market developments...but as the organisation's '*environment*'. (Sakiman, 1979:32)

The above quote is a very powerful criticism of the dual labour market model. The context of an external environment tends to be overlooked in studying organisational dynamics (Thompson and McHugh, 1990:86). This gives the misguided implication that organisations are only accountable to market forces. Albrow (1973: 406) criticizes HRM practices for perceiving organisations in a "social vacuum and ignoring the degree to which its problems were the result of outside pressures." In essence, undermining the external environment implies that organisations are closed systems with rational actors (Barker, 2003: 23). In other instances, there are misconceptions of what factors make up the external environment, for example, demand for a product and/or service. So according to such a perspective, organisational adjustment to the consumer patterns equates adjusting to the external environment (Thompson and McHugh, 1990:88). Notably, such a perspective is not wholly wrong but short-sighted.

Peck (2000:221) on the other hand views the labour market as a social construct. It incorporates numerous rules and types of organisations which condition the manner in which the labour market works and is structured. Accordingly, the third generation of labour market segmentation theories puts forward the idea that the labour market is divided into clusters (Peck, 2000: 223). The clusters come about as a result of segmentation in demand, supply and state intervention (Peck, 2000: 224). However, these shall be further discussed in the chapter three.

2.9.3 Nationalism and Fair Discrimination

For the purposes of this research, focus is placed on how state structures like immigration and labour laws and policies influence the supply of Non-Citizens' into a labour market. This research suggests that state institutions play a key role in the non-citizens' entry levels into the labour market, the efficacy of their worker voice and their opportunities for career development. Furthermore, within the context of organizational restructuring, management has a tendency to take advantage of these institutions in driving down labour costs by employing non-nationals who are not eligible for benefits like pension schemes. This perspective is sustained by the third generation labour market segmentation theories, which propose that the interaction between economic and social factors lead to distinct structures, institutions, and processes that link supply and demand.

In the process of substantiating this argument, fair discrimination¹⁷ will be briefly unpacked within the context of nationalism. Secondly, the theme of 'economic nationalism' will be related to horizontal labour market segmentation by unpacking issues of 'nation building', 'citizenry empowerment' and labour legislation. Nationalism may be traced back to the need to unite a multi-ethnic population within a geographical region (Brass, 1991:19). Ethnicity is defined by De Vos (1975:16) as "the subjective, symbolic or emblematic use by a group of people ... of any aspect of culture in order to differentiate themselves from other groups". The outcome of which creates the rules on inclusion and exclusion of rights, benefits and access to power. Brass (1991:19) affirms this premise by stating that "ethnicity ... also involves ... a claim to status and recognition". Thus, through the rules of inclusion and exclusion, nationalism becomes a form of fair discrimination.

Nationalism is often a reaction to exploitation of the indigenous group/s by an alien group (Brass, 1991:41). It is also often connected to the struggle to create a new state or liberate a state from tyrannical rule (Billing, 1995:5; Burnell, 1986: 7). However, Billing (1995:6) is adamant that nationalism needs to be expanded to include the ideological ways in which nation-states are promoted, protected and preserved. Similarly, Brass (1991:49) points out that for a successful nationalist movement there is a need for effective mobilization of ethnic groups, skilled leadership and resources to gain and maintain support. All of which are

¹⁷ The legally sanctioned practice of treating a group of (Non-Citizens') workers within the workplace less fairly than other groups of (citizen) workers.

important factors in the promotion, protection and preservation for a nation state. In other words, nationalism goes beyond the creation of a new state, it also entails nation building. The latter is made up of various facets. However, for the purposes of this research, the economic aspect of nation building holds the most relevance.

2.9.4 Economic Nationalism and Horizontal Labour Market Segmentation

Economic nationalism may be viewed as a component of nationalism (Burnell, 1986:1). As a term that is often loosely used by economists, it has no agreed definition. This could be attributed to how its meaning is often grounded in a specific context because of its historical setting, nationalism and the ideologies that inform it (Burnell, 1986:25). It is often propelled by various causes. The most relevant causes to this research include a nation-building exercise through the indigenization and localization of personnel (Burnell, 1986:55). Since World War II, the practice of economic nationalism has been mostly associated with less developed states, especially those in Sub-Saharan Africa and Asia. The 1960s and 1970s were characterised by an industrial nationalism that was inspired by the threat of foreign control over natural resources and allied industries. This was characteristic of Zambia and Chile's copper mining industries (Burnell, 1986:2). The 1960s and the 1970s were also periods that were often linked to Fordism because of the protectionist policies and controls such as those in India during the late 1970s (Burnell, 1986:3). This was evidenced by International Business Machines and Coca Cola withdrawing their investments from India because of local equity participation laws and policies.

Economic nationalism has led to the official (and in some cases unofficial) discrimination, especially within the labour market. Burnell (1986:4) refers to this as 'economic discrimination'. Economic discrimination has often been inspired by political, ideological and national security reasons. An example of this would be the forced migration of Muslims from Burma to Bangladesh in 1978. The shift from Fordism to not-Fordism was also characterised by the change from state control towards a free market economy.

Economic nationalism has often been criticized by economists for hindering the maximization of welfare and economic development (Burnell, 1986:5). However, such a perspective tends to ignore socio-economic issues. The role of the state is to play a unifying

role between different ethnicities who equally qualify to be citizens by empowering them (Brass, 1991:19; Argandona and Gual, 2002:55). This role has been extended to the workplace and is illustrated by the rights and duties, benefits and access to resources a worker may be eligible for. So, within the workplace, citizenship “also involves a claim to status and recognition, either as a superior group or as a group at least equal to other groups” (Brass, 1991:19). In this sense, a workplace becomes a platform through which available resources, social benefits and opportunities are made available to the ‘citizen worker’ (Brass, 1991:41; Fevre, 1992:24; Fine, 1998:87; Argandona and Gual, 2002:49; Barker, 2003:13). To ensure citizenry empowerment occurs, legislation and policies are put in place (Argandona and Gual, 2002:51-2; Fleetwood, 2006: 60).

To sum up, empowerment structures aimed at a specific group of people lead to ‘fair discrimination’ (Argandona and Gual, 2002:53). This discrimination is legitimate in the sense that it is grounded in laws and policies. In addition, it ensures that citizens benefit by getting access to their rights, benefits and resources (Argandona and Gual, 2002: 76). In contrast, workers who do not fit the criteria are not eligible for citizen benefits resulting in horizontal labour market segmentation (Argandona and Gual, 2002:76).

2.10 CONCLUSION

This chapter has problematised FFM by focusing on the dependent contractor. The ambiguous nature of the employment relationship is identified as a root cause of the dependent contractor’s disempowerment in terms of career development and, representation and participation within the workplace. The practice of FFM was contextualized within the health sector to illustrate how non-citizen professional nurses are affected by the practice of FFM in relation to career development. The global shortage of professional nurses was identified as a leading facilitator in the contraction of non-citizen staff in hospitals. Horizontal labour market segmentation is an outcome of the practice of FFM. External conditions like economic nationalism play a contributory role in facilitating horizontal labour market segmentation.

CHAPTER THREE

3.0 THE BOTSWANA PROFESSIONAL NURSING SITUATION

3.1 INTRODUCTION

The main role of this chapter is to further develop the context within which this study will be done. This will be done by carrying out a historical overview of Botswana's economy. This is with the aim of creating an understanding of Botswana's current predicament of a skilled manpower shortage, especially in the professional nursing sector. This chapter proceeds to outline the professional nursing terrain in Botswana. The shortage of professional nurses and horizontal labour market segmentation as an outcome of this shortage are highlighted. This chapter proceeds to argue that FFM is a tool that facilitates horizontal labour market segmentation in light of economic nationalism. The purpose of this overview is to create an immediate context within which the professional nurses at GPH work in.

3.2 A HISTORICAL OVERVIEW OF BOTSWANA'S ECONOMIC DEVELOPMENT

To understand contemporary organizational restructuring in Botswana, a brief historical background is necessary. Mogalakwe (1997:3) notes that the Botswana economy is marked by three phases of development. The first phase (1885-1965) was characterised by integration into capitalism through colonialism. The second phase (1966-1990) was characterised by the period of post-colonial Botswana, which was characterised by direct state intervention in the economy. The third phase (1990-to date), which is representative of contemporary Botswana, is characterised by a neo-liberal form of state involvement. Each phase of capitalism also represents a change in organizational structure.

Botswana's integration into capitalism was characterised by minimal investment by the colonial government (Acemoglu, Johnson and Robinson, 2001:1; Kiiza, 2006:6). This is attributed to several factors (Acemoglu *et al*, 2001:2). Firstly, Botswana was acquired solely as a matter of strategic positioning to block the Boers and Germans from gaining access into

the interior of Southern Africa (Acemoglu *et al*, 2001:13; Kiiza, 2006:7). Furthermore, Botswana's geographical features, desert land and land locked status made it very unappealing for the British colonial government to develop. As a result, Botswana was a peripheral concern to the British (Acemoglu *et al*, 2001:4). Therefore, when Botswana became an independent state in 1966 it only had about twelve kilometres of paved road, extremely low literacy levels and an underdeveloped health system and economy (Acemoglu *et al*, 2001:2). In fact, it was labelled the third poorest country in the world (Kiiza, 2006:7).

In some respects, the Botswana state may be described as a developmental state. Chang (1999:192-199) defines a developmental state as "a state that pursues policies that coordinate investment plans; has national development vision - implying that the state is an entrepreneurial agent; that engages in institution building to promote growth and development; and that finally, plays a role in domestic conflict management". Several factors in the Botswana context necessitated state-funded development. As previously mentioned, the minimal investment by the colonial government meant that Botswana at independence in 1966 inherited a very poor economy (Acemoglu *et al*, 2001:11). The economic turn-about is attributed to the discovery of diamonds and the adoption of policies which attracted foreign investors (Acemoglu *et al*, 2001:18; Jefferis and Kelly, 1999:212). The discovery of diamonds in 1967 in Orapa and later in Letlhakane, Jwaneng and most recently Sua, meant that the state could afford to embark on a road towards a developmental state (Chang, 1999:192-9; Kiiza, 2006:7).

The Botswana economy has been characterised as one of close state supervision and control of labour (Mogalakwe, 1997:1). Consequently, there are repressive legislation and policies that resulted in labour taking on a junior position in the industrial relations system. Wage restraint, industrial peace, political stability and national development are the four principles that guide industrial relations in Botswana (Mogalakwe, 1997:68). Bearing in mind that the state plays the dual role of a developmentalist state and employer, it needs to maintain control over the labour movement.

Botswana has followed a neo-liberal stance towards its development since independence (Mogalakwe, 1997:16). For example, instead of nationalizing the diamond industry, the state chose to invite private investors in the form of De Beers mining company to develop it. The Botswana government managed to negotiate a partnership with De Beers mining company

for an equitable partnership in profit sharing (Acemoglu *et al*, 2001:18; Khanya College, 2003:17; Jefferis and Kelly, 1999: 212; Kiiza, 2006:12). This contributed greatly towards public expenditure and the amassing of government savings (Jefferis and Kelly, 1999:212). This meant that the state could shift from a failing agricultural to a predominantly diamond-mining based economy (Khanya College, 2003:17). As a result, the state could afford heavy investments in physical infrastructure in the form of roads, housing, water and electricity and human capital through education, training and health (Acemoglu *et al*, 2001:4; Jefferis and Kelly, 1999:212). These investments were guided by cautious and practical fiscal policies, which ensured accountability and 'sensible' spending.

Such a stance may be attributed to the belief adopted that production is best stimulated by the institution of private property and the market (Mogalakwe, 1997:16). This has led to a reliance on foreign capital and expertise. The economic strategy is based on the belief that foreign capital and expertise will develop local entrepreneurship (Mogalakwe, 1997:16). Such a take on economic development dates back to the conditions of a newly independent Botswana state, which inherited an underdeveloped economy and poor infrastructure (Mogalakwe, 1997:19). The state witnessed accelerated economic development that resulted in structural changes. For example, there was a marked growth of formal sector employment, urbanization, and development of physical infrastructure, health and education institutions. Because of the above-mentioned factors, the 1980s saw Botswana experience rapid growth (Leith, 2000:4; Khanya College, 2003:24). Education improved vastly. By the 1980s, primary school education was practically universal and primary health care was available to the majority of the population (Harvey, n.d.:340). Physical infrastructure like roads and water supply had expanded significantly and was well maintained. By the mid-1980s, Botswana contributed 30 per cent of the worlds' supply of gem diamonds (Harvey, n.d.:338).

Botswana's economy is purported to have been very successful from 1966 to 1990. Economic development was guided by national planning processes informed by the principles of rapid growth, social justice, economic independence and sustained production (Leith, 2000:19). However, according to Mogalakwe (1997:16), the developmental strategy employed by the state was geared towards foreign capital and expertise to develop local entrepreneurship. The third phase of economic development (1990 to date) in Botswana has witnessed the state stepping away from the fore-front of development.

To sum up this section, the common thread that has run through all of Botswana's stages of economic development is a lack of skilled citizenry. The skills shortage among the citizenry had two major implications. Firstly, the use of non-citizen manpower in the development of the state's economy and the need to gradually localize all offices held by Non-Citizens'. The rest of this chapter will address the implication that these two implications had on the professional nurse labour market in Botswana. The themes of economic nationalism and horizontal labour market segmentation through the practice of FFM are also further developed. Thereafter, documented records of restructuring at GPH will be reviewed in light of the professional nurse shortage and the practice of FFM.

3.3 PROFESSIONAL NURSING IN BOTSWANA

The historical overview of Botswana's economic development provides a context within which the causes of the skills shortage and use of non-citizen labour are identified. This section aims to contextualise the issues of skills shortage and use of non-citizen labour within Botswana's professional nursing sector. This section also serves to highlight the fact that these issues are not unique to Botswana.

3.3.1 A Shortage of Professional Nurses

The shortage of nurses is not unique to Botswana, but is an international phenomenon (Buchan, Hancock and Rafferty, 1997; Tuttas, 2003:226; Seboni, 2009: 1035). With the realisation of an international shortage of professional nurses, hospitals with the resources have taken to offering good packages to attract nursing staff (Tuttas, 2003: 234; Cheung and Aiken, 2006:357). This has led to local professional nurses migrating from Botswana to international destinations like the United Kingdom, Australia, the United States of America, Saudi Arabia and the United Arab Emirates (Baputiki, 2009). To accentuate the nursing shortage, local lecturers are also migrating overseas, thus further undermining the quality of training provided. On the local front, nurses have been going to hospitals that offer better working conditions. GPH held a monopoly within the private health sector from the early 1990s to 2000 (Mooketsi, 2009). However, smaller private hospitals have since opened in Maun and more recently, another large private hospital, Bokomoso, was opened in

Gaborone (Mooketsi, 2009). Reportedly, Bokomoso is a joint venture between BPOMAS and Pula Medical Aid Fund (Mooketsi, 2009). Although it is non-profit orientated, it will compete with GPH.

The opening of Bokomoso has allegedly led to a local brain drain from government hospitals and clinics and possibly GPH (Mooketsi, 2009; Morula, 2009). Princess Marina, Botswana's largest government hospital, has allegedly lost 20 of its staff members to Bokomoso (Morula, 2009). However, it was not established how many professional nurses have moved to Bokomoso. The migration towards the private sector has been precipitated by the government refusing to allocate scarce skills allowance although it acknowledges the nurses' shortage (Morula, 2009). This is in addition to low remuneration packages and poor working conditions.

In a bid to alleviate the local shortage, the intake of trainee professional nurses was doubled in 2001 (BOPA, 2001). Hospitals, especially in less developed geographical areas, were under or unstaffed. For example, in 2001 the Mmashoro maternity wing had no mid-wives. This effectively forced expectant mothers to travel to Serowe, which is 80km away (BOPA, 2001). It has been established that the shortage of workers in the nursing sector is attributed to several factors (Baputaki, 2009). These factors include poor working conditions such as long working hours, understaffing, poor remuneration and a failure to practice alternative work patterns like flexi-time. Other factors include poor and/or limited opportunities for further studies in Botswana and local and international brain drain.

3.4 LABOUR MARKET SEGMENTATION

3.4.1 Segmented Demand

Priority is given to the demand side of the labour market as this is where jobs structures are fashioned with regard to level [in terms of skills] and type [core or periphery] are determined (Peck, 2000:224). Job structures are influenced by the technical requirements of different labour processes, stability of different product markets, labour control strategies used by employers and effects of the industrial structure (Peck, 2000:224-225). Looking at the FFM, global pressures for flexibility and market forces have led to the need for numerical and

functional flexibilities. Whether that same could be said for GPH will be explored in chapter 5. The 1998 and 2003 down scaling exercises were due to a drop in demand in both instances (BOPA, 2003). So in these two cases market forces did play a role in the need for numerical flexibility. Secondly, the global professional nurse shortage has led to a majority of the professional nurse staff being non-citizen. This shows that GPH did not actively seek to hire non-citizen professional nurses to drive down labour costs. Yet again, it appears that market forces have driven it to hire non-citizen professional nurses to fulfil its functional and numerical needs.

The side effects of this have been horizontal labour market segmentation along lines of citizenship status rather than skill (Polavieja, 2002: 2). As previously mentioned, citizen and non-citizen professional nurses are governed by different rules in some instances like tenureship (Employment of Non-Citizens' Act, s 6). As a result the employment relationship for non-citizen professional nurses exudes dynamics that are different from citizen professional nurses. For example non-citizen professional nurses are not eligible for permanent employment. In the face of labour legislation and manpower policies, GPH is not obligated to fully develop their skills through constant and rigorous training.

3.4.2 Segmented Supply

Segmentation in labour supply is created by a mixture of economic and social conditions (Peck, 1994: 147; Fine, 1998:125; Jenkins, 2004:17). It is these same conditions and institutions that influence in restricting labour supply. Labour is socially produced and reproduced outside the workplace (Sehgal, 2008:51). In the Botswana context, professional nurse labour supply has been segmented through various factors. The Botswana society has failed to meet its local demand for professional nurses. Although this could be attributed to the failure of social production and reproduction, there is evidence that the government has taken steps to augment social production. By doubling the professional nurse student intake, Botswana has managed to get a relatively young local professional nurse workforce. However, despite increased intake and a relatively young professional nurse workforce, Botswana has still failed to meet local professional nurse demand. The expansion of the private and public health sectors and the global professional nurse shortage has also added on the inability to meet local demand.

Segmented labour supply has come about as a result of hiring non-citizen professional nurses to meet local demand. The rationale behind contingent labour is that it is required for numerical purposes thus giving it a temporary nature. In relation to labour supply, the professional nurse shortage is perceived to be a temporary issue rather than a long term one. This is supported by the two year length of the employment contracts awarded to non-citizen professional nurses at GPH. With increased enrolment in training institutions, the Botswana government expects to reduce the supply for 'contingent' professional nurses. However the efficacy of such a perspective is questionable as locally trained professional nurses are emigrating to better paying institutions outside Botswana.

The engagement of non-citizen professional nurses has led to an exploitation of the 'social divide' of citizenship status. In theory, contingent workers are cheaper to employ than permanent ones. Therefore the increased use of contingent workers theoretically drives down labour costs for GPH. Furthermore, non-citizen professional nurses are not in a position "to place excessive demands and politically effective expectations about *their* needs for the means of subsistence" (Offe and Hinrichs, 1985:36-7). In fact, the contingent professional nurses act as a safety valve for the labour market. Should there be a boom in local supply in the near future; non-citizen professional nurses would be the most affected group of workers as the key condition of their engagement is a local supply shortage. It is for such a reason that Peck (2000:232) sees the engagement of contingent workers as a means of 'social regulation'.

3.4.3 State Intervention

The state carries a key role in shaping the external environment by coordinating the dynamics between demand and supply (Thompson and McHugh, 1990:111; Peck, 2000:233). The state is often recognised in its political and economic capacities yet its social trait is often left wanting (Thompson and McHugh, 1990:112). The state functions within the global market by setting out "the requirements of capital accumulation and reproduction" (Thompson and McHugh, 1990:113). In other words, the state creates a setting for prosperous capital accumulation to facilitate social welfare development. It is for this reason that the state is highly dependent on "capital accumulation for its economic resources" (Thompson and McHugh, 1990:113). However, it also has to balance this out with social pressures that may contradict capital accumulation interests.

The state has to formulate active labour market policies and programmes aimed at maximizing the quality of employment (Ramos, Surinach and Artis, 2009:1). Examples of this would in the Botswana context are the Non-Citizens' Employment Act and the Manpower and Localization Policies. These are aimed at enriching the local supply of labour by improving the quantity and quality of labour supply and altering its distribution (Barker, 2003:27; Peck, 2000:224). This is a clear example of developing structures which aid in the compensation for the inability of the market to meet social needs to maintain public legitimacy (Thompson and McHugh, 1990:114; Peck, 2000:224).

Botswana offers a case study of how state intervention in the name of economic nationalism and fair discrimination can influence labour supply into the labour market. In 1966 when Botswana became an independent republic, there was an acute awareness of a skilled manpower shortage. The shortage was attributed to the minimal investment into education by the colonial government (Acemoglu *et al* 2001:2). As a result most skilled jobs were staffed with non-citizen workers (Hope, 1995:53). In an effort to solve this problem, the Localization Policy was promulgated in 1966 (Hope, 1995:59). Localization refers to the process of substituting non-citizen held offices with Botswana. Although the Localization Policy was initially intended for the public sector, progressively there has been a push to localize the private sector as well. Localization is the means by which the Botswana government is empowering and developing its citizens through its economy.

As was previously pointed out, the labour market is a vehicle through which a nation's resources are distributed among its populace (Barker, 2003:13). It is therefore within the government's interests to have as many citizens as possible entering the labour market. In addition, increased citizen employment contributes towards nation building. In Botswana there were four main triggers that called for economic nationalism (Hope, 1995:59). The first trigger was its pre-colonial legacy of an underdeveloped economy which also pointed towards an economically disempowered population. The second trigger was non-citizen worker-led economic development as a result of a local lack of skilled manpower. Such development has two negative impacts on Botswana. Non-citizen skilled manpower was a great expense for the government thus making it difficult to sustain. The third trigger was the need to mobilize its citizenry for the promotion, protection and preservation of Botswana. Lastly, was the need to grow and maintain an internationally recognized competitive edge.

In line with the Localization Policy, employment and manpower development legislation and policies were promulgated to ensure that resources were distributed to citizens. The enactment of citizen empowerment has led to fair discrimination in favour of citizens within the labour markets. The practise of fair discrimination has become a necessity as a means of transferring economic empowerment from non-citizen to citizen workers (Government Paper No. 1, 1990:5). The groundwork for fair discrimination has been set out by the state restricting the supply and demand of non-citizen workers. Clear evidence of this is presented in s4 of the Employment of Non-Citizens' Act¹⁸. For example, s4 (1) qualifies the conditions under which a non-citizen may be employed thus restricting their supply into the labour market. In addition, s4 (2) sets out the conditions under which an employer may hire a non-citizen worker thus restricting demand for non-citizen workers. Other than this Act, is the arduous process of applying for a work permit. Although the state is assigned with the role of managing the labour market dynamics, its intervention is often labelled as a "flawed and sometimes haphazard process" (Peck, 2000:234). This is attributed to how the process is at times informed by inadequate analyses and prescriptions. In addition, state intervention tends to be of a lagged nature. This has often led to lagged responses and unforeseen consequences like marginalisation of some groups of workers. As a result, state intervention is not entirely rational.

This research puts forward the argument that the labour market exists in clusters rather than a single entity (Rubery, 1992: 246). It is for this reason that state intervention tends to have unintended consequences (Peck, 2000:234). Different labour markets have different needs therefore it is reasonable to have fair discriminatory practices in labour markets that are highly populated by Non-Citizens' but also has a sufficient local supply of manpower.

¹⁷ 4. Control of employment, etc., of non-citizens

(1) No non-citizen shall engage in any occupation for reward or profit unless-

(a) he is the holder of a work permit issued to him under this Act permitting him to be employed or to engage in and he is employed or otherwise so engaged in accordance with the terms thereof and the conditions, if any, attached thereto; or

(b) he is the holder of a certificate of exemption issued to him under this Act.

(2) No person shall employ a non-citizen unless-

(a) the non-citizen is the holder of a work permit issued to him under this Act permitting him to be employed and he is employed in accordance with the terms thereof and the conditions, if any, attached thereto; or

(b) the non-citizen is the holder of a certificate of exemption issued to him under this Act.

(3) Any person who contravenes this section shall be guilty of an offence and liable to a fine not exceeding P1 000 or to imprisonment for a term not exceeding 12 months, or to both.

(4) Where, in any proceedings for an offence under this section, it is alleged in the charge that an accused or any other person was at a time specified therein a non-citizen, the court shall presume that he was at that time a non-citizen unless the contrary is proved.

However, this is not the case in the GPH context as the local professional nurse supply is insufficient. This shortage is alleviated but not solved by non-citizen professional nurses. Therefore this research argues that it is not rational to have the very same controls in labour markets which do not exhibit the same traits.

3.4.4. Horizontal Labour Market Segmentation among Professional Nurses

It has been argued that the hiring of non-citizen professional nurses has led to horizontal labour market segmentation since non-citizen nurses were allegedly paid more than local nurses (BOPA, 2001). If the non-citizen nurses hold better qualifications and more work experience, then it is possible that they could be paid more than local nurses. However, since the report did not consider such variables, it is not conclusive. Nonetheless, when the historical context of Botswana's labour market is examined, the argument for a horizontally segmented labour market holds some validity. There is evidence that reveals a horizontally segmented labour market in favour of Non-Citizens', which is rooted, in Botswana's historical context as the following subsection shall illustrate this.

As was previously mentioned, post-independence Botswana was characterised by poor infrastructural resources (Acemoglu, Johnson and Robinson, 2001:1; Kiiza, 2006:6). Consequently, there was a major deficit in the local skills base (Somolekae, 1998:118; Mpabanga, 2004:30; Gwebu, 2006:200). As Somolekae (1998:118) points out: "there was a dual need for localization and training". However, this was not feasible because Botswana lacked skilled citizen personnel to train other citizen workers. So, "from the 1980s to the 1990s, Botswana had an open migration policy intended to attract qualified human resources ... The immigrants were granted incentives in the form of competitive salaries" (Gwebu, 2006:200). Similarly, Mogalakwe (1997:62) notes that the people who earned the highest salaries were mostly Non-Citizens'. This was made possible by the high demand for skilled labour, which created job opportunities, especially in the service sector (Gwebu, 2006:194). The Botswana government played a major role in the creation of demand for and supply of non-citizen skilled labour. Although the Botswana economy grew, it was at the cost of social equity amongst its citizens (Mogalakwe, 1997:62).

Conversely, it has been argued that there was indeed horizontal labour market segmentation, but in the favour of citizen professional nurses. In fact, Nyamnjoh (2006:2) argues that both

skilled and unskilled non-citizen workers are subjected to exploitation. This is evidenced by the fact that they are paid lower wages, are subjected to poor working conditions, have poorer opportunities for promotion and lack the protection of labour laws. In as much as the system of hiring non-citizen skilled labour played a key role in the growth of the Botswana economy, the government had the foresight to identify it as a non-sustainable system (Gwebu, 2006: 200). This led to the government taking a lead role in training and developing local skills (Mpabanga: 2004:30). A manifestation of this move is the development and enactment of various training and localization policies. These policies offer guidance on how organisations may train and develop local employees through in-service training, which is facilitated by the practice of having citizen under-studies to non-citizen workers (Mpabanga, 2004: 30; Gwebu, 2006: 200; Maipose, 2009: 115). In addition, Government Paper 1 of 2001 on Citizen Entrepreneur Mortgage Assistance Equity Fund (CEMAEF) explicitly states that the

government is committed to citizen economic empowerment as evidenced by a number of programmes and policies that have been put in place ... Although the programmes and policies are not specifically referred to as citizen economic empowerment policies ... They are to all intents and purposes, solid citizen economic empowerment tools.

Economic empowerment can only come about if there are economic opportunities. According to Government Paper No. 2 of 1982 on National Policy on Economic Opportunities, economic opportunities are “a process by which each Botswana has to utilise Botswana’s national resources to improve his [sic] living standard by his [sic] own effort”. This description reflects a theme of economic nationalism, which is confirmed by the various policies and legislations to be analysed below. Somolekae (1998:119) describes localization as a process that “involves some transformation not just in numbers of foreign versus locals but transformation of a colonial public service into an indigenous one”. This localization and training process was not restricted to the government sectors, but also applied to the parastatal and private sectors (Somolekae, 1998: 118; Mpabanga, 2004:30). The government also sought to acquire and retain highly skilled labour in all industries. As a result, private and parastatal firms are subject to wage restraint

as a means of facilitating economic growth and promoting social harmony and social justice, by expanding employment opportunities, preventing the widening of income disparities between urban

and rural areas, and between rich and poor, as well as maintaining Botswana's competitive advantages vis-à-vis its trading partners (Government Paper No. 1, 1990:5).

The above quote is the government's justification for wage restraint policies. As a result, wages of professional nurses in the private sector are inevitably less than those of professional nurses in the government sector. This disparity in wages between the government and private sector could account for the high percentage of non-citizen professional nurses at GPH. Citizen professional nurses are most likely to work in the government sector as higher wages acts as a pull factor. This results in the creation of demand for non-citizen professional nurses in the private health sector. It also means that non-citizen professional nurses in the private sector earn less than the professional nurses (irrespective of citizenship) in the government sector.

During the course of the training and localization process, there was a shift from the "preceding open policy to a restrictive protectionist immigration policy ... Self-sufficiency in human resources led to the progressive curtailment of fringe benefits and non-renewals of non-citizen contracts" (Gwebu, 2006:200). Proof of restrictive and protectionist measures taken against non-citizen skilled workers is section (5) (6) in The Employment of Non-Citizens' Act 19 of 1992¹⁹. The 1990s witnessed a rise in nationalism in Botswana. Gwebu (2006: 265) notes that Botswana citizens felt "very strongly about their national identity and citizenship rights: most respondents suspected temporary immigrants of wanting only to exploit Botswana's financial resources". Somolekae (1998:119) echoes similar sentiments of nationalism by describing localization as "an extraordinary important process for any country on the verge of embarking on a process of socio-economic development".

However, in the face of a global professional nurse shortage, government hospitals still contract non-citizen staff. To offset the professional nursing skill shortage, non-citizen nurses from various destinations like Southern Africa, Latin America and Asia have been hired to staff the urban and rural health institutions (Baputiki, 2009). In 2000, BOPA (2000)

¹⁹ (6) For the purpose of determining an application placed before it in accordance with subsection (1), the Board shall take into account - (a) the effect of issuing a work permit or renewing the existing work permit upon the opportunities for employment or for other engagement for reward or profit in the occupation in question, as the case may be, open to citizens of Botswana; and (b) where the application relates to employment, the arrangements made or to be made by the employer to train a citizen of Botswana to replace the person in respect of whom the application is made in the event of a work permit being issued to him or his existing work permit being renewed.

published that just over 90 per cent of the GPH nursing staff were not Botswana citizens. The employment of non-citizen nurses has brought about implications for service delivery and the local nursing labour market. With regard to service delivery, it has been argued that non-citizen nurses offer inferior service delivery, especially in less developed areas (BOPA, 2001). This is attributed to their inability to speak local dialects. Consequently, they do not understand local patients who cannot converse in English (BOPA, 2001). However, this issue is not a focus area to this research.

3.5 CONCLUSION

Chapter three has depicted the external factors that have influenced the manner in which FFM is practiced at GPH. This feat was carried by firstly laying out Botswana's economic history. Botswana's economic history illustrates how the demand for non-citizen skilled labour was created. This relates to the study because it explains the presence of non-citizen professional nurses at GPH. Secondly, by showing how Botswana has also been affected by the global professional nurse shortage. The migration of Botswana professional nurses to better paying contexts had further deepened the demand for non-citizen professional nurses. In relation to the study, it also explains the presence of non-citizen professional nurses at GPH. Horizontal labour market segmentation among professional nurses underscores the necessity for the socio-economic empowerment of Botswana. The foundations of citizen socio-economic empowerment are enacted through labour laws and policies which have legitimised the practice of FFM along lines of citizenship status. In relation to the study, it explains why the majority of the professional nurses at GPH are Non-Citizens'.

CHAPTER FOUR

4.0 RESEARCH DESIGN

4.1 INTRODUCTION

This chapter provides an outline of how the study was planned, conducted and analysed. This section will describe how this study was carried out by looking at important factors such as the time plan, the type of data collected and the strategies used to collect the data. A description of encounters experienced by the researcher within the field will also be explored. These encounters influenced the manner in which the data was collected. Problems were encountered especially with regard to the questionnaires. These encounters show the importance of 'flexibility' within a research design. Key aspects such as the nature of the study, methods of data collection, field encounters and background and context will be focused on.

With regard to the nature of research, the research objective plays a key role in determining its methodology. The central objective of this research is to examine the impact of FFM on 'dependent contractors' (non-citizen professional nurses) in terms of career development, and representation and participation within the GPH context. To fulfil the central objective, three key themes will be explored in relation the study. The first theme is the nature of the employment relationship of non-citizen professional nurses. The second theme is on career development opportunities for non-citizen professional. The third theme on the efficacy of representation and participation available to the non-citizen professional nurses.

The case study approach was relevant to the objective of this research, which was to examine the impact of FFM on non-citizen professional nurses at GPH. The background information provided in the previous chapter provided an overview of the external environment within which the case study of GPH would be carried out. The global professional nurse shortage plays a role in explaining why GPH a great majority on non-citizen staff in its employ.

4.2 RESEARCH OBJECTIVES

Derived from the research title is the main objective; to uncover and critically analyse the disempowering traits of the practice of FFM. The concept of worker disempowerment is broken down into: the nature of the employment relationship; a poor career development; and a weak worker voice. These are the three components by which this study is guided. Focus is placed on a specific type of worker; the dependent contractor. Non-citizen professional nurses are categorized as dependent contractors. The nature of the employment relationship is assessed to identify its disempowering qualities for the non-citizen professional nurses at GPH. Thereafter, the implications of the nature of the employment relationship on career development and the worker voice are considered.

4.3 NATURE OF THE STUDY

4.3.1 A Case Study Approach

This research adopted a case study approach to fulfil its central objectives. It was deemed most appropriate as the study focuses on how the practice of FFM has influenced the previously mentioned components negatively. Furthermore, a case study approach deals with real life contexts. Therefore it may be used as a tool to generate practical knowledge. Case studies have on occasion been criticised for being narrowly focused. As a result, the knowledge generated cannot be generalised. However, this particular study does not seek to generate such knowledge. Within the case study approach three tools were used and these were questionnaires, in-depth interviews and document analysis. These tools shall be discussed in greater detail at a later stage in this chapter. The primary units of analysis are the non-citizen professional nurses as it their experiences and opinions that play a crucial role in fulfilling themes on career development opportunities and the efficacy of representation and participation. The secondary units of analysis are documents which entail the employment contract, legislation and hospital pamphlets issued out to professional nursing staff. Documentation serves the role of confirming and/or refuting the experiences and opinions of non-citizen professional nurses.

From the literature review, the common thread of worker disempowerment runs through all the themes. This study argues that as a result of the ambiguous nature of the employment

relationship, the dependent contractor is disempowered as the worker rights and benefits they can claim from their employer also become unclear. They are also not in a position to place excessive demands on their employers. To confirm or refute this theme, the employment contract and labour legislation and policies have a primary role. The experiences and opinions of the non-citizen professional nurses will have a supplementary function. In relation to the study, the ambiguous nature of the employment relationship enforces the practice of FFM. Especially in instances where management is presented with opportunities of reducing labour costs by choosing which rights and duties to fulfil.

Expanding on the first theme, the second theme argues that as a result of the ambiguous employment relationship, career development is negatively impacted on. The negative impact on career development contributes towards the non-citizen professional nurses' disempowerment. Non-citizen professional nurses' experiences and opinions are the key source of data. Document analysis will also be carried out to examine the available portals for opportunities. Relating the second theme to the study, issue like localisation, tenure, Performance Management, and opportunities for study will be tied back to career development. It will be argued that disempowerment in the form of poor career development opportunities is facilitated through the practice of FFM.

Still, rooted in the first theme, the third theme questions the efficacy of representation and participation available to non-citizen professional nurses. As dependent contractors, non-citizen professional nurses are not eligible to enter trade unions. Nonetheless, other options like communicative involvement and work councils act as tools through which they can express their worker voice. Non-citizen professional nurses' experiences and opinions and document analysis will be employed. This study argues that the available tools for expressing the worker voice are not effective as a result of the insecurity that the ambiguous employment presents to the non-citizen professional nurses.

4.4 DATA COLLECTION AND EVALUATION

When it comes to data collection and evaluation, several important factors have to be considered. These factors include identifying the respondents to participate in the research, ways in which to reach them, the methods used to collect the data, and how that data will be

evaluated and analysed. The data was collected within one month. The breakdown of data collection will be discussed in the following sub-sections.

4.4.1 Research Participation and Ethical Issues

It is of the utmost importance to gain informed consent from the respondents (Neuman, 1997; Harvey and MacDonald, 1993; Babbie and Mouton, 2002:520). A failure to disclose the objectives of the research to the respondents may result in a reluctance to participate. Full disclosure may result in gaining the respondents' trust and co-operation. A gatekeeper was essential to gain access to the relevant population. It was through the gatekeeper that the respondents' consent, trust and co-operation were gained. This research delved into the respondents' professional lives and misuse of any data collected may have placed a potential threat on their livelihoods. It is for this reason that the researcher has an ethical obligation to the respondents. The researcher needs to ensure that the participants' "rights, privacy and welfare" are protected (Berg, 2007:53). In terms of this research, the respondents were assured of protection through anonymity and confidentiality of any data they entrusted to the researcher.

Bearing in mind that this research was aimed at the generation of a social understanding of organizational phenomena, there was no need for a sampling frame (Harvey and MacDonald, 1993:119). In addition, there had been no recent research carried out that would have given an indication of the total number GPH employees and the various categories they fall into. As a result, non-random sampling was used to locate respondents. Snowball sampling was used to locate the sample subjects through the gatekeeper. The gatekeeper directed the researcher to other participants within her network of work colleagues. In this manner, the researcher was able to locate more non-citizen professional nurses to participate in the study.

4.4.2 Document Analysis

The first week in the field was spent collecting data that would depict the context of GPH (Harvey and MacDonald, 1993:29). Newspaper articles were used as a secondary data source in relation to collecting information about GPH. The data was derived from local newspapers like Mmegi, the Botswana Press Agency (BOPA) and the Sunday Standard. The

media offered a readily available source of information on GPH as an organisation. The newspaper articles also contributed towards the refining of the questionnaire and interview schedules. By presenting facts about GPH, the questionnaire and interview schedules were then further contextualised to suit the respective respondents within or connected to the organisation.

The main potential problem faced with regard to information gained through the media is the issue of content bias (Harvey and MacDonald, 1993:45). In an attempt to overcome this problem, a critical analysis of the various articles was carried out. Two main aspects were analysed and these were the relationship between the media and GPH. The second aspect was the wider context within which the media and GPH exist. The relationship between the media and GPH was analysed by looking at the connotations that the article conveyed (Harvey and MacDonald, 1993:43-6). The levels of positive or negative reporting hint towards the objectivity of reporting where GPH is concerned. The wider context within which the media and GPH exist is viewed by looking at whether the media reporting is factual reporting, agenda setting or is a mere reflection of dominant ideological messages (Harvey and MacDonald, 1993:44).

As revealed by the various articles pertaining to GPH, the reporting was deemed as being objective in nature. However, looking at the wider context, a seemingly less positive picture is painted. From the late 1990s, Botswana have become increasingly intolerant of Non-Citizens' (Campbell and Ouch, 2003:2; Nyamnjoh, 2002:756). This intolerance is based on the unsubstantiated fear of competing with Non-Citizens' for scarce resources (Campbell and Ouch, 2003:13; Lesetedi and Modie-Moroka, 2007:3). However, it has been noted that foreign investors are welcome as a means of job creation. GPH is owned by the Life Group, a non-Motswana owned group of companies. In the face of skills shortages in Botswana, GPH has taken to employing mostly non-Batswana nurses (Chwaane, 2008; Baputaki, 2009; BOPA 2000; Lesetedi and Modie-Moroka, 2007:3). Despite the highly nationalistic attitude reflected by society, the media appears to be factual in its reporting.

Other important sources of data include work contracts, information booklets, employee guide manuals, charts and hospital policies. Through these sources, some of the data obtained in the questionnaires and interviews was validated. Secondly, detailed data on some aspects like employee evaluation and managerial systems was supplied, thus providing a

good foundation for in-depth content analysis. Lastly, the information obtained from the content analysis could be used as a comparative tool between theory and reality of the organizational dynamics at GPH.

4.4.3 Questionnaires

In the previous section, reference was made to the fact that this research is qualitative and quantitative. In this section, the quantitative aspects of the data collection will be discussed. The quantitative feature in this research was the use of questionnaires in the collection of some of the primary data. The questionnaire itself was not wholly quantitative in nature as it also contained self-completion questions whose responses may not necessarily be quantified as is the case with closed-ended questions.

Questionnaires are often used to collect quantifiable data like demographic traits (Harvey and MacDonald, 1993:101). Skeletal frames of the questionnaire had been constructed before going into the field, but were later refined during the first week in the field to ensure that the questions were contextually correct. The refined questionnaire had 36 questions. The questionnaires were then distributed through the gatekeeper during the second week and collected in the third week. Within the context of this research, the questionnaire served several purposes. It served the primary role of collecting measurable data like the respondents' traits like, nationality and years of work experience. More importantly, it provided a pilot study for the in-depth interviews. It was through the questionnaires that the researcher was able to pinpoint issues that the employees perceived to be sensitive. This point will be further expanded in the following section.

Self-completion questionnaires were used. A mixture of open and closed questions made up the questionnaire. The closed questions had pre-coded answers that were entered into a data file using Microsoft Excel. This was with the aim of turning the raw data from the questionnaires into a more presentable form; namely, data records (Neuman, 1997: 295). Within this program data tables and graphs were constructed to depict the data collected. However, the construction of tables and graphs was only possible for the pre-coded data.

A positivist take on research is not without its weaknesses. For example, with regard to the questionnaire as a tool for data collection, closed-ended questions tend to narrow the spectrum through which the respondents may express themselves. The pre-coded nature of closed-ended questionnaires thus leads to a loss of vital information. Furthermore, it does not allow for the explanation of answers. Respondents may, for instance, provide the same response but for different reasons. Therefore, this weakness leaves room for misinterpretation of data. With regard to this research, the researcher attempted to counter this weakness by including open-ended questions that encouraged the respondents to provide reasons for the answers given in the closed-ended questions.

The tendency for some respondents not to answer all the questions presented a major problem in the data collection of the self-administered questionnaires. This was the case for most open-ended questions. Furthermore, because of the anonymous nature of participation the researcher could not re-visit the respondents to question their failure to respond to some questions. The lack of response is then left to various interpretations, some of which may be incorrect. For example, some of the respondents may not have understood the question itself and may have needed the question to be explained, the question may have been too sensitive to answer, or the respondents may have been pressed for time and may simply have found it easier to only fill in the closed-ended questions. Although this presented a potential problem, it was instead turned into a positive as it pointed to issues that could be probed for in the in-depth interviews. What led to this realization was that the questions not answered by the respondents followed a similar pattern.

Another major problem was the issue of representivity, especially in terms of demographic traits and nationality. The busy nature of the nursing profession needed to be taken into account. As a result, the questionnaires were not a proportional representation of the hospital nursing staff. However, they do offer a good insight into the GPH context and aid in the general identification of major issues pertinent to this research.

4.4.4 Interviews

The qualitative aspect of this research was manifested through the in-depth interviews. The researcher administered the interviews with the aim of countering the fact that the researcher

was not able to administer the questionnaire and would be able to probe further for some of the questions that were not answered in the questionnaire. Hence, in-depth interviews are a depiction/manifestation of the realist epistemic take on research. This study puts forward that the context within which FFM is implemented at has disempowering effects on non-citizen professional nurses. The context is shaped by the global shortage of professional nurses and the Botswana's socio-economic setting. The use of in-depth interviews as a data collection tool provided insight on how non-citizen professional nurses related to their work environment.

As alluded to in the previous paragraph, in-depth interviews countered the weaknesses in the questionnaire. The in-depth interviews were carried out in the fourth week after a great majority (94 per cent) of the questionnaires had been returned during the third week. This delay was aimed at identifying issues from the questionnaires that could be further investigated through the in-depth interview. Before going out in the field, a skeletal frame of the interview schedule had been constructed. The newspaper articles and the questionnaires contributed towards the filling out the skeletal frame of the interview schedule. Four interview schedules were constructed. These were aimed at the HR officer of GPH, the nursing staff, the satellite clinics and the nursing agency owner. From the nursing staff, respondents occupying different nursing positions or statuses were selected. These included unit managers, deputy unit managers, ordinary nurses from different wards, nurses from nursing agencies and former staff. The objective was to obtain as much data from a variety of different sources for a comprehensive comparative analysis.

Once the respondents' trust has been gained it must be maintained. Through various interactions with potential respondents, the realization came that the phrasing of some questions in the interview schedule may lead to the generation of suspicion. This meant that the questions had to be rephrased in a manner that would ensure that the essence of the question would not be lost and the relevant information that the question sought would be obtained. This was done by giving a group of questions a short introduction, an example of this is shown below.

1. For the survival of any business be it factory, a hotel or in this case, a hospital - that business needs to be responsive to its external environment in terms of tax, labour laws or policies, technology and even local culture. To be able to do this the business

has to go through a constant restructuring process to improve competitiveness (Lee and Clarke, 1999).

- a. With this in mind, how does GPH as a company go about informing you, its staff, about implementing a restructuring exercise?
- b. How does this differ from the last hospital you worked in?
- c. Were you working here in 2003?

If yes, according to the Botswana Press Agency (10 December 2003), 110 employees were retrenched to reduce operating costs.

- d. Do you know how management determined who could go and who could stay? Did they use any particular system (e.g. last-in-first-out or those who were close to retirement age were asked to leave)?
- e. Were other options like wages-cuts or flexi-work offered in place of retrenchment?
- f. In relation to the last question, how did the retrenchments affect the remaining staff? Were new positions created? Were old positions done away with or consolidated?

Although the short introduction made the interview and questions longer, it made the interview less threatening and the questions more comprehensive. Moreover, the introduction leading to the questions served several roles. It relieved the respondents from the anxiety of failing to answer any questions asked. Secondly, it gave the respondents a depiction of the context within which the question was asked thus encouraging relevant responses. Lastly, it gave the respondents the opportunity think out their answers before providing a response.

As shown above, most of the questions were open-ended. There were several instances where there was unscheduled probing to steer the respondents into providing relevant answers to the questions asked or further exploration of a given answer. The interviews were recorded on a digital recorder with the respondents' express permission and were later

imported into NVivo8 for transcription purposes²⁰. Twelve respondents were interviewed. Nine of the respondents are professional nurses and three of the respondents fall into the managerial ranks. Eight of the professional nurses interviewed are Non-Citizens' and only one is a Motswana. The Human Resource Manager, a Motswana was also interviewed.

4.5 CONCLUSION

Chapter 4 has set out the manner in which the study was conducted. In doing so, the research objectives were clearly outlined to show the parameters of the study. The research objectives also alluded to the use of a case study approach. Some advantages and disadvantages of the case study approach were briefly mentioned. However, it was concluded that the objectives of the study legitimated the use of a case study approach. Data collection and evaluation were also discussed to show the specific tools that this study employed. These were document analysis, questionnaires and interviews. Lastly, research participation and ethics were discussed to show the researcher's consciousness of participants' right to privacy and their welfare.

²⁰ NVivo8 is a software program designed to aid in the analysis of qualitative data. One of its various functions includes transcription software that allows the transcriber to reduce the speed of the conversation to facilitate accurate transcription of the interview.

CHAPTER 5

5.0 AN AMBIGUOUS EMPLOYMENT RELATIONSHIP FOR DEPENDENT CONTRACTORS

5.1 INTRODUCTION

This chapter puts forward that as a result of the ambiguous nature of the employment relationship, the dependent contractor is disempowered as the worker rights and benefits they can claim from their employer also become unclear. Firstly, this chapter shall justify why this study has labelled non-citizen professional nurses at GPH as dependent contractors. Secondly, the aspects of the employment relation that make it ambiguous shall be identified. Then it shall proceed to illustrate how the identified aspects lead to the disempowerment of the non-citizen professional nurses. The data used to justify this chapter's central argument will be extrapolated from documentation, the questionnaires and the in-depth interviews.

5.2 NON-CITIZEN PROFESSIONAL NURSES EMPLOYED AS DEPENDENT CONTRACTORS AT GABORONE PRIVATE HOSPITAL

Bearing in mind that there is a [citizen] professional nurse shortage and the government is in the process of localising²¹ all non-citizen held positions, non-citizen professional nurses cannot be hired as permanent staff in any hospital in Botswana. So, to ease the [citizen] professional shortage, non-citizen professional nurses are contracted to supply their labour in the fulfilment of the services that GPH offers. This is reflective of what Cappelli (2006:182) described as reliance on the external labour market. In chapter two, it was found that the Botswana labour laws did not distinguish between dependent and independent contractors. This study argues that non-citizen professional nurses at GPH are dependent contractors because they are economically dependent on the income that they receive from the hospital.

²¹ The Employment Of Non-Citizens' Act

(6) for the purpose of determining an application placed before it in accordance with Subsection (1), the board shall take into account-

(b) where the application relates to employment, the arrangements made or to be made by the employer to train a citizen of Botswana to replace the person in respect of whom the application is made in the event of a work permit being issued to him or his existing work permit being renewed.

To support this claim is s11 of the Employment Contract²² which claims exclusivity over the non-citizen professional nurses.

In chapter three, this study established that Botswana was also affected by the global professional nurse shortage. It was also established that the citizen professional nurses were more likely to work for government hospitals than private hospitals. It was also established that in 2000, a vast majority of the professional nurses at GPH were not Batswana. Because of the policy on wage restraint, parastatal and private organisations were not in an environment where they could offer better packages than the government. So government hospitals offered better wages than private hospitals. To sustain this argument, Mr Motsopa, the Human Resources Manager, stated the following:

The global nurses' shortage is compounded by the mere fact that when Botswana started the nursing school, it was only looking after itself. There was nobody who was having a private nursing hospital. So now we see this as a huge development where private hospitals are coming into Botswana and this huge shortage of nurses because we now tend to get those trained nurses from government. And government has also expanded their facilities and as such they put the strain on themselves as well because these facilities don't have nurses. So generally, there's a shortage. UK was recruiting, US was recruiting [and], Australia was recruiting. I can cite a few of the nurses who left us here to go to those countries. So there is a serious shortage of nurses. I guess we're all in the same boat in terms of nursing availability. So, the one who pays the best is the one who will take the nurses.

Mr Motsopa provided an insight on how the global professional nursing shortage had affected Botswana and more specifically GPH. As a corporate organisational structure, GPH was faced with the key objective of improving organisational efficiency at reduced costs. In this case, the wage restraint policy played a key role in reducing labour costs.

²² Section 11 of the Employment Contract

During the continuance of this Agreement the Employee will:

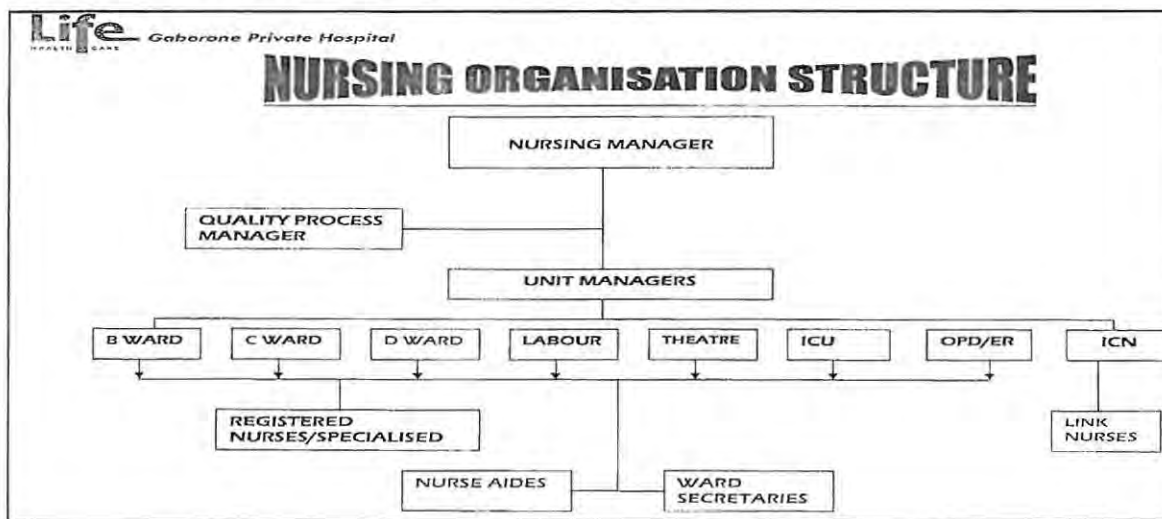
11.1 well and faithfully serve the Employer in such capacity as aforesaid and will at all times devote his full and whole attention to his duties hereunder and shall not during the continuance of this Agreement be engaged or interested either directly or indirectly in any capacity whatsoever other than business of the Employer to which he has been appointed;

11.2 be true and faithful to the Employer in all dealing and transaction whatsoever relating to the Employer's business.

5.2.1 FUNCTIONAL AND NUMERICAL FLEXIBILITIES AT GABORONE PRIVATE HOSPITAL

The shortage of citizen professional nurses at GPH created a demand for non-citizen professional nurses. To attain functional flexibility, non-citizen professional nurses were contracted to fulfil core functions of the hospital. Core functions are firm specific functions. Relating this to the GPH context, firm specific functions were the health care services on offer. Figure 1 depicts the professional nurse organisation structure. It also depicts the firm specific functions and roles for professional nurses are required.

Figure 1 The Nursing Organisational Structure



The different services offered by GPH are also depicted by the different departments that Figure 1 shows. Each of these departments represented a core function that required manpower. Table 1 indicates that a great majority of the professional nurses who took part in the questionnaire study had more than one qualification. The only Motswana to take part in this study held one qualification, a diploma in general nursing. This signified that in the recruiting of non-citizen professional nurses at GPH, those most likely to be hired hold two or more qualifications. More evidence is presented by respondent I:

...these are staff that was hired because they were very, very experienced. And some of them had been 'in-charges' wherever they had come from and they know how to manage.

This translated into functional flexibility as the non-citizen professional nurses are able to work in more than one ward. However, the capacity to work in different wards is dependent on whether or not that particular qualification has been registered with the Botswana Nursing and Mid-Wifery Council (BNMC).²³

Table 1 Number of Qualifications

Number Of Qualifications	Frequency	Percentage
1	10	30
2	19	58
3	2	6
4	2	6
Total	33	100

In addition to functional flexibility, numerical flexibility was sought, even more so in the face of professional nurse shortages. The strategies that were carried out to induce numerical flexibility included the overtime system, flexi-time and the engagement of agency professional nurses. Respondent I described the overtime system as follows:

Like the day you are off duty, if there is a need for an extra member of staff, they [management] will call you.

Respondent F problematized the practice of flexi-time:

But the problem with flexi-hours is that you wouldn't see the difference since you are on a contract you know the pay would [be] there anyway, whether you were at home or not. It wouldn't mean that you get less money if you work less hours or if you work more hours. The only place that flexing would help would be if you have fewer patients, then those nurses can be off when you are not too busy and when it's busy you write them in. but the hours will be correlating

From respondent F's statement, it appeared that flexi-work was aimed more towards numerical flexibility rather than functional and financial flexibilities. By calling in on-call professional nurses to work the immediate gain was numerical flexibility. Plus, the hospital reduces extra labour costs as the demand for agency professional nurses is significantly lessened. Although the overtime system sounded similar to flexi-work, GPH was bound by its employment contract. Therefore, it did not have the liberty to change its remuneration

²³ Section 8 of the Nurses and Midwives Act of Botswana.

methods where flexi-time was concerned. On the other hand, with the over-time system, the professional nurses got an overtime allowance.

Another measure taken to supplement the numerical flexibility was the use of agency professional nurses. The shortage of professional nurses in Botswana had led to the creation of a demand for agency professional nurses in government as well as the private sectors. According to Sister H (a former GPH employee), who owned and ran a nursing agency, she supplied professional nurses to GPH, government hospitals, private clinics and private homecare. Sister H employed both Botswana and Non-Citizens' professional nurses. She stated that her agency bridged the gap between health institutions and the external labour market. In fact, she noted that GPH was her biggest client. The use of agency professional nurses in the GPH context appeared to serve two roles. Firstly, it was a coping strategy through numerical flexibility. Secondly, it contributed towards increasing production at a low costs thus encouraging financial flexibility.

5.3 THE IMPACT OF THE [STAFF OR PERSONNEL] SHORTAGE ON NUMERICAL AND FUNCTIONAL FLEXIBILITIES

The last section mapped out a rationale for the hiring of non-citizen professional nurses as dependent contractors. This section argues that GPH faced a shortage despite contracting non-citizen professional nurses as dependent contractors. Since GPH was faced with a shortage this study argues that functional and numerical flexibilities were not fully attainable. The substantiation of this is in how GPH streamlined its services. To illustrate this claim, the following sub-sections will discuss how GPH has streamlined its services through role revision, the organisational structure and services offered.

5.3.1 Role Revision and Clinical Care

This section aims to trace how streamlining has influenced the roles that professional nurses have had to shed and/or take on. In addition, the major implications of role revision and clinical care will be weighed against the levels of functional and numerical flexibilities. To fulfil these objectives, the changes that have come about as a result of the 2003 restructuring exercise will be identified. Secondly, the issue of nursing skills shortage was taken into

account with regard to role revision. Also, as an outcome of organisational restructuring, the changes in work practices were also taken into account.

As mentioned before, in 2003 GPH underwent a downscaling exercise in which 110 employees were retrenched (BOPA, 2003). Although just under a quarter of them were professional nurses, their retrenchment bore more significance than that of the clerical and administrative staff. Because professional nurses have firm-specific skills, they were the main vehicle through which GPH delivered its services. The major changes that this research uncovered were the long-term scaling down of operations, removal of senior posts and changes in work practices.

The downscaling of operations meant that certain wards and those who staffed them were directly affected:

They looked at the clientele as well. They reduced the number of beds...So, which meant some wards had to close (Respondent B)

The above quote correlated with the press report that GPH had experienced a drastic drop in demand and was forced to downscale its operations (BOPA, 2003). The downscaling of operations suggested a need to reduce labour costs. When asked about the system used to retrench professional nurses, most respondents who were employed at GPH in 2003 stated that it was the last-in-first-out system. It appears that this was in addition to other means:

People would volunteer, if you wanted to retire...And if that didn't work, then it was 'last-in-first-out' (Respondent F)

If an employee was a good employee, does her work well and has been there for quite a long time, they were not affected. But if you were a new employee, whether you were good or whatever, you were the ones who were targeted (Respondent I).

The HR manager, Mr Motsopa stated:

Obviously the labour legislation dictates if you want to retrench labour what method you should follow. In our case, we could not follow that method 100 per cent. We could do it on the clerical side but we could not do it on professional staff, like nurses because it gets into the context of the attitudes of individuals. So, we had to put that into perspective, the quality of the service that the individual

provides. You might be having the same qualifications but you might not be performing at the same level. So, we were forced to retain the best possible candidates that we wanted to keep. Based on those criteria, not necessarily based on the first-in-last-out. But, based on the quality of the individual and the performance rating that individuals received over the years.

The process described by Mr Motsopa is cited in section 25 of the Employment Act²⁴. Three managerial posts of the two Night Superintendents and the Continued Education Coordinator were dissolved. The roles that each office held were described by respondents as follows:

The Night Superintendent's duties were opposite to the Day Duty Matron. So, she did all the Matron's job at night. Managing the nursing staff and making sure that the patients are all comfortable and that smooth running of the hospital at night (Respondent F)

Respondent I explained why the Night Superintendents' office had two posts. She stated:

...It was two posts actually, for the Sisters to be on night duty. One would say, have seven nights [on night duty], on her seven days off [duty], the other one would come and fit in and they would work like that.

According to respondent F, the role of the Continued Education Coordinator was as follows:

When they say Continued Education Coordinator...You are a nurse but you wish to keep upgrading yourself...therefore her role was to identify the areas where nurses were lacking and then actually plan for those gaps.

The removal of the posts and retrenchments led to role revision for the remaining professional nursing staff. When asked about the fate of these three posts, the respondents stated that the post of the Continued Education Coordinator had been phased out and the duties of the Night Superintendent had been re-assigned to senior professional nurses:

²⁴ 25(1) Where an employer terminates contracts of employment for the purpose of reducing the size of his work force, he shall do so in respect of each category of employee, wherever reasonably practicable, in accordance with the principle commonly known as first-in-last-out: Provided that in so doing the employer shall take into account-

(i) the need for the efficient operation of the undertaking in question; and
(ii) the ability, experience, skill and occupational qualifications of each employee concerned.

(2) Without prejudice to the other provisions of this Part in relation to the giving of notice, when an employer forms an intention to terminate contracts of employment for the purpose of reducing the size of his work force, he shall forthwith give written notice of that intention to the Commissioner and to every employee to be or likely to be directly affected by the reduction.

A senior member of staff, they are the ones that will have to cover the hospital...most of the time they are experienced ... Each ward will see [to] their own needs, but for accountability purposes, they will just give the bleep, keys and responsibilities to one person. And you [person in charge] will only be useful if any ward has a query... (Respondent I)

Just to be answerable, like to phone doctors or to phone whoever is needed (Respondent B).

Although the senior professional nurses assigned to these duties are from supposedly “fairly quiet wards” according to respondent B, the merger of managerial and nursing duties led to work intensification for them. However, respondent I did not appear to find this to be the case even though her statement demonstrated it:

and you [the Acting Night Superintendent] will only ever be useful if any ward had a query ... And you would be having your own patients, so it will be a matter of advice ... And then in the morning, if there was any crisis, which ever nurse was on cover [at] that time will give the report to the management

The reassignment of the Night Superintendent’s duties to senior professional nurses was clear evidence of role revision. Despite the work intensification, respondent I stated that this was more effective than filling in these posts:

It is actually very effective because the staff ...was hired because they were very, very experienced. And some of them had been ‘in-charges’ where ever they had come from and they know how to manage. So it works out well that you wonder how those others [former Night Superintendents] were doing the job, were getting paid doing really nothing.

For taking on the role of the Night Superintendent, professional nurses got paid a minimal allowance by the hospital. This offered evidence that there had been deliberate attempts to reduce labour costs through work intensification for professional nurses

In other contexts described by Lee and Clarke (1999), Pillar and Jarjoura (1999) and some of the respondents, there was a decentralisation of functions through clinical care teams. Each team is comprised of professional nurses with specialities that are relevant to the patients’ treatment plan. So, each member within a care team had a specific role to play in the clinical care of a patient. Respondent I, who had work experience from a government hospital in her home country, provides an example of the decentralisation of functions within a clinical care team as follows:

If you are in a ward, you will be allocating duties. If you are giving injections to everyone in the ward. If you are the one in-charge that day, certain days you have to order certain items you use in the ward. You know I have to order... the dressing, medication... If you are supposed to deal with diets, you will know that this patient according to his condition he needs this type of diet...

A team approach to clinical care represents a decentralisation of functions in the sense that each team member can concentrate on a specific task. However, in the face of global and especially local professional nurse shortages, GPH was forced to centralize its clinical care through a cluster of strategies. Examples of these strategies are Quality Care for general wards and Total Nursing Care for the ICU. Each strategy is guided by the needs of clinical care that each ward requires. A single professional nurse is assigned to two or more patients and is in charge of all their needs. These may range from non-clinical needs like baths to clinical needs like canulation. Respondent I described Quality Care as follows:

They [management] have a system of patient allocation and it's complete nursing care you give to the patient. The patients you are allocated, everything they require you have to do it. And that means you see that our patients are comfortable and that they have no pain by giving analgesia when necessary. And if they have any problems you are supposed to help them. Whatever you cannot manage, you report to the unit manager in the ward

Respondent A described Total Nursing Care as follows:

Total Nursing Care is that bathing them, as in bathing from top to toe. Including mouth care, change the linen and if we look at their nutrition status. We put up drips and any other nursing duties. Then health education if the patient is conscious. We help educate them but per condition is done by the doctor. Us, we just emphasis if they have got questions. There are other areas but we just can't tell them what if this is an operation, what did the doctor find? [How did the operation?] That one is up to the doctor. Us, what we do is tell them what you need to do, why do you need physio. That's what we educate them on if they are conscious. If they are unconscious we educate the relatives what they do when they come to the patient, that they should talk to the patient, touch the patient, that psychological support which they are supposed to give.

It is through the centralization of clinical care that GPH appeared to be able to plan its services and deliver them in a cost effective manner. The practice of these various strategies was a way of coming to terms with the professional nursing shortage. A single professional

nurse catered for a group of patients thus doing away with the need for a clinical team, which requires more manpower.

Although the cluster of strategies adopted were perhaps the most feasible in the face of global professional nurse shortages, this research unearthed some of their shortcomings. The practice of these strategies led neither to higher job satisfaction nor higher morale. In fact, they appeared to have had adverse results. For instance, all the respondents stated that their workloads had progressively increased. GPH management recognised and acknowledged the professional nurse shortage. Shortages in key areas such as ICU and Midwifery have been seriously affected. Shortages are attributed to various causes. In the case of Botswana, some specialties like Intensive Care are not taught locally. Respondent A from the ICU described how her workload had increased over time:

When we started [working at GPH], it was three nurses per shift [now it is two]...Most of the time you get an agency nurse who doesn't have ICU experience. So it will be just like a figure but the work- it will be so much.

Respondent F from the maternity ward echoed this sentiment insofar as agency nurses are concerned:

If you think of the agency nurses; you have to orientate them and then make sure that they do well. They are here and then in two days they are gone and another one comes. So you get that problem

Respondent C from a general ward pointed out the problems of having a high patient to nurse ratio:

This one compromises the quality care we are supposed to be [giving] because instead of two [nurses] nursing five patients...you [one nurse] end up nursing eight patients

All three respondents revealed pertinent issues in terms of workload. Firstly, GPH appeared to be under-staffed as the number of on-duty professional nurses in ICU had dropped from three to two. Secondly, by engaging agency professional nurses the workload was further increased for the more 'permanent' professional nurses. They had to carry out their duties as well as induct the agency professional nurses. Thirdly, there was no guarantee that agency professional nurses engaged had specific specialties. Agency professional nurses were only

engaged in cases of severe shortages, so there was no guarantee that the orientated agency professional nurses would be re-assigned to the same ward. Increased workload posed a threat to the quality of clinical care provided.

To conclude, throughout this sub-section there has been an emphasis on the professional nursing staff shortage. Relating the shortage to the FFM, role revision occurred to reduce labour costs. In addition, GPH had low numerical flexibility and this is illustrated by how work was reorganised according to the available professional nurses. The shortages within the ICU and labour ward are a depiction of low functional flexibility. Professional nurses from the less specialized wards cannot be assigned to the specialized wards.

5.3.2 Changes to the Organisational Structure

This section aims to investigate how streamlining impacted the GPH organisational structure. In addition, the manner in which streamlining occurred at GPH will also be unpacked. The implications of reorganization at GPH for clinical care delivery and professional nurses will also be investigated. Lee and Clarke (1999) argued that one of the ways in which streamlining had been manifested was through FCCs. The key point in their argument is that FCCs lower the operational costs of a hospital (Lee and Clarke, 1999).

Within the GPH context, streamlining of operations occurred through the disengagement of on-site clinics. The clinics were opened in 1998 and 1999. According to respondent I, the professional nurses that went to the doctors' clinics were paid by the hospital. Then in 2003, when the clinics became private, some doctors did not opt to hire the professional nurses. Some preferred nurse aids meaning some of the professional nurses were retrenched because of privatization. Respondent I recalled that there was a professional nurse, who was retrenched by a doctor from one of the clinics, but was re-employed by the hospital. The professional nurses who were not retrenched were taken in by the doctors as full-time staff. Others were told they could stay at the private clinics, but at a lower salary because initially the doctors used to pay a little more than the hospital salary. However, after privatization the doctors feared that there was not enough business to sustain the higher salaries so they opted to get nurse aids or professional nurses who were paid less. Those doctors who had

professional nurse spouses in the same field opted to take their wives instead of hiring a professional nurse.

According to press reports, it was also at this time that GPH underwent its first publicized downscaling of operation. The need to downscale had been brought about by financial difficulties. Mr Motsopa provided a brief description of the rationale behind the opening of the on-site private clinics:

These clinics are purely made for doctors' specialties. We want doctors to be independent ... from the hospital ... So, basically these clinics are meant to support the hospital...we provide the clinics so that the doctors don't rely on the hospital. So it also goes to remuneration, with the hospital we don't have the money to remunerate the doctors because we cannot evaluate their work...So they should be able to be judged of their professionalism by their patients.

Like the FCCs, the on-site clinics catered for specific patient and physician populations. The clinics' independent status means that, like FCCs, they were run as separate business entities. The independent status of the clinics led to a decentralisation of power and a drastic shortening of the hospital and clinic's organisational hierarchy. The clinics had complete prerogative in terms of financial planning, hiring of staff and infrastructure development. Power decentralisation also contributed towards effective management and resource utilization (Lee and Clarke, 1999). Working within a specialized context means focus is placed on acquiring and retaining the relevant knowledge, skills and technology. In addition, the respective doctors either employ or become directors who are responsible for operations and 'business' development. The independent on-site clinics then act as support structures for GPH. A symbiotic relationship was formed through referrals between the clinics and GPH. Furthermore, GPH provided physical infrastructure in the form of the buildings in which the clinics are housed, operating theatres, wards, a pharmacy and staff. The provision of such infrastructure was aimed at procedures that could not be carried out in the respective clinics.

Because of this structure, the doctors are more accountable to external forces like their patients and professional councils. Mrs Museta, a qualified professional nurse and co-owner of a private gynaecology clinic, explained the stages through which the private clinics affiliated to GPH go through to operate:

For you to be admitted [practice] into this hospital [GPH]: one, you must be registered with the national health organisation of the country and then you must also be qualified. So for any person to go there, well, particularly pertaining us [practitioners] you have to be qualified for the specialty, isn't it? Registered with the organisation the national health organisation of that country. You must have a license which is renewed yearly, besides your papers [work and residents permits]. For anyone especially us who are foreigners, you must have that. And then as a doctor, the license must also have an insurance which covers you in case of litigations. And then the rest, what is that thing? You apply to the hospital board. The hospital board will sit down and if they accept you...then they give you permission to be able to admit into their hospital, yes. And this remains as long as you are registered as long as you have got your insurance and there are no problems with you and the management. But we don't pay anything to them, we give them business.

Mrs Museta's description provided evidence of how the on-site clinics were run like separate business entities. It is for this reason that GPH had been able to reduce its operating costs significantly. The costs of investment in knowledge, skills and technology were left to the respective clinics. With regard to labour costs, doctors were not paid by GPH. Mr Motsopa justified this in terms of the fact that GPH could not evaluate the doctors' work because of the independent status of their clinics. The doctors who ran the clinics were not accountable to GPH. The doctors did not pay to practice at GPH either. Expenses were charged to the respective parties. The patients are charged a doctor's fee by their respective doctors. Medication used was charged by the pharmacy. Tests were charged by the laboratory. Dressings, time in hospital and clinical care are charged by GPH. The manner in which medical expenses are drawn up is further evidence of decentralisation of operations at GPH.

5.3.3 Implications of Changes to the Organisational Structure

According to the literature, decentralisation is supposed to have several positive impacts on the efficiency of the organisation (Lee and Clarke, 1999; Pillar and Jarjoura, 1999). For example, the creation of FCCs has not only cut operation costs but has also made delivery of clinical care timelier. FCCs are located on-site and as a result transport costs and the time spent on transfers are reduced. Secondly, although FCCs are run like separate business entities, their location makes aspects like co-ordination and communication more efficient (Morgan, 1989:65). This is because the organisational hierarchy is more flattened, thus communication channels are much shorter in comparison to a bureaucratic structure.

Sister H described GPH as a 'one-stop-shop' where everything is paid for separately. She acknowledged that some functions like laboratory testing had been externalized. However, Mrs Museta presented a different picture. She stated that previously referrals were "just a phone call" away. According to Mrs Museta, promptness is a feature that has progressively declined. She recalled her experience as a patient at GPH as follows:

So you find *kuti*²⁵ now that it takes time, frustration and at the end of the day the patient is not cared for properly, especially on the physiotherapy bit. I realized it when I was admitted; if I wasn't a nurse- not this time- the last time when I had a major op [eration], there was nobody. The following morning when the physiotherapists should come in for their rounds to check on you, exercise, start you on the breathing exercises, movements and coordinating *nema*²⁶ nurses and within a day you are supposed to be getting up and sitting and then the next day you are walking, that sort of thing. There was nothing like that because *aakuku*²⁷ outside so the hospital is thinking of saving money, I think. And the frustration of also calling these people [physiotherapists]. Now they have got their private practice outside.

Although Mrs Museta's experience may have been an isolated incident, there was evidence which suggested that decentralisation had led to the stretching of resources. Although decentralisation was supposed to open communication channels, it appeared that the opposite had occurred. She went on to describe how her own patients had been affected by the decentralisation process:

You can imagine *vaMuseta*²⁸, right now he has got a patient in labour but for him to leave this practice to go and see that patient, it means leaving everything here. Frustrating his own patients and also now to run and do those ... But also frustrating that one [patient in labour] because she is also waiting. This is where it comes in, where things are not properly centralised. During our times when we...had these doctors, if he wasn't there, there was always someone else- I suppose private practice wasn't that big when we trained. It was there but not so big. There was always someone on hand to takeover or look after these patients during the day. Then after hours there are some on-call people.

Practitioners were caught between their private practice and the patients that need to be attended to in hospital. This, in turn, had affected the promptness with which clinical care may be delivered to patients.

²⁵ Means 'that' in Shona.

²⁶ Means 'with' in Shona.

²⁷ Means 'is over there' in Shona. Is made in reference to a person's location.

²⁸ 'I'a' means 'Mr' in Shona: Mr. Museta.

Mrs Museta also mentioned a further consequence of decentralisation for the private sector:

...but with us as private practitioners when we look at it from the point of view *yepractice*²⁹ and GPH and the decentralisation, it opens up for us.

Decentralisation has generated greater demand for private health care through referrals. Another direct consequence of decentralisation has also meant an increment in medical bills. Each firm within a system of firms monitors its own financial performance. In addition, the private on-site clinics like GPH are profit-orientated. The high medical bills are a bid to cover the costs of revenue spent on knowledge, skills and technological upgrades. To sum up, when GPH initially decentralised its operations to external sources, it was with the aim of downscaling its operation to a more affordable size. GPH appears not actively to have sought organisational flexibility.

5.3.4 Changes to Services Offered

Private hospitals, like any other corporate organisational structure aim to increase production at low costs (Armstrong, 2006:25). In essence, this entails catering for a broader number of patients at lower costs. Acute Patient Care (APC) is a strategy through which this can be achieved. The minimal time spent in hospital means that patients are treated at lower costs. It also means that patient turnover is increased. This section will investigate how APC is practiced at GPH. To do so, the various perceptions of APC will be examined. In the process, the implications of APC revealed by this research will be unpacked.

Mr Motsopa did not explicitly state whether GPH practices APC. However, he did point out some important issues. The professional nurse respondents expanded on the issues that he raised. When asked if APC is practiced at GPH, Mr Motsopa responded as follows:

Our main aim is actually to minimize the time the patient stays in the hospital. Our average time is three days...not those who are terminally ill. Of course, those who are terminally ill will be longer, but the general admission should be three days.

²⁹ 'Ye' means 'of the' in Shona: of the practice.

The key points highlighted by this statement are that there has been an explicit effort to reduce the number of days that patients spend in the hospital. Secondly, this minimal stay is contextual as it can only be practised in general wards. Thirdly, minimal hospitalization is a key trait of APC. Therefore, it may be assumed that APC is practised at GPH. To support the first point, respondent G from a general ward, gave a more detailed explanation of how APC is applied:

We are trying by all means to get to the patient in like three or four days ... The first two [days], we have to find out what the problem is. On the second day we have to be putting the patient on aggressive treatment. On the third day, we have to be able to...make arrangements for moderate treatment. May be oral if the patient is on injections, so that ... on the fourth and fifth day, the patient can continue with their therapy at home. We have basically tried to stabilize the patient within a short period of time. And then they [the patients] can continue their care whilst they are at home.

As evidence that APC was only practised in general wards, the respondents from ICU did not believe that it was practised at all. They attributed this to a lack of a sufficiently developed home-based care system. Understandably, in their line of work, they catered to patients in critical condition who could not necessarily be admitted and discharged in three to four days. In contrast, respondents from general wards stated that the length of a patient's admission hinged on the extent to which they were able to afford their stay:

What you have is a company and for it to say business is doing well, is for it to have more patients. And honestly, the longer they [patients] stay, the more money they [GPH] get. Even though the patient came and stayed a shorter time [than] you would expect (Respondent I).

This statement highlighted another aspect that Mr Motsopa did not mention. He did not mention why the GPH adopted APC. The statement is an acknowledgment that GPH has taken measures to ensure that where possible, patient turnover is increased at low costs.

5.3.5 Implications of Changes to Services Offered

The practice of Acute Patient Care (APC) is not without consequences. It is a reflection of how the organisational structure had changed over time. More specifically, it is a depiction of role revision for the professional nurses and how the context of patient care had changed. The shortening of the period of patient care had serious implications. The three to four days in

which patient care occurs had become an intense period for both the patients and professional nurses. For the professional nurses, their workload was increased as they had a much shorter and more strenuous period to deliver patient care. The compression of patient care also led to work intensification in face of professional nurse shortages.

I think because being a private hospital we don't extend our services into the communities...but the best may be ... if they needed home-based care, the agencies would ... take over. So, may be we'll just tell the relatives of the patients that there's an agency, see if they can help you (Respondent F).

To support this, Sister H supplied professional nurses to people who need home-based care.

..Hospitals mainly but now and again [we] send ... nurses to patients' homes. Because we don't have a step down facility to say when somebody is still quite sick and still needs basic care they are discharged prematurely because of the severe shortage of nurses. So they are sent home but at home there's nobody to look after them.

Early discharge for patients led to the increased demand for more private health care in the absence of an institutionalized home-based care system. When patients were discharged, they were still in needed of clinical care. This situation widened the market for nursing agencies and private clinics. For the terminally ill, professional nurses may be hired from nursing agencies for home-based care.

To sum up, this study has defended its stance on viewing non-citizen professional nurses as dependent contractors. This was carried out by arguing that in the face of shortages, non-citizen professional nurses provided functional, numerical and financial flexibilities. Secondly, this study argued that despite their presence, non-citizen professional nurses had not fully satiated the demand for professional nurses. To support this claim, it was argued that other measures like the overtime system, flexi-time and the use of agency professional nurses had been used in attempts to satiate the professional nurse shortage. Thereafter, the implications of the professional nurse shortage on the organisational structure and services offered were examined. In essence this section sought to depict the context and implications of the engagement of non-citizen professional nurses at GPH. The next section proceeds to look at the context and implications of the nature of employment relationship between GPH senior management and non-citizen professional nurses.

5.4 THE AMBIGUOUS NATURE OF THE EMPLOYMENT RELATIONSHIP

An employment contract sets out what each party within the employment relationship may expect in terms of rights, benefits and duties. This section sets out to argue that in cases where the employment contract is ambiguous, disempowerment of the worker is inevitable. In the GPH context, this study argues that non-citizen professional nurses are disempowered because the 'foundations' of their employment contracts lack clarity on key definitions and implicitly aim to disempower them. These foundations are made up of various policies and pieces of legislation. However, this study focuses on economic nationalism, the localization policy and labour legislation.

5.4.1 ECONOMIC NATIONALISM AND THE LOCALIZATION POLICY

The concept of economic nationalism within the Botswana context is rooted in the history of its economic development which was riddled with a skilled citizenship manpower shortage. Economic nationalism was manifested through various policies but the one most relevant to this study is the localization policy. The localization policy as was explained in various sections in chapter three is a process to replace all non-citizen held offices with citizens. The rationale behind this is to use the workplace as a platform on which resources can be redistributed to economically active citizens. This study argues that the localization policy has contributed towards the ambiguity in the nature of the employment relationship between senior management and non-citizen professional nurses at GPH. It enables loopholes in the labour legislations which translate into ambiguous employment contracts.

5.4.1.1 Labour Legislation

In chapter two, it was duly noted that section 2 of The Employment Act of the Republic of Botswana³⁰ provided a broad definition of the term contractor. There is no differentiation between independent contractors and dependent contractors. The definition provided was biased in favour of an independent contractor. So implicitly, dependent contractors were not mentioned in the Employment Act. Consequently, such a broad definition is open to

³⁰ "Contractor" means a person who contracts with a principal to supply labour or to carry out the whole or any part of any work undertaken by the principal in the course of or for the purposes of the principal's trade or business;

misinterpretation for senior management when drafting contracts for dependent contractors. Furthermore, it is important to take into account dependent contractors and independent contractors have differing needs in terms of supplying their labour. For example, dependent contractors have similar needs to employees in terms of issues like study leave for skill upgrades. In contexts like GPH skill upgrades are important as they contribute towards functional flexibility. By omitting to contextualize the differences between dependent and independent contractors, these needs are not taken into consideration.

5.4.1.2 The Ambiguous Employment Contract

This section sets out to show the contradictory nature of the employment contract given to non-citizen professional nurse at GPH. The title³¹ on the contract acknowledges the non-citizen professional nurse as an employee rather than a dependent contractor. There is a contradiction between the title of the contract and the true status of the non-citizen professional nurses. By virtue of the title of the contract, non-citizen professional nurses should then be awarded the rights and benefits that would accrue to a permanent employee. However a critical analysis of the ‘employment contract’ revealed this not to be the case. Firstly, only Batswana are eligible to enter [permanent] employment contracts according to premise of the localization policy. Although there was no explicit mention of only Batswana being eligible to enter [permanent] employment contracts. Section 5 (6) (1) of the Non-Citizens’ Employment Act³² implies that Non-Citizens’ are not eligible for permanent employment. This meant that non-citizen professional nurses, by virtue of being [dependent] contractors cannot enter into employment contracts. To further support this claim Table 2 revealed the nature of the ‘employment’ relationship of the questionnaire participants. Table 2 also revealed that an overwhelming majority of the questionnaire participants were not Batswana. Table 3 provided a breakdown of the various nationalities.

³¹ The title reads, “Employment Contract”.

³² (6) For the purpose of determining an application placed before it in accordance with subsection (1), the Board shall take into account-

(a) the effect of issuing a work permit or renewing the existing work permit upon the opportunities for employment or for other engagement for reward or profit in the occupation in question, as the case may be, open to citizens of Botswana; and
(b) where the application relates to employment, the arrangements made or to be made by the employer to train a citizen of Botswana to replace the person in respect of whom the application is made in the event of a work permit being issued to him or his existing work permit being renewed.

Table 2 **Condition of Employment**

Condition of Employment	Frequency	Percentage
Permanent	1	3
Contract	32	97
Total	33	100

Table 3 **Nationalities of Questionnaire Participants**

Nationality	Frequency	Percentage
Zimbabwean	20	61
Zambian	9	27
Tanzanian	1	3
Malawian	2	6
Motswana	1	3
Total	33	100

Secondly, non-citizen professional nurses were only awarded a maximum of two years per contract as is evidenced by Table 4 below. As a consequence of their condition of employment non-citizen professional nurses could only accrue gratuity instead of a pension³³ that is intrinsic to a permanent employment contract. In addition to gratuity, other benefits included housing, medical aid, leave of thirty-seven days per year and paid sick leave of fourteen days per year. The awarding of gratuity is contradictory to the title of the contract. The accrual of gratuity was an implicit recognition that the non-citizen professional nurses are not permanent workers, yet the title insinuated otherwise. Furthermore the other benefits presented recognition of the economic dependent nature of non-citizen professional nurses to GPH. In fact, the contract enforced the dependency through the exclusivity clause.³⁴ So, although the contents of the contract recognise non-citizen professional nurses as dependent contractors, the title of the contract illustrated otherwise.

³³ Section 7 of the Employment contract.

³⁴ Section 11 of the Employment Contract.

Table 4 **Length of Current Contract**

Length of Current Contract	Frequency	Percentage
6 Months	3	9
18 Months	1	3
2 Years	27	82
Dnw ³⁵	1	3
N/A ³⁶	1	3
Total	33	100

To sum up, the contract between non-citizen professional nurses and the GPH senior management is disempowering in the sense that it is misleading. It implicitly recognises that non-citizen professional nurses have the same needs as permanent employees yet it does not award them the same amenities.

5.5 HORIZONTAL LABOUR MARKET SEGMENTATION

According to Atkinson (1994:338), the premise of FFM is systematic horizontal labour market segmentation to induce functional, numerical and financial flexibilities. Relating this argument to GPH, this study found that it was relevant. Firstly, the nature of relationship between GPH senior management and the non-citizen professional nurses facilitated horizontal labour market segmentation through the ‘employment’ contract. As a result of their lack of citizenship, non-citizen professional nurses could not be hired on a permanent basis unlike Motswana professional nurses. In this regard, the benefits which non-citizen professional nurses receive differ to those of Motswana professional nurses to some extent. For example, non-citizen professional nurses did not receive pension benefits yet Batswana professional nurses do. So in the GPH context, horizontal labour market segmentation occurred along lines of nationality. This translated into different ‘worker’ benefits.

As was mentioned earlier, functional flexibility was achieved by hiring non-citizen professional nurses with two or more qualifications. Horizontal labour market segmentation at GPH facilitates numerical flexibility through the nature of their employment contract. By hiring an overwhelming majority of non-citizen professional nurses, the core labour force becomes increasingly peripheral. This study argues that such an approach to numerical

³⁵ Did not write.

³⁶ The question was not applicable to that particular respondent as he was a permanent employee.

flexibility also facilitates financial flexibility. The 2003 downsizing process that GPH went through provides a good example. The allocation of two year contracts meant that those whose contract end coincided with the downsizing process simply did not have their contracts renewed. Of the twelve respondents, only five were employed by GPH in 2003. All five concurred that the procedures used to downsize the professional nursing staff were informed by section 25 of the Employment Act.³⁷ Focusing on section 25 (1), through the last-in-first-out policy, financial flexibility is achieved through low severance pay³⁸. GPH was able to match its professional nursing staff to the drop in demand for health care services. Horizontal labour market segmentation leads to disempowerment in the sense that non-citizen professional nurses are the most vulnerable to redundancy. This argument is based on the length of their tenure and the labour legislation on redundancy.

5.6 CONCLUSION: AMBIGUITY LEADS TO DISEMPOWERMENT

To conclude this chapter, the key points which show how an ambiguous employment relationship can lead to disempowerment have been highlighted. In the GPH context, the contract between non-citizen professional nurses and senior management is informed by the localization policy and labour legislation. Each of these contributed towards the facilitation of FFM at GPH. Horizontal labour market segmentation as a result occurred along lines of nationality for the purposes of attaining functional, numerical and financial flexibilities. The next chapter will develop how an ambiguous employment relationship impacts on the career development of non-citizen professional nurses. It will argue that as a result of a contradictory contract between GPH senior management and non-citizen professional nurses, disempowerment occurred through poor career development.

³⁷ 25(1) Where an employer terminates contracts of employment for the purpose of reducing the size of his work force, he shall do so in respect of each category of employee, wherever reasonably practicable, in accordance with the principle commonly known as first-in-last-out: Provided that in so doing the employer shall take into account-

(i) the need for the efficient operation of the undertaking in question; and
(ii) the ability, experience, skill and occupational qualifications of each employee concerned.

(2) Without prejudice to the other provisions of this Part in relation to the giving of notice, when an employer forms an intention to terminate contracts of employment for the purpose of reducing the size of his work force, he shall forthwith give written notice of that intention to the Commissioner and to every employee to be or likely to be directly affected by the reduction.

³⁸ Section 4 (4.1.2) of the Employment Contract:

This Agreement shall terminate: Where notice is given by the Employer or the Employee pursuant to Clause 4.1.1 hereof forthwith upon payment by the Employer to the Employee or by the Employee to the Employer three (3) months basic salary in lieu of that notice;

CHAPTER 6

6.0 DISEMPOWERMENT THROUGH POOR CAREER DEVELOPMENT

6.1 INTRODUCTION

The last chapter highlighted a contradictory contract between GPH senior management and non-citizen professional nurses. As was previously mentioned, this chapter will argue that non-citizen professional nurses were also disempowered through poor career progression. To support this argument, this chapter will argue that the ambiguous and temporary nature of the relationship between senior GPH management and non-citizen professional nurses had a negative impact on career progression. As dependent contractors, the duty and responsibility of skills development falls squarely on the non-citizen professional nurses. The temporary nature of their tenure does not allow for GPH funded study leave. Simultaneously, their work schedule does not facilitate private skills development. In addition, as a result of the localization policy, skill development within GPH was aimed at citizen employees rather than the non-citizen professional nurses. The negative impact on career development contributes towards the non-citizen professional nurses' disempowerment. To trace how disempowerment occurred to non-citizen professional nurses, the next section will carry out a critical analysis of Performance Management at GPH.

6.2 PERFORMANCE MANAGEMENT AT GABORONE PRIVATE HOSPITAL

Performance Management is part of the HRM practice at GPH. It is made up of two parts, Joint Performance Management (JPM) and Individual Performance Plan (IPP). JPM focuses on providing professional nursing staff insight and input into planning aspects of the labour process whereas, IPP focuses on long term career aspirations (Life Healthcare, 2009:5; 11). As previously mentioned in chapter two, Performance Management entails assessment of actual performance against set targets, employee development, guide to job changes and remuneration increments (Armstrong, 2006:496). Although this section aims to focus on IPP in terms of career development, reference is made to JPM as it has key influence on IPP. Quality evaluation is complementary to Performance Management as it also offers

constructive criticism into the labour process and the performance of individual professional nursing staff.

6.2.1 Joint Performance Management at Gaborone Private Hospital

JPM serves the role of identifying and contextualising organisational targets against which individual employee assessment of actual performance is run (Armstrong, 2006:496). Respondent B described JPM as follows:

The Unit Manager and the members of staff, they set goals. We have got what we call objectives, which we will need to achieve by the end of the year. So, you start setting those objectives which you will have come up with. You sit down; you come with means of achieving those goals. Those are the objectives. Mid-way through the year, you review. You sit down- because by then, you may have delegated each one. You review how far they have gone and at the end of the year, you do another review.

At GPH, organisational objectives for a planning period are identified as Critical Success Factors (CSF) as shown by Table 5 (Life Healthcare, 2009:6). CSFs were derived from GPH's executive strategic objectives (Life Healthcare, 2009:6).

Table 5 Gaborone Private Hospital Critical Success Factors for 2009

Deliver uncompromising quality to our customers.
Develop a growth agenda that increases revenue and delivers growth of >20% per annum.
Develop our people and recognize the diverse contributions of individuals and teams.
Implement a flexible marketing strategy that results in a distinctive competitive advantage evidenced by increased market share.
Transform the organization to sustain our healthcare business in a changing socio-political environment.

Source: Performance Management at Life Healthcare: An Employee Guide (2009:5)

The role of JPM is to contextualize the CSFs into departmental objectives. For example, the first CFS would translate into various departmental objectives like “satisfied customers, a safe patient environment, correctly completed documents and resolved customer queries”

(Life Healthcare, 2009:6). The latter example shows how a CSF is contextualized into departmental objective by identifying departmental customer needs and planning how to meet them. Departmental objectives are referred to as Key Performance Areas (KPA). According to Armstrong (2006:496), Performance Management is a planned process built around key elements of consensus, measurement, feedback, positive reinforcement and dialogue. This study argues that JPM at GPH appeared to reflect the qualities mentioned by Armstrong. To further support this observation is Mr Motsopa's description of JPM:

We use the JPM to evaluate our staff in terms of their capabilities, the type of tasks that we set them to do. So, each manager sits down with each and every employee in his department and they both do a joint performance form. That joint form is basically to put the strategies in place as to what this person should do within the first six months of the year and that can be reached at the end of six months...It's joint because we don't want to place any employee under pressure, so they all do a joint thing...Basically we want to make them talk, so this is why it must be a joint performance. At the end of the year it gets evaluated by ... the [unit] manager, so that there's no friction. Issues in regard to performance, where the manager and staff are not at talking level, you will get a disgruntled employee. But, where they are at a talking level, they know everything can be discussed and put on paper. We are actually trying to make them talk... We don't put the onus on the manager only.

Consensus, dialogue and measurement between line managers and professional nursing staff are evidenced by how KPAs are jointly discussed and measurement is agreed upon. KPAs are further jointly contextualized into individual worker objectives which are referred to as IPP. Line managers and professional nursing staff jointly discuss, review and measure IPP using the grading rates shown by Table 6.

Table 6 Individual Performance Planning Grading Rates

PERFORMANCE RATING		SCALE
More than meets the standard	Excellent - it would be very difficult to improve on performance	8
	Performance consistently exceeds the standard requirement	7
	Performance exceeds the standard requirement in many cases	6
Meets the standard	Fulfils job requirements at all times	5
	Fulfils most job requirements to a satisfactory degree	4
	Performance is only just satisfactory	3
Does not meet the standard	Does not entirely satisfy certain job requirements	2
	Performance is completely inadequate	1

Source: Performance Management at Life Healthcare: An Employee Guide (2009:12).

6.2.2 Joint Performance Management and Conflict in the Employment Relationship

The above description of JPM offers a unitarist perspective of organisational Performance Management. The study presented evidence of professional nursing staff sharing the overall goal of increasing hospital profits with senior management. However, the literature in chapter two revealed that employment relationship is inherently conflictual, meaning that managerial interests did not necessarily reflect those of the professional nurses. This section puts forward that at GPH, the managerial perception of JPM was not reflected by the professional nursing staff. The differing perspectives of JPM provided evidence that the relationship between senior management and that of the professional nurses was indeed conflictual. Furthermore, this section argues that the practice of FFM led to further disempowerment of the non-citizen professional nursing staff. Because a great majority of the professional nursing staff were made up of dependent contractors, open contestation of managerial interest was circumvented. The circumvention of open conflict led to increased control over the labour process. The next chapter will further explore how open contestation of managerial interests had been restricted.

The objective role of JPM appeared to be a channel used to develop and nurture a sense of ownership over the work process among professional nursing staff. This was done by

including non-managerial staff in contributing towards planning the labour process. However, it appeared that the professional nursing staff had not fully bought into the managerial objectives. Respondent C's provided an insight on how professional nurses perceived JPM:

It [JPM] is only done at the end of the year just to get those forms filled in for them [Senior Management]. They [Unit Managers] don't have time for that – to do the evaluation. So it's just at the end of the year where they [Unit Managers] scribble this and that. As a result, I don't think it really works.

Respondent C pointed out the flaws in the JPM system. Firstly, she noted that it was not carried out often enough for it to have any real value. The respondents who were Unit Managers pointed out that appraisals were carried out thrice annually. According to the Performance Management Employee Guide, performance review discussions are supposed to be carried out at least twice a month (Life Healthcare, 2009:7). Secondly, perhaps this could also be an indication of how the professional nurse skills shortage has affected the efficiency of the running of the hospital. Respondent A also pointed out that as a deputy Unit Manager she was so busy with paper work and patients that it left her with very little time to spare for bi-monthly evaluation meetings with her ward's professional nurses. Thirdly, the inability to carry out bi-monthly evaluation meetings could also relate to an overworked middle management that is barely coping with its workload. Lastly, because of all of these factors, the professional nurses did not 'fully' develop and nurture a sense of ownership over the work process.

However, respondent I revealed an awareness that showed that some sense of ownership over the work process had been instilled into the professional nursing staff. She stated:

Because it is our business, we have to have more patience.

Respondent I recognised that the professional nursing staff and senior management had the common goal of aspiring to making a profit. However, the motives of senior management differed. Referring back to Table 5, the second CSF³⁹ in comparison to Respondent I's following statement revealed that the motives behind aspiring for organisational efficiency differ:

³⁹ Develop a growth agenda that increases revenue and delivers growth of >20% per annum.

If the hospital has more money we can also hope to have a raise in salary. So it is joint, we are working together.

Opposing motives as those presented by senior management and the non-citizen professional nurses have led to undercurrent conflict. The reason that the conflict is implicit rather than explicit⁴⁰ is because of the practice of FFM. As a result of their insecure status, non-citizen professional nurses were not in a position to explicitly express their displeasure with senior management. As dependent contractors, they had insecure tenures in the sense that there was no guarantee that their two year contracts would be renewed. So, it was not in the interests of the non-citizen professional nurses to displease senior management.

In cases where non-citizen professional nurses have openly expressed their displeasure, they have been informed to resign. Two respondents attest to this:

If there is anything that you are not happy about. May be you would talk to your sister-in-charge. But then I don't know how effective that would be. Because it's like: 'what we are giving you is this, if you are not happy with it, pack your bags and leave' (Respondent C).

The reality of the situation is it's a matter of 'take it or leave it' ... Because should you tell them you don't like this they may tell you there are so many entrances which you can get out (Respondent I).

As a result of the above given opinions, some non-citizen professional nurses have opted to leave GPH.

Because most nurses are expatriates - so what has been happening - you move out. Not that it was written out but that's what the staff have been doing (Respondent A).

And they know they have employed people who come from a worse situation than where ever. So they just tell you to take it or leave it. Otherwise if you are not interested you have to move out (Respondent C).

And I think may be those who were really aggrieved would have left (Respondent F).

⁴⁰ Like in the form of strikes, demonstrations or go-slows.

The non-citizen professional nurses who chose to stay displayed a sense of powerlessness:

So if there's a problem you have which you feel they [management] have not been fair to you. You have to swallow it and just get it out of your mind and continue working. (Respondent I)

To conclude, the evidence provided revealed that through the practice of FFM, senior management managed to obtain greater control over the labour process. Firstly, by engaging non-citizen, the relationship between senior management and the professional nurses is individualised through a short-term contract. Secondly, by hiring highly qualified non-citizen professional nurses, functional flexibility appeared to have been attained. Lastly, the engagement of dependent contractors with insecure tenure had played a role in the evasion of open expression of conflict.

6.2.3 Lack of Transparency in Reward Systems

The last section revealed that the practice of FFM at GPH had enabled senior management to obtain a firmer grip of control over the labour process while circumventing open conflict. This section seeks to show how a lack of transparency in the reward systems contributed towards the conflictual relationship between senior management and non-citizen professional nurses. The annual salary increments and the monthly High Flyer awards system will be critically analysed in relation to the set objective. It will also be argued that the lack of transparency has contributed towards the sense of powerlessness that was identified in the last section.

Annual increments were based on the performance ratings illustrated in Table 6. Respondent D highlighted the lack of transparency in the annual salary increments. She stated that because of the secretive nature of JPM, she did not understand how increments were determined. In fact, she pointed out that every professional nurse was given the same percentage increment, yet performance ratings differed. As a result, she did not understand how JPM worked in relation to her salary increments. Respondent D's opinion of Performance Management alluded to a lack of transparency in the process. Respondent I also alluded to a lack of transparency in the reward system. She stated:

It's not very clear, you don't see it. All you see is you just come to work and you want to put up your best and you want make sure there are no complaints levelled against you. So you always are on guard and you hope for a raise for the following year. Every January, that's when nurses are given a bit of a raise, which is really minimal.

A lack of transparency in the annual increments only served to instil distrust and suspicion into the whole process. Performance Management contributed towards long-term results. However, in between appraisals there was a system in place that offers all GPH staff short-term rewards. Mr Motsopa stated that there is a monthly quality meeting where staff that performed outstandingly were recognised. They received the High Flyer Award if they had been nominated by other staff members and by the quality committee. The recipient of the award was described as someone who performed beyond his or her job description. To recognize this feat, a tea was provided in his or her honour to present the award, a token of appreciation and a portrait photo of him or her was hung in the reception area for a month.

Respondents A, B, F and G gave descriptions similar to that of Mr Motsopa. Notably, all but respondent G fell within middle management. On the other hand, it appeared that most of the professional nurses who did not fall within middle management were not very sure how award winners were nominated. In fact in some cases they revealed some discontent with the system.

They say its people who go the extra mile but then I don't know what they [management] call an extra mile... You don't go for tea break because now you ... think: 'Ah! No, I have to do this and that before I go away'. So that it means - it just shows that being a professional there are some things that you see *kuti*⁴¹, these ones can't wait. I have to do A-B-C before ... going for my break. But then at the same time such things; it's not everybody who will recognise that (Respondent C).

I have no idea. I know there are some people -not only nurses. They will say that this one is the Flyer of the month but it depends on the nurses and the employees themselves. They say, 'Okay, this one did very well, they went an extra mile. This and that.' That's all (Respondent E).

The professional nurses' lack of knowledge on how the High Flyer award winner is nominated appeared to reveal a lack of fairness, equity and transparency in the process. This study puts forward that the absence of fairness, equity and transparency in the reward systems

⁴¹ *Kuti* means 'That' in Shona

served to highlight a lack of trust between senior management and non-citizen professional nurses. In addition, it also brought to light more disempowering qualities within the 'employment relationship'. The lack of transparency in the annual increments based on Individual Performance Planning grading rates revealed.

6.3 WAGE RESTRAINT

Wage restraint as cited by Mogalakwe (1997:68) was one of the pillars of industrial relations in Botswana. Wage restraint was even more prominently practiced in the parastatal and private sectors. This was to avoid direct competition with the government for skilled labour. The quote below revealed that GPH was not an exception;

Like, we used to be the best payer, now the government is the best payer. So we are- and the only thing we can do to try and match the government because we can no longer see ourselves as the higher paying institution. Because of the economic reasons and the government will also say: 'If you pay more than me that means you will have stolen the majority of my nurses and I provide as a government basic health care'. We provide high quality care, so this is where the difference comes in (Mr Motsopa).

In chapter five, the wage restraint policy was mentioned in relation to financial flexibility. However, this section seeks to illustrate it as a disempowering entity within the employment relationship. It will be argued that wage restraint at GPH had been practiced in a manner that discredited the non-citizen professional nurses of their past experience in their respective fields. As a consequence, the non-citizen professional nurses are deprived of economic benefits like wages that also reflected their experience before they got contracted by GPH. Table 7 below is a reflection of how much non-citizen professional nurses are remunerated.

Table 7 Fixed Flat Rates per Job Category and Unit for 2009⁴²

Job Category	Job Title	Hourly Rate	Sunday Night/Day	Public Holiday
EN ⁴³	EN	P 37.50	P 50.00	P 70.00
Staff Nurse	Staff Nurse	P 37.50	P 50.00	P 70.00
RN ⁴⁴	Registered Nurses- Theatre	P 58.00	P 72.50	P 85.00
	Registered Nurses- ICU	P 45.00	P 57.50	P 75.00
	Registered Nurses-Labour	P 37.50	P 50.00	P 70.00
	Registered Nurse	P 37.50	P 50.00	P 70.00

For the purposes of this study the irrelevant columns have been omitted.

From the above table, it is clear that a vast past experience was not considered in setting of salary rates. The quote below from respondents B, H and I served to support this claim.

It's the time you came to work for the hospital. That's what I think. Okay, there is starting salary when you start because most of us are contract workers. So every year there is this increment based on merit. The merit considers the JPM points you get (Respondent B).

Your numbers of years at the institution, if you are new you are started at the bottom (Respondent H).

They will in most cases say anyone who is a State Registered Nurse and has had two years' experience; they will give a certain salary. Whether you have had 20 years' experience they are not interested (Respondent I).

However, professional qualifications in the form of academic qualifications and registration with Botswana Nursing and Midwifery Council were taken into account for remuneration. This is evidenced by the terminology used to distinguish the different grades and nursing professions. For example, theatre and ICU nursing courses were not taught in Botswana so the professional nurses registered in these disciplines were paid a higher hourly rate in comparison to the other disciplines.

It was clear that the non-citizen professional nurses were to some extent aware of the practice of wage restraint at GPH. However, none of the respondents other than Mr. Motsopa

⁴² Monetary value is stated in the Botswana Pula (BWP)

⁴³ Enrolled Nurse

⁴⁴ Registered Nurse

appeared to have a clear comprehension of the rationale behind it. Respondent I showed an awareness of restrained wage growth.

I feel that they are like they don't want our salaries to keep on going up. Especially the more you more you are senior, the salary it's really very minimal and this is common of private sector because they also want the money. So I think they fear if they give you more, more, more for people who have stayed, it will end up being too much which they will not be able to manage (Respondent I).

From the above quote, it is clear that respondent I was not aware of the rationale behind the wage restraint. Wage restraint for the non-citizen professional nurses translated into exploitation as evidenced by respondent D below:

I really think that nurses are under paid a lot, a great deal especially in the Southern Africa and because I really think the work that we do doesn't correspond [with the pay] at all (Respondent D).

The perceived exploitation was magnified by the skills shortage. In chapter three it was identified that the government refused to allocate a scarce skills allowance to the nursing profession (Morula, 2009). So in essence, wage restraint in the face of a severe skills shortage was disempowering with regard to remuneration.

6.4 INDIVIDUAL PERFORMANCE PLANS AT GABORONE PRIVATE HOSPITAL

The IPP section is developed by the individual professional nurse and the immediate manager and is then reviewed by the next level manager over time (Life Healthcare, 2009:11). Applications for promotions or transfers within the hospital had to be accompanied by an IPP form. Respective professional nurses were required to identify their career goals and chart out a career path that would facilitate the fulfilment of their career goals (Life Healthcare, 2009:5). Goal fulfilment entails formal education and skills development. IPP thus presented a record of a respective professional nurse's career path. With this in mind, this section argues that as a result of their status, non-citizen professional nurses were not afforded the opportunities to fully develop their career paths (Baputaki, 2009). The disempowerment was rooted in the nature of their employment relationship. Non-citizen professional nurses were not eligible for employment contracts that exceed two years at a time. What this meant is that their employment was of a contingent nature (Atkinson, 1985:18; 1994:339; Pollert,

1994:343; Thompson and McHugh, 1996:196; Rubery and Grimshaw, 2003:138). The renewal of their employment contract was dependent on the local supply of professional nurses. Therefore, 'theoretically' it was not certain that their employment contract would be renewed. Therefore investing into non-citizen professional nurses' long term career development was not a viable option for GPH senior management. So, the length of employment contracts appeared to restrict non-citizen professional nurse exposure to formal education and skills development.

The data collected from the interviews and questionnaires posed a challenge on what appeared to be the GPH theoretical take on investing into their non-citizen professional nurses' long-term career development. All of the non-citizen professional nurses on two-year employment contracts held one or more previous contracts with GPH as Table 8 shows. According to the data presented by the questionnaires, two thirds of all of the participants held at least one previous two-year contract with GPH.

Table 8 **Number of Previous Contracts**

Number of Previous Contracts	Frequency	Percentage
0	12	36
1	4	12
2	5	15
3	2	6
4	3	9
5	2	6
6	0	0
7	1	3
8	2	6
9	1	3
Did not respond	1	3
Total	33	100

In fact, respondent I held eight previous two year contracts. This illustrated that despite the length of their contracts, non-citizen professional nurses exhibited traits of permanent employees. In addition, it also showed that the local professional nurse shortage was of a long term nature, rather than the short term nature the employment contracts were based on. There was evidence which suggested that there has been a deliberate move to ignore this issue by the government. Feringa, the NAB executive secretary in 2008, pointed out that government

not awarding professional nurses a Scarce Skill Allowance was indicative of ignoring the 'critical shortage' (Chwaane, 2008). This critical shortage was evidenced by non-citizen professional nurses and retired local professional nurses were getting employed in government hospitals. The deliberate move to ignore this has negatively impacted on the non-citizen professional nurses' ability to fully develop their careers.

To their credit, GPH has given its professional nurse staff exposure to some short term professional related programmes. Most of the interviewed professional nurses acknowledged that they had received in-house training programmes. However, the question of the local and international validity of these programmes was met with mixed responses. Some respondents were unsure of the validity of these programmes but some like respondents B and F stated that some programmes like the Peri-natal Education Programmes and Basic Life Support taught through International MARS Rescue were internationally recognised. However, they were unsure of the local validity of these programmes. Respondent B attributed this to how some programmes like Intensive Care Unit were not taught in Botswana thus making them difficult to register with the BNMC. The local validity of a programme and qualifications was determined by BNMC. Respondent C stated that although the programme may not be recognised locally, it built on one's experience and curriculum vitae.

The programmes offered by GPH held some value, however, programmes with more substance like higher grade diplomas, degrees and post-graduate programmes were not offered. The literature revealed that 'magnet hospitals' attract and retain staff through in-house degree programmes (Cheung and Aiken, 2006: 357). These hospitals take into account funding and offered study friendly working hours for professional nurses (Cheung and Aiken, 2006: 357). Most of the professional nurses interviewed expressed their interest in upgrading their current qualification. However, some like respondent I pointed out that this was not possible.

It would be nice, but at our hospital they [senior management] don't really cater for...helping someone to further themselves. So what you brought in with you remains what you still have unless you can do it on your own without the hospital even knowing. But then the problem is [the] off-duty system or the working hours are not conducive for any of the after work furthering [of] your education (Respondent I).

Yes I have, but then like right now in Botswana, it's not really possible for me because... I don't know... maybe using distant learning I would. But then I haven't got the funds to do that (Respondent C).

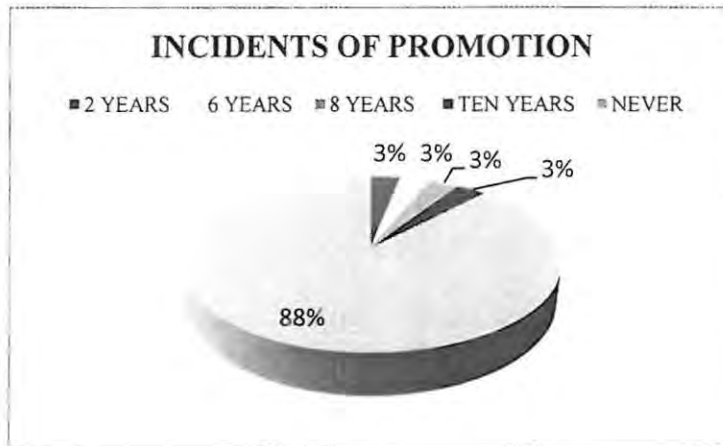
There is this challenge of personal development and sometimes you feel like I have worked for this long I need to know this much. So, that is actually an inspiration to say, "as senior staff here I need to have at least upgraded to this level so that I can be at par with the development the- the entire development of the nursing profession (Respondent G).

To the support the statements was evidence from data collected from the questionnaires. Only one out of thirty-three participants had taken study leave but at her own expense. Respondent C also cited financial difficulty as the main reason behind her failure to upgrade her qualifications. Overall, GPH did not appear to offer an environment which facilitated career development. In essence, this disempowered the professional nurse staff, irrespective of their nationality. When questioned about in-house degree programmes, Mr Motsopa recognised the need to improve the professional nurse skills base. However, he stated that GPH did not meet the Tertiary Education Council's standards to have in-house degree programmes.

Another possible reason put forward by Pearce (1998:32) could be that non-citizen professional nurses are not really seen as employees but rather as 'contractors' selling their services to their client, GPH. As a result, the onus for skill upgrades and career development does not fall on GPH but rather on themselves. However, should in-house degree programmes become a reality, there would be a need to review contract length as two years is not enough time for a degree programme. Perhaps this lack of career development is another contributory factor to why GPH was faced with a professional nursing staff shortage.

The localisation policy also played a role in the retarded career development of non-citizen professional nurses at GPH. Because of the localisation policy, non-citizen professional nurses were viewed as contingent workers. As contingent workers, it appears that they were over looked for promotions. This is evidenced by Figure 3 below which revealed that a great proportion of the questionnaire respondents had never been promoted at GPH.

Figure 2 Incidents of Promotions at Gaborone Private Hospital



6.5 QUALITY EVALUATION AT GABORONE PRIVATE HOSPITAL

What differentiated quality evaluation from Performance Management was that it came from an external source; the customers. Its relevancy to this study is that it contributed towards Performance Management. Quality evaluation was essentially based on customer feedback on services rendered. Information from customers was obtained through questionnaires, comment cards and electronic key evaluators. These tools of data collection were located at key points in each department throughout the hospital. The patients were required to use one or more of these tools on the day of their discharge. When they filled in the comment cards (Figure 3), patients were required to also fill in their contact details (Figure 4) as part of the follow-up process in quality evaluation investigations.

Figure 3 Comment Card

Customer Comments:

Do you want to compliment anyone for excellence? _____

Other comments: How can we further improve our service to you? _____



Figure 4 Customer Contacts Details



The questionnaires were divided into different sections, which included professional nurse promptness and knowledge on condition as well as the food and levels of comfort. From the descriptions given of the questionnaires by respondent F among others, it became clear that the questionnaires sought ordinal data. Although closed-ended questions are presented, senior management sought for customers to rank their preferences among the choice of answers given. The answers range from 'strongly agree' through to 'agree' to 'undecided' and 'disagree' to 'strongly disagree'. Similarly, the electronic key evaluator sought ordinal data with the very same range of possible responses. However, unlike the questionnaire, it only had five questions. The collection of ordinal data from these two tools was relevant to the GPH. Senior management sought to measure the levels of quality of their services.

The comment card differed from the other two tools in that it was open-ended. It presented a platform for both customers and management. For customers, they got the opportunity to express fair comment and constructive criticism. For management, they were presented with the prospect of further investigations of any complaints lodged by the customers. Customer feedback was evaluated at the previously mentioned quality meetings.

The role of quality evaluation was essentially to measure the grade of services offered to customers (Armstrong, 2006:496). It is important to note that there were various factors that fed into the overall levels of quality. It was these various factors that the respondents brought to light in relation to hospital administration. Respondent A stated that customer feedback helped to identify and highlight weaknesses in service provision. Respondent C stated that the hospital's biggest weakness was the professional nurse shortage. In her opinion, increasing professional nursing staff would solve this weakness. Respondent B also expanded on respondent A's point by stating that identifying and solving the weaknesses would improve

services. This aided in understanding and contextualizing customer needs, as respondent G pointed out. Respondent I pointed out that Quality evaluation helped to keep management more aware of what happened in the wards. Lastly, respondent D felt that positive feedback was a form of encouragement to continue providing good services.

When asked about the accuracy of quality evaluation, a great majority of the respondents stated that there were discrepancies. They went on to provide possible reasons for these discrepancies. Respondent A pointed out that at times patient comments are out of context. The example she gave was of a patient lodging a complaint about an outsourced worker instead of commenting on the quality of clinical care that he or she had received. Respondent B stated that quality evaluation was not necessarily representative of all the patients that came through GPH. She argued that customer response levels were dependent on the department. In the general wards, the environment was more controlled, as result customer response was higher. In contrast, in the Emergency Room the environment was less controlled. Consequently, the response rate is not truly representative. Respondent C also stated that some customers from the general wards were so disgusted with the service they received that they outrightly refused to take part in any form of quality evaluation. This deprived the hospital of vital data it could have used to better its services.

Respondent E argued that at times there was a discrepancy between two tools used by the same patient. For example, on the Electronic Key Evaluator the patient may have provided positive feedback, but on the comment card they may have provided negative feedback. Perhaps respondent G's perspective offers an insight into why patients would provide contradictory feedback. She alluded to a lack of objectivity on the patients' part, which influenced their evaluation. She pointed out that their emotional state was often reflected by how they filled in comment cards.

Mr Motsopa provided other contexts within which dissatisfaction may occur and how this distorted the accuracy levels. Factors like faulty machines and/or programmes, broken down telecommunication facilities or temporary acute staff shortages were considered when complaints are followed up. Furthermore, there were incidents where customers entered the wrong data on the Electronic Key Evaluator by mistake. In some cases, they did not remember providing the information. As part of the follow-up procedure, the customers were telephoned to gather more in-depth information on a complaint lodged. However, respondent

A pointed out that when some customers were called, they denied filling in the information on the comment card.

To sum up, quality evaluation offered the customers' perspectives on staff performance. Relating it to the study, respondent A pointed out that quality evaluation played a crucial role in identifying lacking areas. So this study argues that quality evaluation is important in identifying areas in need for skill upgrades among the professional nursing staff. The next section deals with how the practice of FFM at GPH has hindered career progression from non-citizen professional nurses.

6.6 CONCLUSION

This chapter has argued that non-citizen professional nurses were disempowered through poor career progression. Evidence of this was presented by the negative impact that the nature of their employment relationship had on IPP. The professional nursing shortage rendered JPM ineffective because the unit managers had no time to carryout timely follow ups. Other issues that compounded the disempowerment were a lack of transparency in the remuneration and reward systems and, wage restraint. The next chapter will argue that the practice of FFM has incapacitated the worker voice of the non-citizen professional nurses at GPH.

CHAPTER 7

7.0 DISEMPOWERMENT AND WORKER VOICE

7.1 INTRODUCTION

This chapter seeks to illustrate disempowerment through a weakened worker voice as a result of the practice of FFM. In the process of which it will also identify the type of HRM practised at GPH as a mixture of benevolent and restrained autocracies as identified by Dundon and Rollinson (2004:40) in chapter two. The previously identified types of representation and participation will be used to substantiate the claim. These are communicative involvement and work councils. In addition, this chapter will also reveal how the types of representation and participation available to non-citizen professional nurses are inherently disempowering. Lastly, this chapter will investigate the lack of trade union representation of non-citizen professional nurses at GPH.

7.2 HUMAN RESOURCE MANAGEMENT AT GABORONE PRIVATE HOSPITAL

In chapter two, it was noted that the primary goal for senior managerial goal within the organisation is to increase productivity at low costs (Edwards, 1979: viii; Hall, 2000:33; Armstrong, 2006:386). In line with this argument is Table 5 in chapter six which depicted such sentiment in the case of GPH. This section argues that the HRM style practiced at GPH is best described as a mixture of benevolent and restrained autocracies. As was cited in chapter two, the HRM style often sets the agenda for the types of worker representation and participation. However, this section sets to chart out a foundation for next section which will critically analyse representation and participation for dependent contractors at GPH.

HRM in the GPH context is a vehicle through which the previously mentioned senior managerial primary goals can be attained. To support this claim is senior managerial attitude towards non-citizen professional nurses shall be critically analysed. In course of this critical analysis, the perspectives of three groups shall be considered. These are senior management,

middle management and the non-citizen professional nurses. The forms of worker representation and participation and the nature of the employment relationship will be used as tools to critically analyse senior managerial attitude towards non-citizen professional nurses.

7.2.1 The Benevolent Autocratic Traits

To reveal the benevolent nature of the HRM style at GPH are three factors. Firstly, this section argues that Performance Management and the Consultative Communication Forum were a facade of joint regulation. This was reflected by how middle management in the form of unit managers and the [non-citizen] professional nurses did not feel that JPM was effective. The professional nurses' shortage was cited as being the root of its inefficacy. According to that Performance Management Booklet, IPP was meant to be a joint process towards the career growth of [non-citizen] professional nurses. However, because of the contingent nature of their employment relationship, non-citizen professional nurses faced a retarded career growth. This was depicted by Figure 4 in chapter six. To further support the claim a facade of joint regulation was the efficacy of the CCF. As a result of the precarious nature of their employment relationship, non-citizen professional nurses like respondent C did not feel that they could freely express their honest opinions. As a result, input from the non-citizen professional nurses appeared to be censored.

Secondly, co-operation was gained through persuasion rather than voluntary input from the [non-citizen] professional nurses. Mr Motsopa's⁴⁵ description of JPM in chapter six reflected the benevolent autocratic nature of HRM at GPH. A general overview of his description of JPM depicted a sophisticated HRM as described by Dundon and Rollinson (2004:40). A more critical analysis of the same description uncovered the autocratic nature of the JPM. The autocratic nature is reflected by how senior management aimed to increase control over the labour process by persuading worker co-operation. Evidence of this was presented by how Mr. Motsopa repeatedly stated one of the objectives of JPM was to 'make' the [non-citizen] professional nurses talk.

Lastly, this section argues that senior managerial attitude is depicted by viewing workers as factors of production rather than valued assets. Evidence of this claim is illustrated by the

⁴⁵ As HRM manager, Mr Motsopa falls within the senior managerial ranks.

ambiguous nature of the employment relationship between senior management and the non-citizen professional nurses as was argued in chapter five. It also illustrated by the poor career progression of the non-citizen professional nurses as was argued in chapter six. However, it is important to note that the precarious nature of the employment relationship is attributed to external influences that were cited earlier. These were the localisation policy in chapter three and Non-Citizens' Employment Act in chapter five. The localisation policies and Non-citizen Employment Act influenced the nature of the employment contract which GPH senior management signed with non-citizen professional nurses. The nature of the employment contract rendered the non-citizen professional nurses as contingent workers. In light of this, it is more rational for senior management to view non-citizen professional nurses as factors of production rather than valued assets. However, this was contradictory to the true nature of the non-citizen professional nurses' status because Table 8 revealed that although they were contingent workers, the non-citizen professional nurses portrayed tenure of permanent workers. Therefore, by virtue of this and the citizen professional nurses' skills shortage, non-citizen professional nurses should be viewed as valuable assets rather than factors of production.

7.2.2 The Restrained Autocratic Traits

It has been argued that the HRM style at GPH is a mixture of benevolent and restrained autocracies. This section aims to identify and address the restrained autocratic traits that the HRM system at GPH depicts. Firstly, similar to benevolent autocracy, workers are viewed as factors of production rather than valued assets under a restrained autocratic HRM. To illustrate the restrained autocratic traits secondly, it will be argued that senior management at GPH guards its prerogatives through HRM. The last section on benevolent autocracy illustrated how GPH senior management had used JPM to control the labour process. In addition to JPM is the CCF which is also used as a mechanism guard managerial prerogatives. The CCF identified as a managerial initiative and this is evidenced by how some respondents had described it as something that senior management had started.

Thirdly, the CCF is more of a paternalistic nature than it is representative or consultative. The paternalistic nature is illustrated by how the CCF is a 'generous gesture' on senior managements' part to share some of its decision making power with employees. Unlike the

paternalistic work council described by Rogers and Streeck (1995:10), the CCF is not intended to circumvent trade unions. Instead, it appears to be an attempt at filling in a void because non-citizen professional nurses are not eligible to be in trade unions. Representivity is illustrated by how each unit has a representative who sits on the CCF. The consultative nature is illustrated by how the CCF is supposedly as joint consultative forum. However, because of the 'covert lack of freedom of expression in addition to censorship'⁴⁶, it becomes evident that CCF was not aimed at the [non-citizen] professional nurses directly influencing their immediate work environment. Rather, CCF was aimed at cultivating a pseudo-sense of participation in decision making and a tool used in an attempt to indoctrinate professional nurses into the senior managerial goals.

Thirdly, as a result of the not overly obtrusive nature of restrained autocracy, the labour process is challenged covertly. The not overly obtrusive nature of a restrained autocratic system is revealed by how disempowerment is not an overt nature. For example, both Performance Management and the CCF both were used as smoke screens for joint consultation. The study has shown both Performance Management and CCF appear to be ineffective because non-citizen professional nurses cannot openly challenge senior management. For example, they are not in a position to confront management on issues like the lack of transparency in the reward system in fear of endangering their opportunities for contract renewals. So, the labour process is challenged covertly through desertion. In the last chapter, several respondents stated that highly aggrieved non-citizen professional nurses deserted GPH. Even Mr Motsopa indirectly alluded to desertion as well when he mentioned that GPH had lost some of its professional nurses to the United Kingdom, United States of America and Australia.

One of the major outcomes of a restrained autocracy was low trust levels between senior management and the non-citizen professional nurses. This study argues that in the GPH context, the paradoxical nature of the HRM system has led to covert disempowerment. The paradoxical nature of the HRM is brought out by the seeming benevolent aspects like joint decision making. This is in contrast to a precarious employment relationship which led to a fear of free expression. In addition, the contingent nature of their employment relationship renders IPP invalid. The lack of trust between the two is portrayed by a lack of freedom of

⁴⁶ To be expanded on in the following sections

expression on the part of the non-citizen professional nurses and the manner in which desertion is a mechanism used to challenge the labour process.

7.3 FORMS OF REPRESENTATION AND PARTICIPATION AT GABORONE PRIVATE HOSPITAL

The context in which worker representation and participation exists is increasingly changing with increased reliance on the external labour market (Cappelli, 2006:182). An expanding peripheral work force has meant that a large group of workers have fallen through pro-worker structures that were engineered for a permanent work force (Wilthagen and Tros, 2004:169). An example of such structures is trade unionism. In addition, management has increasingly sought out internal channels to communicate with employees (Gallie *et al*, 1998:87). This is not to say that pro-worker structures like trade unions are the only channels through which management can communicate with employees. Internal structures like work councils have and continue to co-exist with external structures (Watling and Snook, 2003:261). However, the context within which these internal structures operate in has changed. The forms of worker representation and participation identified at GPH are communicative involvement and indirect consultation. In addition, the objectives of the channels will be used to identify their disempowering qualities on professional nurses. Trade union participation and representation are also mentioned.

7.3.1 Communicative Involvement

Communicative involvement as a form of worker representation and participation took on various forms at GPH. With this in mind, this section will identify the aspects of the worker representation and participation that the forms of communicative involvement present. The types of communicative involvement identified by the respondents at GPH were meetings, memorandums, notices and information pamphlets. All of these are formal procedures through which information is disseminated.

A number of the respondents pointed out that information ‘filtered’ down to the professional nurses through meetings. From the data collected from the in-depth interviews, there were separate meetings for different levels. Mr Motsopa pointed out that there were monthly ‘Quality Meetings’ which were hosted by the Quality Manager. The Quality Committee

discussed issues of service delivery and outstanding employees. Respondent B stated that there were also managerial meetings which were referred to as the 'Managers Power Hour' where top management met with middle management to share information. Information received at these meetings was then dispersed to the professional nurses. Respondent G pointed out that for professional nurses there were different types of meetings for different issues:

Some meetings are weekly depending on what has to be discussed. You know some matters need to be urgently attended to ... and there's the monthly one where everybody else has to come...but mostly it's just monthly.

Respondents C, G and I stated that memoranda, notices and information pamphlets were also used to disperse new information. A good example of these types of communicative involvement was the Performance Management employee guide. It provided information on how the process of Performance Management worked by explaining its key traits. For example, by it explained the purpose of Performance Management; professional nurses were made aware of their role and contributions to the organisational structure (Life Healthcare, 2009:3).

By linking these identified forms of communicative involvement to the objectives put forward by Gallie *et al* (1998:91), it becomes clear that GPH aims towards cultivating a strong sense of participation. By sharing information with the employees, they become relatively aware of some organisational developments (Gallie *et al*, 1998: 96). To support this statement is the following from the Performance Management Employee Guide:

Performance Management ... recognises the contributions that *I* make to the company (Life Healthcare, 2009:3).

By being projected as a valuable asset to GPH, it appeared that a sense of participation was evoked among professional nurses. Respondent I's statement reflected this:

Because it is *our business*, we have to have more patience. If the hospital has more money, we can also hope to have a raise in salary

Despite the move to cultivate a strong sense of participation by management, the professional nurses did not influence their immediate environment and work process (Gallie *et al*,1998: 96). This can arguably be linked to a number of factors like their contextual role (Henderson, 2006:21). As was pointed in chapter five, a professional nurse's role was contextualised by the services offered by the ward they work in. Some wards, like ICU, required nurses to have a supplementary role, whereas less specialized wards required a more auxiliary role. In a supplementary role, the professional nurses act as an extension of the medical role played by the doctor. In contrast, an auxiliary role is one where the nurse cannot carry any of the functions of the doctor like canulation.

In relation to the nursing profession as a whole, irrespective of the ward that the professional nurse works in, he or she is stereotyped by management as assuming an auxiliary role to the medical profession (Henderson, 2006:23). The implication of this stereotyping is that professional nurses are not considered to be highly skilled workers inspite of their specializations. As a result, they do not qualify for direct representation and participation through structures like quality circles (Gallie *et al*,1998: 90). The unintended outcome of this is that professional nurses are disempowered in the sense that cannot directly contribute into their immediate environment and work process. This is despite their intimate knowledge of technology and work process (Potterfield, 1999:2; Ahanotu, 1998:181). At GPH, their intimate knowledge of technology and work process was evidenced by how some professional nurses took up the role of Night Superintendent with ease. In addition, respondent I pointed out that some the professional nurses at GPH had held managerial positions in their last places of employment.

Another feature of disempowerment was the nature of communicative involvement; it did not facilitate two-way communication channels. Meetings at GPH were of a hierarchical nature as was evidenced by the different levels of meetings. The meetings were not designed to be information sharing platforms but rather mechanisms through which information was predominantly handed down from the top. Thus, the nature of meetings at GPH was inherently disempowering for (non-citizen) professional nurses. Memoranda, notices and information pamphlets were also reflective of worker disempowerment as they also shared the inherent trait of a one way communication channel.

To sum up, communicative involvement at GPH did not aim to empower workers. Rather, its objective was to evoke a sense of participation, which made worker co-operation more viable. The sharing of information created a sense of awareness, which in turn created an illusion empowerment. Awareness did not necessarily equate empowerment if the (non-citizen) professional nurses were not presented with the opportunity to influence their immediate work environment through a two-way communication channel. A lack of such empowerment was evidenced by how some respondents pointed out that disgruntled professional nurses have resorted to desertion.

7.3.2 Indirect Consultation

Indirect consultative representation and participation at GPH was characterised by the CCF (Gallie *et al*, 1998: 99). The CCF was equated to a paternalistic work council in a previous section. It was through representatives that [non-citizen] professional nurses gave input into the work process. The CCF met with management to discuss issues that professional nurses wanted to be highlighted , as stated by respondent E. As its title suggests, it was a consultative work council. As a consultative work council, the CCF appeared to be an extension of communicative involvement. This was in the sense that the main objective behind its existence was to facilitate two way communication and make worker cooperation easier. This was illustrated by Mr Motsopa's description of the CCF. He stated that it was through the CCF that 'non-confidential' information was shared. By attaining worker cooperation, issues like the quality of service delivery were taken seriously by the [non-citizen] professional nurses. The quality of service delivery played a big role in the competitiveness and organisational growth of GPH. This was shown by how respondent I referred to patients as customers and how she also acknowledged that poor service delivery would drive existent and potential customers to the competitors.

Arguably, the CCF could have been said to be a channel that facilitated two-way interaction that communication involvement did not. However, there was evidence that suggested otherwise. Although it could be viewed as an empowering structure, the manner in which information was conferred reflected disempowerment. To support this observation is the manner in which information is presented to the CCF. Mr Motsopa stated that 'non-confidential' information was first put through to management before it is discussed with the

CCF. Firstly, Mr. Motsopa did not qualify what he meant by the term ‘non-confidential information’. This could be viewed as the first stage of information censorship. Workers were not made fully aware of the true nature of information pertaining to the hospital. Secondly, putting the non-confidential information before senior management before conferring it to the CCF, implied a second stage of censorship. The information then received by the CCF has been censored twice thus making its content suspicious. This dual censorship was a clear indication of senior management taking steps to guard its prerogatives. Hiding the true nature of information from the CCF was disempowering in the sense that the decisions made based on censored information.

The manner in which the CCF functioned⁴⁷ did not fall under managerial prerogatives although it was a managerial initiative. So, the anonymity of contributions detracted from the inherently unequal employment relationship. Theoretically, the CCF was supposed to remove fears of worker intimidation that were often associated with direct confrontation. However, this was not the case as was evidenced by respondent C. She stated that in her ward a Motswana professional nurse was nominated to represent the ward because the other professional nurses felt that he would be able to freely express himself. On the other hand, she felt he did not represent the non-citizen professional nurse’s plights. Her stance was based on how non-citizen professional nurses feared that by freely expressing themselves as CCF representatives, their chances of contract renewal would be diminished. Although this research did not uncover any evidence of intimidations of such a nature, there appeared to be a sense of desolation among the non-citizen professional nurses where representation was concerned. For example, quite a number of the respondents felt that non-citizen professional nurses had no true representation and that accounted for why disgruntled professional nurses left GPH. In such a situation, structures like CCF were not empowering as the professional nurses especially non-citizen professional nurses felt that they had to censor themselves. Censorship of any kind hindered their freedom of participating in potentially empowering structures.

In conclusion, the very nature of the CCF was not an empowerment tool but rather a mechanism through which compliance could be attained. This in itself was disempowering as [non-citizen] professional nurses are not awarded an appropriate platform for input.

⁴⁷ For example, who the professional nurses elected to represent them on the CCF.

Secondly, the dual censorship that the information shared with the CCF went through undermined its efficacy as a channel for worker representation and participation. Lastly, the self-imposed censorship that non-citizen professional nurses practiced also served to undermine the efficacy of the CCF as a channel for worker representation and participation. Although the CCF could have been a potentially empowering structure for (non-citizen) professional nurses, the context in which it operated in tainted its chances of being an empowering tool.

7.4 LACK OF TRADE UNION REPRESENTATION FOR NON-CITIZEN PROFESSIONAL NURSES

A theme of desolation in terms of worker representation and participation was identified in the last chapter. This theme appeared to be more established in terms of trade union representation. Data from the questionnaires revealed that all but one (a Motswana professional nurse) of the respondents was associated to neither nursing trade union nor a body with such a function. The importance of this observation to this section of the research is that it showed an instance of where poor access to correct information had further restricted professional nurse access to empowerment. This section set out to investigate from the data collected why non-citizen professional nurse were not affiliated to a professional nursing trade union. In the course of this investigation, reference shall be made to the external support structures in place for professional nurses, worker legislation and the GPH employment contract.

Within the Botswana context, there were two main bodies that presided over the nursing profession. These were the Botswana Nursing and Mid-Wifery Council (BNMC) and the National Association of Nursing and Mid-Wifery (NAB/BNA). BNMC was a body that was established by s3 of the Nurses and Midwives Act. Its duties and powers were articulated in section 7⁴⁸. According to section 10⁴⁹, no professional nurse was allowed to practice without out registering with BNMC. However, BNMC is a profession council not a trade union. The NAB/BNA is closely associated with BNMC as was evidenced by s3 of the Nurses and

⁴⁸7.(1) It shall be the duty of the Council to ensure and maintain a high standard of nursing and midwifery education in Botswana and the establishment of the safe and effective practice of nursing and midwifery.

⁴⁹ 10 (1) No person shall practise as an enrolled nurse, a midwife or nurse unless his name appears in the appropriate register referred to in section 8 and he is in possession of a current practising certificate entitling him to practise as such enrolled nurse, midwife or nurse in Botswana.

Midwives Act. This section promulgates that the current NAB/BNA president sat in on the BNMC. NAB/BNA took on the role of a trade union for professional nurses. This was evidenced by its value statement below

The NAB believes in the respect, dignity and uniqueness of human beings. Therefore we value the importance of our members, clients, employers and other stakeholders as contributors in reaching the goal of health for all. We value the power of organized groups to act collectively to effect change, provide quality care and improve customer satisfaction. NAB believes that improvement of the socio-economic welfare of nurses is a vital ingredient for effective service delivery. We believe that the development of nurses and the profession will enhance contributions to policy and programme development for a better health service (NAB/BNA, 2009).

In the course of promoting professional nurse welfare, NAB/BNA offered to assist professional nurses “who, by reason of adversity, are in need of assistance, at the discretion of the Executive committee” (NAB/BNA 2009). In doing so NAB/BNA established itself as a body that facilitated external professional nurse representation and participation. Unlike communicative involvement and indirect consultation, trade union representation was not a managerial initiative. It was for this reason that management could not manipulate its initiatives.

There were three types of membership with the NAB/BNA. These were life membership, junior membership and full membership (NAB/BNA 2009). Of these, the most relevant to this research is full membership. Full membership was “open to any nurse who is on the Register of the Nursing and Midwifery Council of Botswana or whose general nursing and/or midwifery diploma entitles her/him to be so registered” (NAB/BNA 2009). This then proves that membership is not limited to citizen professional nurses. In fact, respondents F and G recognized this and went on to mention that all professional nurses were encouraged to join although it came down to personal choice. What neither of them recognised was that only permanent professional nurses irrespective of citizenship were eligible to join the BNA/NAB. However, in light of the Non-citizen Employment Act and the localization policy, non-citizen professional nurses could not be permanently employed.

The opinions of respondents A and I reflected the above argument. Respondent A alleged that trade union membership for non-citizen professional nurses was illegal and that senior management had informed her of this. Respondent I claimed contract workers were not

permitted to join trade unions and she was informed of this in her employment contract. Respondents A and I were correct in the sense that as a result of their dependent contractor status, non-citizen professional nurses could not legally join the BNA/NAB. However, a copy of the employment contract did not reflect respondent I's claim. There was also no conclusive evidence to prove or disprove that all employment contracts issued to periodical contract professional nurses were identical. From the data collected from the questionnaires, it is of interest to note that just under half of the participants did not think that they were legally allowed to be trade union members. Table 9 below shows the rest of the responses given by the participants. Therefore, the figures shown in Table 10 relating to trade union membership are not surprising. None of the participants were members of NAB/ BNA.

Table 9 Legitimacy of Trade Union Membership

Legitimacy Of Trade Union Membership	Frequency	Percentage
Yes	3	9
No	16	48
Not Sure	13	39
Did Not Respond	1	3
Total	33	100

Table 10 Trade Union Membership

Trade Union Membership	Frequency	Percentage
Yes	0	0
No	33	100
Total	33	100

It is interesting to note that when reference was made to the absence of professional nurse trade unionism, Mr Motsopa pointed out that the 'general labour laws' did not differentiate between contract workers and permanent workers. Both types of workers were eligible for trade union membership unless the law specifically stated that a certain group of workers are not eligible. He attributed respondent I's opinion to personal perception rather than fact.

It is important to understand how the respondents' opinions came about. With this in mind, a lack of trade union activity among the non-citizen professional nurses could be attributed to covert suppression and substitution by senior management. Covert suppression within the

GPH context was also evidenced by not necessarily misinformation, but rather a lack of information. Senior management had experts in the form the HR manager, Mr Motsopa, to inform it of its organisational rights and duties. However, the same courtesy was not necessarily extended to the non-citizen professional nurses. This was evidenced by the responses of respondents F and G in relation to trade union membership. There also appeared to be an undercurrent of intimidation in terms of contract renewal.

The creation of CCF could also be a covert form of trade union substitution. In the GPH context, substitution was not aimed at undermining trade union activity but rather eliciting non-citizen professional nurse cooperation to maintain a competitive edge. The efficacy of this was questionable as the non-citizen professional nurses regard management with suspicion. However, what can be inferred from Mr Motsopa's statement below is that trade unions were not a favourable channel as their 'external' interference is not necessarily constructive:

Trade unions are only aiders to conflict resolution. They only aid us. At the end of the day it is management who should handle conflict and deal with it through discipline... You try to minimize the conflict and where you can you bring in the union and say your union member you can be present when we talk to this individual. And sometimes the union takes it back to their employers even though I can tell when the employee is subjected to discipline the union will not always tell their members the correctness about it. They will keep quiet, when the person is dismissed that is when they will make a noise about it. I am in favour of the union because as I said the unions are aiders. Sometimes they can aid you in terms of how you should handle their member because we allow them when it is their member. When it is not their member they employee has the choice to bring in any employee to the disciplinary hearing.

Notably, the above statement was not in reference to non-citizen professional nurses but rather to other members of staff at GPH. However, it did reveal managerial attitude towards trade union activity. It appeared that managerial attitude towards trade unions was not purely negative. But there was evidence suggesting that management preferred for issues to be dealt with internally without external interference from trade unions. Trade unions were only viewed as aiders to conflict resolutions processes.

7.5 CONCLUSION

Throughout this study, reference has been made to how the practice of FFM has led to different treatment for workers of similar productivity. This chapter sought to illustrate how the practice of FFM weakened the worker voice of the non-citizen professional nurses at GPH. The root of the weakened worker voice is located in the nature of the employment relationship. The unstable nature of contingent employment led to non-citizen professional nurses trying to preserve their tenure through self-censorship in the CCF. Secondly, the types of representation and participation the non-citizen professional nurses had access to did not appear to be empowering. The information passed onto the CCF was censored. The CCF and JPM were all aimed at attaining worker co-operation rather than joint decision making. Because of their precarious employment relationship, non-citizen professional nurses appeared to be intimidated rather than persuaded to co-operate. Intimidation was also shown by desertion rather than open confrontation with the senior management. In light of this, this study argued that the type of HRM practiced at GPH was a mixture of benevolent and restrained autocracy. Lastly, the lack of trade union representation and participation for non-citizen professional nurses was attributed to dependent contractor nature of their employment status. A lack of trade union representation and participation has meant that a potentially empowering venue has been blocked. Trade union representation was found to be potentially empowering because it was external to GPH and unlike the CCF, it was not a managerial initiative. Furthermore, the non-citizen professional nurses may not have had to subject themselves to self-censorship.

CHAPTER 8

8.0 CONCLUSION

8.1 INTRODUCTION

In this final chapter, the study will be concluded by identifying and summarizing what each building block contributed towards the study.

8.2 THE INTRODUCTORY CHAPTER

Chapter 1 set out the context within which GPH exists. By providing a brief background on GPH, the restructuring processes that have occurred may be traced. In addition, the factors that contributed towards are also identified to illustrate GPH's external environment. This chapter also linked the relevancy of this study to the Industrial Sociology discipline. Thereafter, a brief outline of the study was laid out.

8.3 LITERATURE REVIEW

Chapter 2 provided the first step towards the research by tracing the changes in the nature of work, organisations and employment relationships. In doing so, a backdrop against which the study is set in was laid out. The idea of FFM was identified as being rooted with the post-Fordist paradigm. Focus was placed on how the practice of FFM impacted the employment relationship, worker representation and participation and career development of dependent contractors. Thereafter, these impacts were applied to the health care sector where the migrant professional nurse was identified as a dependent contractor. Lastly, the external conditions which facilitated disempowerment were identified.

8.4 THE BOTSWANA PROFESSIONAL NURSING SITUATION

Chapter 3 in some regards is an extension of chapter 2. However, chapter 3 was more concerned with the professional nursing context within Botswana. Factors like Botswana's historical economic development and the shortage of professional nurses were discussed to illustrate the immediate context within which GPH exists.

8.5 RESEARCH DESIGN

Chapter 4 addressed research design issues. The research objectives were clearly outlined to show the parameters of the research. The case study approach to research reflected the nature of the study. The use of the case study approach was justified by the research objectives which called for an approach that generated practical knowledge. Three tools were used in the collection of data and these were document analysis, questionnaires and in-depth interviews.

8.6 THE AMBIGUOUS EMPLOYMENT RELATIONSHIP

Chapter 5 dealt with the classification of non-citizen professional nurses and their role within the GPH in relation to FFM. The non-citizen professional nurses were classified as dependent contractors. The study proceeded to defend its stance based on the employment contract, labour laws and policies. A gap within the labour laws was identified. The Botswana labour laws did not differentiate between dependent and independent contractors. This gap meant that non-citizen professional nurses at GPH were wrongly classified as employees in their employment contracts, yet they showed traits of dependent contractors. The wrong classification resulted in an ambiguous employment relationship.

The presence of non-citizen professional nurses at GPH facilitated functional and numerical flexibilities. However, the global professional nurses' shortage had undermined these flexibilities as was evidenced by flexing and the overtime shifts. Functional flexibility was evidenced through role revision. Senior non-citizen professional nursing staff on night duty also assumed the role of the Night Superintendent. The Night Superintendent position had been phased out as a part of the streamlining process GPH underwent. Role revision also

implied organisations restructuring which was evidenced by the privatization of the on-site clinics to doctors.

Four key findings were explored in chapter 5. Firstly, there is a gap in the Botswana labour law; dependent contractors are not differentiated from independent contractors. Secondly, as a result of misclassification, the non-citizen professional nurses were in an ambiguous employment relationship with GPH senior management. Thirdly, non-citizen professional nurses were essential to the functional and numerical flexibilities at GPH, despite their ambiguous status. Fourthly, the foundations of horizontal labour market segmentation were entrenched in the localization policy and labour laws. Lastly, GPH had not been unscathed by the global professional nursing shortage.

8.7 POOR CAREER DEVELOPMENT

Chapter 6 argued that one of the implications of an ambiguous employment relationship was retarded career development. This argument was based on how, as dependent contractors, the duty of skills development is implicitly shifted from the employer to the non-citizen professional nurses. On the other hand, the temporary nature of their tenure and a heavy workload did not facilitate self-funded skills development. The outcome was that non-citizen professional nurses experienced a retarded career development. On a more positive note, GPH offered all professional nursing staff in-house short courses.

The manner in which Performance Management was carried disempowered non-citizen professional nurses. Firstly, as a consequence of the critical professional nursing staff shortage, unit managers did not have the time to carry out timely follow-ups of JPM. This had an impact on IPP because the points scored in JPM were a part of IPP. Secondly, the contingent nature of their employment meant that non-citizen professional nurses were not eligible for promotions. This rendered IPP irrelevant within the GPH context. Other issues which compounded the non-citizen professional nurses' disempowerment were wage restraint and a lack of transparency in the reward systems. The lack of transparency in the reward systems brought about issues of mistrust between senior management and the non-citizen professional nurses.

There were four key findings in chapter six. Firstly, the nature of the employment relationship had a negative impact on the non-citizen professional nurses' career development. The contingent nature of their employment relationship did not facilitate significant skill upgrades. Secondly, the flawed nature of Performance Management contributed towards the non-citizen professional nurses' career retardation. JPM [which was a part of IPP through its point system] was flawed because of a manpower shortage; unit managers could not carry out timely follow-ups. IPP was flawed because it was designed for permanent staff rather than contingent staff. Thirdly, there were low trust levels between the professional nurses and senior management. This was evidenced by the lack of transparency and accountability in the reward system. Lastly, there were low incidents of promotion among non-citizen professional nurses. This was attributed to the nature contingent of their employment relationship. The contingent nature of their tenure rendered non-citizen professional nurses ineligible for IPP, a key aspect within the promotion process.

8.8 A WEAK WORKER VOICE

Chapter 7 sought to show how the practice of FFM had weakened the worker voice of non-citizen professional nurses. Other than the contingent nature of their employment relationship, HRM was cited as a contributory cause. The HRM practiced at GPH was characterized as having a mixture of benevolent and restrained autocratic traits. The manner in which HRM was practiced at GPH tended to influence the efficacy of the worker voice. Chapter 7 proceeded to illustrate how HRM influenced the identified forms of worker representation and participation.

Communicative involvement and indirect consultative were the identified forms of worker representation and participation. They were mainly characterized by the trickling down of information from senior management to the professional nursing staff. The trickling down effect of information was noted to be an attribute of autocratic HRM practices. The aim behind them was to obtain worker co-operation through persuasion rather than direct input and influence into the immediate working environment. The lack of trade union membership at GPH was pointed out as an illustration of the legal implications of being a dependent contractor. As dependent contractors, non-citizen professional nurses were not eligible to become trade union members.

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APPENDIX 1

REFLECTIONS ON THE FLEXIBLE FIRM AND WORKER DISEMPOWERMENT

Disempowerment at GPH has been manifested through worker representation and participation and ineffective skill upgrade. These forms of disempowerment are compounded by the global professional nurse shortage and maladministration of available human resources (Buchan *et al*, 2003: 26). This study concludes that a re-conceptualization of the role professional nurses, a re-conceptualization professional nurse representation and participation, reorganization of tasks, effective use of human resources and continued education are required.

Effective Use of Human Resources

For the effective use of human resources certain foundational changes that need to be made. The first of these changes entail re-conceptualizing the role of professional nurses (Henderson, 2006:21). Nursing in the Botswana context needs to be acknowledged as an independent discipline rather than a secondary one. Evidence from the data collected suggests that professional nurses are mostly viewed to have an auxiliary role rather than a supplementary role. This is evidenced by how the Ministry of Health acknowledges the shortage but will not allocate a scarce skills allowance to the nursing profession (Morula, 2009). As a result both local and non-citizen professional nurses leave Botswana for the better paying institutions outside Botswana (Baputaki, 2009). Even Mr Motsopa points out that GPH have lost some its professional nurses to institutions in the United Kingdom, Australia and Canada.

At GPH only ICU professional nurses are permitted to carry out procedures like canulation whereas in other wards that duty is solely left to the doctor. Further evidence of their auxiliary role is evident in the forms of worker participation and representation. The data collected reveals that cooperation rather than direction participation into the labour process is sought out from professional nurses. As an outcome this non-citizen professional nurses especially feel powerless in several contexts. They feel that they are not free to express their concerns to senior management. Non-citizen professional nurses also appear to be ignorant

about their participation and representation rights. There is limited exposure to continued education (Cheung and Aiken, 2006: 358). The overall effect is worker disempowerment. This has only served to worsen a bad situation as professional nurses would rather exit the organisation than resolve their issues with the hospital.

This disempowerment was reflected on the functional and numerical flexibilities of the organisational structure. A relatively high professional nurse turnover may have a negative impact on the flexibility levels of the organisational structure. A heavy workload, the hiring of agency professional nurses and the use of the overtime systems reveals that there is poor internal numerical flexibility. The centralization of some clinical procedures like canulation and Total Nursing Care reduced the opportunities for functional flexibility among professional nurses and nurse aids.

Effective human resource utilization through the decentralisation of some processes and continued education could remedy some of the identified issues (Tuttas, 2003:231). The decentralisation of some procedures like canulation from doctors to professional nurses could lead to more functional flexibility for professional nurses. The shifting of such a procedure would not leave the hospital to legal action as such procedures are a part of the professional nurses' initial training. Teamwork and quality circles among professional nurses and nurse aids can be used to remedy the lack of direct input into worker participation and representation (Tuttas, 2003:231).

Secondly, the professional nurse shortage appears to be of a long term nature rather than a short term one. As a result, the two year contracts awarded to non-citizen professional nurses are of minimal value to alleviating the professional nurse shortage in Botswana (Morula, 2009). In the GPH context it leaves the hospital vulnerable to more shortages if non-citizen professional nurses do not renew their contracts. The long term nature of professional nurse shortage is shown by how non-citizen professional nurses are able to hold 9 consecutive two year contracts with GPH. Although this could warrant a misuse of the contract system, Botswana and GPH in particular is to an extent in dire need of professional nurses (Wilthagen and Tros, 2004: 172).

What this research suggests is gradual increment of tenureship with the GPH with each renewal (Wilthagen and Tros, 2004: 172). For example the first contract can be two years, the

next one can be three years and the subsequent ones can be five years. Of course each renewal would be subject to section (5) (6) of the Employment of Non-Citizens' Act and the respective professional nurse's overall performance. The key advantages of such an arrangement would be retention of skilled professional nurse staff and it would also form a foundation for extensive skill upgrades like degree programmes (Cheung and Aiken, 2006:357). The gradual increment of tenureship could also be used a pull factor for recruitment of professional nurse staff.

Thirdly, the more systematic use of nurse aids to alleviate the professional nurse workload (Tuttas, 2003:231). The decentralisation of Total Nursing Care could serve such a role. If the duties of professional nurses were decentralised workload could possibly be greatly reduced. Tuttas (2003:231) puts forward the idea of listing professional nurse duties then redistributing the non-clinical related duties to a team of trained nurse aids. However, issues of supervision come into question. When questioned about the use of nurse aids as a way of alleviating the work load, Respondent G stated that it was not a good idea because nurse aids require constant supervision. Constant supervision only served to increase the workload. Tuttas (2003:233) recognised this problem but came up with a possible solution which shifts the burden of supervision to a senior ranking nurse aid.

This nurse aid could undergo extensive supervision training. Another possible solution could be that all nurse aids undergo extensive supervision training and have rotational team leadership. Specific duties like baths, reading temperatures, feeding and weight measurements are allocated to respective nurse aids with a team. Supervisory tools like task registers could be used for transparency and accountability purposes. The team leader's duties would entail being in supervision, follow ups, charge of task registers, reporting to the respective professional nurses, receiving orders and allocating duties to the team of nurse aids (Tuttas, 2003: 231).

This research concludes that such a model could potentially be beneficial to the GPH context. At the time that this research was carried out, Respondent A revealed that the hospital provided 'Total Nursing Care' to its patients in ICU. Essentially, this type of patient care appears to be highly centralised as the professional nurse carries out all of the care requirements which range from clinical to non-clinical duties. With the 2003 restructuring exercise, the professional nurse to patient ratio had been decreased. So an induced low

professional nurse to patient ratio and a highly centralised care regime for patients only served to increase the workload.

The possible benefit of adopting the suggested model could play a crucial role in the increment of numerical and functional flexibility (Atkinson, 1985:18; 1994:339). Firstly, this forms a foundational training platform for nurse aids who might wish to progress on to being professional nurses. Secondly, rotational supervision equips the nurse aids with administrative and leadership skills (Tuttas, 2003:233). Thirdly, GPH would be cultivating its own skills base within its organisational structures (Cheung and Aiken, 2006:357). This could play a key role in recruiting and retention of skilled citizen staff. Notably, only skilled non-citizen personnel are awarded work permits. This means that the nurse aids are Batswana. By training them and offering nurse aids opportunities to upgrade their qualifications, GPH would be potentially solving the problem of insufficient local supply of professional nurses (Morula, 2009; Baputaki, 2009). In addition, the systematic use of nurse aids could reduce labour costs by possibly reducing the demand for agency professional nurses. Lastly, team work gives the nurse aids more direct control over their work process by giving them room to come up with innovative ways to carry out their duties (Tuttas, 2003: 233). So, not only does GPH elicit cooperation from this particular group of workers. It also has their loyalty as direct input elicits a sense of ownership.

Continued Education

This research has identified a lack of continued education ethos at GPH. When asked if they wished to upgrade their current qualifications most of the interviewed respondents stated that they would. This reveals that although the non-citizen professional nurses wish to upgrade their qualifications, they lack a medium within which to do so. In the 2003 restructuring exercise, the office of Continued Education Officer was removed. This research suggests that this office be reinstated to help cultivate a spirit of continued education among the workforce, irrespective of citizenship. All of the interviewed respondents concurred that there was a professional nurse shortage especially within the Intensive Care and Theatre nursing disciplines. A Continued Education Officer played the key role of identifying where the hospital is lacking in terms of professional nurse skills and remedying these shortages through skill upgrade programmes.

Mr Motsopa pointed out that GPH did not meet the Tertiary Education Council's standards to be a training hospital. As a result, the hospital was forced to rely on external sources for extensive skill upgrades. The danger of this is that there is poor professional nurse retention and recruitment irrespective of citizenship (Baputaki, 2009). After receiving their qualifications from external sources professional nurses are willing to sell their labour power to the highest bidder rather than staying at GPH. As a result, GPH was forced to recruit for more professional nurses on a regular basis. Poor retention was compounded by poor working conditions.

Poor retention may be remedied by internalizing extensive training. This could be done by taking part in virtual training (Lindeman, 2009:6). Professional nurses would not have to physically leave their place of work to undergo continued education. This is in line with that of North Shore-Long Island Jewish Health System which sought to bring the classroom to the professional nurses to encourage continued education (Cheung and Aiken, 2006:358). Virtual training for professional nurses would mean that all who are exposed to it become computer literate. With the increased computerization of the work process, computer literacy becomes a very important skill to acquire. Perhaps GPH could follow the lead of Mayo Clinic in Phoenix Arizona by trading some training space for access to training courses for its staff (Cheung and Aiken, 2006:361). By going into alliances with local and international training institutions GPH may be able to improve the quality of its professional nurse skill base (Cheung and Aiken, 2006: 360).

Cultivating an Environment for Continued Education

One of the reasons that Botswana is facing problems in retaining and recruiting local professional nurses is a lack of career opportunities (Baputaki, 2009). The biggest setback identified by this research is that GPH did not cultivate an environment for continued education for professional nurses. The most salient hindrances to continued education identified by this research include a lack of financial support, a work schedule not conducive for continued education and the absence of incentives to encourage continued education among professional nurses. GPH as a private institution in Botswana is also with faced with

the disadvantage of being incapable of offering a better wage package than the government (Government Paper No.1, 1990:5). However, this research suggests that by cultivating an environment for continued education, GPH could possibly become a magnet hospital (Cheung and Aiken, 2006:357). Tenure, a study friendly work schedule, free training, bridging forums, bursaries and scholarships are some of the incentives GPH could use to encourage continued education (Cheung and Aiken, 2006: 358).

The gradual attainment for more secure tenureship could play a pivotal role in professional nurse retention especially with non-citizen professional nurses. More secure tenureship could be tied in with attainment of more worker rights. Similar to the 'four phase system' in the Netherlands, the first contract for non-citizen professional nurses could be characterised by minimal benefits (Wilthagen and Tros, 2004: 172). Contract renewal will be based on section (5) (6) of the Employment of Non-Citizens' Act and performance. The subsequent contracts could come with increased eligibility for continued education facilities like bursaries, scholarships and a study friendly work schedule. Upon completion of any courses part taken by the professional nurses, they are bonded to GPH for no more than three years. All subsequent contract renewals will be subject to section (5) (6) of the Employment of Non-Citizens' Act and performance.

But then the problem is [the] off-duty system or the working hours are not conducive for any of the after work furthering of your education (Respondent I)

As the above quote reveals, a work friendly schedule is key in facilitating continued education (Cheung and Aiken, 2006:357). It appears that the North Shore-Long Island Jewish Health System was able to formulate a study friendly work schedule by shifting the classroom to the workplace (Cheung and Aiken, 2006:358). Time spent in between an external training centre and the hospital is eliminated. Training is incorporated into the work process making the work experience a learning process as well for professional nurses. For programmes not available in Botswana, virtual training from internationally recognised institutions could be used (Lindeman, 2000:7). The active promotion and use of virtual training could remove the need for professional nurses irrespective of citizenship to leave Botswana for career development purposes.

Respondent C put a lack of financial support as a hindrance to continued education. Bursaries and/or scholarships could be used as incentives to encourage continued education. Hackensack University Medical Centre (HUMC) followed a 'Tri-level approach' which included financial support for those professional nurses who wished to take part in continued education (Cheung and Aiken, 2006:358). HUMC established three scholarship funds for its professional nurse staff. One of the outcomes of the 'Tri-level approach' has been that just over half (55 per cent) of the professional nurse staff holds an undergraduate degree or higher qualifications (Cheung and Aiken, 2006:359). Similarly, Children's Hospital of Philadelphia (CHOP) offers annual scholarships of USD10 000 to its professional nurse staff (Cheung and Aiken, 2006:360). This subsequently has resulted in a great majority (87 per cent) of the professional nurses hold undergraduate degrees or higher qualifications (Cheung and Aiken, 2006:361). Free training in minor certificates could be used as part of a reward system for professional nurses who have completed extensive programmes (Cheung and Aiken, 2006: 360).

Bridging forums within the GPH context could play a key role in recruiting more Batswana professional nurses. Cheung and Aiken (2006:360) mention a Nursing Club in the CHOP context where nurse aids are provided with information to make informed decisions about a career in professional nursing. A possible alliance with BNA/NAB could be used to expose nurse aids to the choices and information they can access about the nursing profession. In addition, BNA/NAB could also use this as a platform to recruit more members from GPH. BNA/NAB could play a major role in informing the professional nurses at GPH of their worker rights. All of the above mentioned suggestions for turning GPH into a magnet institution will lead to it being in indirect competition with the government for professional nurses.

APPENDIX 2

INTERVIEW SCHEDULE FOR PROFESSIONAL NURSING STAFF

1. For the survival of any business be it factory, a hotel or in this case a hospital- that business needs to be responsive to its external environment- in terms of tax, labour laws or policies, technology and even local culture. To be able to do this the business has to constantly go through restructuring processes to improve competitiveness (Lee and Clarke, from the 1992 November edition of Healthcare Financial Management Journal).

- a. With this in mind, how does GPH as a company go about informing you, its staff about implementing a restructuring exercise?
- b. How does this differ from the last hospital you worked in?
- c. Were you working here in 2003?

If yes, according to the Botswana Press Agency (published 10 December 2003), 110 employees were retrenched to reduce operating costs.

- d. Do you know how management determined who could go and who could stay? Did they use any particular system e.g. last-in-first-out or those who were close to retirement age were asked to leave?
- e. Were other options like wages-cuts or flexi-work offered in place of retrenchment?
- f. In relation to the last question, how did the retrenchments affect the remaining staff? Were new positions created? Were old positions done away with or consolidated?

2. From the 1990s hospitals, especially private hospitals have been run like a corporate, for example patients are no longer just patients; they have also become customers. With regard to this (Pillar and Jarjoura, from the 1999 May Journal of Nursing Administration)
 - a. What measures are taken by GPH to ensure customer service expectations are met?
 - b. Do you have customer satisfactory surveys? What role do these play in the administration of the hospital?
 - c. When evaluating customer feedback, what factors are considered? For example pain management, education pertaining to condition received while hospitalised and promptness of staff.
 - d. How accurate do you think these customer satisfactory surveys?
 - e. Did you have customer satisfactory surveys at the last hospital you worked at?
 - f. Why do you think this was so?
3. To ensure that nursing staff is retained, and kept in top notch performance, there is need to regularly evaluate and re-evaluate the staff body.
 - a. How is the nursing staff members evaluated at GPH?
 - b. How does this differ from the other hospitals you have worked at?
 - c. How are outstanding nursing staff members recognised?
 - d. How does this differ from the other hospitals you have worked at?
4. I've read in various nursing journals (Journal of Nursing Administration) about the global nurses' shortage especially in areas of specialty like ICU. I've also read that in-house degree programmes are a good way of recruiting and retaining staff (6 case

studies were carried by Cheung, Aiken and Faan in the 2006 edition of Journal of Nursing Administration).

- a. With this in mind, have you ever considered upgrading your current qualifications?
 - i. Yes/No...Why?
 - b. Would having in-house degree programmes encourage you to upgrade your current qualifications?
 - i. Yes/ No...Why?
 - c. Is your salary structured according to your academic qualifications?
 - d. If you wished to change departments within the hospital for example to another ward, would you be able to?
 - e. If you were promoted to an administrative level for example, unit manager. Do you think that the hospital would provide an administrative induction course?
 - i. Why?
 - f. When you were promoted to an administrative level, did the hospital offer you any administrative induction training?
5. I've read in various nursing journals (Journal of Nursing Administration) about the global nurses' shortage especially in areas of specialty like ICU and Midwifery.
- a. Would you say that GPH experiences nurse shortage?
 - i. If yes, how do cope with it?
 - ii. If no, how does the hospital manage to maintain a good nurse to patient ratio?
 - b. In the face of staff shortages would you say that your workload has increased?

- c. Could you provide me with a brief description of your duties? I.e. do you educate the patient and his/ her family on the patient's condition?
 - i. Was this the case in the last hospital you worked in?
 - d. What would you say are your biggest challenges as a nurse?
6. In various case studies carried out overseas, the shortage of nurses has been dealt with by increasing the number of non-registered personnel. In doing so these non-registered personnel/ nurse aids are delegated and supervised over some of duties performed by registered nurses. However, for this to be effective, the non-trained personnel have to be educated and trained to reduce the room of errors. With this in mind
- a. Do you think that by adopting such policy would help lessen the work load?
 - i. Yes/No...Why?
 - b. From your own observations, would you say that the number of nurse aids or enrolled nurses employed at GPH has increased?
 - c. Could you describe the duties that nurse aids have to carry out?
 - d. What is the difference between a Registered Nurse and an Enrolled Nurse?
 - e. How long is your working week?
 - f. How many hours a day do you work?
 - g. In terms of overtime, what is the longest period per week have you worked?
7. As a result of the nursing skills' shortage globally. Expatriate nurses are being hired on contract bases to as a temporary strategy to alleviate this shortage. A student nurse

was also quoted in Botswana Press Agency (21 February 2001) stating that language and cultural factors impacted on the quality of customer care.

- a. My question to you is do you think that language and cultural factors impacted on the quality of customer care.
 - i. Yes/No...Why?
 - b. How were you recruited by GPH?
 - c. How does your current employment relationship differ from the last? For example, were you on contract or a permanent worker or work part-time?
8. Traditionally, trade unions were synonymous with work places. However with the introduction and implementation of concepts like organisational flexibility, trade unions have somewhat become impotent.
- a. What channels are available to you to express any grievances and issues of conflict you might experience?
 - b. Do you think that these channels are effective?
 - i. Yes/No...why?
 - c. How do these channels differ from the last hospital you worked in?
9. From the in-house training sessions that the nursing staff receive
- a. Are the certificates internationally recognised?
 - b. Are the certificates recognised by any local nurse training institutes?
10. One of the many methods used by management overseas to make workers more compliant to managerial policies is the selling of company shares to the workers.
- a. With this in mind, would you be willing to invest in GPH by buying shares if it were an option?
 - i. Why?

11. One of the many ways in which hospital systems internationally have restructured is the introduction of acute patient care (reduced stay in hospitals and more focus on home-based care). For example, in the maternity unit, the moment a patient delivers they are moved from the delivery suites to the obstetrics, gynaecology and nursery ward.

- a. Would you say that there is an equivalent system here at GPH?
- b. If there is one please explain it to me
- c. If at all, how does this differ from the last hospital you worked in?

APPENDIX 3

INTERVIEW SCHEDULE FOR HR OFFICER

1. For the survival of any business be it factory, a hotel or in this case a hospital- that business needs to be responsive to its external environment- in terms of tax, labour laws or policies, technology and even local culture. To be able to do this the business has to constantly go through restructuring processes to improve competitiveness (Lee and Clarke, from the 1992 November edition of Healthcare Financial Management Journal).
 - a. With this in mind, how does GPH as a company go about informing its staff and implementing a restructuring exercise?

2. From the 1990s hospitals, especially private hospitals have been run like a corporate, for example patients are no longer just patients, they have also become customers. With regard to this (Pillar and Jarjoura, from the 1999 May Journal of Nursing Administration)
 - a. What measures are taken by GPH to ensure customer service expectations are met?

 - b. Do you have customer satisfactory surveys? What role do these play in the administration of the hospital?

 - c. When evaluating customer feedback, what factors are considered? For example pain management, education pertaining to condition received while hospitalised and promptness of staff.

 - d. How accurate do you think these customer satisfactory surveys?

3. To ensure that nursing staff is retained, and kept in top notch performance, there is need to regularly evaluate and re-evaluate your staff body.

- a. How is the nursing staff evaluated?
 - b. How are outstanding nursing staff recognised?
4. One of the many ways in which hospital systems internationally have restructured is the introduction of 'acute patient care' (reduced stay in hospitals and more focus on home-based care). For example, in the maternity unit, the moment a patient delivers they are moved from the delivery suites to the obstetrics, gynaecology and nursery ward.
 - a. Would you say that there is an equivalent system here at GPH?
 - b. If there is one please explain it to me?
5. I've read in various nursing journals (Journal of Nursing Administration) about the global nurses' shortage especially in areas of speciality like ICU. I've also read that in-house degree programmes are a good way of recruiting and retaining staff (6 case studies were carried by Cheung, Aiken and Faan in the 2006 edition of Journal of Nursing Administration). With this in mind, have you ever considered having in-house degree programmes to up-grade your current staff's skills base?
 - a. Why is this so?
 - b. Have you ever considered entering into a partnership with local nursing training schools to upgrade your current nursing staff's skill base?
 - c. Would you say that GPH experiences nurse shortage?
 - i. If yes, how do cope with it?
 - ii. If no, how does the hospital manage to maintain a good nurse to patient ratio?

6. One of the ways that commercial hospitals have cut costs is through decentralisation of specialities into 'focused care centres' (these are mini-hospitals/ clinics that serve specific patients). With this in mind
 - a. What relationship does GPH have with the on-site clinics?
 - b. When were they open?
 - c. Are these clinics independent of the hospital or are affiliated to the hospital?

7. According to the Botswana Press Agency (10 December 2003), GPH was forced to retrench 110 employees to reduce running costs. According to this report medical, clerical and administrative staff were affected.
 - a. Now, my question to you is, how did you determine who could go and who could stay? Did you use any particular system e.g. last-in-first-out or those who were close to retirement age were asked to leave?
 - b. In relation to the last question, how did the retrenchments affect the unaffected staff? Were new positions created? Were old positions done away with or consolidated?

8. Traditionally, trade unions were synonymous with work places. However with the introduction and implementation of concepts like organisational flexibility, trade unions have somewhat become impotent.
 - a. Putting the GPH context into mind, how do you handle staffs' grievances and issues of conflict in the absence of trade union representation?
 - b. What channels are open to them for general contributions towards the running of the hospital?

APPENDIX 4

QUESTION FOR AGENCY OWNER

1. When did you open your agency?
2. What inspired you to open it?
3. What major problems did you experience when you first started operating?
4. In what type of health institutions do you operate? (i.e. Hospitals government and private, Clinics government and non-government)
5. How do you publicize/ promote your services to
 - a. Hospitals/ Clinics
 - b. Nurses seeking employment
6. Do you have Batswana nurses in your agency?
7. On average how many nurses do you deploy out in a week/ month/ year?
8. What benefits do your nurses gain from their membership with your agency?

APPENDIX 5

QUESTIONNAIRE SCHEDULE FOR NURSES

1. What nationality are you?

.....

2. What is your gender?

Male Female

3. What is the condition of your employment?

Permanent Contract Nursing Agency

Temporary Casual

4. For how many years have you worked for GPH?

.....

5. How many previous contracts do you hold with GPH?

.....

6. What is the length of your current contract?

.....

7. Which of the following benefits do you have?

Housing Medical Aid Transport

Pension Gratuity Sick leave

Study leave Vacation

8. Are you affiliated to any professional councils?

Yes (Within Botswana) Yes (Within and Outside Botswana)

No

9. If yes, which ones?

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10. What role do they play in the advancement of your career?

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11. Are you legally allowed to be a member of trade union?

Yes No Not sure

12. Are you a member of a trade union?

Yes No

13. If yes, which one?

.....

14. Do you plan to renew your contract?

Yes No Not Sure

15. What are your professional qualifications?

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16. When and where did you train?

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17. Other than GPH, which hospitals have you worked for?

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18. Have you been promoted at GPH in the past

- | | | |
|--------------------------------------|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Two Years | <input type="checkbox"/> Four Years | <input type="checkbox"/> Six Years |
| <input type="checkbox"/> Eight Years | <input type="checkbox"/> Ten Years | <input type="checkbox"/> Never |

19. Does GPH offer any training courses?

- | | | |
|------------------------------|-----------------------------|-----------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not sure |
|------------------------------|-----------------------------|-----------------------------------|

20. If yes, which ones have you undergone?

.....
.....
.....
.....

21. At the end of the training session, what documentation do you receive?

A Certificate A diploma Nothing

Other (Please specify)

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22. Have you ever taken study leave since you started working at GPH?

Yes No

23. Are you provided with a study allowance?

Yes No Not sure

24. Do you think bettering your qualifications will improve your chances of a promotion?

Yes No Not Sure

25. Why?

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26. If given the choice and opportunity, would you buy shares in the hospital?

Yes No Not sure

27. Would you be willing to invest your gratuity/ pension in the hospital?

Yes No Not sure

28. Why?

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29. Do you think that being a shareholder in the hospital would improve your work conditions and environment?

Yes No Not sure

30. Why?

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31. Do you think that being a shareholder in the hospital would make you more receptive to the management's policies?

Yes No Not sure

32. Why?

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33. Do you think the hospital would perform better with more invest?

Yes No Not sure

34. Why?

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35. Would you be willing to invest in another private hospital, other than GPH?

Yes

No

Not sure

36. Why?

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* Thank you for participating in this questionnaire.