NATIONALISM, BUREAUCRACY AND THE DEVELOPMENTAL STATE: THE SOUTH AFRICAN CASE[1]

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ABSTRACT

This article undertakes a concrete analysis of the workings of the post-apartheid South African state bureaucracy, within the state hospitals and provincial health departments, in an effort to understand the reasons for its poor functioning. The research points to a contradictory set of rationales shaping the workings of the bureaucracy, which may be ascribed to the tensions identified within the nationalist project by Partha Chatterjee. The article discusses six key features of the post-apartheid bureaucracy: class formation, ambivalence towards skill, the importance of 'face', hierarchy, ambivalence towards authority, and budgetary rituals. It argues that these constitute a set of informal rationales shaped by the imperative to undo racism and white domination in the state and in the society more broadly, and that they tend to work against and erode the Weberian rationales for a meritocratic and effective state bureaucracy. There is a tension at the heart of the nationalist project between the aspiration to construct a 'modern' state and the drive to assert African sovereignty through dismantling white domination. There is little chance of establishing a developmental state (for which the hallmark is effective bureaucracy) in South Africa unless nationalism can be reshaped to define meeting the needs of the people as the central strategy for overcoming the legacy of apartheid.

Keywords: bureaucracy, developmental state, modernity, nationalism, post-colonial

INTRODUCTION

It is common cause that large sections of the South African state are institutionally ineffective or dysfunctional.[2] It is also common cause that the sustained economic growth rate of the first 15 years of democracy has left too many South African citizens untouched, and the problems of poverty and joblessness loom as large as they did on the eve of democracy. While the popular response to this has taken the form of a rash of militant protests, frequently issuing in violent actions by both protesters and police, the response inside the ANC and the policy circles associated with it has been a growing

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commitment to fashion a 'developmental state' (Edigheji **date**; HSRC Conference 2008; *New Agenda* 29 2008). The literature on developmental states, despite considerable variation over what the developmental focus of such states should be as well as over the appropriate form of government, tends to agree that effective state institutions are a central characteristic; an important question, therefore, concerns the prospects for overcoming ineffectiveness within the South African state.

This article undertakes a concrete analysis of the workings of the South African state bureaucracy, within the state hospitals and provincial health departments, in an effort to understand the reasons for its poor functioning. My research points to a contradictory set of rationales shaping the workings of the bureaucracy, which may be ascribed to the tensions within the nationalist project. As Partha Chatterjee has observed, nationalist thought is marked by contradiction: on the one hand, it subscribes to the Western 'modern' route to development, while on the other it asserts the autonomous identity of a national culture; it therefore 'simultaneously rejects and accepts the dominance, both epistemic and moral, of an alien culture'. On the one hand it submits to the domination of a world order which presents itself in the form of modern science, technology and the requirements for 'development', while on the other 'nationalism remains reluctant, complaining, demanding, sometimes angry, at other times just shamefaced' (Chatterjee 1986: 11, 169). This question is intimately tied up with the debate about the developmental state, for, as Mkandawire argues (2001: 291), the 'main force' behind developmentalist ideology 'has usually been nationalism, inducing nations to seek to "catch up" with countries considered as more developed ...'.

Chatterjee's analysis remains at the level of nationalism as a set of ideas, as an ideology. In this article I explore the tensions within nationalism at the micro-level of concrete bureaucratic practices. Inside the bureaucracy of the South African state, I argue, this tension takes the form of contradictory rationales for bureaucratic practices: on the one hand, the aspiration to establish a modern, effective bureaucracy, on the other the drive to subvert the dominance of whites and the apartheid system enshrined in the previous state, and promote the rapid formation of a new black elite. The second set of rationales is organised around a cluster of six distinct but interrelated themes – class formation, ambivalence towards skill, the maintenance of face, hierarchy, ambivalence towards authority, and the prevalence of budgetary rituals – and does not take as its primary purpose the fashioning of effective state institutions. It is the tensions between these different rationales, and the salience of the second set, that accounts for much of the dysfunctionality of state institutions. The article concludes that post-apartheid modernity, characterised by African nationalism, is profoundly shaped by the racial form of modernity introduced by colonialism and apartheid, and briefly discusses the potential for recasting the purposes of the state.

But before exploring the workings of the bureaucracy in greater depth, it is necessary to locate this in some discussion of the notion of a 'developmental state' in general, and of the African state in particular.

WHAT IS THE DEVELOPMENTAL STATE?

Initially the concept of the developmental state was modelled on an analysis of the role of the state in the successful industrialisation strategies of Japan and the Asian Tigers. The emphasis in this analysis was on the *dirigiste* role of the state in initiating and shaping industrialisation strategies by mobilising scarce resources and focusing them on selected industrial initiatives. More recently there has been a shift in emphasis in the literature towards the importance of human development (Evans 2009) and the possibilities of establishing a 'social democratic developmental state' on the global periphery, drawing on the experiences of Costa Rica, Mauritius, Chile and the state of Kerala in India (Sandbrook et al. 2007). This corresponds as well to a new emphasis on the developmental state as a *democratic* state (Edigheji 2005; Evans 2009; Pillay 2007; Sandbrook et al. 2007), and the basket of developmental states is expanded to include Ireland, the Scandinavian countries and Botswana (Edigheji et al. 2008; Mkandawire 2001).

The wide range of state and governmental forms, and contrasting models of development, said to constitute 'the developmental state' does raise the question whether this is a coherent concept at all. The only shared features are an ideological commitment to 'development' – whatever that may be – and the idea that such a state is an active or interventionist one (although the inclusion of Botswana throws even this into question), with the capability to set appropriate developmental goals, develop the policies that have the greatest likelihood of achieving those goals, and then implement them effectively. There is general agreement that state capability is crucial for the successful developmental state, frequently encapsulated in the idea that such a state requires a Weberian bureaucracy, for which Peter Evans has provided the most detailed prescription: corporate cohesion and the insulation of the bureaucracy from special interests, the concentration of expertise in the bureaucracy through meritocratic recruitment, and the provision of long-term career rewards as well as a distinctive and rewarding status to officials (Evans 1995, 2009; Evans & Rauch 1999). Indeed, the comparative study of 35 developing countries by Evans and Rauch (1999) implies that the key factor in economic development may be the quality of state bureaucracy, rather than any particular model of development.

It must be noted that Weber's account of the distinguishing features of modern democracy is a generic one. His theoretical concern was to identify the defining features of an epochal shift in state form, from the pre-modern state defined by patrimonial relations to the modern state defined by neutral, non-discriminatory and rule-bound relations between state and citizen. While his account of bureaucratic rationales and functioning provides an ideal-type description of modern bureaucracy, it should not be confused with concrete descriptions of how the 'machinery of state' functions – a conflation found, for example, in Chipken (2008).

The organisation of modern bureaucracy in different state institutions is complex, and necessarily varies significantly across institutions depending on their different

labour processes and functions. For example, an institution organised primarily around the processing of documents, such as home affairs offices, will differ significantly from the organisation of education or policing or the provision of clean water. The location of high-skill functions, which require relatively more discretionary flexibility, in relation to lower skill functions which are more routinised, has significant implications for how institutions are structured. Likewise, the degree of discretion or innovation required by front-line service providers varies substantially from institution to institution (cashiers and clerks, police officers and nurses). These factors make the metaphor of 'state machinery' an extremely loose and mostly misleading one for understanding how state institutions work.

In the case of the public health sector, the focus of this article, the labour process in public hospitals is distinguished by the high level of skills concentrated at the service delivery interface – in the wards, in the operating theatres, at casualty or outpatients. The role of doctors and nurses defines the structure of this labour process. A high level of skill and professional discretion does not, however, reduce the need for established protocols, routines and procedures of the sort highlighted by Weberian analysis; on the contrary, such routines are critical for effective diagnosis and medical interventions. For example, an effectively functioning ward is structured around a strict sequence of time-bound routines (washing; feeding; checking temperatures, pulses and urine; administering medications and applying dressings, etc) and systems of recording and reporting. Without this, patient care becomes a hit and miss affair. At the same time, these strict routines must provide both the information base and the space for discretion and judgement based on the skill and experience of health professionals, since human ill health is an extremely complex and highly variable phenomenon. Thus, any notion of a simplistic Weberian machinery is inadequate to the analysis of health care bureaucracy.

If a high level of state capability is a defining feature of developmental states, and the kind of capability required is one that is able to take initiatives, to innovate or facilitate innovation, and to effectively implement its policies, then the bureaucracy of state institutions has to feature both well-organised and effective routines, as well as analytical, discretionary and innovative capacity, and integrate these in appropriate ways. Neither of these obtain in the South African case, as this article demonstrates.

THE STATE IN AFRICA

The literature on the state in Africa is quite sharply divided between broad-sweep generalisations about Africa as a continent of failed states, exemplified by what Ferguson (2006: 5) calls the 'dubious recent culturology' of Chabal and Daloz (1999), and the attempt to identify a record of relatively effective states through a more nuanced analysis of specific states, such as that of Mkandawire (2001).

For Chabal and Daloz, the state in large parts of sub-Saharan Africa is a 'pseudo-Western façade' which disguises the fact that neither politics nor state institutions have been emancipated from society and have therefore never been institutionalised. Africa

therefore lacks the kind of independent modern bureaucracy identified by Weber, and the public service remains particularistic and personalised, with relations between the elite and the people organised through patronage and clientelism. This process they call the 'informalisation of politics', and they seek its roots both in precolonial political structures as well as in the colonial state which, they argue, was usually 'weak, thin and lacked bureaucracy', so that there was significant continuity between the personalised, arbitrary and informal practices of colonial rule and precolonial politics, rather than a Weberian rupture. It must be said that their analysis has both left-wing and right-wing analogues, from Franz Fanon's disdain for the 'intellectual laziness: spiritual penury and ... profoundly cosmopolitan mould' of the national middle classes in Africa (1967: 119), to the implicit racism with which RW Johnson describes the civil service as a 'black hole of low skills, corruption and incompetence' (2009: 62). Quite clearly, no state with such characteristics could meet the requirements for a developmental state.

Mkandawire provides an alternative narrative of the post-independent state in Africa, arguing that several could be described as developmental states, with growth rates equal to or outperforming countries such as Indonesia or Malaysia. Ten of the 27 countries whose growth rates averaged 6 per cent or higher between 1967 and 1980, were African, including Gabon, Botswana, Congo, Nigeria, Kenya and Cote d'Ivoire. Progress in social and physical infrastructure was 'even more impressive'. Mkandawire takes issue with the neo-Weberian critique of those who, like Chabal and Daloz, argue that the state in Africa is fatally undermined by its failure to establish the independent rational-legal bureaucracy required by modernisation, since they ignore the evidence of effective state operations in Africa and mythologise the virtues of states elsewhere, particularly in East Asia. Patrimonial practices, corruption and rent seeking take place in many modernising states, including East Asian exemplars, and their impact – whether positive or negative – on economic growth has not been sufficiently researched to support the conclusions reached by such writers about the state in Africa. Furthermore, the current institutional weaknesses of African states are in many cases attributable to structural adjustment policies of 'rolling back the state' which were forced onto them by foreign governments and aid agencies, and which drastically stripped states of institutional capacity.

It is not easy to reconcile these two contrasting accounts of the state in post-independent sub-Saharan Africa. Both draw attention to existing phenomena. One obvious point is that there is a variety of state experiences on the continent, and Chabal and Daloz have in mind different countries to those Mkandawire discusses, although it is difficult to tell because their mode of argument is sweeping generalisation. A different problem is that neither engages in a close analysis of the internal functioning of 'actually existing' African states, which might allow for a more nuanced understanding of the forces at play.

In this article I try to undertake just such an analysis of state institutions in South Africa, in particular the provincial health departments and their public hospitals, in order to understand their inner workings and rationales. My research suggests that the post-

apartheid bureaucracy differs significantly in its functioning, rationales and meaning-formation from the ideal-typical model of modern bureaucracy described by Weber and proposed by Evans for the developmental state.

Modern bureaucratic practices were introduced to South Africa through processes of colonial conquest and domination, and were fundamentally shaped by this history. Modernity in South Africa necessarily took a distinctively colonial form, and post-apartheid modernity is shaped both by this history and by the struggle against it – that is, a national and democratic struggle against a modernity which is inextricably meshed with racial domination. If the modern state form is the core institution of modernity, then it is inevitable that it will be quite fundamentally marked by this history and these struggles. In the case of the state bureaucracy, this marking takes the form of a tension between the project of building a state resting on the 'modern' bureaucratic skills and procedures previously controlled by whites, and the project of rooting out the systemic humiliations and oppressions of white domination, and in its place enshrining the sovereignty and dignity of Africans. These tensions within the functioning of the state bureaucracy may be regarded as intrinsic to the nationalist project of constructing a new post-apartheid social order.

My study is located in a large-scale and complex public service delivery agency, the Health Department and its public hospitals. Such a focus is consistent with the new emphasis in the literature on human capability development as both the goal and the necessary condition for successful development strategies. My analysis begins by providing a very brief description of dysfunctionality in public hospitals, and then discusses six key features of the post-apartheid bureaucracy which together inscribe non-Weberian rationales in the inner functioning of the bureaucracy: black class formation mediated through affirmative action, ambivalence towards skill, the significance of 'face', hierarchy, ambivalence towards authority, and the rituals of budgetary discipline.

PUBLIC HOSPITALS: A CASE STUDY OF DECLINE

In previous work, my colleagues and I have argued that public hospitals in South Africa are dysfunctional and suffer from high degrees of institutional stress – a finding consistent with the results of other investigations into public hospitals. According to the doctors and nurses we interviewed, the results were poor clinical outcomes and higher levels of morbidity and mortality than ought to be the case. We found that over-centralisation, fragmentation into silo structures, low management capacity and understaffing were the primary causes of institutional stress and poor healthcare outcomes (Von Holdt & Maserumule 2005; Von Holdt & Murphy 2007).

These issues constitute a systemic dysfunctionality which affect all aspects of hospital functioning. Poor maintenance, failure to repair or fix equipment, lack of linen, dirty linen, procurement failures, the breakdown of lifts, dirty wards, budget overruns, poor labour relations, unfilled posts, inability to budget or control costs, failure to

supply drugs or medical sundries, ill-discipline, lost records – there is no end to the list of frustrations and problems that staff experience.

The problem is not only that public hospitals are characterised by ineffective functioning and poor healthcare results; it is that the public hospitals and the public health system more broadly actually seem to be in a state of decline. Nurses refer to three key changes with the transition to democracy: firstly, the 'most important change with democracy' is the shortage of posts. Second, in the apartheid era the lifts used to work, and they used to get the necessary medical supplies, drugs and linen in the wards. In other words, the hospital support systems used to function effectively.[3] The third change, in their view, is the breakdown of discipline because the unions 'have taken over the hospital' (Von Holdt & Maserumule 2005: 447, 450; Interview with professional nurses, March 2007). Staff experience an extremely high level of burnout as a consequence (Schneider et al. 2005).

In summary, the inability of the health department bureaucracy to perform effectively has systemic causes. What accounts for this? Why has the democratic state been unable to address such systemic problems? Why is it that the political and administrative leadership seem unable to develop and implement a strategic response?

KEY FEATURES OF THE POST-APARTHEID BUREAUCRACY

In this section of the article, I identify six important features of the post-apartheid bureaucracy that underlie and provide some explanation for the dysfunctionality and management failures described above. In identifying and attempting to understand these features I draw on eight years of participant observation as an activist,[4] researcher, adviser and consultant in processes of hospital change, as well as on discussions and interviews with key informants in hospitals and health departments. It is important to note that this study is part of an ongoing research project and represents an initial attempt to formulate the findings.

It often seems to the doctors, nurses and others who work directly with patients that departmental bureaucracy has little patience with or interest in the problems they experience. Indeed, it frequently seems that health service delivery is secondary or even incidental to the real purposes of the bureaucracy. Attempts to come to an understanding of this requires a shift in focus: in place of analysing management structures and system inadequacies, it requires that attention be paid to organisational culture and processes of meaning-formation, the informal codes which shape officials' priorities, choices and interactions with others.

Class formation

Black class formation is a central policy imperative for nationalism, both as a form of redress for past discrimination, and as a strategy for breaking the shackles of white domination in the state and the economy. Employment equity legislation encourages

the filling of posts by black employees and constitutes a crucial lever for the formation of a black middle class, and black economic empowerment policies oblige the state to use its resources to leverage the formation of a black business class through tender procedures. These policies legitimate a focus on upward mobility on the part of public service officials.[5]

Affirmative action and the shortage of skills create numerous opportunities for upward mobility within the bureaucracy, generating a powerful culture of moving onwards and upwards. The average annual mobility rate across the public service is 32 per cent in national departments and 38 per cent in provincial departments, while the vacancy rate in national departments is 25 per cent for senior management, and 31 per cent for middle management (Naidoo 2008).[6] The culture of moving onwards and upwards encourages an attitude of 'facing upwards' towards the next job prospect, rather than 'facing downwards' – that is, focusing on improving the functioning of the domain that the official is responsible for. There is a high turnover of incumbents, and a significant number move out of the agency or department where they are located, as the figures quoted above demonstrate, making it difficult to create a stable body of expertise in the functioning of a specific department such as health.

Particularly for managers with generic skills (such as HR or finance), procedures governing promotion mean that actual work performance has little impact on career prospects. Managers cannot reward individuals who have performed well by promoting them, but have to advertise vacancies and select from all applicants; on the other hand, an individual can apply for any post they want to, and frequently apply elsewhere in the public service, in other sections, agencies or departments where managers cannot draw on direct experience of their achievements or failures.

Processes of rapid upward mobility and class formation have come to constitute a core rationale of bureaucratic functioning, one which competes with the rationale of public service and healthcare delivery in numerous ways. Equity indicators, for example, become more important than clinical indicators (in fact, clinical data barely exists, which seems not to trouble departmental officials). The first question asked of any project tends to be about its implications for employment equity targets, rather than its implications for improved healthcare. As Chipkin (2008) argues, affirmative action targets create an incentive to leave vacant those posts for which there are no suitably qualified black candidates, rather than filling them with qualified white candidates if they are available – with an obvious impact on departmental performance. More broadly, the orientation of officials upwards, towards their own career mobility, undermines work performance and the creation of a stable, functioning bureaucracy.

Ambivalence towards skill

Skill has a complex history in South Africa. Modern skills, such as medical, engineering and scientific skills or those required to manage a modern state, entered South Africa as part of the ideological and technological apparatus of colonial domination. From the

beginning of their history here, therefore, they were bound up with racial domination. Skill, even the hardest of 'hard' skills, is never only technical, but is always necessarily social and is bound up with the social structuring of power. Indeed, access, authority and hierarchy in relation to skills and knowledge are governed by social protocols which are integral to the broader distribution of power across society, and in South Africa these were defined by a long history of colonialism and apartheid. Modern knowledge systems were taken to differentiate 'civilised' Europeans from 'primitive' Africans. Such knowledge systems were used to control and oppress blacks, while blacks were at the same time systematically denied access to them.

To take one example, the rigorous and systematic codes and procedures of the modern Weberian bureaucracy were dedicated to the management and control of the black population through the mechanisms of racial differentiation in the Population Registration Act, and through the massive machinery of the pass system and its associated institutions (Posel 1991). To take another example, in the workplace the distinction between primitive and civilised justified the exclusion of Africans from the legal category of 'employee' and therefore from 'modern' workplace and trade union rights (Von Holdt 2003).

Racial protocols were integral to the functioning of the apartheid health system as well. All health facilities were, of course, racially segregated. Initially, the health professions were regarded as the preserve of 'Europeans'. When the state began training black nurses in large numbers in order to staff black hospitals, they were trained in segregated facilities, and part of their training was devoted to supposedly 'civilised' etiquette, such as how to eat with knives and forks (Interview with matron, 29 January 2008). Black nurses were not allowed to provide care to white patients in white hospitals. Black nurses did their practical training in overcrowded and under-resourced black hospitals (Marks 1994: 172).

In an interview, a highly qualified and experienced white nursing manager described her shock when she first experienced the conditions as a matron in a large black training hospital in the 1980s:

> I was shocked by the conditions they had to work under – there were patients in bed, under the bed, down the passages. It was appalling. I had never experienced something like it. I felt sorry for the nurses, they actually couldn't nurse, it was just first aid. They had never known normal nursing conditions. They were in fact trained in abnormal nursing. They ignored aseptic technique, they never were able to apply it, so they never learnt it. There was a lack of facilities for washing hands – one basin at the front of the ward. If you were at the back attending to the 67th patient in a 48-bed ward, there was no way you would come all the way to the front to wash at the basin before attending to the 68th patient. So the crisis became the standard, the norm. (Matron, 29 January 2008)

Nurses trained under such conditions, she believed, would not be able to learn what she regarded as 'proper' nursing. In the late 1980s, she went on, when the shortage of white nurses compelled white hospitals to start employing black nurses, the matrons insisted

that black nurses take a six-month induction course to upgrade their skills so that they would be fully competent to meet the standards required in their wards. This incident captures some of the ambiguities and complexities that shape the social meaning of skill: was the insistence on additional training motivated by a real skills deficit, or by racial prejudice, or by both? Whatever the case, such incidents reinforced both white prejudice and black resentment.

Nurses working at Chris Hani Baragwanath Hospital described a similarly complex relationship with white doctors and professors during the apartheid period: on the one hand, they had enormous respect for the knowledge and authority of the professors, and developed close working relationships; on the other, this power and authority was inseparable from the hierarchy of white and black: 'It was apartheid time – they were superior, more demanding, they expected us to do as they wished.' Black nurses were fearful of the power of white professors, as they were of the authority of the white matrons who oversaw the nursing functions of the hospital.

As these examples show, it is extremely difficult to disentangle skill, knowledge and racial power; indeed, they were inseparable. The consequence in the post-apartheid state is ambivalence towards skill and those, mostly white, who have high levels of skill and expertise as a consequence of the policies of apartheid. For example, when a (female white) HR officer at Chris Hani Baragwanath Hospital applied for new HR management post at the hospital, her appointment was highly contested by some (black) managers on racial grounds, despite the fact that her track record demonstrated high levels of competency, which was cited by the (white male) clinician to whom she would report. In a second example, a (female black) clinician applied for a post in a clinical department, and was turned down by the (white male) departmental head on the grounds that there was a better qualified (white) applicant. This decision was overturned by the (black) CEO and departmental officials on the grounds that she was sufficiently qualified, a view supported by my informant, a (white male) clinician. Nonetheless, her (white male) colleagues were sufficiently hostile to make her life a misery, and she was forced to leave. In a third example, the (female black) HR director of a large academic hospital showed herself to be incompetent for the job, but could not be removed because of support from senior departmental officials. These examples demonstrate three features of the post-apartheid bureaucracy: ambivalence towards skill, ongoing contestation over the meaning of skill and its relationship with race, and, as a consequence of these, growing ambiguity about what constitutes skill.[7] The overall result is a devaluing of skills and the spreading of incompetency through the bureaucracy, as senior officials who themselves lack the competence to assess the requisite skills in turn appoint and protect underqualified officials below them.

There remains an ambivalent attitude in general towards white doctors on the part of the health authorities. On the one hand, their expertise is respected, while on the other they are regarded as troublesome and ungovernable, because they are relatively independent and can be outspoken about conditions that affect their patients. This is particularly so in academic hospitals, where many of them are in 'dual posts', which

means they are appointed by and accountable to both the provincial authorities and the university. The removal of a hospital CEO who had been 'captured' by the clinicians, illustrates this attitude. Similar ambivalence seems to be in play in the public accusation by the KwaZulu-Natal Health MEC that white doctors in rural facilities are racist – this in a context where it is desperately difficult to find doctors willing to serve in rural hospitals (see below). This is probably also why the Gauteng provincial department has adopted an organogram for its hospitals which disempowers its clinical heads by confining them to the margins of management structures.

The devaluation of skill does not only affect white personnel, but also skilled black professionals. Nurses are, like doctors, marginalised in management structures. In an example outside the health sector, a highly competent water manager in a local authority was forced to resign in the face of trumped-up corruption charges, because he himself constituted an obstacle to corrupt practices in the tendering for lucrative contracts (Muller 2008).

As with class formation, and very much linked to it, the ambivalence towards skill finds a voice in nationalism, and works directly against the meritocracy of Weberian bureaucracy, ensuring that health departments and hospitals cannot function effectively.

The significance of 'face'

The state is the quintessential domain of African sovereignty in post-apartheid South Africa, and represents the conquest of the citadel of white sovereignty. The apartheid state summed up and elaborated in its harshest form the entire colonial history of the country. It was the instrument of white domination, serving to dispossess and oppress the colonised people and to systematically order society along racial lines that disempowered, demeaned and denigrated blacks, and Africans in particular. In this it came to represent a particular version of 'Europe'; the Europe that colonised and dominated its African possessions and was embodied in the European settler population.

However, the post-apartheid democratic state remains fragile in its role as the domain of African sovereignty, surrounded as it continues to be by 'Europe'. Business and professional associations remain dominated by white experts, and the media, if no longer necessarily controlled by whites, seem often to represent a discourse that continues to be shaped by 'European' Western norms and assumptions.[8] Beyond these, but allied to them and immensely powerful in the global world as well as specifically in our postcolonial national territory, the discourses and prejudices of the metropolitan powers cast the critical 'racial gaze' theorised by Frantz Fanon (Gibson 2003: 21ff) on the new government, and at the same time constrain the powers of its newly conquered state.

This situation – the conquest of sovereignty and the simultaneous constraining of sovereignty – elevates the importance of authority, reputation and 'face' in the state. Nationalism becomes the quintessential ideological form for asserting and buttressing 'face'. The newly-won African sovereignty may appear to be under siege not only from

without, but also from within the state. The state apparatuses inherited from apartheid were orientated towards white domination, and many of the personnel of that state remained in place after the democratic rupture and, indeed, still do.[9] In the health sector, for example, many doctors, and most of the most experienced and authoritative clinical leadership, are still white. Here we can see how the issues of upward mobility and transformation, and of skill and knowledge, intersect with those of authority and face.

This dynamic – the interplay between the 'racial gaze', 'face', nationalism and scepticism towards the claims of Western scientific knowledge – played a significant role in the breakdown of relations between the AIDS lobby and government, as well as the genesis of AIDS dissidence within government. In 1996, the government commissioned a play, *Sarafina 2,* for an exorbitant sum as a strategy to raise public awareness about HIV/AIDS. Despite good intentions, it was a poor strategy. AIDS activists, opposition parties and the media were critical, and the press engaged in an orgy of vilification of the Health Minister, Nkosazana Zuma, resorting to not very subtle racist stereotyping. As Lesley Lawson comments in her thorough and balanced book, it was as if this incident 'had opened the floodgates to a torrent of suppressed anger, disappointment, envy and hostility towards the country's new leaders' (Lawson 2008: 103–106). Government leaders, in turn, were angry and defensive, and this was the first rupture between the AIDS lobby and leaders such as Minister Zuma. AIDS dissidence was, at least in part, a response to this kind of tacitly racist vitriol, as well as the stereotyping of African sexuality (Lawson 2008, see for example pages 21–31, 233, 235–236, 251). The response was a nationalist one, asserting 'face' and dismissing Western science.

Inside the bureaucracy, the seeming-fragility of African sovereignty is linked to the culture of extreme deference towards authority and towards the administrative and political leadership. This is organised around elaborate rituals of power and respect. When a Minister or MEC is going to visit a hospital, it is convulsed by efforts to focus all available resources on making it as presentable as possible: patient care is put on hold while senior nurses are deployed to make sure that wards and corridors are cleaned, managers ensure that the grass – which generally grows knee-high because there are insufficient gardeners – is mown, doctors are instructed to make their domains as presentable as possible. Nurses, doctors and managers are well aware that it is a sham hospital that is being presented for scrutiny, and the message is to prevent, at all costs, the politician from seeing the real hospital.

The emphasis on deference extends through the middle and upper reaches of the bureaucracy, reinforcing the culture of 'facing upwards'. The consequence is that provincial officials and political heads get to hear what hospital managers believe they want to hear, rather than a frank account of what is happening in the institution and on the ground. This contributes to the failure to understand and solve delivery breakdowns. The importance of saving face translates into a practice of axing the messengers who bring bad news, or finding scapegoats when things go wrong. 'Troublesome' clinicians – the CEO who was too close to clinicians, Deputy Health Minister Nozizwe Madlala-Routledge who was fired in 2007 for speaking out about hospital conditions after visiting

a hospital in the Eastern Cape and describing the rate of stillborn births as a 'national emergency' – provide instances of this.

The case of the white doctor who threw a picture of the KwaZulu-Natal MEC into a dustbin after hearing her tell staff that white doctors are only interested in profit, is also telling. The doctor was suspended pending a disciplinary enquiry, the MEC publicly accused white doctors of being racist, while the Health Minister told reporters that the incident 'smells of anarchy' (*Mail and Guardian*, 25 April–1 May 2008, 2–8 May 2008; *Business Day*, 6 May 2008). In this case the picture had become a highly charged symbol of respect and face. From one side the incident appears as a typical case of how the concern with face overshadows crucial delivery concerns, while from another an agent of the colonial gaze is deliberately undermining the authority and credibility of the state.

'Face' need not necessarily undermine management effectiveness or the pursuit of departmental goals; perhaps 'face' is an important ritual in all bureaucracies. However, where it draws attention away from the purpose of the institution, and indeed works to prevent people from addressing real problems, then it does undermine institutional effectiveness.

Hierarchy

Strict hierarchy is an intrinsic aspect of the bureaucracy Weber described, facilitating accountability and the rational organisation of structure, and ensuring that rules are followed. However, when hierarchy is disembedded from meritocratic appointment procedures and the concentration of expertise, and is associated instead with rapid class formation, ambivalence towards skill and the assertion of 'face', then it ceases to serve organisational effectiveness but becomes, rather, an impediment.

An authoritarian hierarchy characterised the apartheid bureaucracy (Posel 1999). The post-apartheid bureaucracy remains extremely hierarchical, although probably less authoritarian. There is a pervasive culture of deference within the bureaucracy, and provincial officials tend to adopt an autocratic attitude towards senior managers in the hospitals and treat them as junior employees. Hierarchy and deference are closely associated with the assertion of 'face', rapid upward mobility and ambivalence towards skills. Officials who have been promoted beyond their competence levels, or who operate in an environment where skill is ambiguous and contested, remain uncertain about their own skills and job performance, and their authority may come to seem precarious. The assertion of 'face' and hierarchy become mechanisms to conceal these problems and avoid challenges. It becomes impossible to raise or acknowledge the pervasive institutional failure and poor performance of hospitals and the health system more generally; indeed, these are denied. As a result, the bureaucracy can no longer recognise problems in the system, account for them, or try to solve them.

The general tendency, identified earlier, to 'face upwards' is reinforced by the specific career dynamics of those senior officials whose careers are tied to the health

department – that is, professionals such as doctors or nurses who have chosen a career in the administration. They are highly visible to the top managers within the department, and their careers therefore depend on whether they are viewed favourably by these managers. This encourages such officials to concentrate on meeting the requirements of the senior departmental managers, whether or not these contribute to solving the problems faced by managers lower in the hierarchy or to improving health care delivery. Hospital managers, therefore, fear to rock the boat, innovate and take risks, or contradict provincial officials.

It might seem that the dependency of senior hospital officials on the good opinion of departmental managers would improve accountability for results achieved; however, where the top managers are ill equipped to understand operational realities, ill informed, overwhelmed and more concerned with reputation and the preservation of 'face' than what happens in hospitals, real hospital performance in terms of improving healthcare outcomes plays little role in career progression. Indeed, the absence of meaningful clinical data suggests that clinical performance is of little interest to departmental officials.

In one case, a hospital CEO and his management team were removed at least in part because they were regarded as too responsive to the hospital clinicians, and were replaced by a new team dispatched from head office with an explicit mandate to regain control over them. To the doctors and nurses it was abundantly clear that the new team was less competent than the old, and had little interest in the problems experienced at ward level. Indeed, the new CEO displayed an embarrassing ignorance about the hospital functioning over three or four years of tenure. In contrast to the despair of the clinicians, the most senior managers at head office expressed satisfaction with the performance of the new team, because they had managed to gain some control over costs and had improved financial reporting.

Hierarchy and deference therefore play the role in nationalist practice of bolstering authority and 'face', and substituting for the ambivalence towards skill and the undermining of meritocracy. In other words, it serves the opposite function of that reserved for it in Weberian bureaucracy. Paradoxically, though, it is associated as well with ambivalence towards authority and the breakdown of discipline.

Ambivalence towards authority

Discipline at many public hospitals has broken down (Von Holdt & Maserumule 2005; Von Holdt & Murphy 2007). This applies not only to lower-level support workers, such as cleaners and clerks, but also to professionals such as nurses and the doctors who do private practice work in the time that they owe the state as their employer, as well as to non-performing managers.

The old apartheid workplace order was an authoritarian one, and this authoritarianism was inseparable from the racial authority established by apartheid. The Chris Hani Baragwanath nurses quoted above suggested their fearfulness and anxiety in the face of the authority of white doctors and matrons. For support workers the work regime was

even harsher, as they were employed on permanent casual contracts, which meant they could be dismissed with immediate effect. Black workers had no trade union rights, and nurses were legally barred from striking.

This apartheid workplace order was unravelled in a series of often bloody strikes in the early 1990s, which culminated in the recognition of public service unions and the incorporation of the public service into the labour relations regime of the country. The apartheid workplace order was shattered, but this did not mean that it had been replaced by a new, legitimate workplace order or that discipline was re-established on a new consensual basis. Research conducted at Chris Hani Baragwanath suggests that authority and discipline remain highly contested. A cleaner described the change:

> The hospital has been a mess since 1992. Workers used to fear their supervisors and run to do their work. When we came back after the 1992 strike we found cleaners and ward attendants without discipline, without training. We found trolleys everywhere. The ones who were employed as strike breakers are the problem – there is tension between them and other workers, and they are uncontrollable. They bring guns and alcohol to work. Now discipline is applied in a discriminatory way. (Von Holdt & Maserumule 2005: 450)

Speaking with indignation from within their status-conscious and authoritarian nursing culture, the chief professional nurses associated this situation with the broader changes brought about by democratisation:

> When the ANC took over, everything became relaxed; you could do anything in the new dispensation … The lowest categories control the hospital. Since the unions were introduced the shop stewards have been running the hospital, but they cannot even write their names! They get out of hand and it is difficult to handle. Management is scared to discipline and control. The shop stewards confront and victimise the nurses. We also belong to a union but we do our job. Everyone barks at us. We have no dignity; we are degraded. There is supposed to be democracy, but not in the manner of Baragwanath. (Von Holdt & Maserumule 2005: 450)

Incoherent institutional design, poor policies and the lack of HR strategies contribute to this problem. However, it is also a symptom of an underlying ambivalence towards authority. Like skill, the illegitimacy and racism of historical authority structures and practices in hospitals have left a legacy of uncertainty about, and contestation over, legitimate management and supervisory practices. One aspect of this is the parallel authority structure provided by the ANC and its alliance with COSATU. Shop stewards therefore have a high political status, which means that their meetings with CEOs, senior departmental officials and MECs are intrinsically ambiguous. At higher levels of the bureaucracy a moral economy of 'face' applies: a negligent or incompetent official is seldom punished or fired, because this would undermine the workings of 'face', in which all have a stake.

As a result of these factors, supervisors at all levels abandon the assertion of authority and prefer not to make use of disciplinary procedures, as it is simply too much trouble, sometimes dangerous, and inadequately supported by management.

This, in turn, further weakens authority. The result was described by a focus group of shop stewards, who stated that 80 per cent of the employees in their hospital 'regarded corruption as part of their job description', and by corruption they meant activities ranging from eating meals intended for patients, to the theft of hospital equipment (Shop steward focus group, April 2007).

Rituals of budgetary discipline

The budget plays an extremely important role in departmental and hospital activities, and yet at the same time the budget and the rituals that surround budgeting bear next to no relationship to the concrete healthcare activities of the hospitals. Budgets are drawn up in head office and are based on historical allocations and ultimately decisions made in national and provincial treasuries. In any case, financial systems do not record expenditure in a way that can relate activity to costs, so it is impossible to engage meaningfully with budgeting at hospital level. Managers of functional domains have no idea what their budgets are supposed to be and cannot therefore manage costs. The redirection of resources from hospitals to primary care, together with inadequate budget allocations, means that many hospitals suffer from under-budgeting.

What under-budgeting means for those who work in hospitals is understaffing and increased workloads and stress, shortages of equipment, medical materials, linen and drugs, and constant system breakdowns. As the end of the financial year draws near, and head office officials realise that hospitals are overspending, enormous pressure is put on them to cut costs with measures such as reducing pharmaceutical inventory, cancelling elective surgery, freezing unfilled posts, and so on. While this might reduce spending overruns, it generates wastage of a different sort as highly paid specialists and expensive equipment are left idle.

Although clinicians and nursing managers are invited to contribute to budget discussions at hospital level, at the end of the day decisions are imposed from the centre. This generates tensions between clinicians and managers, as the latter tend to police the decisions made by their superiors rather than fighting for better budgets on behalf of the patient. It is in this context that head office officials prefer a CEO who is compliant, often to the detriment of hospital functioning.

Officials, hospital managers and clinicians are left in little doubt that it is the budget and the rituals that surround it, that are primary. Budgetary discipline is, of course, important in any effective state apparatus. However, where discipline is imposed on the basis of budgets that bear no meaningful relationship with reality, it is liable to convey messages that have little to do with discipline. The impact on service delivery is profound, because the signals that these budget rituals convey, is that service delivery is of secondary importance. Rhetoric about public service, and attitudinal programmes such as Batho Phele, cannot be taken seriously by staff who know that under-budgeting and hospital dysfunctionality undermine their ability to perform their tasks and prevent adequate patient care. If their superiors in the bureaucracy care so little about the people

who do the work or about the patients who are compelled to make use of the public health system, why should overworked nurses, doctors and cleaners care? That many do still care is one of the unsung miracles of the post-apartheid state.

SUMMARY

The six key features of the bureaucracy discussed above tend to reinforce one another: assertiveness about black class formation and sovereignty produces ambivalence towards and contestation over skills and experience; high vacancy rates, affirmative action targets and rapid mobility mean that personnel who lack the requisite skills and experience are often employed in key jobs; this further undermines skill as a criterion, and reinforces the sense of fragility and the importance of deference and 'face' to mask this; skills gaps and deference tend to elevate the importance of rules, procedures and hierarchy for their own sake, while at the same time ambivalence towards authority undermines these; the nationalist discourse through which these goals are legitimated discourages a focus on effective organisational performance; while the elevated significance of budgetary rituals further displaces the clinical process to the margin of bureaucratic concerns. One result is poor organisational design, with fragmentation of authority, control and systems, which ensures an even greater disconnection between what the bureaucracy does and the clinical process.

This is not to say that the nationalist rationales described here, which are generated by the struggle against racial domination, have completely displaced the 'normal' Weberian functioning of the bureaucracy, nor to deny that many officials work extremely hard and are dedicated to performing their tasks. Indeed, nationalism also drives the desire to establish a modern 'world-class' state. It is rather that nationalism entails contradictory projects, so that bureaucratic rationales are overlaid with other, informal meanings and practices, which tend to slow down, divert or retard achieving the goals that would be ascribed to a 'rational' Weberian bureaucracy – in this case, improved delivery of health services. The bureaucracy is characterised by contradictory rationales, purposes and meanings which make it difficult to establish efficient routines or to grasp the real problems and seek innovative solutions.

This complex and contradictory environment has a paradoxical effect on the matrix of strict rules, procedures and routines that supposedly characterise Weberian bureaucracy. On the one hand, officials at all levels stick as closely as possible to rules and procedures, or elaborate new ones that often have a perverse effect on clinical functioning. In many cases these have the effect of preventing discretion or innovation, but also undermine what ought to be straightforward and effective routines, such as delivering clean laundry or pharmaceutical supplies. On the other hand, the routines and procedures that are vital to maintaining clinical control, for example in the wards and operating theatres, are eroded and eventually disappear. The nationalist state, as currently constituted, is able to provide neither bureaucratic routines nor the bureaucratic expertise on which innovation rests.

It is clear that elite-formation is at the heart of these processes, the driving force around which they cohere; indeed, elite formation has become one of the key purposes of the state shaped by nationalism, and in a number of state institutions, *the* purpose. The importance of establishing and buttressing African sovereignty, or leading the formation of a black middle class, is not to be dismissed; indeed, these goals are essential to rolling back the legacy of colonialism and apartheid, and creating the leadership and skills depth required for the rebuilding of our society. The formation of a black middle class is as important for the stabilisation of society as it is for economic growth, and without state intervention little progress will be made on these fronts. African sovereignty in the form of control of the state is the necessary condition for everything else. The question is how to reconcile these goals with those of effective state functioning.

CONCLUDING DISCUSSION

The research presented here shows how the tensions within nationalism at the level of ideology and state policy correspond to contradictory practices within the state bureaucracy in South Africa. Weberian bureaucracy is, sociologically speaking, one of the core institutions of Western modernity: it is what makes the modern state and the modern capitalist economy possible. It is also at the core of what a 'developmental state' is and what it can do. Modernity was imposed on South Africa through colonial conquest and then elaborated and solidified through the successive forms of the 'internal colonialist' state, thus exemplifying the 'imperialism of the universal' (Bourdieu 2000: 71, 78). Indeed, conquest, racial domination and violence were the modes of modernity in colonies such as South Africa. Modernity – modern state bureaucracy, modern systems of rational and scientific knowledge, and the various modalities of modern sovereignty such as democracy, the nation, citizenship and individual rights – took very specific colonial and racial forms.[10]

The historical shifts in the meaning of the state for the oppressed and then liberated indigenous population of South Africa is captured in the following table:

Table 1: Contrasting purposes of the apartheid and the post-apartheid state

Apartheid state[11]	Post-apartheid nationalist state
1. Suppressed black class formation	1. Supports black class formation
2. Modern 'European' knowledge and skill to advance the interests of white and dominate blacks	2. Ambivalence towards and contestation over modern 'European' skills
3. Instrument of colonial and white racist domination	3. Instrument of African sovereignty and 'face' surrounded by the 'racial gaze' of Europe
4. Hierarchical, authoritarian, racist	4. Hierarchical, with emphasis on deference and status
5. Violent, repressive, authoritarian	5. Ambivalence towards authority, high levels of contestation, breakdown of discipline
6. Sufficient budget for white minority	6. Rituals of budgetary discipline signal that service delivery is secondary

The historical specificity of the South African state means that it is deeply marked both by its colonial and apartheid history, as well as by the struggles of the oppressed indigenous people to establish zones of sovereignty, self-definition and empowerment. These struggles involve *a simultane*ous appropriation and rejection, a tension *between* the appropriation and rejection of modernity, or rather, since modernity is not a monolithic structure, a tension *over* the selective appropriation and rejection of different aspects of modernity. The state bureaucracy is one such aspect, and it is marked by contestation over its purposes and meaning. Thus, the features that have been identified in this article are not necessarily characteristic of all the organs of the state. Some public hospitals work relatively well. Pockets of highly efficient Weberian bureaucracy do exist: the SA Revenue Services, national Treasury, the (ex) Scorpions, all exhibit features of Weberian bureaucracy such as meritocracy, a high premium placed on skill and expertise, and corporate cohesiveness. How such bureaucracies have been established and maintained (or not, in the case of the Scorpions) would be an important subject for investigation.

It is interesting, however, that national Treasury is not only the site of this kind of bureaucracy, but is (and perhaps this is changing under its new leadership) also intellectually the site of an extreme version of economic orthodoxy, ranging from GEAR to fiscal discipline more generally, regressive taxation, inflation targeting, and so on. On the face of it, this may seem – and it has been lauded as such – like the successful replication of the authentic 'European' model of the modern state; yet it may as plausibly be seen as a neocolonial internalisation of the 'racial gaze' in the form of the policy prescriptions of the Washington consensus institutions for the developing world. This orthodoxy has had a destructive impact on the capacity (including financial capacity) of many service delivery departments such as health, where it has translated into the

budgetary rituals, described above, which bear little relation to Weberian rationality. Yet they are the inevitable outcome of 'budgetary discipline', when it is imposed on far-flung reaches of the bureaucracy that are functioning according to non-Weberian rationales. In this they resemble the strange mutations that imperial decrees may take when they arrive in distant reaches of the empire, where they have to be translated into local languages and contexts by local proxies of the imperial centre.

Contrast this adoption of a rigorous orthodoxy by the Treasury with the aggressive adoption of a heterodox dissidence on the issue of HIV/AIDS by the dysfunctional health department, and one begins to grasp the complex and contradictory way in which the appropriation and rejection of modernity plays itself out within the apparatuses of the state. Overall, however, it must be said that many, if not most, of our state departments are dysfunctional, if considered from the classical Weberian perspective. This constitutes a major obstacle to any attempt to implement the strategies of a developmental state.

The analysis of the internal workings of the South African state, put forward in this article, suggests that some elements of the arguments of both Chabal and Daloz (1999) and Mkandawire (2001) may apply. The modern state and aspects of the patrimonial state coexist in uneasy tension. There is a spectrum of effectiveness, with some state institutions relatively effective, and others where Weberian bureaucracy is unravelled by the 'hidden transcripts' of informal nationalist practices.[12] The reality is that the South African state, like nationalism, is a contradictory terrain.

It is worth noting that the South African state has been here before. Posel (1999) has documented the way the National Party government adopted policies of affirmative action and the political deployment of Afrikaners into the public service, displacing experienced English-speaking public servants at the same time as apartheid social engineering required a massive expansion of the state bureaucracy (from 140 000 in 1930, to 550 000 by 1970!). The result was large staff shortages, growing incompetence and mediocrity amongst public servants, low morale and (according to opposition parties, staff associations and academics) 'total dislocation and disintegration of the service' and a 'virtual collapse of administration in many spheres' by the 1960s. The National Party government was, of course, the vehicle for Afrikaner nationalism, which appears to have been marked by similar contradictions to the African nationalism which has replaced it. The state inherited by the ANC was, therefore, in some ways an incapacitated state rather than the model of Weberian rationality fondly remembered by many whites. However, as the nurses quoted earlier in this article warn us, many institutions of the South African state have suffered a further decline since democracy.

What can be done?

Can the post-apartheid bureaucracy be reformed in such a way as to take it closer to the Weberian ideal and make the effective delivery of public services and development – both human and economic – a core rationale? How could this be done?[13] Reform would require that nationalism redefine its goals, or the contradictory projects it informs. This

cannot be a matter of nationalism transcending the contradictions at its heart, since these are not simply a matter of ideology or discursively constructed meanings, but are a response to the real dilemmas of contradictory history. It should be remembered that the state projects in countries such as Korea and Taiwan were also the products of nationalism, and that they successfully established high-capability states. However, they had their own indigenous histories of meritocratic bureaucracy based on indigenous technologies of writing; it may perhaps be argued that such societies were in the process of establishing their own versions of modernity before contact with Europe, which constituted a resource of great value in establishing their own modern states. Nationalism as such cannot be the obstacle, but rather particular forms of nationalism shaped by particular histories. Is it possible to recast the reactive racial nationalism identified in this article, which should be understood 'as a distorted riposte to the ambiguous aggression of the imperialism of the universal', into a form conducive to what Bourdieu calls the 'Realpolitik of the universal' which seeks to make the fruits of modernity accessible to all (Bourdieu 2000: 78, 80).

Such a set of reforms in South Africa would have to define meeting the needs of the people as the most profound way of uprooting white domination and its legacy, while crafting improved strategies for the elite formation which is so important for the skills depth and innovative capability our society requires. However, whether the project of elite formation which is central to the current version of nationalism can be recast or diverted in this way is questionable, since it is underpinned by an extremely powerful array of forces both within and outside the ANC and the state, and located at all levels – from local to national. But perhaps the post-Polokwane contestations within the ANC will test this possibility; the rhetoric, at least, suggests a serious concern with meeting the needs of the poor.

The question confronting us as society, and confronting too the ANC, is what sort of state we want, and how we might go about constructing it. At its root this is a question of how we want to define post-apartheid nationalism and modernity. To adopt a developmentalist ideology without addressing these questions will simply create more opportunities for strange rituals that have little bearing on what actually happens inside the state and even less impact on the needs of the people, no matter how pleasing they might be to progressive policy advocates.

NOTES

1 This article has evolved through several different forms, being first presented at a Human Sciences Research Council & Development Bank of South Africa workshop on the 'The potential for and challenges of constructing a developmental state in South Africa' in June 2008, and thereafter at several other forums, including the Congress of the South African Sociological Association in July 2009. I would like to thank all the participants in these fora who commented on the paper, as well as two anonymous reviewers for SARS whose comments were extremely helpful. An earlier version of this article will be published in O. Edigheji (ed). *Constructing a Democratic Developmental State in South Africa: Potentials and Challenges* (HSRC Press, Cape Town).

2 See, for example, Atkinson 2007; Centre for Development and Enterprise 2007; Schneider et al. 2007; Sloth-Nielsen 2007 and Southall 2007.

3 This does not mean that the apartheid health services delivered adequate health care to black patients; on the contrary, there was a great shortage of facilities and extreme overcrowding in the wards (Marks 1994: 176–177).

4 This started when the National Education Health and Allied Workers Union (NEHAWU) invited the COSATU research institute where I was an employee, NALEDI, to assist with proposals for transforming the functioning of Chris Hani Baragwanath Hospital in 2000.

5 It is beyond the scope of this article to consider the role of this rationale in legitimising the widespread corruption in the public service, but see Hyslop (2004).

6 There are significant questions concerning the validity of the vacancy data due to discrepancies in the available data (Naidoo 2008: 124).

7 The necessity of designating racial and gender attributes in the above examples demonstrates the impossibility of disentangling race and skill when the terrain is so contested.

8 For example, in the treatment of the Zuma presidential campaign.

9 Despite assertive affirmative action policies, just less than 60 per cent of senior managers in the civil service were African in 2006 (Naidoo 2008: 112), from which it can be inferred that the proportion of white senior managers was somewhere around 25–30 per cent, although only 13 per cent of all public servants were white. Of course, many of them were post-apartheid appointees who were associated with the liberation movement.

10 Colonial modernity was, of course, also contradictory, in that some of the colonised were able to access modern education and professional careers, and so were able to appropriate discourses of citizenship, individual rights and nationalism for national liberatory goals.

11 Here we are concerned with the practices of the apartheid state towards the black population; it was of course also nationalist in relation to the Afrikaner population (see later in the article).

12 See Scott (1990).

13 Technical proposals exist (for health, examples are Eisenstein et al (2008) and 'Roadmap' (2008)). The problem addressed here is the prospects for a state capable of implementing technical proposals.

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