Decentralisation and the impact on Human Resource Management in China and South Africa

Report by

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BACKGROUND AND OBJECTIVES

Decentralisation is a commonly used element of reform both across government and within specific sectors. In most countries, in particular the poorest, the staffing of the public sector is challenging and some of the biggest difficulties are in the health sector. An important question for health service planners and managers is whether decentralisation will help with the staffing of health services, or simply make matters worse.

Decentralisation is a complex concept. It has a variety of forms: deconcentration, devolution, delegation and privatisation. The purpose may be to increase political democratisation, improve decision-making thereby the efficiency and responsiveness of services, or be a means of divesting the state of responsibilities for providing services. The complexity arises when different forms and different objectives co-exist.

Decentralisation may provide opportunities for improving services, but at the same time it will create problems and challenges - such as developing sufficient managerial capacity, and risks, for example, of increasing inequity and local capture of resources – in particular in the political area of staffing. It is important that monitoring systems are established to ensure that opportunities are not missed and challenges and risks are appropriately addressed. Such monitoring systems are rarely found in use in developing country health systems. Therefore a wider initiative has been planned to develop and test such systems. This study represents the first part of this initiative aimed at exploring the impact of decentralisation on human resource management in the health sector, and developing an approach for monitoring this over time during the process of implementing decentralisation policies. The objectives of the study were:

- To examine whether or not the actual impact of decentralisation of the management of health services has provided opportunities to improve human resource management and staff performance;
- To develop guidelines that can be used for measuring the impact of decentralisation on human resource management and staff performance;
- To assess the extent to which decentralisation has led to increased efficiency in use of health human resources;
- To examine changes in performance of health professionals under the decentralised health care system;
- To provide policy-makers with appropriate policy recommendations and suggestions on how best to use the opportunities created by decentralisation to improve human resource management.

METHODS
General design
In order to gain a broad exposure to the impact of decentralisation on human resource management (HRM) in this preliminary research phase we aimed for diversity, choosing sites in two different continents, with different types of health systems, political and economic contexts, and forms of decentralisation.

To answer our question about the impact of decentralisation on HRM we wanted to find out what had changed regarding to location of the HRM decision-making, and what impact that had had on the staffing of health services, and ultimately on the effectiveness of the delivery of health services. Our outcome measures were to be linked to effectiveness and efficiency - two key objectives of most reform programmes. Though the importance of the impact on equity is fully appreciated, in this initial phase of the research it would not be possible to get sufficient coverage to detect much in relation to geographical differences. We did, however, decide to include richer and poorer locations for the study in China (where the decentralisation process was much further advanced) since it was hypothesised that decentralisation can have positive impact on HRM in more developed areas, while it may have negative impact in relatively poor areas where there is lack of social capital.

In this exploratory phase in which we were concerned with identifying issues about HR and decentralisation depth of understanding was considered more important than breadth. We therefore chose the case study approach, fully recognising the limitations that this would have for the generalisation of our findings.

The two country case studies follow three common steps: 1. identify the nature of the recent or current decentralisation process or processes in terms of purpose and structural change; 2. identify the human resource management functions that had actually been decentralised; and 3. identify the impact on HRM. The scope of HRM functions to be considered was not limited, but the focus was on the areas of staffing supply (HR planning and recruitment and selection), performance management (rewards, appraisal and promotion) and training[1].

China
The study was carried out in Fujian Province which has provincial, prefectoral, county, and township levels of government. The research strategy was to examine the impact of decentralisation at county hospital and township health centre (THC) levels in one richer and one poorer county (Xinlou and Liancheng counties). One county hospital and 5 THCs were selected in each county.

Facility and staffing surveys were used to identify trends of change covering the period 1987-2000, supplemented by interviews with 58 key informants and focus group discussions. An understanding of changes in the policy environment was through a document review and key informant interviews from national to township levels. Focus group discussions were conducted with staff and clients. The main data collection period was collected in August 2001.

Following an initial analysis of the data collected areas requiring further explanation for a better understanding of the decentralisation process and its impact on HRM were identified. Related questions were put to key informants in a follow-up phase in November 2001.

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[1] Adapted from a framework in Martinez, J. and T. Martineau (1998). "Rethinking human resources: an agenda for the millennium." *Health Policy and Planning* **13**(4): 345-58.

South Africa
In South Africa the study was carried out in the former Region E of Eastern Cape Province, one of nine of the country's provinces. The research covered 25 primary health care facilities in what started as 2 districts, but which merged during the period of the study to become Alfred Nzo District.

The methodology used was similar to that of the China case study. The period covered by surveys was 1996 – 2000. The researchers attempted to use the national public service staffing database – PERSAL – but it was not possible to get outputs for the main period under study. The survey was carried out in October 2001, and following initial analysis of the data a follow-up meeting took place with managers in June 2002 to clarify questions arising.

Quality assurance
Overall quality assurance was provided by an Advisory Panel which reviewed the study design at a time when the South African and Chinese partners were visiting Liverpool. The Advisory Panel also reviewed and provided feedback on the draft research report.

Limitations
Limitations of the study were associated with a retrospective study with no baseline and loss of institutional memory due to personnel changes and poor recall of events. In addition the availability of routine data was patchy. Triangulation through the use of a variety of data sources and types of informants was used in an attempt to compensate. The iterative stages of analysis brought up more questions each time about the process and impact of decentralisation. More time could have been devoted to developing the questions during the first analysis phase in order to make the follow visits more fruitful.

A fuller description of the methods is provided in Annex 2.

FINDINGS

The policy context
China has shifted from a planned to a "social market economy" which has led to more local revenue generation and funding of public services. This shift has led to pressure to reduce employment costs, contributing to the rising unemployment levels. The impact of these reforms on the health sector is the introduction of user fees. As salaries are often tied to the generation of these fees, managers find themselves in an ambiguous situation regarding the old social responsibility for providing employment and new pressures on cost reduction. South Africa has also been undergoing major changes, due to the dismantling of the apartheid regime and the new policies of reconstruction and unification of a previously highly fragmented system. The health sector has been establishing a brand-new district-based primary health care system. At the same time as strengthening the public services the government, as in China, has tried to reduce employment costs through freezing recruitment. In the Eastern Cape Province there was a further moratorium on staff appointments from 1998 due to shortage of funds.

Types of decentralisation
Decentralisation in China has not been uniform. In Longyan prefecture of Fujian province it started in 1988 with the **delegation** of the budget from the county health bureau to hospitals and township health centres (THC) (Figure 1)[2] in line with the

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[2] See tables and figures in Annex 1.

'director responsibility system'[3] that was being installed in other enterprises in the province. In 1992 authority was **devolved** from the county to township governments, so the township government took over control of the THCs (Figure 2). Following an evaluation of the devolution in Liancheng county which reflected poorly on the management by the township government, control over the THCs reverted to the county health bureau. The situation in Xinlou remained unchanged. The South African government **devolved** budgets to the provinces in 1997 with the aim of further devolving power to district councils. The boundaries of these councils were not agreed until December 2000 (during the study) at which point the health district boundaries became co-terminus with those of the district councils. The **deconcentration** process by the Department of Health to create health districts was somewhat independent of the broader devolution process. In the Eastern Cape Province this included the establishment of temporary Regional Health Offices, and temporary district structures until the boundaries of the district councils had been agreed (Figure 3). The health services were still being run by the Department of Health through their own district structures at the time of the study.

HR functions

Control over **staffing supply** had been largely decentralised in the China case study. Though the number of staff recruited was reduced in county hospitals in both counties (despite hospital directors being pressurised to employ some staff unnecessarily), overall staff numbers rose (Table 1). This might be because of lower turnover due to the overall increase in unemployment. Productivity rose in Xinlou, but fell in Liancheng. Recruitment increased in THCs in both counties, though Xinlou controlled this in the last period (Table 2). Productivity rose in Xinlou, but fell in Liancheng. The responsibility for selecting recruits was given to hospital managers, but clawed back by the county level authorities in 1999 (see Table 3 regarding managerial levels) and because of alleged abuses of the system an examination committee was set up at prefectoral level to select new graduates. In contrast, THC directors in Liancheng retained some of their independence in staff selection following the reversal of the devolution process in that county. A major change, unrelated to decentralisation, was that graduates were given the power to select where *they* wanted to go, and they generally preferred to work in richer areas like Xinlou. Because of the province-wide recruitment freeze in place in Eastern Cape, South Africa, the staffing supply functions could not be reported as having been decentralised. Neither the provincial nor the district authorities were able to respond to the rising workload identified by the study (Table 4).

The main form of **performance management** found in the China case study was the use of financial incentives. As part of the 'director responsibility system' of 1988 managers could use 5% of the surpluses generated as performance-based bonuses. The so-called 'red envelope' system was far from transparent. Managers were also given the authority to vary the proportion of staff salaries between a basic salary and a performance-related element e.g. based on the number of patients seen. Known as a 'floating salary'[4] the variable element ranged from 0% for preventive care staff to 100% in one THC in Liancheng county. The floating salary system appeared to increase productivity – in one THC in Xinlou county outpatient numbers increased from 14,776 in 1991 to 20,906 in 2000 and staff interviews confirmed that it was a motivating factor – but it was leading to unnecessary consultations, over-prescribing (and thus hindering access to services), and detering collaboration between staff. It was cancelled by higher authorities in August 2000. The 'red envelope' system was cancelled by the prefecture level government in 1999 because it was being abused

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[3] A translation of the Chinese term: 'Yuan Zhang Fu Ze Zhi'.
[4] The term 'floating salary system' is directly translated from Chinese 'Fu Dong Gong Zi Zhi'

by managers. In theory managers had the power to dismiss staff, though examples were given of this authority being overridden by the county health bureau.

In South Africa district managers were given the authority to promote staff up to Level 8 (e.g. professional nurse) within their current rank ("notch" promotion) though only one such promotion was identified in the case study area in 2000. Managers were given the power to deal with minor disciplinary cases. They also discovered that even with limited decentralised access to the payroll they could freeze the salaries of staff on extended unauthorised absence and that the effect was quite dramatic.

Responsibility for major decisions relating to **training** in the China case study were delegated in 1988, and with this came the responsibility for financing training. The overall figures for training are rather distorted by external funding provided by a project under a World Bank loan. However in the period '98-'00, after this project had ended, doctors were getting far more training than nurses (e.g. 10 times more in Xinlou county hospital and nearly 15 times more in Liancheng's THCs – see Tables 5 and 6), because – it was said – their additional skills could generate more income for the institution. Training in areas of preventive care was being neglected. Managers clearly saw training as an investment, with some complaining that having received in-service training which is a prerequisite for promotion staff would often leave. This even influenced recruitment practices with preference being given to candidates who already had received in-service training, or lived locally and would have more reason to stay.

In South Africa decisions relating to training have also been decentralised, but the budget is still held at the provincial level. Most of the training was actually funded by outside agencies that provide a range of assistance in the province. District managers have improved co-ordination of training and are now keeping training records. They are also using training creatively to overcome some of the staffing shortages which are largely due to the externally imposed recruitment freeze. In the absence of pharmacists, pharmacy assistants are being trained to order and dispense drugs. Drivers are being trained as transport managers.

Box 1: Summary of main HR functions decentralised by country

	China	S Africa
HR planning	Authority to decide on numbers and mix of staff; authority sometimes overridden.	No control given.
Recruitment & selection	Depends on different types of staff; some decentralised authority retracted. New graduates given choice.	Authority provided; not used due to freeze on recruitment
Performance Management	Authority to distribute bonuses and to determine types of performance related salary for different categories of staff.	Authority to promote staff up to Level 8 within rank.
Discipline	Ability to withhold bonuses, but power to dismiss staff frustrated by higher levels.	Authority for dealing with minor disciplinary cases; can stop salary payment in case of long-term absence.
Training	Full control over allocation and selection given as well as responsibility to generate funds for training.	Authority to use funds given, but with exception of external project funds, very little actually allocated.

The process of decentralising HR functions
The process of decentralisation in the China case study seems to have largely been governed by policy instruments both for the delegation and the devolution. They contain little detail on the implementation process of any aspects of managerial decentralisation. There was no evidence that human resources issues were seen as priorities on the change agenda. For example, the difficulties of implementing performance-related salary arrangements are well-known and yet managers did not appear to have had any guidance on this. In the South African case study there were more examples of preparation for decentralisation in general, and for assuming HR functions. For example, training was given in managing minor disciplinary cases, the use of the personnel information system and coordination of training. Due to the protracted process of decentralisation and the hiatus created by having interim structures it is possible that some managers or potential managers were trained but we not included in the final management teams and some that were included missed out on the training. No strategy document for decentralising the HR functions was found.

The impact of decentralisation on human resource management
Measuring the impact of decentralisation on HRM proved to be problematic, because – in addition to methodological limitations such as lack of baseline data and institutional memory loss – of problems of attribution. The financial pressures in China and the recruitment freezes in South Africa appear to have had far greater impact on HRM than decentralisation. Nevertheless, managers in both case studies demonstrated the use of decentralised authority in the area of HRM. Sometimes these decisions appeared to be contributing to the overall efficiency and performance of the health services e.g. the control of long-term staff absence in South Africa. At other times, whilst managers seemed to be making appropriate use of their authority

to meet their immediate organisational objectives e.g. in the selection of staff who could raise their income-generating capacity for training, such decisions could jeopardise the performance and efficiency of the health service at a wider level by neglecting public health services. The differences in ability of the richer and poorer counties studied in China to attract and develop staff illustrate the potential dangers of increasing the inequity in service provision.

The higher authorities in China did eventually – for whatever reason – identify some of the problems with HRM and took action. However, much of the damage will already have been done, and overruling managers who are being expected to use initiative and to take risks will be demoralising.

Based on the findings from this study we recommend that planners of decentralisation strategies that include decentralising HR functions:
1. ensure that HRM is clearly on the agenda of decentralisation so that it is included in the planning stage;
2. ensure that clear strategies for decentralising HRM are developed; these should include decisions about what functions should be decentralised, and when or how they might be phased in; and what functions should be retained – if only temporarily – by the centre; the strategies should include clear but flexible implementation plans and capacity building for both managers at the decentralised levels and managers who are letting go of authority and taking on different roles;
3. develop a system to monitor the decentralisation of different HRM functions; this will include monitoring of both the process of implementing the changes and the impact of the changes on HRM and the wider health system objectives; linked to the monitoring there should be a feedback process to enable planners and managers to make necessary adjustments to the process of decentralising HRM so that both HR and wider health system objectives are successfully met. Some guidelines for establishing such a system of monitoring and feedback are given in Annex 4.

As the process of decentralisation is ongoing in the Eastern Cape, the provincial department of health should build on the experiences of this project to ensure that a system is developed – using Annex 4 as a resource – to monitor further implementation of the decentralisation of HRM in the health sector. Wider use of this approach to monitoring should also be of use in other provinces in the country.

The Fudan University based members of the research have recently undertaken a further project on decentralisation in Zhabei district of Shanghai. Their research question 'Can delegation of community health service centre improve community health care?' is covering the area of management including the management of human resources. The experience of the research on decentralisation in Fujian province is proving to be extremely useful.

One reason that HRM is so low on the reform agenda in the health sector is the lack of expertise in this area. Through collaboration in this study and the associated Liverpool-based fellowships, we feel that capacity has been enhanced in both South Africa and China. In the latter countries our collaborators have already started to put their new skills to use in the Shanghai-based project described above.

DISSEMINATION

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A paper was published based on the literature review[5] (see Annex 4 for full paper). Eight papers have been published in Chinese journals. Presentations have been given at international conferences in Portugal and South Africa. Full titles with abstracts are given in Annex 5 All project outputs are publicised on the project web page (http://pcwww.liv.ac.uk/~martinea/DECENT~1/index.htm).

An international workshop which was also attended by policy-makers from the Eastern Cape province was held in Johannesburg in July 2002 (see Annex 6 for report) to disseminate the results of this study. A national workshop which was also attended by policy-makers from Fujian province was held in Shanghai in September 2002 (see Annex 7 for report).

A more detailed report of this study (c.55pp+Annexes) has been nearly completed and will be disseminated to a wide audience and placed on the project website. An article on the overall findings of the research project and an article on the South African case study are planned.

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[5] Wang Y, Collins C, Tang S, and Martineau T. Health systems decentralization and human resources management in low and middle income countries. *Public Administration and Development* 2002;22(5):439-453. (see Annex 4)

Annexes

Annex 1: List of tables and figures

Figure 1: Delegation from County Health Bureau to health institutions in Longyan Prefecture, 1988
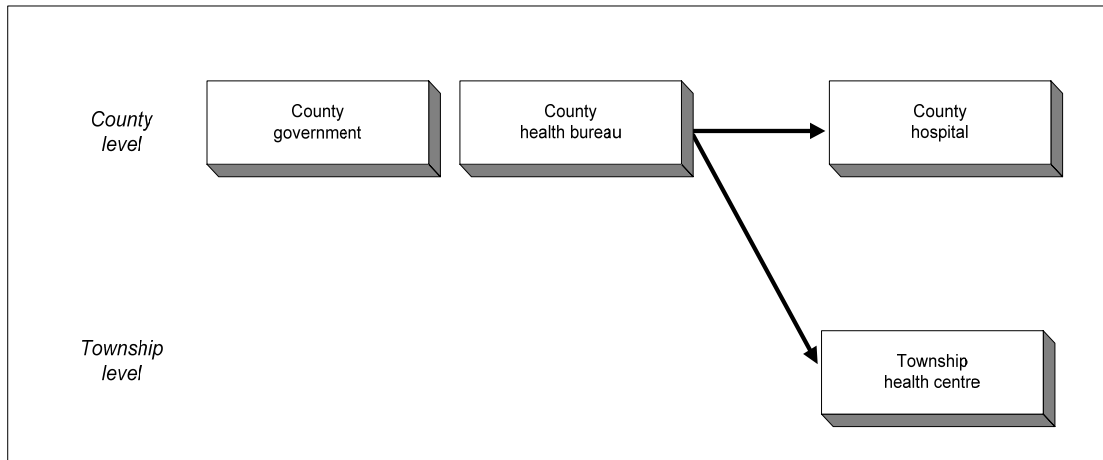
Figure 2: Devolution from county to township government levels in Longyan prefecture, 1992
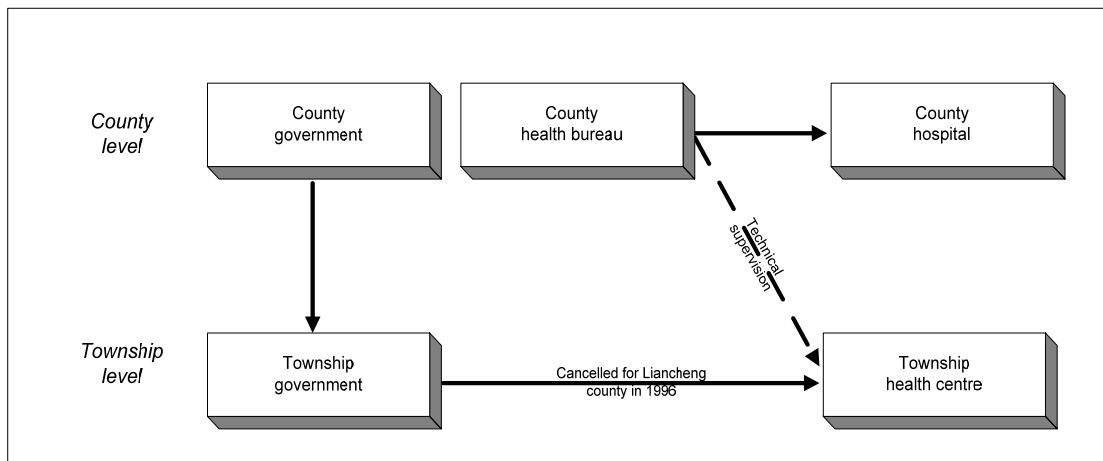
Figure 3: Two forms of decentralisation affecting the health sector in South Africa with key dates

Deconcentration stream

Devolution stream

Central DoH

Provincial DoH
from 1994

(Regional Office)
'95-'00

(Health districts)
'95-'00

Central government

Provincial government
from 1994

(municipalities)

Municipalities
from '00

Temporary structure in brackets

Table 1: Change in staff numbers, recruitment and workload in Liancheng and Xinlou county hospitals over time

Years →	87	88-93	94-97	98-00
Liancheng county hospital				
Annual average number of hospital staff	153	195.5	236	239
Annual average number of staff recruited		19.6	17.25	7
Annual average daily workload per doctor	16	13.3	10.8	10.1
Xinlou county hospital				
Annual average number of hospital staff		228	265.5	276
Annual average number of staff recruited			16.3	7
Annual average daily workload per doctor		20	19.9	22
Stages of decentralisation		*Delegation →*		

Source: Facility survey

Table 2: Change in staff numbers, recruitment and workload in Liancheng and Xinlou THCs over time

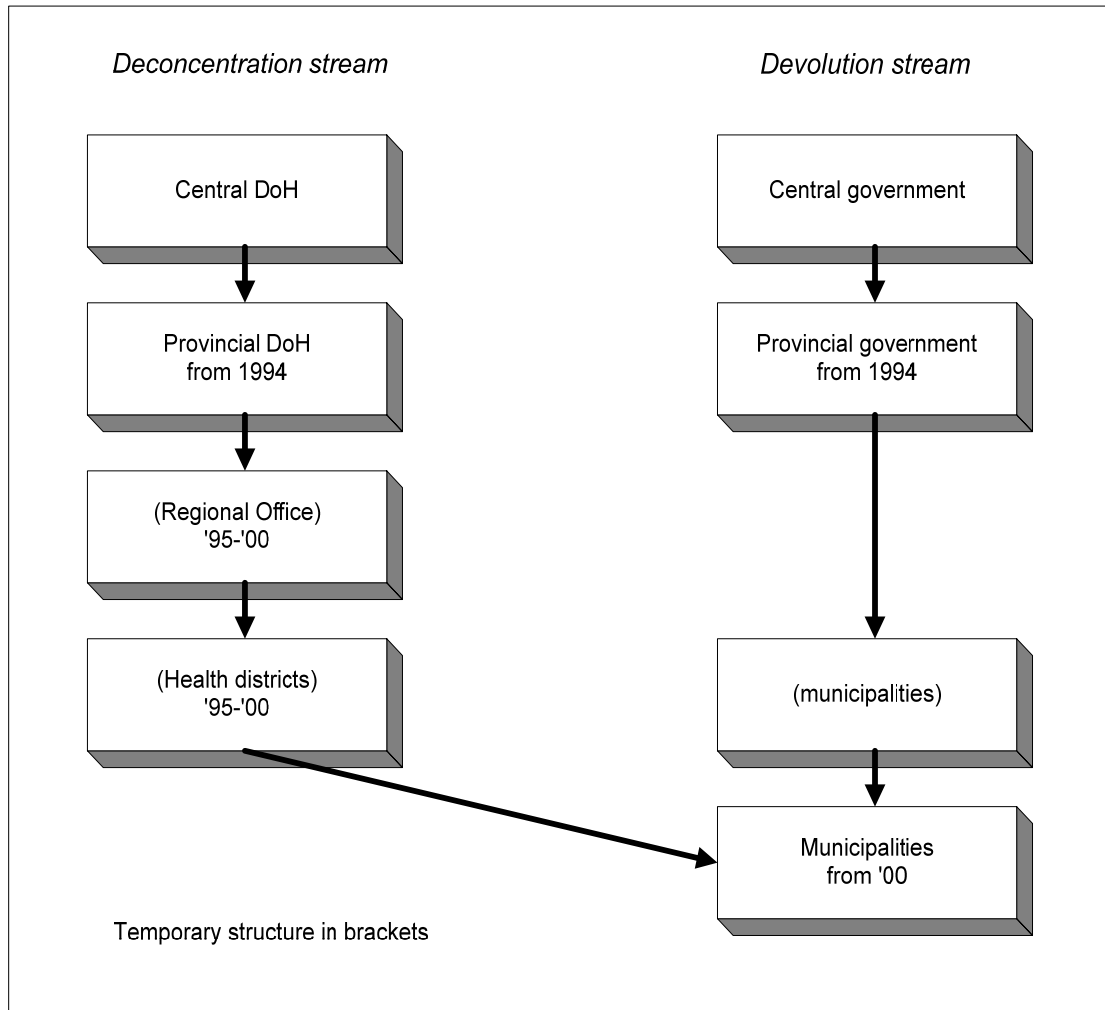| Years →	91	92-4	95-7	98-00
Liancheng county THCs				
Annual average number of staff per THC	20.2	20.5	23.6	26.1
Annual average number of staff recruited per THC	2.3	2.7	3	2.6
Annual average daily outpatient visits per doctor	4.9	5.1	4.5	4
Xinlou county THCs				
Annual average number of staff per THC	23.3	25.5	26.3	28.2
Annual average number of staff recruited per THC	2.5	3.3	3.4	1.7
Annual average daily outpatient visits per doctor	8.4	7.3	10.5	12.6
Stages of decentralisation	*Delegation →*	*Devolution →*	*Recentralisation Liancheng only →*	

Source: Facility survey

Table 3: Change in authority to appoint senior staff in hospitals and THCs

	Manager category	Before 1988	1988 to 1993	1993 to 1999	After 1999
County hospital (CH)	deputy director	CPB appoints.	CH and CHB recommend, CPB appoints.	CPB appoints.	CPB appoints.
	functional department director	CHB appoints.	CH appoints and reports to CHB.	CH recommend and CHB appoints.	CPB appoints.
	professional department director	CHB appoints.	CH appoints and reports to CHB.	CH recommend and CHB appoints.	CH recommend and CHB appoints.
Township health centre (THC)	Director	CPB appoints.	CHB recommend, CPB appoints.	CPB appoints.	CPB appoints.
	Department director	CHB appoints.	Director of THC appoints and report to CHB	Director of THC appoints and report to CHB	Director of THC appoints and report to CHB

Key:
THC for township health centre
CH for county hospital
CHB for county health bureau
CPB for county propaganda bureau

Table 4: Staff workload for the years 1996, 1998 and 2000, Alfred Nzo District

	1996	1998	2000
Annual number of patients visits	113,502	225,958	384,759
Total number of consulting staff	31	30	33
Average consultation per staff per day	16.6	34.1	52.8

Source: Facility survey, October 2001

Table 5: Average number of in-service training days per staff type in county hospitals

County	Type	1987	88-93	94-97	98-00
Xinluo	**Doctors**	n/a	36.7	23	47.3
	Nurses	n/a	4.9	1.5	4.5
	Others	n/a	0.2	0.3	0.3
	All staff	n/a	14.5	7.4	15.8
Liancheng	**Doctors**	4.2	8.6	7	7.9
	Nurses	1.4	0.1	1.6	1.8
	Others	0	0	0	0
	All staff	2.5	4.3	4.4	4.8

Table 6: Average number of in-service training days per staff type in THCs

County	Type	1991	92-94	95-97	98-00
Xinluo	**Doctors**	13.8	18.5	19	17.4
	Nurses	0	1.1	3.7	14.3
	Preventive staff	0	40.9	0.9	0.4
	Others	15.0	3.2	20.5	51.2
	All staff	7.2	15.8	9.7	19.2
Liancheng	**Doctors**	17.2	5.5	26.9	29.9
	Nurses	11.6	4.0	7.5	2.0
	Preventive staff	0.8	8.1	30.1	9.5
	Others	0.8	3.2	1.5	10.5
	All staff	8.2	4.3	16.7	17.0

Annex 2: Methodology

This annex provides information on the overall study framework and design; the methods and data collection; and the methods of analysis. Finally quality assurance methods and the study limitations are described.

2.1: Overall study framework

To get a broad exposure to the impact of decentralisation on HRM in this preliminary research phase we aimed for diversity. We chose two different continents, different types of health systems and political and economic context, different types of decentralisation and at different stages. We chose to look at eastern China where the decentralisation process had taken place some time ago and had largely been influenced by economic reforms and primary health care had long been established; and South Africa where decentralisation was still in progress and was being influenced by concerns for establishing an equitable primary health care system. The focus of the enquiry was at the levels close to service delivery, which in South Africa was the district and in China is the county.

To answer our question about the impact of decentralisation on HRM we wanted to find out what had changed regarding to location of the HRM decision-making, and what impact that had had on the staffing of health services, and ultimately on the effectiveness of the delivery of health services. Our outcome measures were to be linked to effectiveness and efficiency - two key objectives of most reform programmes. We recognised the importance of the impact on equity, though at this stage (Phase 1) of the wider research initiative it was not going to be possible to get sufficient coverage to detect much in relation to geographical differences. We did, however, decided to include richer and poorer locations for the study in China (where the decentralisation process was much further advanced) since it was hypothesised that decentralisation can have positive impact on HR management in more developed areas, while it may have negative impact in relative poor areas where there is lack of social capital.

In this exploratory phase in which we were concerned with identifying issues about HR and decentralisation depth of understanding was considered more important than breadth. We therefore chose to use the case study approach, recognising the limitations that this would have for the generalisation of our findings.

2.2: Overall design

Objectives

The following objectives were developed to answer our questions about the impact of decentralisation on HRM:

1. To examine whether or not the actual impact of decentralisation of the management of health services has provided opportunities to improve human resource management and staff performance;

2. To develop guidelines that can be used for measuring the impact of decentralisation on human resource management and staff performance;

3. To assess the extent to which decentralisation has led to increased efficiency in use of health human resources;

4. To examine changes in performance of health professionals under the decentralised health care system;

5. To provide policy-makers with appropriate policy recommendations and suggestions on how best to use the opportunities created by decentralisation to improve human resource management.

General features of the design

There were some differences in the design of the two country studies. The common starting point is described here, and the detailed differences later in the chapter.

The first step was to identify the nature of the recent or current decentralisation process or processes in terms of purpose and structural change.

The next step was to identify the human resource management functions that had actually been decentralised, and then to identify the impact. The scope of HRM functions to be considered was not limited, but the focus was on the areas of staffing supply, performance management and training.

Staffing supply
It has been said that the "flexibility in the use of labour ….. is one of the most sought after effects of the entire health reform process"[6]. This includes being able to control the numbers and types of staff, and how and where they are used, and thereby improving the efficiency of human resource usage. The ability to plan the number and types of staff employed was examined, as was the control over the process of recruitment and selection which is often suspected to be exposed to local capture in the process of decentralisation.

Performance management
Decentralisation ideally presents managers with the opportunity to have a more direct impact on the performance of their staff. Greater control would be expected over the staff appraisal process, the provision of rewards for good performance and the use of disciplinary procedures for poor performance or misbehaviour. Improved staff performance should lead to enhanced organisational performance or effectiveness.

Training
Managers are often frustrated by decisions on training being made at higher levels resulting often in unnecessary and inappropriate training being provided and important skill requirements not being addressed. Local decision-making should lead

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[6] Saltman Richard, B., von Otter Casten, et al. (1995). Implementing planned markets in health care : balancing social and economic responsibility. Buckingham; Bristol, Pa, Open University Press 1995. p13

to better use of training (more efficient use of training resources and staff time attending training) and better staff performance (and therefore organisational performance and effectiveness).

The literature review (Wang et al 2000) had shown how important the *process* of decentralising HR functions and the impact of changes in the external environment were to the eventual effectiveness of these decentralised functions. These two key areas were therefore included in the investigation.

Study sites

China

The main collaborators for the study were based in Fujian province on the eastern seaboard of China. Two counties were selected in Longyan Prefecture: Xinluo County and Liancheng County. The selection of the two counties were based on the following criteria:

1). One county representing the more developed area of the province and China (Xinluo – GDP 842 Yuan in 2000), and one county representing the less developed area in terms of GDP per capita and average annual income per capita (Liancheng – GDP 595 Yuan in 2000);

2). In both counties some kinds of decentralization of county and township level health services have been implemented over the past five years or so.

3). Local government and health authorities would be willing to co-operate with the research team in the implementing the research project.

One county hospital was selected in each county. There are two kinds of township health centre in each county. One is so-called key health centre; the other is common health centre. In each study county, five township health centres were selected for the study, 2 key health centres and 3 common ones. The selection of the township health centres was carefully considered in terms of technical capacity of the health centres, and the distance between the county capital and the towns where these health centres are physically located.

South Africa

The Eastern Cape is located on the south eastern seaboard of South Africa and is the second largest province with an area of 170 600 km² and represents 14% of South Africa's land mass. It is one the three provinces classified as predominantly rural and poor in South Africa. The Eastern Cape province was selected as it was known that some decentralisation had already taken place and the research partners (HST[7]) had projects in Region E in the north east of the province which would provide access for the study. In line with the China study, two 'health' districts (uMzimkhulu and uMzimvubu) were originally selected in Region E. However, before the main study took place the Alfred Nzo District Council was created covering the area of uMzimkhulu and uMzimvubu health districts. With the merger of district council and health district boundaries, Alfred Nzo also became the new health district. This then became the single study site.

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[7] HST – Health Systems Trust an organisation operating in the district since 1996.

Health services in Alfred Nzo district are provided by three hospitals (Marie-Theresa, Rietvlei and St. Margaret's) and 25primary health centres (PHC). At the time of the study the districts were operating as sub-districts of Alfred Nzo Municipality and separate district management teams were responsible for managing each sub-district.

Methods and data collection

Literature review

Prior to the detailed design of the study in each country, a literature review was carried out. The review looked at decentralisation in general and then focused on the impact of decentralisation policy on human resources in the health sector.   A summary of that review was published (Wang et al 2002) and is provided in Annex 1.

China

Document review
The purpose of the document review was to identify all available documents relevant to the different decentralisation policies and other relevant policies including health sector reform and pay reform to describe the policy context in which the decentralisation of HRM was taking place. Official documents were sought at national down to local levels. Journal and newspaper articles were also sought.

Key informant interviews
Selected key informants were asked about what changes had taken place, why and what the impact had been. Five groups of key informant were used and in some cases specific areas were explored:
- directors of health departments at provincial, prefecture and county levels (views for the future regarding decentralisation);
- directors of health institutions at the county hospital and THCs (details of how decentralisation had been implemented);
- directors of the department involved in personnel matters of health staff – the country personnel bureau, the county propaganda department, and the personnel managers of the country hospitals (changes in appointment and promotion systems and human resource management systems);
- accountants at hospitals and THCs (revenue and expenditure; staff payment systems);
- and township government officials (responsibilities of township government for THCs; support provided for taking on new responsibilities; rationale for devolution).

All interviews were recorded on tape.

Focus group discussions
Focus group discussions were used to determine staff views at county hospital and THC institutions (one FGD representing each) and views of health service users at these institutions (one FGD representing each) on the impact of the decentralisation of HRM. Staff were asked about the changes in health service delivery, labour relations, workload, in-service training, supervision and the incentive system. Health service users were asked about changes in their health seeking behaviour and medical costs, and changes in service delivery and staff attitudes following decentralisation. All focus group discussions were recorded on tape.

<u>Surveys</u>
Two surveys were carried out at county and township levels to get general socio-economic information about the area and general morbidity and mortality and service utilisation data. This data was gathered from annual statistical yearbooks.

A further two surveys were carried out at institution level to get specific information on numbers, flows and types of staff; workload; training; financial sources and expenditures. This data was collected from the records of the hospitals and THCs. Survey forms were sent in advance of a visit by the research team, who then help the facility staff to complete the forms.

The workload figure for doctors in the county hospitals was estimated by combining a inpatient and outpatient workloads, since doctors carry out both tasks[8]. Inpatient workload was calculated by dividing the total annual patient admission days by the product of the annual average number of doctors and the full time equivalent taken as 251 days per year. Outpatient workload is calculated by dividing the total annual number of outpatient visits by the product of annual average number of doctors and the full time equivalent taken as 251 days per year. Dealing with an in-patient is assumed to take 2.5 times longer than an outpatient (Barnum 1992, Yang T 1994[9]). The formula for calculating total workload per doctor is therefore:

Total workload per doctor = (in-patient workload x 2.5) + outpatient workload.

The same workload indicator was intended for THCs, but bed-occupancy data was not available. Hence the outpatient workload data only is used.

Staff of the county hospitals and THCs were surveyed using a questionnaire. The questionnaire included items on personal and job characteristics; and changes in in-service training, supervision, workload and job satisfaction. The views of the informants were sought on the decentralisation policy. 20 staff from each county hospital were randomly selected and five staff from each THC were also randomly selected to complete the questionnaires.

Data for selected years from 1987 to 2000 was collected for the county hospitals. To focus on the devolution process, data was only collected for selected years from 1991 to 2000 at the township level.

<u>Follow-up interviews</u>
Following an initial analysis of the data collected questions were developed to explain changes detected following decentralisation. Questions were developed for selected key informants to try to verify whether changes detected were due wholly or partially to decentralisation, or to other factors.

<u>Timing</u>
The document review was started in April 2001 and most documents used had been collected by the end of the interviews. The key informant interviews and surveys were carried out in August 2001. The follow-up interviews took place in November 2002.

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[8] It was recognised that this was a crude estimation of workload as doctors my carry out other tasks such as preparation and administration in addition to in and outpatient treatment.
[9] Yang T. Human resource development in township hospital. Chinese Primary health care. 1994, (90): 7-10.

South Africa

Document review
The document review had a dual purpose: to inform the development of interview guides for both key informants and facility survey; and to provide a context within which decentralisation and human resource management were implemented since 1996. Published documents and grey literature were reviewed, these included:

- Legislative framework, for example, the constitution of South Africa
- White papers and policies on transformation in the public sector
- Provincial guidelines and directives relating to decentralisation and human resource management
- District memorandums, circulars and notices addressing issues of decentralisation and human resource management at both district and provincial levels.
- Published reports and journal articles.

Key informant interviews
Nine key informants were interviewed. They were selected from the national level representing district development and HRD; at the provincial level representing district development and HRD; and two managers from the district level. Two consultants were interviewed: one who had been supporting the national Department of Health, and one who had been involved with the management of provincial personnel database (PERSAL). Questions were asked about the decentralisation policies and the policy context in which they were being implemented. Informants were asked about the process of decentralisation and in particular what HRM functions had been decentralised and what the process was. All interviews were recorded on tape.

Other interviews
Group interviews were carried out in two PHCs (one less remote and one more remote) to identify staff reactions to changes due to the decentralisation of HR functions. Unlike the China study no patient interviews were carried out.

Surveys
Two surveys were carried out: a health facility survey and a review of personnel records from the personnel information system, PERSAL[10].

A health facility survey was conducted in all 25 PHCs in Alfred Nzo District during the month of October 2001 using self administered questionnaires. Hospitals were excluded in this facility survey because by the time of the study they were managed by the province and all PHC facilities were delegated to district health authorities. The questionnaires were developed by the research team and were designed to track changes between the 1996 and the year 2000 in the following elements:
- Infrastructure
- Staffing
- The range and volume of services offered
- Management systems

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[10] PERSAL – An integrated computerised personnel and salary information system. All personnel and salary information of all officials is kept within the systems which is used to generate a number of personnel related reports. The Department of State Expenditure is the principal for the PERSAL system at national level and at provincial level the oversight responsibility is located in Office of the Treasurers.

Workload was calculated crudely by dividing the annual number of outpatient visits by the total number of daily full time equivalents (number of staff x FTE), on the basis of 221 working days per year[11]

The questionnaires were piloted with clinic supervisors who have an oversight role in these health facilities. The questionnaires were distributed to clinics by the clinic supervisors during their routine clinic visit. Facility managers were given two weeks to respond after which they were to mail the questionnaires back to HST. There was a 100% response rate from the return on the facility survey questionnaires and all questions were answered.

In order to track personnel administration as well as salary related information a two stage process was followed in extracting data from PERSAL system. A copy of PERSAL data sheet was solicited from the provincial office. This provided researchers with a sense of the type of information that could be available from PERSAL. The second phase was to develop templates that were used to extract PERSAL data to be used in the study. The need for such an approach was necessitated by the fact that the PERSAL system is not only used to manage personnel information but it also supports their financial management systems. Therefore, we had to first identify the variables in the system that relate to human resource management and then request for disaggregated data that will fulfil the objectives of the study. It was possible to obtain PERSAL reports from 2000 onwards, but not for preceding years. As the reports had all the information on personnel employment history since the first appointment, it was possible to track changes dating back to the time of an individual's first engagement. PERSAL data reports for the period of September 2000 to February 2002 and tracked changes retrospectively in personnel management systems for the period of 1996-2000 from the provincial level. The variables that the study looked at from the data included the following:

- Staffing – post classification, date of appointment, rank classification
- Staff movement – promotions, secondments, transfers and retirements
- Staff utilisation – job category, job level
- Pay roll information – pay point, salary notch, salary level.

Follow-up interviews
A follow-up meeting with provincial officials was held to check the findings of the study.

Timing
The document review was started in July 2001 and though most documents used had been collected by the end of the interviews, collection went on until the end of the study. The key informant interviews and surveys were carried out in October and November 2001. The follow-up meeting took place in June 2002.

Analysis

China

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[11] The number of working days was calculated by subtracting the number of days leave per year assumed to be equivalent to 20 days and two days off days in 52 weeks, which is equivalent to 104 days. Both off days and leave days were subtracted from 365 days leaving 221 working days per year.

<u>Document review</u>
Policy instruments were classified into themes. They were reviewed for a better understanding of the background, contents and process of the decentralisation policy.

<u>Key informants and FGDs</u>
Data from the interviews and FGDs were transcribed from the tapes. A qualitative data file was compiled from the transcriptions. Data was re-grouped under the following headings: background information, process of decentralisation, the HR functions decentralised, the impact of decentralisation on recruitment and appointment, in-service training, the incentive system, and workload.

<u>Surveys</u>
Data from the facility-based survey were entered into computer separately by two team members, one using SPSS 10.0 and the other using Microsoft Excel 2000, both with a second manual check. Standard statistics including means and percentages were calculated using both packages. Corrections were made to the datasets based on the comparison. The final analyses were then conducted using SPSS.

The data collected from the health staff questionnaire survey were coded and enter into Epi Info.

South Africa

<u>Document review</u>
Policy instruments and other documents collected were classified into themes. They were reviewed for a better understanding of the content and process of the decentralisation policy, the decentralisation specific HRM functions and the wider policy context.   A time-line was developed to better understand the different processes running in parallel.

<u>Key informants</u>
Information from the key informant interviews was categorised thematically according to the framework for analysis and was also used to inform the contextual analysis. These results were also used in triangulating the research findings.

<u>Surveys</u>
Data from the health facilities survey was entered into EPIINFO 2000 and analysed with statistical package (SPSS) for figures and tables. The analysis looked at changes in staffing levels over the period, changes in working load, recruitment patterns, utilisation patterns, staff training etc.

PERSAL data was extracted into Microsoft Excel 2000 spreadsheet and was analysed using both Excel and SPSS for figures. The analysis tracked changes over the period on appointment patterns, distributions of staff by skills mix, salary levels and job levels etc.

2.3: Quality assurance

Overall quality assurance was provided by an Advisory Panel which reviewed the study design at a time when the South African and Chinese partners were visiting Liverpool. The Advisory Panel also reviewed and provided feedback on the draft research report.

The study was submitted for ethical clearance in Liverpool and South Africa.

2.4: Limitations

A number of limitations of the study have been identified:

1. Absence of comprehensive baseline data in both cases making it difficult to make comparisons with before and after situations. The collection of retrospective data helped to get an idea of what the situation was like shortly after decentralisation, but baseline data would have been more accurate. For the qualitative data and in particular the explanations of when and how decisions were made and of trends identified by the data there were problems of loss of both individual and institutional memory – the latter due to staff turnover – and in the case of was a South Africa the loss of Regional Office, an important institutional level in the process of decentralisation.
2. Problems of attribution. Decentralisation of the HR functions was only one of the changes that took place over the period being studied. Other changes might also have had an impact on HR functions and the outcome of those functions. Triangulation and follow-up questioning after an initial analysis of the data was used to reduce the problems of attribution. However, due to the difficulty of interpreting the causal factors of change, less emphasis than was originally planned was placed on outcomes measures.
3. Linked to the problem of attribution is that there is usually a time delay in the impact of decentralising any management functions. It is therefore even more difficult to link the cause of a change to decentralisation.
4. Some attempt was made to investigate the impact of decentralisation of HRM on equity, but due to the limited scope of this study it was limited to a comparison of a richer and a poorer county in China. The impact on equity is raised in the literature and it is recognised that any follow-on study would need to address this issues more thoroughly.
5. The process of decentralisation takes place at the centre, the periphery and at levels of management in between. Again, due to the scope of this exploratory study, the investigation at the higher levels of authority was somewhat limited.

Annex 3: Guidelines for monitoring the decentralisation of HRM

The first section of these guidelines introduces the idea of monitoring the process and impact of the decentralisation of HRM and highlights: the areas to monitored, the monitoring process and who should do it. Section two provides a simple checklist.

Areas to be monitored
The first area to monitor is the development of the plans for the different forms of decentralisation and their potential for supporting HRM objectives. As these are likely to change over time, they need continuous monitoring. A feedback loop is required to ensure that when plans appear not to be supportive of HRM objectives this information can be fed into the policy process.

The wider environment needs to be monitored to detect changes that might impact on decentralised HRM negatively or conversely provide opportunities. Economic and other types of reform, labour market shifts and pressures, are examples highlighted in this study. However, given the large number of variables possible, advice on further areas to monitor is difficult to give. Again, feedback into the policy process is important.

The HRM functions that are actually decentralised should be monitored. The reasons for not decentralising key HRM functions are also important. The amount of decision space should be measured e.g. does the manager have full control over the training budget, or just over the selection of staff and courses attended. It is important here to differentiate between the official line on what has been decentralised, and where for example the centre has not really let go. It is recognised that different HRM functions may be phased in over time – perhaps with the less controversial ones first.

The effectiveness of establishing the HRM functions is highly dependent on the process of decentralisation. The China case study appeared to show little preparation of managers and systems development in this area. The focus should be just as much on what the centre, or other higher level authorities, is doing to plan and support decentralisation, as what is happening at the lower levels. Intention can be monitored through a review of strategy documents, work plans and circulars. The reality of implementation can be monitored through reviews of regular activity reports, evidence of capacity building (training and guidance), systems established. If done on an ongoing basis, problems of recall and loss of institutional memory that we encountered in our study will be avoided.

The choice of areas to investigate impact will be determined to some extent by the wider system objectives and to the specific context such as wider reforms which may impact on the nature of service provision, on the type of pressures on managers and the labour market. It will also depend on the scale of the monitoring exercise and the resources available. In addition to the measures of efficiency and effectiveness, a more comprehensive study should look at the distribution of staff and the impact on equity of service provision, perhaps using sentinel sites.

The areas of HR planning, recruitment and selection and performance management are core HR functions in relation to effectiveness and efficiency. Other areas might be selected in addition or instead of these, depending on the context, such as the employee relations function. The impact on staff morale and motivation would be an important area to monitor. In some organisations this is done by carrying out an annual attitude survey, though the survey might have other objectives, too. Alternatively selective focus group discussions could be used.

The monitoring process

Because of the problems of attribution a strategy of triangulation is needed when measuring the impact of decentralised HRM. This is done by mapping the changes identified e.g. the changes in types of staff recruited identified by survey or analysis of a personnel database against the wider environmental context.   Sometimes relationships will be clear – for example the lack of recruitment by district managers due to a nationwide recruitment freeze. But often it will be necessary to go back to key informants to try to establish or clarify explanations for changes identified. The process of data analysis followed by seeking explanations for phenomena found would need to be regular. Some of the key informants to be consulted when trying to ascertain links between decentralisation of HRM and impact through such follow-up will be the managers of the decentralised units.   The process of feeding back information from the data analysis and discussing possible causes should also act as a learning process of these managers. If they can see what is going wrong, they can probably find ways of making changes within their jurisdiction to correct the situation, thus strengthen their overall capacity to manage.

There will also be problems caused by factors that managers cannot control. This would be one good reason why higher level authorities should be involved in reviewing the monitoring findings. Staff at these levels are better positioned to act on those findings that cannot be dealt with by the decentralised levels.

Who should monitor?

The question of who should do the monitoring then arises. The most obvious group would be those overseeing the implementation of the decentralisation process. One could argue that as part of their new-found management responsibility, the managers at decentralised levels should carry out the monitoring. On the other hand they may be too close to the action to take an objective view. Nonetheless, managers at this level certainly need to be involved if they are to have any ownership of and therefore act on the findings.

Just like any other area of management, technical knowledge is needed for the monitoring of the impact of decentralised HRM. It will therefore be important to have the requisite technical expertise in HRM at the design stage of the monitoring system.   This expertise is equally important at the data analysis stage and the collecting and analysing of follow-up data.

Checklist for monitoring the decentralisation of HRM

This following is a list of suggested areas to be monitored:

Wider environment
The possibilities are too numerous to specify here, but they might include economic shifts, changes in the labour market, public and/or health sector reform, etc.[12]

Plans for decentralisation
- What type (or types) of decentralisation is planned?
- When will it be implemented, and how fast (phased process or "big bang")?
- What management functions will be decentralised?

HRM challenges
- What are the current HRM priorities and objectives?
- Will the planned decentralisation support or hinder the achievement of these objectives?

HRM functions decentralised (what, when, why and degree of decision space)
- HR planning
- recruitment and selection
- performance management
- appraisal
- discipline
- promotion
- training
- pay management
- pay determination
- employee relations/negotiating with unions

Process
- development and implementation of plans and strategies
- capacity building (systems, staffing and training)

Impact
- vacancy analysis (by level of institution, type of service, and geographical location)
- staff retention
- staff morale (attitude survey or focus group discussions)
- volume and relevance of training

Process of monitoring
routine data
- interviews/focus group discussions with staff and managers
- follow-up after initial analysis to identify cause of changes (ie were the changes caused by the decentralisation of the particular HR process, all due to changes in the wider environment).
- feedback to policymakers and managers

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[12] For further information see Martineau, T. and J. Martinez (1997). *Human resources in the health sector: guidelines for appraisal and strategic development*. Brussels, European Commission.pp 39-41. Available at: http://www.liv.ac.uk/lstm/hrdcover.html

Action taken as a result of monitoring
- findings discussed?
- is action taken?
- is learning about decentralising HRM happening?

Who is doing the monitoring?
- policymakers
- managers
- people with HRM expertise
- staff representatives.

Annex 4: Published paper based on literature review

[see separate attachment]

Annex 5: Abstracts of published papers and conference presentations

List of Chinese language publications

Paper 1

Theories and practices of health sector decentralization: a review. Xiaoyun Liu and Shaokang Zhan. China health human resources. 2002, (10): 32.

This paper reviews the theories and practices of health sector decentralization. It summarizes the contexts and objectives, the contents and organizational forms, the implementing process of health sector decentralization. It focuses on discussing the impact of decentralization on health service, from the perspective of local capabilities, equity, health service types and qualities, and so on. A brief introduction is made on the Chinese experiences of health sector decentralization.

Paper 2

Health system decentralization and human resources management in low and middle-income countries. Yan Wang and Shenglan Tang. Chinese Health Policy, 2003, (2): 28.

This is a Chinese version of Yan Wang's paper published on *Public Admin. Dev. 22, 439–453 (2002)*. Dr Xiaoyun Liu made the translation from English into Chinese with the permission of the authors.

The aim of this article is to explore the experiences of human resources management in the context of health sector decentralization. The initial review of health sector decentralization covers issues relating to the context, content, formulation/implementation and impact of decentralization. The review of the literature on human resources management (HRM) and decentralization has identified a number of key points that are organized around the following HRM functions: HR planning/staff supply, personnel administration and employee relations, and performance management. The importance of the management of change is also highlighted. The article concludes by emphasizing the need to include human resources as a key issue in health systems change and emphasizes the areas of policy dialogue and research.

Paper 3

Background and contents of delegation and its impact on health staff performance. Lieping Chen, Baojun Pan, Qiyan Chen, Tim Martineau, Shenglan Tang, Shaokang Zhan and Xiaoyun Liu. Chinese Hospital Management. 2003, (1): 8.

This paper focuses on the background, content and the affects on staff's performance of the delegation. Two counties in different economic levels were selected for the study, with county representing the wealthier area, and county C the poorer area. Both quantitative and qualitative research methods were used to collect and analyze data. Results showed that both the hospital directors and health staff support the delegation policy since it can activate most people's work enthusiasm. Under the decentralization system, health staff in the two selected county hospitals provided more medical service, improves the service quality, and promote their satisfactions degree during work, and have more opportunities to receive in-service training. Limitations of decentralization are also pointed out together with some suggestions for future policy making to improve health staff performance.

Paper 4

Preconditions of township health center devolution. Lieping Chen, Qiyan Chen, Baojun Pan, Shaokang Zhan, Xiaoyun Liu, Jufang Chen, Tim Martineau and Shenglan Tang. Chinese Hospital Management. 2003, (1): 13.

This paper studies the preconditions of devolution of township health centers in Fiujian Province, China. Focus group discussions, key informant interview and some quantitative research methods are used to collect and analyze data. Results showed that devolution of township health centers have better impacts on human resources and health services in relatively developed area that in less developed areas. Different stakeholders including township health centers, township government and county health bureau have quite different opinion on the devolution policy. It is concluded that devolutions of township health centers should be based on certain preconditions, including adequate economic development in local level, adequate management skill of local leaders, and corresponding detailed policies. Neither decentralization nor re-decentralization should be carried out regardless of these preconditions.

Paper 5
Impact of personnel reforms on health human resources under decentralization policy. Xiaoyun Liu, Lieping Chen, Shaokang Zhan, Shenglan Tang and Tim Martineau. Chinese Hospital Management. 2003, (1): 16.

In order to learn the impact of personnel reform on health human resources (HHR)under decentralization policy in rural China, a case study was conducted in two counties in Fujian Province, using both qualitative and quantitative methods. The results showed that hospitals had increased autonomy during personnel reform, but the some policy items cannot be fully and effectively carried out; recruitment system got improved, while staff redeployment were getting deteriorated; generally, the number of HHR increased with qualification improved after decentralization.

Paper 6

Impact of delegation on training and development of health human resources. Qiyan Chen, Lieping Chen, Baojun Pan, Shenglan Tang, Tim Martineau, Shaokang Zhan, Xiaoyun Liu and Jufang Chen. Chinese Hospital Management. 2003, (1): 20.

Objectives: to explore the impact of decentralization on in-service training and development of health human resources. **Methods:** focus group discussion and key informant interview were used to collect qualitative data; quantitative data were collected from annual records kept in county hospitals and township health centers. **Results:** in a decentralized system, managers gave high priority to staff training, health staffs have more opportunities to receive in-service. The staff mix got more rational. **Conclusions:** the delegation is favorable for the training and development of the human resources. But government should invest more on township health centers in poorer areas. Proper policy should be developed to stop the staff loss caused by in-service training.

Paper 7

The Correspondence and homogeneity analysis on some indexes of health services in township health centers. Pan Baojun, Lieping Chen, Shaojuan Liu, Qiyan Chen, Jufang Chen, Tim Martineau, Shenglan Tang, Shaokang Zhan and Xiaoyun Liu. Chinese Hospital Management. 2003, (1): 25.

This paper is to study the relationships of some indicators of health services.: percentage of income from medical service , No of out-patients, and No of inpatients

in township health centers to improve the service. The indicators were divided into 3 levels based on its percentile and analyzed by correspondence analysis and homogeneity analysis, using SPSS 10.0. Results showed positive correlations between the indicators.

Paper 8

8 evaluation methods to evaluate health services in 10 township health centers. Pan Baojun, Lieping Chen, Feng Xu, Qiyan Chen, Jufang Chen, Tim Martineau, Shenglan Tang, Shaokang Zhan and Xiaoyun Liu. Using Chinese Hospital Management. 2003, (1): 27.
This paper used 8 different evaluation methods, including Z score method, rank sum methods, Topsis methods, et al, to evaluate the situation of health services in 10 study township health center. The 10 township health centers were ranked according to the results of health service analysis.

List of English language publications

1. Wang, Y., C. Collins, S. Tang and T. Martineau. (2002). "Health systems decentralization and human resources management in low and middle income countries." *Public Administration and Development* **22**(5): 439-453. (see Annex 4)

2. Bongani Magongo and Nonhlanhla Makhanya "Does decentralisation improve human resource management: a case study from a district in South Africa?" Submitted to *Human Resources for Health* journal (BioMed Central)

Abstract

Background
Decentralisation is one of the popular strategies used for reforming the health sector in the developing countries. South Africa, like many other countries such as Ghana, Zambia, the Philippines etc has embarked on decentralisation of health services as an integral part of health sector reforms. While decentralisation is seen as an opportunity for taking management decision making responsibilities closer to frontline providers, there is little evidence of how decentralisation affect human resource management within the health sector. The research examined how decentralisation of health services has provided opportunities to improve management of human resources and staff performance in the sector.

Method
The study used quantitative and qualitative method to collect data. Data collection methods used self-administered questionnaires, review of personnel data, in-depth interviews and review of published and gray literature on HR and decentralisation. Quantitative data was analysed using SPSS and Excel spread sheet.

Results
There are no set norm or targets for the province on staffing mix between health service providers and non-health service providers. Non health service providers represented only 40% of total staff in the clinics in 1996 by 2000 they represented 46% of total staff. Health service providers fell from 60% of total staff in 1996 to 54% in 2000. The facility survey data indicate failure to balance recruitment of staff and

retention to create stability in their human resources, especially the professional staff. However staff appraisal system was not well understood by staff, from the interviews with staff, staff mentioned were not clear on how they were appraised.

Conclusion
The findings indicate that, decentralisation to districts has so far been limited and hence there has only been a small increase in control over human resource issues since 1996. Training has been the most decentralised function whilst personnel recruitment, discipline, promotions remained with the province. The practice seems to affect the efficiency of personnel management in the district.

Presentations

1. Mr Tim Martineau and Dr Shenglan Tang, Liverpool School of Tropical Medicine, Liverpool, UK; Ms Nonhlanhla Makhanya, Health Systems Trust, South Africa; Dr Lieping Chen, Fujian Provincial Health Bureau, China **'The impact of decentralisation on human resource management in the health sector'.** Presentation to the Third Congress on Tropical Medicine and International Health, September 8-12, 2002. Lisbon, Portugal

Abstract:

Background of study Decentralisation is a popular strategy of reform, which provides opportunities for more appropriate management at the local level. Hence many countries have decentralized their health services in order to improve efficiency in service provision and equity in access to health care. Particular questions have been raised about improvements in the human resource management (HRM), after the decentralization of health services. Few empirical studies have been seen to evaluate the impact of decentralization on HRM in developing country contexts.

Objective To assess the impact of decentralisation on human resource management of health personnel.

Design In China, where decentralisation took place in 1988, the study took place in two counties where changes in the two county hospitals and a sample of Township Health Centres were studied, using health facility surveys, staffing data review and staff interviews and focus group discussions. In South Africa, where decentralisation has been incremental since 1996 (though full devolution is only now beginning) two former districts were studied using health facility surveys and staff interviews; access to staffing data proved problematic. In both countries key informant interviews and document review were also carried out.

Results HRM is affected by many factors, but some clear changes due to decentralisation were observed. In China decentralisation allowed managers to: tailor training to meet organizational objectives; use flexible payment systems to reward performance and productivity. Some extra control of recruitment also increased productivity, though generally control of staff numbers or the pay system was not decentralised. Despite re-centralisation that took place in some rural areas in 1997 because of general management failure, in the rural county studied some of the HRM autonomy remained. In South Africa, the critical functions have been retained at provincial level, though with the abolition of regional offices certain personnel management functions have gone to the district including dealing with minor misconduct cases, access to the electronic payroll and personnel information system

which allows managers to stop pay of staff who are persistently absent. Districts have more responsibility for recruitment, though many vacancies are still frozen.

Conclusion In China the greatest impact of decentralisation on HRM has been in the areas of labour productivity, payment systems and in-service training. This helps managers to meet their objectives, which in turn mostly but not always lead to better health services. In South Africa the impact of decentralisation on HRM to date has been modest, but the set of indicators developed by this project will be invaluable for monitoring full devolution when it eventually occurs.

2. Magongo, Bongani **'Does decentralisation improve HR Management: A case study from Alfred Nzo district in the Eastern Cape'.** Presentation to Public Health 2003
Health systems, development, equity conference, 24 - 26 March 2003, Holiday Inn Eastern Boulevard, Cape Town, South Africa. Presentation slides at:
http://www.hst.org.za/conf03/presentations/L0046.ppt

Abstract

Introduction
Decentralisation is one of the popular strategies used for reforming the health sector in the developing countries. South Africa, like many other countries such as Ghana, Zambia, the Philippines etc has embarked on decentralisation of health services as an integral part of health sector reforms. While decentralisation is seen as an opportunity for taking management decision making responsibilities closer to frontline providers, there is little evidence of how decentralisation affect human resource management within the health sector.

The aim
The research was to examine how decentralisation of health services has provided opportunities to improve management of human resources and staff performance in the sector.

Objectives
- To determine if decentralisation does provide opportunities for improvement of HR management.
- To assess the extent to which decentralisation lead to increased efficiency in human resource management and improved staff performance

Methods
The study used quantitative and qualitative method to assess changes in the management of human resource within a decentralising health care system.
Data collections methods used were document review of published and gray literature on HR and decentralisation, PERSAL data review to identify changes in staffing patterns, characteristics of staff employed, Health Facilities survey to assess if decentralisation has effect on their HR and thus affecting performance of staff and key informant interviews to gain understanding of rationale plans and progress with the decentralisation of human Resource management

Findings.
The findings indicate that, decentralisation to districts has so far been limited and hence there has only been a small increase in control over HR issues since 1996. The incremental decentralisation of responsibilities to districts continues since the LG elections. There is an indication that staff in the districts were being matched to post

and there is a move towards rationalising HR at district level. However indicators for monitoring HRM are lacking thus making it difficult for monitoring the impact of decentralisation on human resource management.

Annex 6: Report of Johannesburg workshop, July 2002

The Effect of Decentralisation on Human Resource Management (HRM) in South Africa and China

Workshop Proceedings

24 – 25 July, 2002

Birchwood Hotel, Johannesburg, South Africa

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Table of contents

Acknowledgements

Study collaborators

The study is lead by Mr Tim Martineau with assistance from Dr Shenglan Tang, both from the Liverpool School of Tropical Medicine, UK.

The partner in China is Dr Lieping Chen of the Fujian Provincial Department of Health, China, with support from Professor Zhan and Dr Liu Xiaoyun of the School of Public Health, Fudan University, Shanghai, China

The partner in South Africa is Mrs Nonhlanhla Makhanya with assistance from Mr Bongani Magongo, both from the Health Systems Trust 's Research Programme

Workshop Planning

Ms. Nonhlanhla Makhanya	Health systems Trust - Research programme
Mr. Bongani Magongo	Health systems Trust – Research programme
Mr. Tim Martineau	Liverpool School of Tropical Medicine
Dr Shenglan Tang	Liverpool School of Tropical Medicine.

Workshop chairpersons

Dr. Thabo Sibeko	Health Systems Trust - Trustee
Dr Thobekile Mjekevu	Department of Health - Eastern Cape Chief Director - District Development
Dr Fitzroy Ambursely	University of Witwatersrand Graduate School of Public & Development management

Welcoming Address

Prof. Rachel Gumbi	National Department of Health – Chief Director Human Resource Directorate
Dr. Zhisha Lou	Fujian Training Centre – Director Human Resource
Mr. David Mametja	Health Systems Trust – Executive Director

Panellists

Mrs. Jennifer Nyoni	Regional Advisor at WHO Regional Office
Mrs. Rose Mdlalose	National Department of Health -Director Human Resource Management
Dr. Yogan Pillay,	Equity Project
Mr. Corrie Smith	Department of Public Service and Administration Senior Manager.
Dr. Uta Lehman	School of Public Health, University of the Western Cape

Note taking

Zandile Zungu	Health Systems Trust

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We would also like to thank Lerato Lebeko, Jurie Thaver and Rachel James of the Health systems Trust for their support in organising the workshop

Introduction

Decentralisation is a common element of reform throughout the world. This may occur within one sector only or on a wider scale such as devolution from central to local government, and impacting on many sectors. Decentralisation is often promoted as a way of improving government services by enabling decision-making to take place closer to the level of service delivery, and may include the management of human resources.

Whilst some research has been done on more general aspects of decentralisation in the health sector, very little has been done on the effect of decentralisation on the management of human resources.

In this regard, the Liverpool School of Tropical Medicine (UK) in partnership with the Health Systems Trust (S.A) and the School of Public Health Fuijan University (China) conducted a research project, which studied the effects of decentralisation on human resource management in the health sector.

The South Africa case study presents the process and progress of decentralisation in the health sector by the effects of decentralisation on selected human resource functions in Alfred Nzo district in the Eastern Cape Province. It explores whether decentralisation provides any opportunities for improving human resource management and how (if any) such opportunities have been exploited. The Chinese case study on the other hand focuses on the impact of decentralisation of health services on human resource management.

The research findings of the two case studies were presented at a dissemination workshop on the 24th and the 25th July 2002 at the Birchwood Hotel in Johannesburg, to a range of stakeholders including health service managers from the national, provincial and district level, and researchers from China and South Africa.

The purpose of the workshop was two-fold. Firstly, it provided an opportunity to share research findings, particularly, those dealing with the implications on policy from management of human resources within a decentralized health care system Secondly, the workshop provided a platform for subjecting the two case studies to peer review with specific focus on methodology of the studies as well as challenges for future research.

Proceedings of the workshop

Day 1

Welcome & opening speeches

*Chairperson - **Dr. Thabo Sibeko***

In his welcoming address, the chairperson gave an overview of the work of the HST over the years, emphasizing the organisation's commitment to support the transformation of South Africa's health system. Participants were then given the opportunity to introduce themselves. (Annex I. List of participants)

In his speech, David Mametja made reference to HST turning 10 years this year. In this regard, he acknowledged the presence of one of the founding members of the HST, Professor R. V. Gumbi. He then highlighted the strategic objectives of the HST and the focal areas of the programmes. Furthermore, he put into context the HRM research by highlighting the organization's key role in health systems research through its research programme; and in particular, the focus on monitoring the impact of decentralisation on equity. He commended the partnership established by the research partner organisations, as a necessary step in the establishment of a meaningful partnership between North and South based expertise. Such a partnership was highlighted as one of the critical success factors in addressing research issues of common interest

Similarly, Dr Zhisha Lou extended his sincere thanks to the funders, the project leader Mr Tim Martineau and all collaborators of this project. He also thanked HST and the DOH for their hospitality. He further expressed his appreciation of the invitation to the workshop and for the opportunity to exchange ideas on issues of common interest between the partner organisations. Furthermore, he acknowledged the complexity of issues around Human Resource Management (HRM) in the public sector, highlighting how human resources has seemed become an important factor in economic development in China. He concluded by saying that he hopes the research findings presented at the workshop would provide useful information to health service managers and policy makers both in China and South Africa.

Presentations

Overview of International experience:
Mr. Tim Martineau
Liverpool School of Tropical Medicine, UK

Tim Martineau gave an overview of the International experience on the effects of decentralisation on Human Resources management (HRM) and within this context, the rationale for the study. He presented the broad study framework and outlined the expectations of the study team from the workshop. These included:

- Sharing the preliminary findings
- Getting general feedback on the study in Day 1 and more specific feedback on the methodology on Day2
- Identifying the next research questions for monitoring the impact of decentralisation on HRM.

HRM and Decentralisation – Case study from China :
Prof. Zhan
School of Public Health Fuijan University

Prof Zhan presented the case study from China in the Fujian Province. In his presentation he outlined the context within which decentralisation has taken place in China. In particular, the complexity of the reform process, that included both delegation and devolution, and to some extent re-centralisation. The presentation also highlighted the pressure on health institutions to generate income following the economic reforms.

Prof. Zhan gave a brief description of the study design and highlighted some of the main findings. The study revealed that managers had used their newly-found freedom to make decisions about training allocation. Furthermore, managers were able to use financial incentives to encourage staff performance. (Although the outcome was not always in the best interest of the patient). The study also found that managers had more control over staff recruitment which resulted in an improvement in the match between staff complement and workload in some instances. However, they still found it difficult to dismiss staff. There was little evidence to show that managers had been prepared to take on additional HRM responsibilities that came with the decentralisation.

HRM and Decentralisation – Case study from South Africa:
Mrs Nonhlanhla Makhanya
Research Programme Health Systems Trust

Nonhlanhla outlined the context in which the decentralisation of HRM had taken place within the South African health sector since 1996. This essentially involved a merger of three separate administrations. The effects of decentralisation on HRM in the Alfred Nzo district of the Eastern Cape province were highlighted in the presentation. The study indicated that district level managers had used some of their delegated authority to plan for recruitment, promotion, appraisals and development of staff, as well as carrying out minor disciplinary procedures. A major constraint was staffing shortages over which managers had little control.

PANEL DISCUSSION

Dr Thobekile Mjekevu, Chief Director of District Systems Development in the Eastern Cape, facilitated the panel discussion. Panellists were asked to comment on several general questions relating to the studies. In addition, each panellist was requested to give a particular perspective relevant to his/her background.

Panellists and perspectives:

The effects of decentralisation on HRM - international perspective
Mrs. Jennifer Nyoni : Regional Advisor at WHO Regional Office

"It's key for managers to allow others to manage"

Mrs Nyoni gave an overview of the international perspective on the effects of decentralisation on human resource management. She commended the meeting as a milestone in beginning to question the impact of decentralisation on HRM. Her view is that while this is a critical approach in providing evidence required a service planning, more often than not effects of change on HRM are often under estimated

Furthermore, Mrs Nyoni outlined the focus of the World Health Organisation (WHO) on HR issues their primary focus is to provide support for research studies that would assist the public sector in ensuring that, "*there are the right people with the right skills at the right time*". She highlighted their priority areas of the research including:

- Assessment of the implications for HR in all approaches to service delivery.
- Addressing issues of personnel utilisation in the face of high rates of migration.
- The development implementation and monitoring of a staff retention strategy in the public sector.
- What HR skills are required for the various forms of decentralisation.
- HR implications on implementation of country programmes.

HRM in South Africa -- a perspective of the National Department of Health
Mrs. Rose Mdlalose : Director of Human Resource Management, Dept. of Health

"I can think of a lot more people who could have benefited from this meeting"

In her comments Mrs Mdlalose mentioned her host of problems experienced by the Department of Health around the HRM. Her view was that "more people could have benefited from this meeting". While acknowledging the rural focus of the South African Case study as appropriate, she encouraged researchers to consider expanding future research such that it provides managers with the national picture.

Perspective of the non-government organisations
Dr Yogan Pillay: National Dept. of Health Equity Project

"lack of studies indicate how complex the area is "

Dr Pillay commended the research team for tackling research and such a complex area. While he finds the study methodology problematic, he also acknowledges lack of research studies in this area has a clear indication of how complex this area is. As a result he suggested that future research in this area should address the following issues:

- which HR functions should be decentralised.
- What are the implications for decentralising financial management function.
- What indicators to be monitored and for what purpose.
- Systems fur HR decentralisation including determining:
  - What skills are required at each level?
  - What's the role of the centre in monitoring?

What is happening in other public sector departments
Mr. Corrie Smith: Senior Manager, Department of Public Service and Administration

"HR issues in the health sector corresponds to what is happening in the public sector"

Mr Smith commented that the picture provided by the South African Case study seems to correspond with what is happening in the public sector in general. Furthermore Mr Smith remarked that there are no conclusive studies that give a clear picture of the impact of decentralisation on HRM across the public sector. However, what seemed to emerge from the data management systems used by the public sector is that workload is a real issue although its effects have not been quantified. Other challenges in the public sector include:

- Devolution of powers to the institutional level.
- Capacity building on HRM at all levels within the public sector.
- Strengthening information management systems.

Comments on the research study methodology and areas for further research
Dr Uta Lehman: School of Public Health, University of the Western Cape

"This study does not lead to a randomised controlled trial time research"

In her comments, while Dr Lehmann emphasised the need for research to be guided by sound research methodology, she also cautioned the audience that authenticity of this research project could not be derived from randomised controlled trial time research methodology. Furthermore, she gave an overview of areas for future research. Her area of interest used on addressing the effects of changes on front-line service providers:

- Is the required capacity in place.
- How is health personnel treated in the process of change.
- How can we make the system run efficiently -- there is a need to explore the qualitative component of efficiency by asking the good research questions.
- A need to develop a toolbox for HR that will assist in addressing issues of:
  - payroll management
  - quality of care
  - need for new tools that would allow researchers to explore "soft issues".

Discussions

Following the brief perspectives presented by the panellists there was a plenary discussion. Due to participant mix, there was a greater focus on the South African report.   There was general agreement that this was an important topic of study. Noting the process of decentralisation in South Africa, it became clear that further follow-up studies are required to track the decentralisation process and its impact on HRM.

It was apparent that in both China and South Africa, there was no explicit guidance on the decentralisation of HRM. More attention had probably been paid to financial decentralisation. Managers at the decentralised level were inadequately prepared to carry out the new HR functions yet the demands at this level were massive as they included the process of change management.   It was noted that the situation in the South African Health Sector was no different from any other sector in this respect.

Dr Tang summed up the session. He was pleased that there are agreements on decentralisation and its impacts on HRM. He thanked the panellists and participants for their contributions.

Closure

Dr Mjekevu thanked the South African and the Chinese researchers and the Liverpool School of Tropical Medicine for the hard work undertaken in conducting the study. He also extended his sincere thanks to the funders DFID and HST for doing this kind of research.

Day 2

The second day was attended by a smaller group of participants chosen for their specific interest in this area of research.

Dr Fitzroy Ambursley facilitated the proceedings of the day.. He started by summarising some of the key issues that had arisen from Day 1. Two presentations followed giving details of the methodology used in the two case studies.

Key Issues Raised

1. Did the study achieve its original objectives, and if the objectives were amended, what were the revised objectives?
2. Where any attempt is made to identify valid indicators to assess:
    a. The impact of decentralisation on HRM and staff performance
    b. Opportunities to improve HRM and staff performance and,
    c. Increased efficiency in the use of human resources.
3. Have suitable guidelines been developed in previous studies to monitor the impact of decentralisation on HRM or does the study provides sufficient information to enable such guidelines to be developed?
4. Did the researchers identify an appropriate methodology for the determining whether the HRM changes observed were caused by decentralisation as opposed to other variables?
5. What, if any evidence do the researchers have to prove that the observed changes on HRM were brought about by decentralisation as opposed to any other variables?
6. What definition of decentralisation was used in the study and what was the typology of decentralisation observed in South Africa and China?
7. What definition of HRM was used in the study and which HRM functions were examined?
8. What criteria we used to select the study sides and how relevant are the chosen sites to districts undergoing decentralisation in South Africa, China, and elsewhere?
9. Did the study examined developments at the centre together with those in the districts in order to obtain a holistic understanding of the decentralisation process that was observed?

Methodology of the Chinese case study

Dr Liu Xiaoyun presented the methodology used in the study, including site selection, the data collection and analysis procedures used. He also highlighted some of the lessons learnt from the study. For example, that it was important to collect and analyse the quantitative data first and then return to the site to seek explanations for unexpected findings.   The limitation of this study was the difficulty in finding informants who had accurate information.

Methodology of the South African case study

Mr Bongani Magongo presented the case study by describing the design and the methods used. He provided some additional results to those presented on Day 1 to illustrate the kind of findings available. He also commented on some of the limitations of the study including access to the personnel information system in the district.

Following the presentations there were some questions and discussion on the methodology. Dr Ambursley suggested that further discussion could take place in the working groups.

Working groups

The final session was carried out in two groups: one focusing on the South Africa study and one on the Chinese study.

The groups reflected on the studies and the issues that had arisen during the workshop. The South Africa group also considered the possibilities for further studies in this area.

Each group then reported back to the plenary.   Suggestions included:
• the need to clarify the decentralisation models during the study. This
• the need to emphasised the dynamic nature of the changes that took place during the period under review.
• Support for further research -- particularly in South Africa -- and building on the baseline provided by the study. Some guidelines developed from the study would therefore be important.

CONCLUSION AND WAY FORWARD

The workshop provided a platform for experts in the field of human resource management to share experiences, debate on various points in an effort to assist the researchers in finalising the project. The workshop also began to highlight issues for further research in this area. The following were defined as the main areas to research the South African health services:
• The development of a methodology from conducting HR research.
• Assessing the implications for HR in all approaches to service delivery.
• Address issues of personnel utilisation in the face of high rate of migration.
• Determination of skills required the each form of decentralisation.
• Defining the purpose for monitoring and pre-requisite indicators.
• The development of an HR "toolbox".

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Annexure 1: List of participants

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* - also attended the second day

Annexure 2- 6: Presentations

PowerPoint presentations are included in the hard copy of the report available from Health Systems Trust.

Annex 7: Report of Shanghai workshop, September 2002

Decentralization and Human Resource Management
Dissemination Workshop Report
Sep. 2002 Shanghai

Part 1: Introduction of the workshop

Revenue: Department of Social Medicine and Health Statistics, School of Public
        Health, Fudan University, Shanghai, China
Date: 27th September 2002

This workshop was to disseminate the research findings of the project 'Decentralization and Human Resource Management ' funded by the ESCOR of the Department for International Development, UK. The overall aim of the research project was to explore whether or not decentralization has a positive impact on management and deployment of health personnel and on staff performance.

The period of the China case study was October 2000 to September 2002. After the completion of study design, data collection, data processing and analysis, China part took the responsibility of conducting this dissemination workshop in Shanghai, with support from Liverpool School of Tropical Medicine, the leading institution of the project. Prof Shaokang Zhan from School of Public Health, Fudan University, Shanghai, was the main organizer.

The objectives of the workshop were to disseminate key findings and policy implications to main stakeholders, to disseminate detailed findings and research methods to researchers, and to discuss and revise the policy brief (see timetable in Appendix 1). The participants included famous scholars in health administration, health economics, health human resource management, and social medicine, projector officer from DFID, principal investigator from Liverpool School of Tropical Medicine, relevant policy makers, journalist, and research team members (see Appendix 2).

Part 2: Research team reports

According to schedule, the research team reported the research findings in day 1 of the workshop. First, Dr. Shenglan Tang from Liverpool School of Tropical Medicine introduced the international experience on the effect of decentralization on Human Resource Management. Dr. Lieping Chen, Director of Women and Children' Hospital of Fujian Province, China, reported the key research findings. Dr. Xiaoyun Liu from School of Public Health, Fudan University, Shanghai, presented the methodology of the research. It was followed by 4 specific reports: Preconditions of decentralization at township level, Impact of personnel reform on HHR, Impact of decentralization on in-service training, and impact of delegation on performance management.

About 20 minutes were left after each report for the participants to raise their questions and present their opinions.

Part 3: Panel Discussion

4 panelists were invited to participate the panel discussion. They were Professor Shanglian Hu from School of Public Health, Fudan University, expert on health economics, Professor Youlong Gong from School of Public Health, Fudan University, expert on health human resource management, professor Tuohong Zhang from

School of Public Health, Bejing University, expert on Social Medicine, and Prof Aitian Yin from Weifang Medical College, Shandong Province, expert on health administration.

The panelists evaluated the project highly, and presented their instructive suggestions and recommendations for the future researches as well. The questions raised during the panel discussion were mainly in the following area.

1. This case study was conducted in China, with international financial and technical supports. The research area concerns very critical issues during the health sector reform in China. The methodology of using both qualitative and quantitative research methods is rational, and the research findings and conclusions are credible. It is developing a new research area in China, and the research findings will be highly valuable for the future policy making.

2. Instructive suggestions and recommendations were provided during the panel discussion, which include:

   • **Overall evaluation of the decentralization impact.** The impact of decentralization on HRM can be regarded as a process. The end point of the process will be the change of health system performance, including the change of quality, efficiency, and equity, etc. Evaluating the overall impact of decentralization may illustrate the advantages and disadvantages of decentralization more clearly.
   • **Serious consideration of other influencing factors of HRM.** Apart from decentralization, many other factors, like economic factors, government and policy factors, management ability factors, etc. may have more impacts on HRM. To identify the confounding factors and to objectively evaluate the impact of decentralization plays a key role in this project. Some qualitative methods can be used to solve this problem. Delphi method was also suggested in the panel discussion.
   • **Further analysis using more political theories,** such as stakeholder analysis, may produce additional valuable findings.

Part 4: Policy brief discussion

Based on the research findings, the project team drafted a policy brief and submitted it to the workshop for discussion and revision. All participants read through the policy brief and give their suggestions during the discussion in day 2 of the workshop. They suggested that the research-based policy suggestion should be consistent with the national policies on rural health sector reform, that different stakeholders should be take into consideration when developing the policy suggestion, and that the policy suggestion should be developed in a macro and systematic way to make sure they are adaptable and feasible.

In conclusion, the Shanghai workshop has successfully met the initial objectives. The information collected from the workshop will be of great use for the future researches.

Decentralization and the Impact on HRM in China
A dissemination Workshop

Venue: Department of social medicine and health statistics, Fudan University, Shanghai, China
Date: 27th September 2002

Objectives:
1. To disseminate the key findings and policy implications to main stakeholders
2. To discuss detailed findings and research methods to researchers.
3. To discuss and finalize the policy brief.

Chairpersons: Professor Shaokang Zhan
            Dr. Lieping Chen

Day 1 (27th September)

8:30 - 8:40	Registration
8:40 - 9:20	Overview of international experience on the effect of decentralization on human resource management **Dr. Shenglan Tang** **Liverpool School of Tropical Medicine**
9:20 -10:00	Introduction of main findings **D. Lieping Chen** **Director of Women and Children's Hospital, Fuzhou, Fujian Povince**
10:00 - 10:10	**Coffee break**
10:10 - 10:50	Presentation on methodology **Dr Xiaoyun Liu** **School of Public Health, Fudan university, Shanghai**
10:50 - 11:30	Preconditions of decentralization at township level **Prof. Baojun Pan** **Deputy director of CDC of Fujian Province**
11:30 - 14:00	**LUNCH**
14:00 - 14:40	Impact of personnel reform on HHR **Dr Xiaoyun Liu**
14:40 - 15:20	Impact of decentralization on in-service training **Prof. Baojun Pan**
15:20 - 16:00	Impact of delegation on performance management **Dr. Lieping Chen**

Day 2 (28th September)

8:30 - 10:30	Panel discussion
10:30 - 10:40	**Coffee break**
10:40 - 11:30	Discuss and revise the policy brief draft
11:30	LUNCH

Appendix 2: Participants list for HR Workshop in Shanghai on 27 Sep. 2002

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