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The Rise of Outsourcing and Casualisation of Nurses in the Private Hospital Sector

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Abstract

The nursing sector occupies a contradictory position within the contemporary healthcare system. Nurses perform essential work that sustains life and ensures the functioning of health institutions, yet many are employed under precarious conditions that undermine their stability, recognition and economic security. This contradiction is particularly evident in South Africa's private hospital sector, where nursing agencies have become a central mechanism for organising and managing labour. While agency employment offers flexibility for healthcare institutions, it often transfers the risks and insecurities of employment onto nurses through irregular work, income uncertainty and limited employment protections. This paper examines how agency nurses experience and navigate precarious employment within South Africa's private hospital sector. Drawing on qualitative evidence, it explores nurses' everyday working conditions and how workplace precarity extends beyond the hospital into the home, shaping family life, financial security and social wellbeing. Rather than treating agency nurses as passive victims of insecure employment, the paper highlights their agency by examining the strategies they employ to negotiate, resist and adapt to precarious conditions. The paper argues that although agency nurses are embedded within exploitative labour relations that prioritise flexibility and cost reduction, they actively create alternative forms of sustenance and survival. These strategies include building informal support networks, diversifying income sources and exercising individual and collective forms of resistance that challenge the constraints imposed by precarious work. By highlighting nurses' everyday practices of resilience and resistance, the paper contributes to broader debates on labour precarity, agency work and care work. It demonstrates that while precarious employment reproduces insecurity and inequality, agency nurses continue to forge meaningful pathways towards economic survival and collective wellbeing within an increasingly marketised healthcare system.

Keywords: Agency Nursing, Casualisation, Labour Precarity, Social Reproduction, Private hospital sector

Introduction

Nursing occupies a contradictory position within contemporary healthcare systems. Nurses are widely recognised as essential workers whose labour sustains life, health and social wellbeing, yet their work is increasingly organised through precarious forms of employment that undermine stability, recognition and security. This contradiction is particularly visible in South Africa's private hospital sector, where nursing agencies have become a central mechanism for managing labour. Over the past two decades, private hospitals have increasingly relied on outsourcing and temporary employment agencies to regulate staffing levels in response to fluctuating patient admissions. While this model is framed as necessary for efficiency and flexibility, it shifts the economic risk onto nurses. Agency nurses perform the same clinical duties as permanently employed staff and are subject to the same professional standards, yet they lack job security, employment benefits and institutional recognition. Their work is indispensable, but their employment remains insecure.

This paper examines how agency nurses experience and navigate precarity within South Africa's private hospital sector. It asks three central questions. How is precarity produced through everyday institutional practices inside private hospitals? How does insecure employment extend beyond the workplace into the home and family life? How do agency nurses resist or negotiate insecurity under conditions that constrain formal collective action?

The study draws on qualitative data collected through semi-structured interviews and focus groups with sixteen nurses working in two private hospitals in Gauteng. Eleven participants were agency nurses and five were permanently employed nurses. This comparative analysis allows the paper to trace how power, hierarchy and differentiation operate within the same institutional space. Face-to-face and telephonic interviews were conducted during nurses' lunch breaks and on their off days to capture their lived experiences of work in the hospital private sector.

This paper argues that agency nursing is not a marginal or temporary phenomenon, but a structural feature of neoliberal restructuring in South Africa's healthcare system. Precarity is a specific, structural and politically induced condition of existence; it is a life-or-work situation characterised by a lack of predictability, stability and rights, which results in marginalisation (Butler, 2009). Precarity within the private hospital is actively produced through institutional practices such as differentiated uniforms, shift cancellations, unfavourable shift allocation systems and surveillance. These mechanisms generate internal hierarchies within hospitals, marking agency nurses as outsiders despite their professional qualifications and skills. Importantly, workplace precarity does not remain confined to the hospital. Insecure and irregular employment reshapes household life, limiting long-term planning, intensifying caregiving burdens

and redistributing financial strain across the family. Agency nursing, therefore, reveals the intersection between productive labour and social reproduction, revealing how the crisis of care is transferred onto those who provide it. Finally, the paper shows that agency nurses are not passive subjects of insecurity. In the absence of strong union protection and formal bargaining power, agency nurses engage in everyday forms of resistance ranging from selective availability and absenteeism to informal networking and job hopping. These practices do not overturn structural inequality, but they allow nurses to reclaim their limited autonomy within highly constrained conditions of work.

The paper proceeds as follows: the first section situates agency nursing within a historical and gendered development of the nursing profession in South Africa. The second traces the rise of outsourcing and the expansion of nursing agencies in the private hospital sector. The third examines how precarity is produced inside hospitals through organisational practices and power hierarchies. The fourth explores how insecure employment reshapes family life and social reproduction. The final section analyses the limits of trade unionism and the everyday forms of resistance through which agency nurses negotiate precarity.

History and gendered foundations of nursing in South Africa

To understand the rise of agency nursing in the private sector, it is necessary to situate contemporary precarity within the longer history of the nursing profession in South Africa. Nursing has never been simply a technical occupation. It has been shaped by racial hierarchy, gendered moral expectations and the shifting political economy of care (Poole and Isaacs, 1997).

Historically, nursing held significant social status within black communities. During apartheid, teaching and nursing were among the few professional pathways available to black women (Cheater, 1974; Marks, 1994; Rispel and Schneider, 1991). As a result, nurses occupied a respected position in township communities and churches. Nursing offered conditional mobility and a degree of respect within deeply racialised and gendered labour markets. It allowed black women to distinguish themselves from other forms of racialised and manual labour. Yet this respectability was fragile, as nursing functioned as a site for both opportunity and domination. Occupational categories for non-white nurses created the appearance of inclusion, while authority and decision-making power remained concentrated in white hands. Professional recognition was structured by racial hierarchy. Thus, from its inception, nursing represented a contradiction as it provided limited mobility while reproducing subordination.

Nursing was also constructed as an extension of women's moral and religious duty. Early professional discourses framed care as a natural feminine quality rather than a specialised skill (Searle, 1965). This moral

framing continues to shape how nursing labour is valued, as it is often perceived as less skilled and therefore less deserving of high remuneration (Ray, 2016). The profession is admired symbolically but undermined materially. The historical dynamics established nursing as a feminised and racialised form of labour long before the expansion of outsourcing. Contemporary precarity must therefore be understood not as a break from history, but as a transformation of longstanding inequalities within new economic conditions (Shin et al., 2023).

The democratic transition after 1994 promised racial redress and professional expansion within nursing. Policies aimed at widening access to training, professionalising the sector and addressing historical inequalities were introduced. Nursing was positioned as a site of transformation. However, these reforms unfolded alongside broader neoliberal economic restructuring. The adaptation of the Growth, Employment and Redistribution (GEAR) strategy prioritised fiscal discipline, market efficiency and private sector growth. Public healthcare spending declined while private healthcare expanded rapidly (Baker, 2010; Turshen, 1999; van Rensburg, 2014). As private hospitals grew in scale and profitability, labour management practices also saw a shift.

Outsourcing and temporary employment became central mechanisms for controlling labour costs and ensuring staffing flexibility. Nursing agencies, once used primarily for emergencies within the private hospital sector, expanded into permanent labour suppliers and, over time, agency nursing became embedded within the infrastructure of private healthcare delivery. This transformation reflects a broader reorganisation of work under neoliberalism, where risk is increasingly transferred from institutions to workers (Kalleberg, 2011; Pons-Vignon and Anseeuw, 2009). Rather than maintaining stable employment relationships, private hospitals externalise labour through agencies. Flexibility is presented as efficiency, but for agency nurses, it changes their security, their benefits and their collective voice. Thus, the expansion of agency nursing is not accidental. It is structurally linked to the post-apartheid political economy.

Commodification of care labour: Rise of casualisation and outsourcing

The growth of nursing agencies illustrates how care labour has become commodified within market-driven health systems. Agencies function as brokers, supplying nurses at different skill levels, from professional nurses to nursing assistants. Olojede and Rispel (2015) show that in terms of casual labour, 87% of nursing agencies reported that they contracted professional nurses, 65% contracted enrolled nurses, while 61% and 67% of the nursing agencies contracted nursing assistants and caregivers. This distribution indicates that nursing agencies do not simply act as reserves for on-demand skilled nursing professionals; they act as active channels of exchange that have access to the full range of nursing labour, from nurses who have

specialised clinical expertise to routine bedside care. In addition, more than 500 nursing agencies were historically registered with the South African Nursing Council (SANC), but legislative changes removed these responsibilities (Olojede, 2012). This shows that the scale of the nursing agency sector is significant, yet difficult to measure due to regulatory gaps.

Rispel and Moorman (2015) state that the nursing agency sector is not as well-regulated as it should be, in that a detailed database of all registered agencies does not exist. This reveals that the sector is larger and more complex than the existing data captures. The absence of comprehensive regulation has contributed to a fragmented and weakly monitored sector. The regulatory gaps benefit private hospitals by ensuring a steady supply of flexible labour while diffusing accountability for their employment conditions. As scholars argue, contemporary healthcare systems increasingly treat nursing labour as a commodity to be deployed according to market demand (Dillard-Wright and Shields-Haas, 2021). Under the agency nursing model, staffing levels fluctuate with patient admissions, bed turnover and medical aid approvals. Labour becomes irregular rather than stable. Agency nurses thus operate within a flexible labour infrastructure where they mitigate hospital uncertainty while absorbing employment insecurity themselves.

The casualisation of nursing cannot be understood solely in the workplace. It intersects with broader questions of social reproduction. Social reproduction highlights how paid and unpaid labour are interconnected in sustaining life and labour power (Bhattacharya, 2017; Fraser, 2016). Nurses occupy a central position in this contradiction. They are responsible for sustaining patients' lives through paid care work, while simultaneously carrying primary responsibility for unpaid caregiving within their own families. When their employment becomes insecure, the effects spill over into family life. The erosion of stable wages intensifies what is described as the "crises of care", where market-driven reforms undermine the very labour required to sustain society. Precarity is therefore not only an employment condition; it is also a social relation that redistributes the costs of care from the institution onto individual women and their families. Agency nursing reflects this crisis. As demand for private healthcare increases, the conditions under which nurses provide care deteriorate. Their professional labour remains indispensable, yet their own capacity for security and long-term planning is undermined.

Precarity at work: A jobless type of employment

Precarity among agency nurses is not incidental or temporary. It is actively induced through everyday organisational practices inside private hospitals. Although agency and permanent nurses perform the same clinical tasks and hold the same professional registration with the South African Nursing Council (SANC), they occupy unequal institutional positions. This inequality is not based on competence but on

employment status. Through work allocation systems and disciplinary mechanisms, hospitals generate internal hierarchies that differentiate belonging, authority and security. Precarity, therefore, operates not only as job insecurity but also as a structural condition that creates marginalisation within the workplace. Agency nurses repeatedly described feeling present in the hospital but never fully part of it, as they are called for shifts only when needed, yet they are excluded from institutional recognition. Events such as Nurses' Day celebrations only include permanently employed staff, Grace explained:

> Sometimes you feel isolated somewhere, somehow, because most of the time the permanent staff and management will do their thing (not include agency nurses), if it is Nurses' Day, they only concentrate on the permanent staff and not the agent.

Such practices within the hospital create an "outsider within" position where workers are structurally inside institutions but symbolically marginalised (Collins, 1999). Precious also held similar sentiments:

> You get discriminated in a way; you are not considered part of that hospital. Because they only call you when they need you. So, it makes me feel as if I don't know my job because if there are mistakes or errors in the ward, it is always agency staff. Even though you have worked in the hospital for 10 years, because you are working for an agency, you are not considered as that institution's employee.

Importantly, this reveals that exclusion in the private hospital sector is normalised. Agency nurses are rarely formally told they do not belong; rather, belonging is withheld from them through different practices that occur within the hospital. This produces a hierarchy in which permanent nurses are recognised as institutional members, while agency nurses remain provisional labour. As Selberg (2013) argues, workplace identities are formed through power relations rather than fixed credentials. The professional identity of agency nurses is therefore undermined not because of a lack of skill, but because institutional practices continuously mark them as secondary. There is a hierarchy that exists within the private hospital. Thus, nurses within the private hospital are divided not by training but by employment status, making precarity embedded within the occupational structure.

One of the most visible mechanisms of differentiation within the private hospital is the uniform. Agency nurses are required to wear uniforms that are distinct from permanent nursing staff. Officially, this distinction is framed solely for identification and administrative purposes, but in practice, it operates as a marker of hierarchy signalling who belongs and who does not. Thandiwe indicated that nurses wear different uniforms so that the hospital can distinguish between agency nurses and permanent nurses. She went on to say that when patients see the difference in the uniforms, they ask many questions. This suggests that wearing different uniforms leaves agency nurses feeling vulnerable to questions that they feel uncomfortable answering. Secondly, wearing different uniforms decreases patients' trust in the agency nurse, as patients tend to question whether agency nurses can accurately perform their job. Emily shared

similar sentiments on how patients treat them when they see them with different uniforms: "Patients treat us very badly because of our uniform, and it can make us feel small the way they do things."

The issue of nurses' uniforms can be linked to Foucault's (1995) analysis of discipline and control, and connections are drawn to the broader idea of the panopticon. The panopticon is used for surveillance and control. Thus, agency nurses' uniforms act as disciplinary tools, making one's employment status instantly visible to managers, permanent staff and patients. Nurses specifically stated that the different uniforms also made it easy to determine which nurses made mistakes. Rispel (2016), in a study on the cost of agency nursing work, states that agency nurses often need more supervision than permanent nurses when giving medication, dressing wounds or dealing with high-tech equipment. Most of the agency nurses in this study held contrasting views as they explained that they were capable of doing their work without any supervision. Agency nurses reported that they had years and some even decades of experience working in the private hospital sector. This, for nurses, proves that they can provide clinical services without needing supervision, contrary to what the available literature shows. Conversely, permanent nurses voiced that agency nurses who came from different institutions needed to be trained, monitored or supervised to ensure that they offered quality services in the private hospital.

Palesa, who has been working as a permanent nurse for 11 years, explained this:

> Some agency nurses have an attitude; when you tell them that this is how the job is done, they will not listen. And we, as permanent staff, attend training, so we are more qualified and more equipped, so we know what is expected of us. If you tell him or her what to do, they feel like you want to control them, and others also use age, whereas this work deals with ranks. Sometimes, my senior can be younger than me, so we deal with ranks here, so they must obey the rules.

This reveals the tensions and power relations that exist between agency nurses and permanent nurses. For Foucault (1995), power operates at the micro level of social relations and it trains bodies to conform. This power within the private hospital is held by permanent nurses, who exert control over agency nurses.

Precarity for agency nurses is also based on economic factors; unlike permanent staff, agency nurses' access to work depends on fluctuating patient numbers. Staffing decisions linked to agency nurses getting shifts are often recalculated daily in response to admissions, discharges and medical aid approvals:

> The disadvantage with agency-based work is that it's only a patient ratio kind of nursing; let's say for instance the ward is 32-bedded and there are sixteen patients in the hospital, you as an agency nurse are going to be cancelled because this is a money-making scheme. Phela (because) this is a private hospital. They work according to the number of patients that they have in the ward. If you are not needed, let's say you're confirmed in the morning that you must come to work, and then during the

> day they discharge patients, just know that you're going to be cancelled later. That's the disadvantage because you can't budget. (Elizabeth interview)

Agency nurses also frequently used the phrase "employed but unemployed" to explain their employment status. Agency nurses are attached to work, yet it lacks guaranteed income. Jabulile captured this paradox: "I am employed, but I am also unemployed in a way … but it is better than doing nothing at home." This condition resembles what some scholars describe as labour commodification under flexible capitalism (Kalleberg, 2011), describing a labour force that is purchased only when immediately profitable.

Thandiswa explained how accruing shifts remain concentrated in permanent nurses' hands:

> If you are an agency nurse, they don't take you seriously, and when the permanent staff are doing wrong things, they will say it's you, and when they don't like you, maybe if you perform better than them, they won't like it. They (permanent nurses) make sure that you don't come in on any of your workdays. If you have 30 days in a month or, let's say, you were booked for 15 days in that month, you will work only three days because they don't like you. Yet there is a register where they book us as agency nurses; the permanent nurse will come and rub you off (erase your name from the register) and put their friends' or their own names in for overtime. Then yeah, it's like that.

This shows that access to income is secured through informal gatekeeping and the power that permanent nurses hold inside the private hospital.

Cancellations within the private hospital act as silent punishment, where permanent nurses use their power to create a docile agency nursing force that never outperforms and never retaliates. Agency nurses who are perceived as difficult, or even those who outperform, risk being excluded from future shifts. Agency nurses' economic insecurity thus reinforces their compliance, creating submission. This makes precarity not only a condition but a tool used for control and compliance.

Agency nurses consistently framed the private hospital as a business rather than a professional community. Jabulile stated:

> It's been hell, I will say, because now there is pressure from the managers, especially in the private sector, because this is a business; they're making money so they will put you under pressure. And when the patient is rude or does you wrong, they won't stand with you. They will stand with the patient and by the patient. Wena (you) are just an agency nurse; you are nothing, and bona (the private hospital) they're pushing money. They're making money using you. Also, the patient is always right, even when they are wrong. They don't care about you. They care about money. Nobody is standing up for you in case something happens. Unless they are suing them, yah, that's when they will take action, because

> now the money is going to go out. But otherwise, nobody is standing up for you. You are nothing to them, just a money-making machine for them.

Rarani (2025) complements this by showing that there is a hyper-commodification of nursing labour that treats skilled clinical care as an interchangeable, just-in-time resource by prioritising rigid accounting metrics and billing margins over holistic patient outcomes. Rarani notes further that health systems routinely subject nurses to dangerous nurse-to-patient ratios, erratic shifts and pervasive workforce burnout.

These insights also reflect a broader shift in healthcare governance, showing how outsourcing reorganises nursing labour around cost-efficiency rather than professional solidarity (Purcell et al., 2004). Loyalty is directed upwards towards profitability rather than towards colleagues. The hospital becomes a marketplace in which nurses compete for shifts. Financial necessity intensifies tensions between permanent and agency nursing staff. Precarity, therefore, fragments collective identity within private hospitals; the internal competition undermines solidarity and weakens the potential for unified action; and the professional community becomes separated along contractual lines rather than skills.

From workplace precarity to family insecurity: The moral economy of care

Workplace precarity does not remain confined to the hospital. For agency nurses, irregular employment and unpredictable wages directly reshape the conditions under which family life is sustained. Income instability undermines long-term planning, intensifies emotional strain and redistributes insecurity across families. Precarity thus becomes not only a labour condition but also a condition that affects the family.

Many nurses described entering and remaining in nursing because of passion. Philani explained that although he initially studied media, he "fell in love with nursing" and would choose it again, and other nurses echoed this sentiment. Ntombi stated: "I enjoy nursing even if there is some strain to it." Thoko described helping patients recover as the most fulfilling part of her work. These narratives align with the historical construction of nursing as a moral duty rather than purely economic labour (Dodson and Zincavage, 2007; Narayan, 2025; Ray, 2016). Care is framed as compassion, devotion and selflessness. Yet this moral framing contains a contradiction. As scholars argue, when care is understood as passion, it becomes easier to underpay and exploit (Wichterich, 2020). And in the moral economy of care, commitment becomes a substitute for compensation. For agency nurses, passion does not shield them from precarity; instead, it sustains their attachment to insecure work. The moral value of helping others coexists with insecurity. The profession is emotionally meaningful, yet economically fragile for agency

nurses. If passion explains entry into nursing, then nurses' children explain their endurance. Agency nurses repeatedly emphasised that they continue working under insecure conditions because of their children.

"I work for my kids and nothing else," Zandile stated during the focus group discussion; others nodded in agreement. Robyn similarly described her children as her primary motivation. The emphasis on "kids" was striking; nurses spoke of them as their central justification for accepting insecurity. Lerato explained the emotional toll of cancelled shifts during festive seasons: "If there are no patients, you will sit at home … and you cannot provide for your kids." This reveals how productive labour and social reproduction intersect. As scholars state, social reproduction refers to the daily and generational work of sustaining life, feeding, educating, caring for and raising children (Bezanson and Luxton, 2006). For agency nurses, insecure wages disrupt this process.

Women remain primarily responsible for unpaid care work (Holden, 2014; Reid and LeDrew, 2013). Agency nurses therefore shoulder a double burden of providing care at work and reproducing care at home. When agency nurses' wages fluctuate, anxiety intensifies. Nurses described feelings of guilt when they were unable to meet their children's expectations. Here we see that precarity is collectively experienced among agency nurses. Agency nurses frequently described their income as sufficient only for immediate survival. Jabulile explained:

> Even if they call you five days a month, you can buy soap, you can buy basic necessities … but you can't buy a house, and you can't take your kids to better schools.

Thandiwe expressed similar frustrations:

> You are there just ukuthi uphile (You are there in the private hospital just to survive).

These accounts reveal what is described as precarious subsistence – wages that cover food and basic necessities but do not allow accumulation, savings or long-term investment. Buying a house, purchasing a car or enrolling children in better schools becomes unattainable (Cohen, 2023). Zanele captured this constraint:

> Because you are not permanent, awukwazi ukuzibopha (you cannot fully commit yourself to anything). You can't buy a house or a car.

Precarity here limits not only income, but also how nurses plan for the future. Life becomes organised around immediate survival rather than upward mobility. This shows the broader condition that exists under capitalism: that being exploited may be preferable to unemployment, yet exploitation itself does not guarantee security (Denning, 2010). Agency nurses remain attached to work that cannot improve their living standards, yet they cannot afford to leave it.

Agency nurses stated that on average they earned R1 500 (approximately. US$91.74) for every shift they worked; nurses stated that they typically worked for five days in a month which would equate their total monthly earnings to R7 500 (US$458) a month, this shows a stark difference from what permanent nurses get paid on average. According to the department of labour, permanently employed nurses earn between R21 000 and R40 000 (US$1 283-US$2 440 USD) a month depending on experience and specialisation. Permanent nurses stated that they end up fighting for shifts because of the money.

Palesa, who is a permanent nurse, stated: "We sometimes do overtime as permanent nurses because we need the extra cash." This raises questions about how this affects agency nurses' already limited shifts. The experiences of agency nurses reflect a crisis of care, as market-driven reforms expand the demand for healthcare while undermining the stability of those who provide it. Institutions externalise risk onto workers, and workers absorb that risk within their households. Agency nurses occupy a deeply contradictory position as they sustain the health of others while struggling to secure the wellbeing of their own families. Paid care and unpaid care collapse into one another under conditions of insecurity (Chopra and Zambeli, 2017). Precarity for nurses moves from the hospital ward into the home. It reshapes not only employment, but the reproduction of everyday life, and survival becomes the organising principle of the family.

Precarity, the failure of trade unionism and everyday forms of resistance

The expansion of agency nursing in South Africa's private hospital sector has occurred alongside the weakening of traditional forms of labour protection (Sefalafala et al., 2024). Casualisation and outsourcing have placed many agency nurses outside the effective reach of labour law and collective bargaining structures. Although the Democratic Nursing Organisation of South Africa (DENOSA) remains the largest union in the sector, its organisational power is limited among agency nurses whose employment status is fragmented and externally sourced. As scholars of labour restructuring argue, processes such as casualisation and externalisation weaken workers' structural power by dispersing employment relationships (Webster and Dor, 2023). In this context, formal collective action becomes difficult to sustain. The question, therefore, is not whether agency nurses resist, but how they express resistance under conditions of insecurity.

Rather than understanding resistance as only visible protest or strike action, it is more useful to conceptualise it as a continuum. Drawing from Scott (1985; 2007; 2016), resistance can include subtle, fragmented and everyday practices through which workers negotiate domination. Agency nurses operate

within private hospitals where open confrontation carries significant personal risk. Agency nurses' participation in strikes or voicing their work-related challenges to management may result in cancelled shifts or exclusion from future work. Their vulnerability limits access to highly visible collective tactics. Resistance, therefore, takes forms that consider risk. Understanding resistance as a continuum allows us to recognise practices that prioritise agency nurses' survival, how they set boundaries and negotiate better working conditions for themselves rather than striving for transformation (Brook, 2001; Chauvin et al., 2026; Crocker, 2019; Lilja and Vinthagen, 2018).

One of the most common forms of resistance described by agency nurses is selective unavailability. Agency nurses spoke about ignoring calls, declining last-minute shifts and even deliberately making themselves "unavailable". Jabulile stated:

> I do not answer my phone when they call me late at night to come to work because where will I get transportation late at night, and if they send the hospital's car, they charge it to le-salary engekho (my salary that is already small), so hayi (so no), I just tell them I am not available tonight.

In a labour system that demands constant flexibility, refusing availability becomes a quiet assertion of one's autonomy. Absenteeism disrupts hospitals' expectations that agency nurses must always respond when called. It reclaims short-term control over time and nurses' health. While management may interpret absenteeism as irresponsibility and even a lack of dependability, agency nurses frame it differently as a way of preserving themselves in a system that does little to support them. Agency nurses work long hours, endure emotional strain and face unstable income; thus, the act of saying no becomes a way of setting boundaries. However, this form of resistance has limited capacity to yield results. It does not change contractual arrangements or eliminate the precarity that already exists. Its power lies in protecting physical and emotional wellbeing rather than attempting to restructure institutional hierarchies that are within the private hospital.

In the absence of strong union representation, agency nurses rely heavily on informal networks. Through WhatsApp groups, personal relationships and word-of-mouth communication, nurses share information about available shifts, warn one another about exploitative managers and exchange strategies for navigating hospital politics (Simpson and Simpson, 2019). These networks function as what Cicellin et al. (2015) describe as a "community of coping". They redistribute risk among workers; rather than confronting management directly, nurses create alternative systems of doing things and mutual support. Informal networks thus reduce isolation and generate micro-solidarity within fragmented employment structures such as agency nursing work. Yet they are also contradictory. Access to shifts may depend on personal connections, which reproduces inequality among nurses themselves. Thus, the informal networks that are created might sustain workers in precarity rather than dismantle it. However, agency nurses weaken control

within private hospitals by decentralising information and creating alternative channels of power for themselves.

Job hopping and moonlighting represent another strategy for negotiating insecurity. Many agency nurses move between agencies or combine multiple jobs to stabilise their income streams. Grace explained: "We rely on working in different hospitals so that we will have enough money to live at the end of the month." This mobility reduces dependence on a single employer. By refusing to pledge exclusive loyalty to institutions that do not offer them the same security in return, through job hopping, agency nurses subtly shift the balance of power. Their labour becomes mobile rather than fixed. Yet this strategy carries costs. Moving from one hospital to another often leads to exhaustion, fragmented work schedules and limited access to benefits or promotion. This strategy manages insecurity rather than resolving it. Job hopping thus reveals the paradox of resistance under neoliberal conditions; strategies that expand autonomy in the short term may deepen precarity in the long term.

At the most visible end of the resistance continuum lies strike action, traditionally understood as the most disruptive form of labour power (Brooks, 2011; Vinthagen and Johansson, 2013; Webster and Dor, 2023). However, for agency nurses, strikes are largely inaccessible. Thandiwe explained: "Agency nurses cannot go on strike like permanent nurses; if we go on strike, we will be unemployed." Agency nurses' employment status allows hospitals to replace them easily or discontinue their shift bookings without any formal dismissals. Unlike permanent employees, they lack institutional protection against any retaliation. Therefore, participation in collective withdrawal of labour carries disproportionate risk. The absence of strikes should therefore not be interpreted as agency workers being passive agents; rather, it should reflect the structural constraints imposed by casualisation, in that where security is absent, overt confrontation becomes costly (Ball et al., 2017).

Conclusion

The rise of outsourcing and casualisation in South Africa's private hospital sector has reshaped the meaning of nursing work. This paper has shown that agency nursing is not a new conception but reflects a structural shift in the political economy of care. Precarity within the workplace cannot be separated from precarity within the home. The insecurities nurses face in private hospitals of irregular income, surveillance and lack of institutional belonging extend into their households and shape how care is organised, how families survive and how intergenerational futures are imagined. Thus, agency nursing is a perfect representation of capitalism's crisis of care, in that the very workers who sustain life are those whose own lives are unstable. The study also shows that agency nurses are not passive subjects of exploitation; through

their acts of absenteeism, informal networking and job hopping, nurses create quiet but significant forms of resistance that allow them to reclaim some of their autonomy within deeply unequal institutions. These everyday tactics expose the contradictions of a private health system that depends on the flexibility and commitment of agency nurses while denying them recognition and security.

Ultimately, agency nurses reveal the contradictions of contemporary capitalism, as they are indispensable yet disposable, visible yet unrecognised and professional yet precarious. Recognising their labour as both productive and reproductive is essential to imagining a more equitable health system –one that values care, not only as a commodity but as a social relation that is crucial to collective wellbeing. By centring the experiences and resistance of agency nurses, this paper contributes to the broader understanding of how precarious workers attempt to sustain their lives in the face of systematic insecurity.

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