
Round table

**Decentralization and Human Resources :
Implications and Impact**

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Abstract :

Decentralization of political and administrative power, combined with a civil service reform, are increasingly prevalent components of health sector reform. The wider implications of decentralization for human resources development are, however, poorly researched and inadequately understood. This paper analyzes these implications from the experience of the author, her colleagues at Management Sciences for Health, and published literature.

Four important human resource issues are found to emerge *as a part* of the process of transferring power to lower management levels. They are the adequacy of available information on human resources, the complexity of transferring staff, the impact of professional associations, unions and registration bodies on the design and implementation of management structures and jobs, and the morale and motivation of health workers.

The key human resource domains where problems arise *as a result* of the way in which decentralized management systems are structured, are identified next. Organizational structures, roles, and responsibilities may become inappropriate, conflict with each other, be disputed or poorly communicated. The viability of developing health services and human resources in a coordinated manner may be in jeopardy because of deteriorating databases, reduced planning capacity, inequitable or inappropriate staff allocation, or decentralization-induced difficulties in career development. The retention of an appropriate training capacity may be threatened, if mistakes are made in allocating training responsibility. Technical and managerial competence may be reduced by a shortage of skilled staff or the deterioration of supervision systems. Finally, performance conditions may be impaired if decentralization impacts on the timely payment of wages and benefits and the availability of essential resources.

Recommendations for other health leaders include becoming an advocate for human resources, anticipating and preparing for the cost and complexity of decentralization, developing a strategic human resources development capability, investing in developing staff, and monitoring the impact of decentralization.

Key Words : decentralization, human resources, power, reform, health sector,

*To conduct great matters and never commit a fault
is above the force of human nature.
(Plutarch ca.46 - ca.120 AD in Life of Fabius)*

Introduction

Decentralization of political and administrative power is becoming an increasingly prevalent component of health sector reform in all parts of the world, from Asia to Africa, from Europe to South America. This transfer of power away from the center is often combined with an effort to reform an outdated and cumbersome civil service structure. These reform processes are particularly true of countries under structural adjustment, where funding agencies such as the World Bank are important partners in the process of reform, and in many instances its driving force. Yet the wider implications of decentralization for human resources planning, training, and management (jointly referred to as human resources development in this paper) are generally poorly researched and inadequately understood.

Human resources are the most important component of the health care system in converting available pharmaceuticals, medical technology, and preventive health information into better health for a nation. Training young people to become skilled health workers takes a long time and the cost of employing them once they are trained is high. In most countries, salaries and benefits consume up to three-quarters of the recurrent health budget. For these reasons, human resource considerations should command a great deal of attention in any decentralization discussion. That this is frequently not the case reflects both the general inattention to human resource issues (other than training) that prevails in many countries and the conceptual vagueness of “decentralization.”

“**Decentralization**” is a term that continues to be used to describe a wide variety of power sharing arrangements.⁽¹⁾ It can signify the transfer of limited administrative responsibility from a central Ministry of Health to local health offices or it can involve the creation of new governmental structures, such as provincial governments, which are responsible for providing health and many other services. The implications of decentralization for human resources for health are greatly influenced by the degree to which political and/or administrative power is transferred, how the new roles are defined, what skills are available at the local level, and what administrative linkages exist between the different management levels, and between the central health authority and the other central government offices that influence resource allocation (such as Ministries of Finance and Civil Service). Finally, they are also influenced by the degree of political will to make decentralization work.

A variety of political and economic reasons can influence a country to transfer power away from a central level. In recent years, however, decentralization has often been implemented as an integral component of health sector reform.⁽²⁾ Health sector reform aims to improve the performance of the sector, and ultimately, the health of the people, through a conscious process of setting sectoral priorities and policies, and then reforming the way health services are structured and financed to fit with the revised priorities and policies. The consequent changes in

organizational structures and institutions, such as National Ministries of Health or the Civil Service, have fundamental human resource implications. The success of health sector reform in reaching its laudable goals will thus depend greatly on the amount of thought and preparation that human resource issues have been given.

This paper analyzes the impact of decentralization on sound human resources development based on the experience of the author and her colleagues at Management Sciences for Health, and the published literature. The findings come mainly, but not exclusively, from countries where decentralization has taken the form of devolution, i.e. where both the decentralized activities and the staff performing them have been transferred substantially outside the central government's direct control. The most glaring problems tend to surface in these countries, and readers will notice that the text gives many examples of the way in which decentralization has jeopardized important aspects of human resources development. **This should, however, not lead to the conclusion that centralization of power would necessarily be a better option.** Rather, these negative examples are presented to highlight the crucial importance of considering human resource implications at every step of the decentralization process.

The paper is divided into three sections. The first section looks at human resource issues that emerge *as a part* of the process of transferring power to lower management levels. The second section focuses on identifying the most important human resource domains where problems arise *as a result* of the way in which decentralized management systems are structured. The third section distills key recommendations for other health leaders who are considering decentralization or implementing reforms.

I. Before the Fact: Human Resources and the Decentralization Process

The decision to decentralize frequently arises outside the health sector and for reasons that have little to do with improving a nation's health. Political considerations are particularly prominent in countries that devolve substantial control over health services to local governments. Such devolution usually also encompasses the transfer of control over peripheral health staff from central to local authorities. The timetable for implementing these new decentralization arrangements is often very constrained, allowing little time for examining the human resource implications of proposed reforms.

The politically highly charged decisions about new roles and responsibilities under devolution must be followed by the definition of new organizational structures, and terms and conditions of service at both the central and peripheral levels, and by the reallocation of staff between these two levels. Four important human resource issues emerge in this process. These are

1. the adequacy of available information on human resources
2. the complexity of transferring human resources

3. the impact of professional associations, unions and registration bodies on the design and implementation of management structures and jobs
4. the morale and motivation of health staff

1. The adequacy of available information on human resources

Decisions on human resources will be sound only if they are based on appropriate and timely information.⁽³⁾ Access to reliable and easily available data on staff is thus crucial to any decision about their allocation. This is true of a country that decides to maintain a single public service structure, as was done in Papua New Guinea, where in the 1980s, each province was formed into a public service department to which members of the national public service were assigned full-time.⁽⁴⁾ It is equally true of a country where members of the national public service become part of local government staff establishments, as in the Philippines.⁽⁵⁾

Basic personnel data, such as a health worker's name, professional qualifications, and age, are more likely to be available at the central level than up-to-date, accurate information on the type and level of position they hold or the cost of employing them. Data on lower-level staff, particularly if they are not considered part of the public service, are often missing. Even where data are available, considerable time may be needed to verify their accuracy and completeness. While salary data are usually more reliable, records on staff positions and the individuals holding those positions that a ministry of health or a public services commission maintain are notoriously flawed and out-of-date. Data on training intakes and outputs are often incomplete and inaccurate, since they come from multiple sources with different schedules of updating and quality control.

Reilly's observations of the situation in Papua New Guinea at the time of decentralization are not unusual:

It was not possible to construct complete organizational structures for each health division of every province because of poor records kept at the Department of Health. The section of the Department which dealt with staffing did not know what positions were available in provinces or who filled them. A similar problem was found with duty statements, which were out of date and not specific to the tasks to be performed.⁽⁶⁾

2. The complexity of transferring human resources

The transfer of human resources to local control is a far more complex process than the hand-over of facilities or equipment. The following categories of issues illustrate the range of decisions that need to be made:

- modifying or creating new organizational structures and positions at the central and local levels, and specifying the linkages between them
- revising job descriptions and reporting relationships
- defining new processes for personnel management
- deciding how to reallocate existing staff to new organizational structures

- transferring personnel records and staff
- mediating if the new employer refuses to accept the transfer
- dealing with individual staff members who will not or cannot transfer

First, decentralization calls for changes in the way human resources are organized into functional health care structures and in the jobs that staff perform. Organizational structures and positions at both the central and local levels require modification to conform with the new division of powers and resource allocation patterns. Existing jobs may need to be redesigned, job descriptions revised and reporting relationships amended to ensure the availability of the right combinations of skills in the new organizational structures. Terms and conditions of service may have to be altered to fit with available resources.

Shaping the post-decentralization pattern of employment in the health sector through organizational design and job re-profiling is highly complex on a technical and operational level. It is also an intensely political and bureaucratic process that involves a variety of institutional actors from health managers and professional associations to government officials and politicians. The differences in prior salary levels and conditions of service make this process particularly challenging in those countries like South Africa, where previously separate health delivery systems are combined under a new decentralized health care structure.⁽⁷⁾

The form that the new organizational structures take can be greatly influenced by central government decisions that emanate from outside the health sector. A stringent target for staff reduction may become their key determinant, if decentralization occurs as a component of a national effort to reform the civil service. Cutting staff strength without considering the larger strategic implications for health care delivery may result in an organizational structure and staffing levels that are detrimental to important components of the health service. In Nepal, for example, the initial cuts at the central level paralyzed essential functions, such as the Expanded Programme on Immunization.⁽⁸⁾

Molding old organizational structures to suit the needs of decentralized management or the creation of new structures may be hindered by a strong agency in charge of the national civil service. In Papua New Guinea, it took a year to convince the Public Services Commission of the need to create an administrator post in the provincial health structures and another two years before these posts were advertised.⁽⁶⁾ In the Philippines, a new Department of Health (DOH) organogram, which was developed with the help of outside consultants, was declared illegal and never implemented. Consequently, the DOH organization chart was characterized for a long time by ad hoc structures, and staff held contractual, rather than permanent “plantilla” (civil service establishment) positions.⁽⁹⁾ The situation was similar in Indonesia, where the national civil service administration could take up to five years to approve a new post.⁽¹⁰⁾

Second, the definition of personnel management processes after decentralization must proceed in parallel with the design of organizational structures. Decisions on how salary scales and position levels are decided, and how recruitment, selection, appointment, performance assessment, or staff discipline will be handled are complex, time-consuming, and again, subject

to the influence of a central civil service agency. Clear definition of these management processes is very important, since labor conflicts may result if they are left too vague. Furthermore, since decentralized units may have little prior experience with human resources management and possess few, if any, human resource management systems, the definition of these processes must be accompanied by the design and implementation of appropriate systems, and the training of staff in their use.

Third, existing staff members must be reallocated to new organizational structures. Personal preferences, career ambitions, or fear of change can make the process of staff allocation an area of high anxiety and much discord. If skilled managers are few, the central-level staff may feel particularly uncomfortable in their proposed new roles as experts and technical advisors and oppose any change. In Papua New Guinea, for example, central-level technical officers who were not well qualified for a role of an expert advisor at the time of decentralization vigorously resisted revising the organizational structure.⁽⁶⁾

Fourth, the personnel files of decentralized health workers must be transmitted to the management level that is now responsible for them. Compiling an accurate personnel record for each individual, with available data on their qualifications and training, employment, salary history, and record of performance, together with the physical transfer of these records, can be a mammoth task. In Mexico, for example, devolution of health services involved the transfer of 116,000 health workers to the state governments.⁽¹¹⁾ Transferring the personnel records of this number of staff provides enormous scope for unintended mistakes, which can sour relationships and take considerable time and effort to set straight.

Fifth, mechanisms are required to mediate disputes regarding the transfer of human resources that may arise between the central and local levels. Chief officials at the decentralized management level may, for legitimate reasons of efficiency or resource constraint, refuse to accept a particular post into their organizational structure. Differences in personality or political views between local health staff and local politicians may make the appointment of a particular individual to that geographic area very difficult. In the Philippines, local chief executives were unwilling to absorb over 4 per cent of the Department of Health personnel by the time the full transfer of assets to local government units (LGUs) was to have been completed.⁽⁵⁾ Even if the central level retains the legal power to force the appointment, the success of the health worker in performing his or her duties in such a hostile environment is threatened.

Finally, managers must decide how to deal with health workers who will not or cannot transfer to their new jobs. These health workers may object to a physical relocation that their reassignment to a new organizational structure demands because of family problems or a lack of accommodation in the new locale. Even where the workers remain in the same locale, their previous lines of communication and authority are likely to be altered. Since individual health workers develop strong loyalties to their coworkers, the patients they serve, and the location they work in, uprooting, whether it be geographic or emotional, is painful for most.

Staff transfers are particularly opposed, when workers are concerned about the long-term security of their employment. Recently, some countries have sought to remove health sector staff

totally from the civil service, thus creating a situation which health staff consider fundamentally threatening to their terms and conditions of service. Evidence is accumulating that these fears may not be groundless. The experiences of Zambia and Sri Lanka, for example, seem to indicate that compensation for the loss of civil service benefits and conditions of service must be very high if health workers are not to be disadvantaged by this change.⁽⁸⁾

There will thus always be some health workers who are reluctant or unable to accept their new assignments. Health sector decision makers must decide the extent to which they are willing to accommodate individual preferences and what sanctions they will apply in the case of those who refuse the transfer.

3. The impact of professional associations, unions and registration bodies

Health workers' associations, unions, and registration bodies are a very powerful force in the design and implementation of decentralized management structures and jobs. A common fear of the members of health workers' associations and unions is that decentralization will jeopardize their tenure or substantially reduce their salaries and benefits. The issue of labor relations is very much at the forefront in South Africa, where the disparity in conditions of employment between local government staff and employees of provincial health departments (the former can earn 40 to 70 percent more than the latter) is a critical issue facing the government in its efforts to institute a unified, district-based health system that provides care in an equitable manner to all South Africans.⁽⁷⁾ Finally, professional registration bodies may be reluctant to approve innovations that successful decentralization demands, such as a re-allocation of responsibilities between professional cadres, re-profiling of jobs, or changes in the training curriculum and level of entry.

4. The morale and motivation of health staff

Issues of morale and motivation of health workers loom very large during the initial period of decentralization, when new structures, roles, and responsibilities are defined and staff transfers implemented. Uncertainty over their own professional futures and legitimate concern about the impact of decentralization on the quality of health services combine to make this a time of high anxiety for health workers. This anxiety may force some of them to seek employment in the private sector or even outside the country. The loss of morale and motivation can also result in the initial withdrawal of health managers, particularly those at the central level, from planning for decentralization. If these managers fail to engage actively in the early debates over decentralization, they miss an important opportunity to influence the detailed design of new structures and roles when these are still subject to change.

Collaborative relationships between central and local staff may become very frayed where a considerable difference of opinion exists about the advisability of decentralization or the speed with which it is being implemented. Central-level staff may be reluctant to hand power to local staff, seeing them as ill-prepared for their new responsibilities. Local staff, in turn, may be eager to gain a bigger say in the management of health services, and resent the slow pace of

reforms. Jealousy over perceived individual gains and losses from decentralization may further damage relations between individual staff members.

Decentralization frequently increases local staff's sense of vulnerability to political crossfire. In Papua New Guinea, decentralization provoked not only an intense power struggle between central and provincial health staff, but also a continuing conflict in many provinces between provincial politicians and public servants.⁽¹²⁾ Few decentralizing health systems have given sufficient attention to developing conflict resolution mechanisms that could provide for timely action in defusing friction.

II. After the Fact: Decentralized Powers and Human Resources

Decentralization is a complex process, frequently undertaken with some urgency and in a highly political environment. Such pressures of implementation can force decisions that in retrospect prove detrimental to guaranteeing equitable, efficient, and competent staffing of health services. This lack of a comprehensive assessment of the human resource implications of decentralization is a frequent finding. In this section, the key human resource domains where problems arise are identified and country examples provided of decentralization's impact.

1. Organizational structures, roles, and responsibilities

Successful decentralization requires that the new organizational structures, roles, and responsibilities be clearly defined, form a functional whole, and be acceptable to the health staff. A review of decentralization in ten countries demonstrated that this area is one of the most problematic for human resources.⁽¹⁾ Difficulties arise for several reasons. First, the definition of organizational structures, roles, and responsibilities may be unclear or inappropriate in view of health sector needs. Second, the roles and responsibilities may conflict with each other. Third, the organizational structures and allocation of roles and responsibilities may be disputed. Fourth, these organizational changes may be inadequately communicated below the central level or change so frequently that no one is clear on the current status.

The organizational structures, roles, and responsibilities of the intermediate, regional level appear to be the hardest to define clearly. The Philippines experience is an interesting case in point. At the time of devolution, the central Department of Health (DOH) retained a regional health office structure as a part of the central DOH. The DOH stated that the role of these DOH Regional Field Offices (DIRFOs) was to serve as "technical resource management centers directing the flow and utilization of DOH-provided assistance to LGUs (Local Government Units)."⁽¹³⁾ While this provided a general guideline about their role, translating it into operational detail took several years. Many questions arose. What exactly was the role of the regional level in negotiating Comprehensive Health Care Agreements between the central DOH and the LGUs? What was their role in monitoring the compliance? How were they expected to support donor-funded projects? Further confusion arose when the central Department of Health established HEAD (Health, Environment and Development) zones. These covered wider geographic areas than the DIRFOs and some regional directors were appointed as

their directors. As other DIRFO directors were not replaced when they resigned, the survival of the DIRFOs themselves was quickly perceived to be in doubt.

Defined roles and responsibilities are sometimes in direct conflict with each other. In Papua New Guinea, where the central level retained the responsibility for formulating national health policy, each province was given the responsibility for developing its own provincial health policies.⁽⁴⁾ The demarcation line between national and provincial policies was, however, not very clear. For example, given the very limited number of trained doctors in the country, a national policy stated that physician resources should be reserved only for staffing hospitals. Some provinces, however, formulated their own human resource policy of staffing key health centers with doctors. They were able to implement this policy by supplementing rural physicians' salaries from provincially raised revenue or by recruiting expatriate volunteers. Inevitably, the equity of medical staffing in the country suffered.

The allocation of roles and responsibilities can be disputed for a number of reasons. Personality conflicts, mistrust, professional pride, or jealousy can all arise in the course of implementing decentralization. A frequent problem area is the relationship between hospital directors and local health managers. Hospital directors in most countries are senior physicians. Considerable resentment may be caused by making these doctors, in the post-decentralization organizational structure, subordinate to a local health manager who is junior in age and experience. This was the case in Nicaragua, where the conflict resulted in the removal of the five largest hospitals from the control of the local SILAIS ("integrated local health administrative systems") where they are geographically located.⁽¹⁴⁾

Finally, the organizational structures and roles may be defined and then re-defined with such frequency that no stakeholder can maintain an accurate comprehension of them. If adequate information about these changes is not transmitted beyond the central level, health workers' adjustment to a new, decentralized health system will not be smooth. In a study by Gilson et al. in South Africa, for example, service providers in all provinces indicated that they were only vaguely aware of the content of decentralization policy discussions. Their high level of job insecurity was thought to be generated, at least in part, by their lack of clarity about the way decentralization would change their work and responsibilities.⁽⁷⁾

2. The viability of coordinated health and human resources development

The human resource function must contribute effectively to making strategic choices about the fundamental reforms in financing, organization and staffing that are essential for developing a nation's health sector. As the 1990 World Health Organization study group on coordinated health and human resources development emphasized, "**human resources have no meaning in isolation, but are an instrument for delivering necessary health care.**"⁽¹⁵⁾ Thus, health services and health personnel planning, production, and management must be well coordinated with each other. There is a real danger, however, that if adequate care is not taken when new organizational structures are designed and powers allocated, decentralization can jeopardize this coordinated development of health services and their staffing.

First, coordinating the development of health services with that of human resources to operate those services requires both reliable data on the numbers, skills, and geographic distribution of health personnel and the capacity to use these data for human resources planning. Decentralization, unfortunately, has the potential to fragment human resource databases by transferring the responsibility for maintaining staff records to decentralized units that lack the necessary systems and skills. This reduces considerably the national capacity for coherent human resources planning. In Papua New Guinea, for example, devolution of power to the provincial level was accompanied with a rapid deterioration of readily usable, reliable information on the number of created positions, vacancies, and training intakes and outputs.⁽⁴⁾

Second, coordinating health and human resources development requires that the allocation of human resources to address health needs be timely and equitable. If the responsibility for service provision is decentralized to local health managers but the allocation of human resources is left to institutions without technical health knowledge, such as a Ministry of Civil Service, the staffing of health facilities can become inefficient and unbalanced. This was the case in Tanzania and also in Papua New Guinea. In Tanzania, health staff were to be allocated between district health facilities by the district executive director (an employee of the Ministry of Local Governments, Cooperatives and Marketing) on the advice of a district medical officer (DMO). Gilson et al. found that in practice, these allocation decisions depended on political and other forces, not only the advice of the DMO. The result was an unbalanced staffing of facilities, for example, a dispensary with a total of 34 staff members compared with an average of 5-6.⁽¹⁶⁾ In Papua New Guinea, where a national Department of Public Services approved the number of health posts, a study of the distribution of rural health workers demonstrated that the allocation of staff to individual rural health facilities was not related to existing workloads.⁽¹⁷⁾

Third, if decentralization isolates national-level decision making on health and human resources development from local-level staffing decisions, the ensuing lack of coordination and conflict have potentially serious consequences for the equitable, affordable, and competent staffing of health facilities. For example, local aspirations are almost certain to take precedence over the greater national good when a decentralized level is given both considerable freedom to decide how it intends to develop and staff its health services and the means to generate revenue to pay for such services. The situation is further complicated if the health workers who transfer take their civil service position with them, as is the case in Nicaragua.⁽¹⁸⁾

The equity of staff distribution is endangered, unless mechanisms exist to expose staffing decisions to national debate and then address the imbalances. Following decentralization in Papua New Guinea, for example, the geographic equity in staff distribution between provinces decreased, as measured by a ratio of health personnel to population.⁽¹²⁾ Rural health service staffing suffered because many provinces created a large administrative structure at the provincial health office with staff positions at higher civil service grades than before decentralization. Civil service grades and benefits for positions of equal responsibility and authority were no longer similar between provinces, and in some provinces, the top positions were at an even higher civil service grade than comparable national positions.

Fourth, the coordination of health and human resources development can be threatened by decentralization-induced difficulties in career development. Such difficulties can arise either through hindrances to career mobility that decentralization brought about or from a lack of access to continuing education. Particularly in countries, where health workers come under a local government, decentralization can severely restrict the access to career opportunities beyond the administrative area in which the staff work. A transfer to a post in another administrative area may require a resignation from the current post and an accompanying loss of benefits. The transfer from one decentralized unit (such as a province) to another often may also require the approval of the administrative head of both the sending and the receiving governmental entity. Understandably, managers are reluctant to lose their most valuable employees and may refuse to approve such a transfer. Even if the approval is forthcoming, the bureaucratic delay in arranging the necessary paperwork can be substantial. Such problems may also complicate the management of specialty training programs involving rotating appointments. Finally, staff development opportunities may be restricted because some lower level units have little or no capacity to mount a program of in-service training for local health staff or because the central level fails to allocate attractive overseas training opportunities equitably.

Finally, staff with special skills, such as health economics or epidemiology, are scarce and generally best utilized at a central level. Decentralization can complicate their effective functioning by restricting their access to necessary data or by hindering the implementation of their recommendations.

3. Sustaining an appropriate training capacity

Decisions made at the time of decentralization about the responsibility for training and training institutions can have a very long-term impact on the availability of staff and their level of competence. Mistakes made in allocating responsibility over training can be costly. In Papua New Guinea, training in general was declared a national responsibility, but training of nurse aides was transferred to the provinces. Adequate care was not taken, however, to ensure that this transfer of responsibility was accompanied by the transfer of commensurate budget resources. While the provincial governments saw training of nurse aides as important, they were unable to fund these programs out of their own budgets. As a result, government training of nurse aides collapsed within three years.⁽⁴⁾

Training institutions should operate within a central framework for the categories and numbers of staff that a nation requires and in accordance with established guidelines and standards on the content and curricula of training. Few decentralizing countries have a clear national human resources plan that is linked to a health systems development plan, and used to guide decisions on the number and types of staff needed. Guidelines and standards for training, in turn, are also often unavailable or at least outdated in view of the changes that decentralization has brought about. This is a key concern facing the Zambian government, which intends to make health training institutions semi-autonomous under the management of their Hospital Board.⁽¹⁹⁾

4. Ensuring technical and managerial competence

Ensuring the technical and managerial competence of health workers through the turbulence of decentralization is a major challenge. The transfer of power raises several complex issues, which alone or in combination jeopardize the competence with which health workers discharge their new post-decentralization duties.

The first issue is a shortage of skilled staff. The new organizational structures and staffing levels may require a quantity of technically trained health staff, especially managers, that the country simply does not possess. In some countries, the shortage is made worse by the reluctance of highly skilled health workers, such as doctors, to move out of the capital city. In countries, where expatriate staff are recruited for government positions to compensate for this shortage, these workers face both considerable obstacles to maintaining the technical quality of their work, such as their limited knowledge of local languages and culture, and potentially also resentment by some of their national colleagues.⁽²⁰⁾

While the numbers of central and peripheral-level managers may be sufficient, these managers may not be equipped with the requisite set of skills for their post-decentralization roles. Bossert points out that central officials must possess skills in policy-making and monitoring, while lower-level officials need more operational and entrepreneurial skills.⁽²¹⁾

A common finding at the country level is that almost all of the training efforts concentrate on lower-level staff, and the capacity building of central-level managers is given far too little attention.⁽¹⁾ Management training for local-level health managers, who frequently have little relevant management experience, often consists of a set of uncoordinated, theoretical courses, workshops, and seminars. These training efforts are commonly organized by centrally run vertical programs with donor funding, and do not provide practical skills and management tools. Little time is left to apply what the staff have learned to their own work settings.⁽²²⁾ An exception to this pattern is the Diploma in Community Medicine program that the Faculty of Medicine in the University of Papua New Guinea set up after decentralization, which was intended to systematically train health workers for senior provincial health management positions.⁽⁴⁾

Peripheral health managers may have received sufficient training in management, but the control of resources has remained centralized. If the newly trained managers are not allowed to use their skills, they are likely to become frustrated and leave the service. The resulting turnover of staff reduces the technical competence of the health service, unless sufficient resources are available to quickly train new staff members to replace those who leave.

Shifting roles may impair the quality and frequency of the supervision and support that individual health workers receive. Perhaps the most difficult shift is where the previous supervisory system operated on the basis of professional lines of authority (i.e., doctors supervising doctors and nurses supervising nurses) but local health staff are now expected to operate under a dual supervisory system. Their technical guidance comes from the central health administration, while administrative supervision comes from the local government chief

administrator. The line between technical guidance and administrative supervision is, however, not very clear. Ill-advised administrative decisions may be in conflict with and thus seriously harm the technical quality of the health care provided.

In their study of decentralization from the provincial to the district level in Papua New Guinea, Campos-Outcalt and his colleagues noted that when the district health staff came under District Assistant Secretaries, any consensus as to who was responsible for monitoring quality was lost.⁽²³⁾ Provincial and district health staff complained about insufficient professional supervision and support and about inappropriate decisions made by the District Assistant Secretaries. They were almost unanimous in their view that the health services were worse off than before decentralization.

Finally, decentralization can politicize decisions on hiring, performance assessment, and staff discipline at the decentralized level so that competence is no longer the basis for hiring and rewards.⁽⁴⁾ While the forces of nepotism and favoritism undoubtedly existed before decentralization, the experience of many countries has been that they become much more difficult to resist when both health managers and politicians live and interact in the same smaller provincial or district headquarters, away from the capital city.

5. Securing adequate performance conditions

Health workers are not able to deliver high-quality health services on a continuous basis if they are preoccupied with providing for their families' needs or lack the necessary pharmaceuticals, equipment, and transport for their work. Decentralization can have a negative impact on both the timely payment of wages and benefits and the availability of essential resources. The recent experiences of Papua New Guinea and the Philippines illustrate these concerns.

In Papua New Guinea, church health services provide about one half of all rural health care, are well-integrated with public sector health services, and receive government subsidies. Recent reforms, which are intended to hand more power to the local government level, unfortunately failed to clarify the relative responsibilities of provincial and local governments. When several of these governments failed to pay the church health subsidy, the churches suffered a severe funding crisis. The national Department of Health became very concerned about the situation, but was unable to resolve the crisis promptly, because it involved fundamental decisions about the roles and responsibilities of the national, provincial, and local governments. Church health workers were not paid for several months and finally the churches in a number of provinces were forced to close their health services until funds became available. Six months after the first closure of church health services, in July 1997, the outgoing Minister for Provincial and Local Government Affairs (who had previously been the Minister of Health) released the following statement:

As the outgoing Minister for Provincial and Local Government Affairs, it has been my responsibility to ensure that provinces meet their contractual arrangement with the various churches, including the church health workers who should not be considered as second class citizens, and the churches should not

continually be placed in situations where they have to beg for what is rightfully theirs. Either they are paid, or they can take other options to secure the grants, including legal action against the individual provincial governments, and worse still total closure.⁽²⁴⁾

In the Philippines, decentralization threatened both the benefits that health workers were entitled to under a centrally set labor agreement (the Magna Carta) and the salary increases that were mandated under a national Salary Standardization Law. The financial base for devolved functions was inadequate, because the variable cost of devolved functions was not congruent with the fixed formula that was used to allocate national revenue among the Local Government Units.⁽⁵⁾ The poorer LGUs were simply unable to fund the payment of Magna Carta benefits and salary increases. The LGU executives in the poorer LGUs were probably also not very motivated to push for extra funding from their own resources, since the financial compensation of devolved health workers in these LGUs was higher than that of the local mayor!

Without adequate resources, health workers do not have even the minimum performance conditions for competent delivery of health care. A study of health system performance in Papua New Guinea after decentralization showed that budget cuts disproportionately affected funding for transport. This seriously reduced health workers' ability to undertake mobile maternal and child health patrols, disease control activities and supervisory visits.⁽²⁵⁾ In the Philippines, a survey of over 5,600 local government officials, health workers and representatives assessed the impact of devolution on health services in June 1994. Of the respondents, 46 percent stated that emergency room drugs were never available after devolution and 61 percent said that operating room drugs were never available.⁽⁵⁾ Prior to devolution, these drugs had generally been available.

III. Recommendations for Health Managers

The previous pages have described several discouraging examples of the impact of decentralization on the availability, competence, and motivation of health workers. While some of these repercussions were perhaps foreseen by those designing the decentralization processes or at least feared by the health workers themselves, many were not anticipated. Taken by surprise, health managers were ill-prepared to respond promptly to the complex issues that arose and to the multiple institutional actors that had a voice. This section aims to extract from these examples a few key recommendations that might prove helpful to other health managers who are considering decentralization or find themselves already in its midst.

1. Become an advocate for human resources

Human resource issues need an advocate in all decentralization debates! Many voices clamor for attention in the fray of decentralization, but regrettably, the cause of human resources development is rarely among them. All health managers should see themselves as

champions of the cause of ensuring equitable, competent, and affordable staffing of health services after decentralization.

2. Anticipate and prepare for the cost and complexity of decentralization

The complexity of decentralization requires a very wide perspective in envisioning the type of human resource issues that are likely to rise. Decentralization carries both financial and emotional costs, and managers must anticipate and be prepared to answer the following kinds of questions:

- How will the future roles of central and local staff be defined?
- How will future planning decisions on the number and type of staff that the nation should develop be made?
- How and by whom will decisions on the staff strength of each decentralized administrative entity be made?
- How will personnel information be gathered and data bases maintained?
- How will salaries be set and paid for?
- Is this arrangement financially viable in the long term?
- What will happen to pensions and other benefits?
- Will established career structures be maintained?
- Will in-service and continuing training opportunities at the decentralized level be sufficient to ensure career development?
- How will staff performance be assessed and by whom?
- Who will be responsible for hiring and firing at the local level?
- What mechanisms will be put in place to address personnel grievances?
- What will be the procedures for transferring health staff from one authority to another?
- What will be the new roles and responsibilities of training institutions?
- What legal implications will decentralization have for the duties and rights of health workers?

By anticipating such questions, health managers can marshal their own resources and, if necessary, call for additional support to respond to these issues in a timely manner.

3. Develop a strategic human resources development capability

Appropriately trained human resources, equitably distributed and in sufficient quantity, are essential for ensuring sustainable benefits from structural and financial reforms in the health sector. A strategic decision making capability for human resources development at the central and local levels is an essential component of decentralization, if human resources planning, training, and management are to support needed health sector reform measures. The development of such a capacity will require a concerted effort in many areas.

First, a fundamental change is needed in the roles of central- and peripheral-level managers. The human resources unit in most ministries of health confines its activities to personnel administration and training, neglecting strategic thinking about future staffing of health services to meet the requirements of health sector development. After decentralization, the

central human resources unit must focus its role on formulating strategic options for developing human resources in coordination with health services development, and on monitoring the equity and quality of staffing .

While the specific role of managers at a decentralized level regarding human resource functions depends on the type and pace of the reforms and the capacities available at the local level, these peripheral health managers must be represented in all strategic discussions about the future staffing of health services. They also have a very important role in developing and implementing performance management mechanisms that improve health workers' productivity and the quality of their work.

Second, readily available, accurate information on human resources, including data on the expenditure on available staff, is essential for strategic development of human resources. If deficiencies are noted in this area, central- and local-level managers must agree on the data that will be collected, how the data are to flow through the health system, who will analyze them, and what the process will be for taking action on the basis of the analyses.

Third, a rational basis must be developed for making human resource decisions, and it must be acceptable to both central and decentralized health authorities. Staffing norms that are based on workloads, such as the Workload Indicators of Staffing Need, are an important guide for planning staff requirements and allocating staff to facilities.⁽²⁶⁾ Guidelines setting out minimum qualifications for a post ensure that staff possess the necessary training for their job. Performance assessment instruments assist managers in making decisions about the level of competence of their staff, and what in-service training they need, while procedures for staff discipline foster fair and impartial decision making.

Finally, a strategic view of human resources development under decentralization requires an ongoing assessment of the performance conditions that health workers face in their new roles. If decentralization is found to seriously damage performance conditions, human resource managers must voice their concern and advocate for improvements. This may require working with central financial authorities to secure health workers' salaries and benefits, improving pharmaceutical procurement mechanisms to guarantee availability of essential drugs or lobbying decentralized government authorities for adequate transport funds for mobile health activities.

4. Invest in developing staff

The change in roles and responsibilities that decentralization generates brings a demand for new skills. Prominent among these are financial, human resources, and logistical management skills, as well as competence in advocacy and negotiation. Investing in staff development at both the central and local levels brings big dividends in determining the eventual success of decentralization. Training must be practical and firmly focused on new job requirements. It must be wide in scope, involving both central and local managers. It must be continual so that the rapid staff turnover that often accompanies decentralization does not dilute the training efforts.

5. Monitor the impact of decentralization on human resources development

Regular monitoring is essential for avoiding decentralization-related human resource concerns from growing into major problems that take a considerable time and resources to solve. Such monitoring should be focused on the *equity* of staff distribution, the *access* to skilled care, and the *quality* and *efficiency* of health personnel.

Monitoring should commence with the collection of baseline data prior to the start of decentralization, and continue as an ongoing component of health sector management. It requires the design and implementation of suitable management processes for ongoing data collection, analysis and interpretation. Most importantly, it must result in action based on the findings. Such action, in turn, is greatly facilitated, if appropriate linkages have been developed between the different institutional actors who influence human resource decisions.

In conclusion, the examples of decentralization's impact on human resources and the lessons derived from them that this paper presents should be seen as a alert about the crucial importance of human resource issues in planning and implementing decentralization. The full implications of decentralization for human resources demand much further study and examination. Interested readers may wish to consult three additional documents: a description of one approach to dividing human resource functions between the central and local levels which is included in the WHO Human Resources Toolkit ⁽²⁷⁾, a decentralization matrix for human resources that the Pan American Health Organization is developing ⁽²⁸⁾, and the checklists for human resource analysis, published by the European Commission.⁽⁸⁾

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Discussion

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This paper is very valuable especially for Thailand which is currently under going **political reform**. This reform should eventually lead to decentralization of power. Whenever the issue of decentralization of power is brought up, there are calls for the election of provincial governors but without sufficient understanding or backing from research results. The Ministry of Public Health (MOPH) is no exception. Ever since the existence of the Tambon (sub-district) Administrative Organization (TAO), a new form of local state authority established in 1995, there have been suggestions that the administration of some 9,000 Health Centres throughout the country should be shifted from the MOPH to the TAO. This suggestion, with lack of clear development methods, has raised concerns over the future success of decentralization.

Most importantly there is a lack of preparation to decentralize power to **local communities**. This may be observed in the lack of support provided to **communities outside the local state authority**. **Local civil society** should be strong enough to work along with local state authorities in order to be able to **support, inspect, and evaluate their performance and efficiency**.

As for health manpower development and decentralization of power, the points of concern are:

1. More pluralistic stakeholders.

Under the current health situation, the production and use of human resources involves various organizations, including the private sector. **After decentralization, various local administrative bodies will also play an important role in outlining the society's demand** in health manpower. Thus, various organizations, including the Bureau of Health Policy and Plan, Health Manpower Development Institute, and Health Systems Research Institute, need to collaborate with private hospitals, professional councils, medical schools, the Civil Service Commission and **local administrative bodies** in systematically planing for the development of health manpower. The systematic planning should begin with the development of accurate, appropriate and up-to-date information on health manpower.

2. Management Capability Under the current situation, most local administrative bodies are unable to manage or administer the public health facilities. This is because the

MOPH owns most of the health services at all levels, thus preventing the local administrative bodies from planning clear roles for health facilities and health manpower development, appropriate to local needs.

Therefore, the most urgent activity is to **develop the capacity of local administrative bodies in the areas of planning and management.**

3. Balance of Power Local administrative bodies will gradually be involved in planning and management for the development of health facilities and manpower. **They will also be able to set-up a system with appropriate incentives for local health personnel.** However, the question of different incentives and development levels may require appropriate central intervention, which creates new challenges to the issue of appropriate balance of power.

Dr Delanyo Dovlo

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I think the paper by Riitta Liisa Kohlemainen-Aitken was quite comprehensive on the issues surrounding Human Resources and Health Sector decentralization.

Our experiences in Ghana have indeed involved dealing with all the various issues that are raised in the paper. This is more so, in a situation where “**before the fact**” and “**after the fact**” phases are a blur of constant changes.

Critically, we have tried to address the issue of developing new Human Resources management systems concurrently with developing new health policies. Our reforms have involved as core changes, the reform of financial management systems, new logistics procurement and supply systems, new administration and management arrangements including those for planning and budgeting, and also new systems for monitoring performance and assigning responsibilities and roles to the decentralized levels. Of course human resources management reforms are a major undertaking of the new system, however these have been less radical than for other systems, perhaps a recognition of the complexities that this poses.

Essential to all the above have been the delineation of roles between the remaining Ministry of Health, and the new and delinked Ghana Health Service to which has been delegated the responsibility for service delivery.

Health reform and decentralization in Ghana have more or less deliberately shifted away **from a devolution approach to a deconcentration** within a national delinked organization. Indeed two conflicting laws still exist, one (PNDC Law 207), espousing devolution of health units to **District Local Governments**, and the **Ghana Health Service law**(Act 525), creating a single organization to cover the same units. **The deconcentration model was adopted because it was felt that it reduces some of the constraints mentioned in the paper under discussion.**

To mention a few :

- The need for a national coordination of the equitable distribution of staff.
- The need for some equalization of conditions and schemes of service to avoid maldistribution given the chronic shortages facing the country.
- The importance of retaining staff and providing a sense of continuity from their civil service employment, ranks and entitlements.

- The need for retaining some central control on standards and quality of staffing and reducing the influence of ethnicity and/or nepotism on staffing at decentralized levels.
- The condition for providing health workers with a more flexible opportunity to transfer from one locality to another without losing benefits etc.,.

It was also clear that major central level functions were important to support the new decentralized levels; long and medium term projections and planning of staff supply and demand including needs for various specialist cadres. Of course this means having close national coordination of health training institutions which **in Ghana, will be retained under the central Ministry of Health.**

The central level also retains considerable influence in monitoring the “performance contracts” that local managers are required to enter into with headquarters before funds are allocated. Obviously such an undertaking requires enormous capacity building, not necessarily at the local levels only, but perhaps more importantly at the national level which has to both undergo significant changes in roles as well as provide technical and managerial support to the newly decentralized levels. Our experience in Ghana is that by ensuring a critical mass of Public Health managers at both national and district levels, and allowing substantial networking between them, we can provide an enabling milieu for decentralization to occur.

Advocacy for Human Resources Strategies requires strategic planning skills, substantial knowledge of Human Resources planning and indeed health policy and planning. Given the tendency to leave HR to Personnel managers (“officers” in Ghana) this is often lacking. It also requires having substantial clout or authority within the Health Service hierarchy.

The emotional costs of decentralization are legion and especially for these resulting from transferring staff to new service conditions and locations, it is essential that the “carrots” and “sticks” are well defined and even then, the former should largely exceed the latter.

But more importantly, in Ghana, we have proposed a three-year structured transition period to help reduce the disruptive effects that can be anticipated and to allow for the development of structures to take care of complaints and quickly dispose of them.

Perhaps more controversially, I submit that what I shall call the “**chaos theory**” of decentralization, i.e.; the poor capacity at decentralized levels and the mismanagement, etc., that accompanies decentralization, should be **regarded as necessary** and at times an unavoidable phase, which helps to prepare local managers through learning from experiences and also helps to expose the inevitable deficiencies and gaps in the best strategies and implementation plans.

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In this important paper, Dr. Kolehmainen-Aitken has raised some crucial human resources development issues in relation to decentralization of health system management. Decentralization of the management of health care, as a component of political devolution of power, has been adopted by most countries for some time. This is particularly so after the adoption of the primary health care goals. Yet, in spite of the high cost of human resources in health care and its centrality in ensuring effective decentralization, we have not compiled and maintained reliable information on the human resources implications. Nor do we have

information from those countries which may have succeeded in transforming their human resources development processes to suit the conditions and requirements of decentralised health systems. At the same time, consequent to some of the negative experiences, there are voices that have begun to sound notes of scepticism on the whole concept of decentralization. Therefore this paper is timely and important.

Dr. Kolehmainen-Aitken raises issues emerging *as a part* of the process of transferring power to lower management levels and those arising *as a result* of the way in which decentralised management systems are structured. While all of these are extremely important in our countries, a few of them are dominant.

In general, few countries have carefully planned the entire decentralization process which could be quite complex. The political decisions have to be carefully translated into administrative and managerial policies and mechanisms. This could be very difficult at the best of times with the best will in the world. And in this regard, the health sector has often been one of the weakest units in the process. The national level managers have neither understood nor planned the process of devolution of the responsibilities. Often they have done so unwillingly, probably not believing fully in it, even when their rhetoric would give the impression that they in fact favoured decentralization.

Secondly, the consistently observed priority in the transfer of management of responsibility to decentralised regions or units has been to concentrate on programme delivery. What functions and activities should be devolved? The human resources component has either been taken for granted or been addressed in an ad hoc manner. The availability, quality and performance of the workers has not been taken seriously, nor assessed systematically. Yet, the improvement of human resources development is the main rationale for decentralization. Certainly it remains the least understood component. It is ironical that the very reasons and advantages of decentralization for improvement of human resources are the same ones that are consistently compromised.

The third major problem, which has been well identified in the paper, is the absence of the capacity for making the strategic decisions regarding human resources development at all levels of management. Very few countries in the Region have adequately established, functional human resources planning and management capability even at the central level. Competency in advocacy, financial and logistical management are obvious weaknesses. Therefore, human resources to support health sector reform measures could not be planned and managed when these deficiencies are persistent.

Given the experiences with decentralization elucidated in the paper, the next question that should be raised is, "whether decentralization should be actively promoted or not?" To my mind the answer is a clear and unequivocal "yes". Our problem is not with the principle and concept of decentralization but with the way it has been/is being implemented in most countries. The rationale for decentralization still remains sound. In fact it could be argued that decentralization, with sufficient attention to the human resources component, may be the only way to achieve equity goals and to ensure basic health care to all sections of the population. What is required is a stronger will and commitment, a greater understanding of the different processes needed to make decentralization work and a close monitoring of the impact of decentralization.

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This paper provides a very good analysis of the impact of decentralization on human resources for health development, found in many countries. It highlighted many lessons regarding the impact of decentralization on the availability, competence and motivation of health workers. It is expected that many discouraging examples from this paper could Stimulate the awareness of health policy makers, so that they will prepare interventions to meet with the anticipated problems, and can lead the reform to better achievements. Although the situation was very comprehensively analysed, some questions needed to be addressed, i.e.,

1. It is very true as mentioned in the paper that ‘human resources have no meaning in isolation, but are instruments for delivering necessary health care, and ‘thus health services and health personnel planning, production and management must be well coordinated with each other’. Many problems are claimed to arise from the decentralized system, e.g., the decision on the allocation of human resources affected by political and other forces, as in the case of Tanzania; the lack of a clear national human resources plan that is linked to the health system development plan to guide decisions on the number and types of staff needed. These problems also occur in the centralised system. So instead of taking these phenomena as the results of decentralization, this integration problem has to be tackled seriously by policy makers both in the decentralised and centralised systems. The additional study of countries, under both the centralised and decentralised systems, which have successful experience in the integration of health services and human resources management, may provide a better understanding of these phenomena.

2. There is a major component in health service development which was not considered in the paper, that is ‘**people**’. The true meaning of decentralization is not only the transferring of administrative power from the central to the local health authorities, but also **to provide the possibility for people to control the health services**. Without the analysis of the implication and impact from this increasing power of the people, the study is not complete, i.e., what is the role of the people in the management of human resources? What are the good examples of the involvement of people in the process of decentralization in terms of human resources and health system development? Does more involvement of people provide more opportunity for them to become human resources for health development by themselves?

3. The lack of examples of successful country experiences including the lack of the analysis on the implication and impact of human resources from people’s involvement, resulted in recommendations covering only the suggestions for health managers to the ‘**what**’ problem they should prepare to face in the whole bureaucratic system for changes. There was a lack of good examples on ‘**how**’ management has to be adapted for better changes, e.g., the strategic development of involvement of ‘**people**’ and the reorientation of health system management mechanisms to be more appropriate for different circumstances of decentralisation.

In conclusion, this paper is excellent in providing the awareness for policy makers on the implications and impacts of decentralisation on human resources. The lessons from many

countries as explained here should stimulate policy makers to be alert and to prepare appropriate interventions so that repeated mistakes will not happen in their implementation for better health development.

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By ample experience in the developing world, the author has vividly depicted what kind of changes happened to health systems in the current flow of decentralization. Unexpected impact on health resource development was disclosed with less awareness from politicians and central policy makers. Since most outgoing countries started changes by reforming only the health service structure and management, the new structure is greatly influenced by central government decisions that emanate from outside the health sector. Those decisions are likely to consider health as a quantifiable output and as a result, HRD is often ignored.

By reason that health care is dealing not only with diseases or biomedical components, but also with social, cultural and ecological contexts, health has then its own human implications. The system involved is also enormous, which complicates and influences either the individual or population. Therefore, introducing any change to the system should be carefully elaborated, based on stringent scientific evidences. However, decentralization in any form, by the government, ends up with drastic and swift process of change to guarantee success with least resistance. Of course, it may provide health providers or policy makers with some benefits but also produces lots of adverse effects on soft components, one of which is human resources.

There is no successful example of achieving a decentralized health system alone without adequate human resources intervention. On the contrary, human resources need opportunities and strong support to develop their potentialities. Autonomy is considered as the end point of decentralization, while self-determination competency reflects the health resources development requirement. In reality, the two components are in imbalance always in transition, and unless the situation is well handled, decentralization will create endless new problems. **Decentralization under unprepared conditions, therefore, should not be initiated.**

The key element of human resource development is to create the self-determination capability of individuals. Critical and systematic thinking affects this and determines how health personnel react to new structures, new roles and responsibilities. This applies regardless to which level or sector they belong to; whether they are central, provincial or local; or in the medical service or public health administration sectors; are being task orientated or human orientated. It is the defect of HRD itself that undermines decentralization causes its collapse.

Considering the complexity of HRD, **it should mainly center around working potential**, rather than quantity, management systems, adequate information, cost analysis or any advocacy tool kits or techniques. Staff either at the central or local level are challenged to cope with emerging, but complex health problems such as those involving life styles, health related behavior and socio-cultural ecological conditions. The philosophy and concept of health needs to be reviewed, as diversity of services is needed to meet the wide demands of the population, instead of the prevailing medical technology and business approaches. Any particular health problems are interpreted injudiciously thus causing interventions to alienate people. Classical roles as experts, policy advocates and technical advisors are often frustrating to the central-level

staff, while at the same time they are reluctant to hand power to local staff. Local staff who are eager to gain power are expected to manage programs and activities efficiently, including monitoring and evaluation, **but are actually unable to do so unless they use hand book or manuals.**

As the result of ignorance of human resources, system turbulence occurs in many aspects as mentioned very clearly in the paper. Human resource strategies can dilute or diminish automatically such system upsets as those caused by imposing new roles and responsibilities to national, regional and local level organizations, institutional or professional conflict, as well as 'dual supervisory systems, less concern in supporting continuing education, or even political interference.

Yet, decentralization is still unavoidable and strongly recommended to energize the health system. The best way is to implement decentralization parallel with systematically designed human resource strategies and intervention programs to achieve self-determination and self-development among staff. This will not only reduce friction but will also facilitate movement towards desired decentralized autonomy.

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Introduction

In the preparation of guidelines for appraising human resources in the health sector⁽¹⁾ referred to in Dr.Kolehmainen-Aitken's paper, we found no recent comprehensive reviews relating to human resources and reforms in the developing world. Though her paper focuses on a single yet major aspect of reforms, it is a most welcome addition to the literature. She raises many important issues which she helpfully follows with practical suggestions. I am tempted to follow up on many of the issues pertinent to health reforms in countries I have visited. I will, however, limit myself to three themes from the paper: preparation; complexity; and impact on health professional and representative groups, and a fourth point on the opportunities presented by reforms.

Preparation for reforms

Health reforms present both threats and opportunities to staff and the management of staff. However, the "general inattention to human resource issues" means that human resources (HR) often does not get on to the reform agenda until it is too late. Why is it that such an important part of health service delivery lags behind financial and managerial changes? Possible explanations are:

- the importance is not recognised (financing mechanisms tend to mask staffing costs);
- lack of in-country experience of how reforms impact on HR leads to complacency;
- piecemeal approach to HR (lots of training; HR units get excited about setting up personnel databases, yet a comprehensive approach to HR is rare so important gaps occur, e.g. personnel management systems, development of organisational culture);

- lack of expertise (expertise in HR-other than medical education-is scarce in ministries of health); incentives structures (resistance by different stakeholders whose interests may be affected by change);
- and long-standing HR problems (staff shortages or maldistribution)⁽²⁾.

To avoid merely reacting to change, the HR arena needs vision(s) of how things could be, and champions-or the author's "advocates"-who, whilst not being expert in HR, understand the issues in broad terms and can represent the HR needs at senior management level. Several visions can be developed before the main shape of the reforms is fixed; these might even help shape better reforms. Having agreed on a vision, this needs to be drummed into the implementers of change, as moving from a centrally controlled system, for example, is not easy for ministry officials.

Experience-both good and bad-from elsewhere in the world is the meat of these visions, and the author's quotation from Plutarch is very relevant here. Governments themselves, however, have little incentive to document their experiences-especially the failures, so this is perhaps the responsibility of the international donor and research community.

Complexity

Because of the many interests involved and the systemic and political nature of employment, the human resource arena can appear frustratingly complex. This makes the kind of transition referred to by the author very difficult. For example, the government's housing policy and management of pensions, both outside the control of the Ministry of Health, have created particular difficulties in the creation of new employment structures in Zambia. Our guidelines⁽¹⁾ were an attempt to help map out the complex area of HR, including the wider systemic influences so that major threats or opportunities would not be overlooked and the real levers of change could be identified. The 'map' covers: the main HRD functions (staffing supply, performance management, personnel administration, employee relations, and education and training); the institutional actors; and the policy context.

Impact on the workforce and representative groups

Members of the workforce, and their representatives, tend to react rationally to change. They are for it if they can see the incentives (these may include job satisfaction and financial benefits); they will oppose it if current incentives (official or unofficial) are threatened. At an early stage, therefore, the current incentives and the effect of change on them need to be fully understood by planners. The author highlights the problem of uncertainty, perhaps the major reason for resistance to change. In some reform programmes communication strategies (newsletters, TV programmes, briefings) are used to inform staff of the implications of change. Nevertheless, reform leaders are often in a dilemma, as doing it for the first time policy is often made "on the fly" and exposure at the policy-making stage could lead to wilder speculation or perhaps even the loss of confidence in the policy makers. Again, back to Plutarch.

Opportunity

The paper comes across as being rather negative about the impact of decentralisation on HR. The success stories for HR in reforms tend to be more in the industrialised countries-the satisfaction that lower level managers get from being able to run their own show, or improved management of individual performance, and changed organisational culture, for example. However, this goes back to my first point. Success both for the management of human resources and for the workforce are more likely to occur if the opportunities are spotted earlier in the reform process, and the HR champions take the initiative to ensure that these opportunities are realised as part of the reforms.

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