

## HEALTH SYSTEMS DECENTRALIZATION AND HUMAN RESOURCES MANAGEMENT IN LOW AND MIDDLE INCOME COUNTRIES

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### SUMMARY

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. Copyright © 2002 John Wiley & Sons, Ltd.

### INTRODUCTION

Human resources (HR) take up the major part of the health system's budget and play a significant role in the amount and quality of health care provision. Paradoxically, they have not been a key part of the health sector reforms introduced in many countries. Reforms have tended to focus on organisational change (such as decentralization, purchaser–provider separation and managed markets), financial reform (such as the shift to user fees or health insurance) and a restructuring in the relative roles and relations between the public and private sectors. In spite of the important roles played by HR in achieving the objectives of health sector reform and decentralization including those related to performance, efficiency and equity (Martinez and Martineau, 1998), they have not received due attention (Buchan, 2000). While changes in human resources management (HRM) have not always been absent, they nevertheless, have been a secondary element.

There are serious concerns around the current management of health human resources in developing countries. A whole range of interrelated problems include, for example, poor staff motivation, lack of clear incentives, inequitable distribution of staff, instability in staffing, recruitment of poorly trained staff and non-existent supervision. In addition, the opportunities presented by bringing decision-making closer to the workers it affects are often missed (Martineau and Buchan, 2001). There can be little doubt that this state of affairs is affecting health and health care. It is important to recognize that these problems cannot be separated from the on-going changes that are taking place in the health sector. In particular, the shift towards health sector decentralization has had an important impact on these staff problems. There are two ways of viewing this. Firstly, decentralization of resources, authority and responsibilities has been placed in a sharper perspective and has given greater visibility to these problems. The shift away from centralised control and the dispersal of authority among semi-autonomous hospitals, district health authorities and local district assemblies has placed human resources on the policy agenda of these authorities. The problems and contradictions of managing health staff can no longer be subsumed totally under the inefficiencies of

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centralised and bureaucratic civil service systems. Hospital boards and district councils are increasingly having to wrestle with the challenges of managing staff. Secondly, decentralization has had a mixed impact on the way in which the management of human resources is conducted. While decentralization can be associated with a more adaptable, flexible and appropriate management of health human resources, it can also nevertheless generate problems, particularly when the decentralised authority lacks the required capacity and/or the full authority to undertake these new management responsibilities.

The aim of this article is to highlight the important issues on human resources management in the context of health sector decentralization by exploring the experiences from low-and-middle income countries.<sup>1</sup> By experiences we refer to the challenges, problems and advances made in HRM within processes of decentralization. The basic question this review is asking is: what is happening to health HRM under decentralization? In order to answer this, the first step is to ask what has happened or is happening in the process of health sector decentralization. This will be the task of the article's first section where brief reference will be made to key features of health sector decentralization covering policy context, policy content, policy formulation and implementation and policy impact.<sup>2</sup> This will provide some initial points that will be picked up in the second section which will analyse the experiences of HRM under decentralization. This will be analysed under four headings: HR planning and staff supply; personnel administration and employee relations; performance management; and managing change. The article will conclude by setting out a framework for policy analysis and research of decentralization and human resources. The importance of this framework is that it may be used as a basis for policy dialogue and analysis involving health sector reformers and human resource specialists. So far that policy dialogue is conspicuous by its absence.

#### HEALTH SYSTEMS DECENTRALIZATION AND HRM

Decentralization usually comes as part of a package of broader public sector and health sector reforms. It may be associated with a Primary Health Care strategy, viewing decentralization as an important means to developing equity, community involvement and an intersectoral approach. In contrast, more contemporary market and neo-liberal approaches to health sector reform provide a different policy background, justification and content to decentralization. They may associate decentralization with new individually based forms of financing health care, the introduction of quasi-market systems in the governmental health sector and the promotion of the private sector, in addition to new mechanisms of quality assurance and consumer approaches to the provision of health care. In fact, we can colour decentralization with different policy objectives according to the way in which we see it fitting into broader strategies of health sector change.

The political characteristic of decentralization suggests that there can be important political (but often not stated) objectives in decentralizing. Decentralization is not politically neutral. It can affect the interests of social and political groups and restructure the access of social political groups to the decision-making points within the public sector. Typical political uses of decentralization are those of shifting blame away from the centre to the periphery, fragmenting political opposition and the expression of political conflict to make it more manageable, operating a strategy of 'divide and rule' and the strengthening of local power elites that operate through political patronage (Collins, 1989). Decisions to decentralize in some countries have been a reflection of political statements by newly elected governments operating a transition from authoritarian to more open democratic systems. This has been the case in the Philippines (Solter, 1999) and Brazil (Collins *et al.*, 2000). In spite of the formal objectives of decentralization policy mentioned above, the rhetoric of decentralization used by the central government often '... veiled other motives and intentions' (Rodinelli, 1983, p. 185) which do not necessarily support health systems development.

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<sup>1</sup>Although the focus of the article is on low-and-middle income countries, attention will be paid to relevant experiences and literature from higher income countries also.

<sup>2</sup>In part, this distinction draws on that developed by Walt (1994) and Walt and Gilson (1994).

The organisational form of decentralization will have an important impact on the way in which HRM will be conducted. It sets out an organisational framework of authority which will determine the organisational location of decentralised managerial authority and the extent of that authority. Ample literature has been dedicated to the definitions and forms of decentralization (Rondinelli and Cheema, 1983; Mills, 1990, 1994; Collins, 1994; Gilson *et al.*, 1994; Smith, 1997). These forms are commonly seen as deconcentration, devolution and delegation. However, the reality of decentralization in a country can be complicated by a mix of different forms of decentralization (Collins, 1994), at different levels of the government hierarchy and for different tasks/responsibilities (Mills, 1994). It is not uncommon, for example, to find two or more of the organisational forms of decentralization operating in one particular health care system. In itself, this is not a problem. In such cases the key issue is the interface between these different forms of decentralization—the points of contact, how they relate to one another and the extent to which the autonomy and management authority over financial, human and physical resources are transferred to the periphery. Clearly the different organisational forms of decentralization will provide structural frameworks leading to different degrees of autonomy in HRM.

The way in which decentralization is formulated and implemented is also an important factor for HRM. We have already seen that some of the driving forces to decentralize are not always an expression of health sector based objectives. There are also cases of a lack of explicit statement 'to explain when, how and why to decentralize' (Wunsch, 1991, p. 15, as quoted from Werlin, 1992, p. 232). In many situations, difficulties in the process of change are a result of lack of consultation and dialogue. In the Philippines, for example, the Ministry of Health was excluded in the initiation and design of the reform (Bossert *et al.*, 2000). Bosman (2000) points to the lack of 'constructive dialogue between *health reformers* and *disease controllers* to maintain service quality while Rafiringason *et al.* (1996) identify a lack of effective communication among the personnel on the objectives, programme and organisation of decentralization in Madagascar.

While many of the objectives associated with decentralization may be widely considered as laudable, there are a number of concerns. These concerns can include the lack of local capacity to take on new roles and responsibilities (Rondinelli, 1983; Chen *et al.*, 1997; Kolehmainen-Aitken, 1999; Tang and Bloom, 2000), the development of inequity particularly in devolution (Gonzalez-Block *et al.*, 1989; Elstad, 1990; Gross *et al.*, 1993; Ostrowska, 1993; Collins and Green, 1994; Bossert, 1996) and the quality and type of health care activities (Okonzi and Lubanga, 1995; Hillier and Shen, 1996; Chen *et al.*, 1997; Xiang *et al.*, 1998; Solter, 1999; Bosman, 2000; Kritski and Ruffino-Netto, 2000).

Decentralization involves a transfer of resources, authority and responsibilities from a higher/central authority to agencies in the institutional and geographical periphery.<sup>3</sup> By definition, this affects the way in which human resources are managed. At the same time, the brief discussion in this section suggests that the context, content, form of formulation/implementation together with its implications of decentralization will have an impact on HRM. This is brought out in Table 1 which relates decentralization issues to specific aspects of HRM.

## CHANGES, CHALLENGES AND OPPORTUNITIES OF HR FUNCTIONS IN DECENTRALISED SYSTEMS

Health sector decentralization involves important changes, sets different challenges and provides new opportunities for the planning, management and development of health human resources. In this section these will be documented, focussing on HR planning and staff supply, personnel administration and employee relations, performance management (see Martineau and Martínez, 1997) and managing change. Each one of these general issues is broken down into more specific themes, as indicated in Table 2. The table also illustrates each of these themes with a typical issue.

### *HR planning and staff supply*

In this section, issues relating to HR planning; staff need assessment; employment patterns; staff mix; recruitment, retaining and re-deploying existing health personnel will be analysed.

<sup>3</sup> Compare with Rondinelli and Cheema (1983).

Table 1. Decentralization, possible key issues and HR implications

Decentralization	Possible Key Issues	Possible HR Implications
Policy context	Manner in which decentralization forms part of health sector reform strategy Extent to which decentralization is part of a broader strategy of political democratization Decentralization leads to reinforcement of power of local political elites	Emphasis on privatization in health sector reform can lead to retrenchment in public service Development of community and political accountability of health sector staff Reinforcement of local patronage over staff
Policy content	Form of decentralization	In devolution, health staff become employees of local authorities, while in delegation, they can become employees of semi-autonomous hospitals/district health boards
Policy formulation and implementation	Degree of consultation in policy process	Professional associations and trade unions can represent interests of health staff
Policy impact	Lack of managerial capacity and planning capacity  Link between decentralization and inequity	Decentralized unit does not have capacity to develop effective human resource management Inequitable distribution of health staff between districts

### *HR planning and decentralization*

The issue of HR planning has not been a key item of health sector reform initiatives. Structural adjustment and new financial arrangements, rather than HR development, have been the focus of health sector reform, including decentralization, in most countries (Adams and Hirschfeld, 1998). In Colombia, '... strategic planning for human resources development was not an issue of [public service] reform. The reformers neglected the importance of the workforce for the achievement of the objectives of the reform. Health workers were not seen as instrumental for change' (Schlette, 1999, pp. 46–47). Also in Zambia, Kalumba (1997, p. 33) sees 'HR development policy lagging behind the rest of the reform programme'.

Kolehmainen-Aitken (1992), using experiences at the initial stage of decentralization in the Papua New Guinea, identified factors contributing to a deterioration in the HR field: planning tasks and responsibilities were ambiguously defined and divided between centre and periphery; information essential for HR planning was poorly managed and stored or even lost during the transition; planning capacity and expertise at peripheral level was poorly prepared for taking up the new tasks. On the other hand, improved general planning capacity and management skills at the district level were observed by Lausie and Thomason (1991) in a province in Papua New Guinea. This followed from formal training courses, management development and exposure to up-taking of planning tasks.

Information and data on the current staffing situation are important for HR planning and development in a decentralised system. The development of health planning activities can be obstructed by the lack of an established information system and the general lack of skills to make use of available information at the district level. Fragmented or eroded HR information in the context of decentralization can be found in both developing (Kolehmainen-Aitken, 1999, p. 51,) and developed countries such as UK (Buchan, 2000).

### *Staff need assessment*

Referring to a decentralised context, Kolehmainen-Aitken and Shipp (1990) have stressed the importance of understanding the current staffing situation. It helps in negotiating the budget for staffing, improving efficiency and

Table 2. Key changes, challenges and opportunities of HR function in decentralized systems

Themes	Sub-themes	Examples of typical issues
HR planning and staff supply	HRD planning and decentralization	Lack of synchronization between decentralization and HRD policies
	Staff needs assessment	Lack of staff need assessment for decentralized units to address issues on equity and work load
	Employment pattern	Shift to employing more temporary and short term or contract based staff; de-linking of health personnel from civil service; transfer of staff from Ministry of Health to local authority, contracting out supportive services
Personnel administration and employee relations	Staff mix	Changing staff mix and impact on costs and types of care
	Recruitment, retaining and re-deploying existing health personnel	Inequitable staff distribution between decentralized areas; role of central transfers in allocating staff to disadvantaged areas; the effects of nepotism on local recruitment
Performance management	Authority over staff	Mixture of local and central control over different aspects of staff management
	Staff pay/salary	Strong central control remains in some cases; limited local capacity for setting up local pay scheme; pay inequality created between decentralized areas
Managing change	Supervision	Poorly defined supervision system; reduced logistics for conducting supervision tasks; lack of technical supervision capacity
	Performance appraisal	Lack of resource at periphery affecting performance
	Education and Training	Lack of local capacity for performance appraisal; lack of clear job description; resistance to performance related pay by staff Reduced resources for staff training at local level
Managing change	Capacity strengthening	Importance of local capacity
	Power relations and conflict	Conflicts between different professional and managerial groups
	Change process	Reduced staff motivation Requires better communication and dialogue between reformer and health personnel

containing cost. For the centre it also allows it to take on a monitoring and planning role in HR development and re-deployment, and to address the issue of equity. While criticizing the traditional methods in assessing staff need and distribution as inadequate, the same authors (1990) report on the experiment of using the Indicators of Staffing Need management tool by the central Department of Health. This tool was used to assess staff requirement through ‘... identifying the major components of a health worker’s job, estimating the standard workload for that job ...’ in the context of decentralization in Papua New Guinea.

### *Employment patterns*

The granting of autonomy to decentralised units and the requirements of cost containment have led to changes in employment patterns. Of particular note is the shift to the employment of temporary or short-term and contract-based employment. In the UK, decentralised trusts as service providers have the authority to decide the number and type of staff required though within a framework of constraints (Collini, 1996). This flexibility was based on the introduction of internal market mechanisms in the 1990s which put the decentralised units in a position to compete

with one another on costs for the same amount of services with agreed quality. Methods used by the trusts to cut costs included the use of short-term staff and contracting out ancillary services.<sup>4</sup>

Contracting out supportive services such as security and janitorial services has also been reported in the Philippines (Sia *et al.*, 2000, p. 68) and is increasingly becoming common in semi-autonomous hospitals (for example in Zambia<sup>5</sup>), but less progress has been made in contracting out to the technical workers in Philippines owing to the organized staff resistance (Sia *et al.*, 2000, p. 68). There is mixed experience of the shifting of professional staff to new employment arrangements. Zambia has been working since the mid-1990s to de-link staff from the civil service, but this has been fraught with difficulties and the process is still not complete.<sup>6</sup> The Philippines adopted a 'big bang' approach to move staff employed by the Department of Health to local government. Even so, employee resistance was so strong that health workers nearly managed to regain their former employment status (Perez, 1998).

### *Staff mix*

In the UK, to achieve cost containment, attention was paid to the '... most cost-effective level of staffing and mix of different grades or occupational groups, [...] rather than focusing on pay levels in the short term' (Buchan, 2000, pp. 320–321). Although the relationship between staff mix, quality of care and cost saving has not been studied to a satisfactory level, re-profiling the workforce may become a long-term measure to reduce the cost on human resources (Buchan, 2000). One expected outcome from the decentralization of health services was to see a rationalisation of health staff mix, to improve efficiency in the use of resources, in the decentralised institutions. Okuonzi and Lubanga (1995, p. 31), in their review of the decentralization process to local government in Uganda, reported on the completion of '... district reviews to determine numbers and mix of staff...' with councils and District Service Committees operating with central guidelines. There is little evidence, however, from developing countries that the staffing mix of professionals has changed as a result of decentralization, and Nigenda and Ruiz (1999) report that in Mexico there were not even changes made to job descriptions or work schedules. The pressure for changes in staffing mix is more likely to come from other initiatives such as the introduction of an essential health package as witnessed for example in Zambia (Huddart and Mbao, 1996) and currently in Malawi (Lake, 2001), or the shortage of more skilled professionals leading to the re-skilling of less qualified professionals, for example the development of the nurse practitioners in South Africa (Geyer *et al.*, 2002). Opportunities provided by the decentralization for achieving more efficient use of staff may be frustrated by external factors. The reduction of financial support from central and local governments and the difficulties in revenue generation from preventive services has led to preventive service facilities/units losing their skilled personnel and at the same time facing the difficulty of attracting young graduates (Xiang *et al.*, 1998). Managers' control over the proportion of staff who do not directly provide health services may be overridden. Research in China showed that the township governments in some poor areas used the power devolved from the county health bureaux to recruit non-health staff for their township health centres, simply because these people were relatives and family members of local elite (Tang and Bloom, 2000).

### *Recruitment, retaining and re-deploying existing health personnel*

The degree of autonomy in recruiting and appointing health personnel by decentralised institutions varies from country to country. A lot will depend here on the type of decentralization being introduced, and the degree and form in which a public service system exists. Under deconcentration, it is most likely that the extent of HRM functions and authority transferred to the local level will be limited. Delegation to semi-autonomous hospitals and

<sup>4</sup>Flexible working arrangements were introduced in the UK, as well as in other developed countries to promote recruitment for certain type of health professionals. This is the case of nurses for which there has been a shortage of supply and mainly with an up-take by female workers, (Bach, 2000, p. 935). However, prejudice against part-time workers and lower job dissatisfaction among part time registered nurses was reported in the UK context (Lane, 1999, as quoted from Bach, 2000, p. 935)

<sup>5</sup>Personal communication between Tim Martineau and Jenny Huddart, Human Resources Consultant, Lusaka.

<sup>6</sup>Personal communication between Tim Martineau and Jenny Huddart, Human Resources Consultant, Lusaka.

devolution to local governments will most likely involve a more extensive form of transfer. Despite the implementation of decentralization policies in some countries, such as Zambia<sup>7</sup> and South Africa, recruitment may take place at the district level, but needs to be confirmed at a higher (provincial) level. In Ghana, a new institution, the Ghana Health Service (GHS), has been established and has taken on the function of delivering health services and in addition to it, plans for having '... authority to make decisions over the elimination and replacement of staff' (Bossert *et al.*, 2000, p. 15). In the Philippines and Uganda, more devolved recruitment practices are in operation (Bossert *et al.*, 2000). Bossert's (2000) analysis of HRD and health sector decentralization in Bolivia, Chile and Colombia is also revealing. Although these countries opted for devolution, their control over human resources was limited. The former recruitment role of the municipalities in Chile was limited by a national statute in 1996, while municipalities in Bolivia and Colombia had no real control over the pay and contracting of local officials classified as public servants. Municipalities in all three countries were allowed, however, to appoint, with some limitations, newly contracted health staff who were not classified as public servants. The autonomy of decentralised units to recruit new staff is often restricted by the budget ceiling on HR expenditure set up by central government. Mills *et al.* (2001) reported a strong central control over staff recruitment in autonomous hospitals in their case studies from four countries, namely Ghana, India, Sri Lanka and Zimbabwe. In Peru, Bach *et al.* (1999, p. 8) reported that strong legislative control on employment gave little room for local '... decision on recruitment and selection, working patterns, working hours and staff mix'.

Although the above cases are reported in the literature, there is nevertheless scanty reference to evaluations of decentralised recruitment. What references there are, do however, raise important issues. For example, the recent attempt in Liaoning Province in China towards setting up an open, fair and competence based recruitment procedure and measures to retain qualified staff in senior positions across government was well received by the public (Tong *et al.*, 1999). Although new staff were selected, important issues remain, such as the role of the Communist Party in the selection process, and the huge amounts of time and resources expended in the recruitment and selection process. This raises issues around the appropriateness, affordability (particularly for those less economically advanced district/areas) and feasibility of the practices.

Criticisms may be found in the literature for both centralised and decentralised recruitment. It is in this area that decentralization and the general objective of most reform programmes of improved equity are at odds—in all types of resource allocation, not just human resources. A centralised allocation system can move resources from areas of relative surplus to relative shortage, and being concerned with the overall performance of the health system, has the incentive to do so, while incentives for managers of decentralised units are to concentrate on the needs of their own patch—at times at the expense of others. Therefore, decentralization and particularly devolution can create inequality, lack of co-ordination and favouritism (as will be discussed below) in the process of recruiting staff. This does, however, raise important questions as to how recruitment and selection should be monitored and implemented in less attractive areas. Unequal distribution of health personnel between rural and urban, and between economically better off and poor areas is a problem felt by many countries. In China, despite the overall increase in the production of western medicine doctors, the phenomenon of unbalanced distribution of trained doctors throughout the country persisted and was exacerbated by economic reform (Gong *et al.*, 1997). As a result, in 1993 '... wealthy counties have almost twice the number of doctors and assistant doctors per thousand than the poor ones' (Gong *et al.*, 1997). Although the causes of this problem are multiple, decentralization can aggravate the situation. This is partially because the decentralised level of rich areas used every means available to attract medical specialists to work in their areas, while the decentralised level of poor areas didn't have any effective means to retain their doctors. This follows from the relaxation of labour market restrictions under the overall decentralization of public administration triggered by the economic reform in China. The weakening of political influence on the operation of public sectors after economic reform was also responsible.

Campos-Outcalt *et al.* (1995) reported that, in Papua New Guinea after decentralization, the problem of transferring staff from one health unit to another between different districts resulted in the co-existence of overstaffing and understaffing in different districts. Unbalanced allocation of health staff can also result from a lack of

<sup>7</sup>Personal communication between Tim Martineau and Jenny Huddart, Human Resources Consultant, Lusaka.

co-ordination and understanding between health facilities and the body/agency responsible for allocating the staff, as Kolehmainen-Aitken (1999, p. 51) reported in Tanzania and Papua New Guinea. Similar problems were also found in some rural counties in China after the decentralization of township level health services (Tang and Bloom, 2000).

Lack of government co-ordination and overall planning for staffing level and recruitment policy leaves the distribution of qualified health personnel to the market economy. The creation or exacerbation of pay differences together with other factors, such as promotion prospects and living conditions in different areas after decentralization, had an impact on the flow of qualified health personnel from poor, rural areas to richer areas, for example in Uganda (Bossert *et al.*, 2000) and China (Gong *et al.*, 1997, p. 324).

Recognizing the need for policy intervention at national level to deal with inequitable staffing, initiatives from the centre may run parallel with decentralised management. A special national programme was introduced to staff unfilled physician posts in remote areas in the Philippines, whilst local government units had to deal with staffing shortages of other categories of staff on their own. In Zambia, a Rural Area Allowances was provided by the centre to address the distribution problem, though it was said that '... the allowance is too little to have the desired effect' (Choongo *et al.*, 1995, p. 22).

Poor quality of staff is also related to nepotism in devolved districts and governments. Tribalism and clientelism contributed to the decline of staff quality in Uganda (Bossert *et al.*, 2000). In Papua New Guinea, the selection of staff under decentralization favoured those candidates who were from the same geographical and political background (Kolehmainen-Aitken, 1991). In a research conducted in rural areas of China, Tang and Bloom (2000, p. 195) reported that '... devolution had contributed to the increased employment of unskilled personnel'. As they hinted, some of these unskilled personnel were relatives and friends of local government officials.

### *Personnel administration and employee relations*

#### *Authority over staff*

Decentralization can involve a transfer of some staff previously employed by central government to local authorities, as has been the case in Uganda (Corkery, 2000) and as will take place in South Africa.<sup>8</sup> It can be argued that to provide responsive health services to the local population, the decentralised district needs to have the authority to decide how many and what type of health staff are required. This was certainly the expectation of health managers in a study conducted in a province in Papua New Guinea (Campos-Outcalt, 1995). Larbi (1997) has pointed out that when the decentralised authority or unit does not possess the corresponding authority over staff, there is no incentive to improve efficiency. Confusion might occur when the control of staff has not been completely transferred from the centre to the periphery. This can be due to the reluctance of the centre to let go of control. It might also be the case that opposition to the transfer can arise when there is an actual or perceived decline in salaries and value of benefits (Conyers *et al.*, 1995). Bossert (2000) also points to how health workers in the municipalities in Colombia can be either nationally determined public servants or locally contracted staff. Although the latter are a relatively small percentage of the total, their numbers are growing.

#### *Staff pay/salary*

Central government determination of salary scales and grading are typically criticised for preventing decentralised units from improving efficiency and performance. Local determination of staff pay/salaries aims to increase the local responsibilities for resource allocation and to allow for the link of pay to the staff performance to be made, as is the case in Britain (Buchan, 2000). In reality, however, complete autonomy of local determination is rare and staff pay is often a combination of both local and central influence. Among those countries where decentralization policy has been implemented but national salary scales for health personnel co-existed, four major factors contributed to this situation:

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<sup>8</sup>Personal communication between Shenglan Tang and Dr T Mjekevu, Acting Head of Eastern Cape Provincial Health Department, South Africa.

- central government was unwilling to transfer responsibilities on salaries and benefits to the decentralised authorities in Ghana (Larbi, 1997);
- the authority of decentralised authority and health units over local pay schemes was not fully exercised, owing to their insufficient capability ‘...to manage the complexities of local pay determination...’ and the limited funds that are necessary for setting up local pay schemes, as found in Britain (Buchan, 2000, p. 323);
- local autonomy was restricted by the rules and regulations set up by central government. Such rules and regulations include overall budget ceiling for human resource cost as found in Ghana and Philippines; or centrally determined pay limit, as found in Britain (Buchan, 2000); and overall central control on staff pay, as found in autonomous hospitals in Ghana, India, Sri Lanka and Zimbabwe (Mills *et al.*, 2001);
- the decentralization of local pay and benefit policy reverted to a nationally unified salary scale and benefit following the opposition from health care workers, as found in the Philippines (Bossert *et al.*, 2000).

Salaries and pay for health personnel in decentralised systems have been a controversial issue. Decentralization has resulted in the creation of differential pay/salaries in different districts (Kolehmainen-Aitken, 1991), and between different occupations (Bach, 2000). However, it has been argued that unified benefits are important to maintain ‘equity of incentives’ to those who perform the same function and to ‘avoid demoralisation’ among health workers in different devolved districts (Sia *et al.*, 2000, p. 69). A particular concern here is that this may lead to inequity of service provision. Less economically advanced districts are more likely to be at risk of losing qualified staff and facing difficulties in recruiting new staff (as pointed out earlier). Consequently, rather than reducing, decentralization can deepen the degree of inequity, as discussed earlier.

Pay/salary inequality can be created through three paths:

- Pay arrangements vary according to different forms of decentralization implemented in the different health facilities in the health care system, and between decentralised and centrally financed health units. For example, in Uganda, the staff working at delegated hospitals receive salaries that are centrally distributed, while health personnel in primary health care in devolved districts may not receive their salary on time or to the full amount (Bossert *et al.*, 2000; Kolehmainen-Aitken, 1999). Differentiated pay was found between health personnel working in state-owned and devolved health centres in rural areas of China (Tang *et al.*, 1994). A decrease of salaries for devolved health care workers in comparison to that of central employees was also reported in the Philippines in the early stage of decentralization (Bossert *et al.*, 2000). However, Bachmann and Makan (1997) found that nurses tended to receive higher wages working for local authorities as opposed to those working for the provincial government in South Africa.
- In spite of nationally unified salary scales, devolved districts can set up their own policy on staff benefits and allowances, as in Uganda (Okuonzi and Lubanga, 1995; Bossert *et al.*, 2000). Centrally determined basic pay with local supplementation can also be found in developed countries, such as in Denmark (Bach, 2000). Consequently, the gross income of health personnel may differ in different districts.
- Significant reductions in staff salary grants from central government can leave the devolved health units struggling to make ends meet. A study in a rural hospital in China found that the percentage of funds from central government for staff salary dropped from 76% in 1990 to 32% in 1994, and total expenditure dropped from 44% in 1981 to 11% in 1994 (Chen *et al.*, 1997). The cuts in central government funding meant that the decentralised unit had to generate finance for paying its employees and buying medical equipment (Bloom and Tang, 1999). Some health units managed to maintain the salary level, but many could not, particularly the health facilities in poor areas (Chen *et al.*, 1997). This means that the decentralised unit has to generate revenue for salaries, creating a perverse incentive for health staff to prescribe expensive drugs and misuse expensive medical investigation with modern technologies (Bloom and Tang, 1999).

To the above, we might also refer to the findings presented by Bossert (2000, p. 37) following research into health sector decentralization in Chile. This suggested that while better off municipalities contracted more doctors than poorer ones, salary levels were not higher. Perhaps contrary to expectations, salary levels were noted to be

higher in rural areas than in urban areas, ‘... suggesting that the decentralization process had forced the rural areas to give higher salaries in order to retain and attract doctors’.

In addressing the issue of HRM, decentralization and equity, a certain form of intervention mechanism is needed to achieve a balance between, on the one hand, the autonomy of decentralised units and, on the other, the need to protect the performance conditions for the health staff working in less desirable areas. In China for example, Gu *et al.* (1995) reported some experiments in rural areas to decrease the dependence on user fees for staff's salary, for example, setting up a salary scheme for village health workers, contracting for a package of services provision, and monitoring the performance of health services providers.

Although, as stated earlier, budgetary terms and central pay scales are the main obstacles to local autonomy, decentralised units can gain their autonomy through creating new posts and post re-profiling in delivering health care. In the UK, a new post of Health Care Assistant was set up in the NHS in 1990, whose responsibilities and pay were decided by decentralised authority. In some cases, a lower starting salary is set in comparison with the equivalent national scale (IDS, 1999, as quoted from Bach, 2000, p. 936).

### *Performance management*

Performance management of staff is much more likely to take place if external management of the performance of an organisation or unit is being applied (Martinez and Martineau, 2001). At the organisational level, it is often introduced with decentralization, for example, in the Philippines, the Department of Health introduced the Comprehensive Health Care Agreement (see Kohlemainen-Aitken, 1998). Service performance—and in turn the performance of the individual—can be affected by lack of adequate resources allocated in a decentralised health system from the centre—a point raised by Kohlemainen-Aitken (1999), drawing on experiences in ten countries.

Supervision, performance appraisal and staff training occur in the literature as performance management issues linked to the process of decentralization.

### *Supervision*

Critical issues can be found in the process of supervision in decentralised systems. Saide and Stewart (2001) identified a number of issues related to poor supervision in a province in Mozambique, such as lack of feedback, poor staff record on training and supervision, and reduced supervision visits. A study by Campos-Outcalt *et al.* (1995) in a province in Papua New Guinea raised issues related to supervision of health units at a lower level:

- There was confusion on who should be responsible for monitoring the quality of the services and assessing health needs;
- although supervision should be from a level that is close to the supervised in the managerial line, the staff in health centres at sub-district level preferred supervision and professional support from the provincial level, since they believed local government officials at the district level did not possess the required health expertise;
- supervision and technical support provided from a higher level to a lower level deteriorated after decentralization, owing to poor management and shortage of transport.

### *Performance appraisal*

Turning to the performance management for individual staff, there are a number of important issues around the use of job descriptions and performance appraisal procedures and systems.

- In China, Tong *et al.* (1999) reported a number of changes occurring in specific provincial, local and city governments, and not necessarily confined to the health sector. For example since decentralization, performance appraisal has been used as a means to identify poor performers and linked to dismissals practised by local government in China. Through performance assessment, staff who did not score a satisfactory performance level were given a training opportunity to improve competence. On the other hand, the same authors note the lack of familiarity among civil servants in China to the system of performance appraisal.
- The use of financial bonuses linked to performance appraisal is also an important but controversial issue in both developed and developing countries. Case studies in Guatemala (where the management decentralization was

from the international headquarters to the country office of the non-government organisation) and in the UK's National Health Service reported that financial bonuses linked to performance were introduced following decentralization. However, following the experience of using them, managers reduced the level of the bonus as the mechanism was proving too divisive.<sup>9</sup> Whilst these examples could be seen as a success in decentralised performance management (and managers' ability to learn from experience), objection to the proposal of the staff appraisal system and its link to remuneration and promotion was reported by Mutizwa-Mangiza (1998, p. 13) in Zimbabwe in the context of health sector reform. This opposition was driven by the poor supervision, poor working environment, potential nepotism, and lack of standard procedure for performance assessment.

#### *Education and training*

In-service training for health professionals and occupational groups is important in keeping staff updated with new knowledge and technology, and in dealing with health problems and needs of the local population. Decentralization can have a problematic impact on training health professionals. Where in-service training was previously funded by central government, decentralization raised difficulties, particularly as to how devolved authorities are to raise the *funds* needed to train its staff (Solter, 1999; WHO, 1988). Lack of crucial information and data on personnel made it difficult to identify the needs for technical, as well as administrative training which are essential for delivering the new services, as found in a province of South Africa (Ruck, 1999).

#### *Managing change*

The way in which changes, including those which affect human resources and their management, are introduced in the processes of decentralization is an important variable. Three specific issues may be mentioned: capacity strengthening, power relations, and the change process.

#### *HR management capacity in decentralised systems*

Capacity strengthening of decentralised units is an important topic, particularly in relation to the structures, skills, systems and values of management and planning. HR concerns are important issues in decentralised health management strengthening (Collins, 1994). As with other areas of management, the extent of the capacity building required (both in volume and the starting level of the HR skills base) may be underestimated (Martineau and Buchan, 2001).

#### *Power relations and conflict*

Decentralization is not politically neutral, but affects the relationships of power between work groups in health care organisations. For example, devolution introduces political accountability and marks out the role of locally elected politicians in local councils. The executive head of district health services is placed under the authority of the local council. Mutizwa-Mangiza (1998, p. 11), however, views the devolution to the rural district councils in Zimbabwe as strengthening the authority of the District Medical Officer (DMO). This position is held by a doctor: 'Other health workers are already demoralized by the fact that doctors are always in charge of all health institutions above the health centre, regardless of how much training and experience other health professionals have. Nurses regard themselves as one of the cadres whose basic training programme fully incorporates a management dimension and yet are never given full responsibility.' Moreover, nurses and senior/middle level managers are far from supporters of the decentralization policy in Zimbabwe.

In contrast, the delegation of semi-autonomy to hospitals represents a shift in authority towards the new management board of the hospital. A related issue is the extent to which management authority is subsequently decentralised within a hospital and its impact on power relations. Thus Boyce (1993, p. 208) has pointed to '... divisionalisation, decentralization, unit management, clinical directorates, functional units, service development groups, program management, clinical units, product-line management, patient focused units' in the USA and UK. A theme which runs through these cases is the role of the medical profession in hospital decision-making.

<sup>9</sup>These case studies are available at: <http://www.liv.ac.uk/lstm/hsrpn10.html>

A specific aspect of Boyce's work is the impact of this shift on allied health professions in Australia, Canada, Sweden, UK and USA. Pallesen and Peddersen (1993) have also analysed the process of decentralizing management responsibility in hospitals in Denmark. Meanwhile, when local determination on pay is possible, trade unions have taken a strong role in pay negotiation in some countries, as in Denmark where pay negotiation for nurses was conducted by The Danish Nurses' Association (Bach, 2000).

### *Change process*

A review of selected cases of health sector reform and decentralization raises concern over the actual change process. Decentralization is part of a package of reforms that have a complex impact on the motivation of health workers. This has raised important issues around the anxieties felt by health staff about the reform process and its potential impact on their job security and benefit, the lack of planning and the weak consultation involved (Mutizwa-Mangiza, 1998; Bennett and Franco, 1999). Resistance to and protest against health sector reform from health personnel has been reported in a number of countries. Strikes have been launched by health personnel in, for example, the Philippines and Colombia (Schlette, 1999) due to lack of involvement in the reform planning and implementation process and anticipated deterioration of working conditions. Resistance to devolving salary scales and pay is also an issue for health personnel, as noted by Kolehmainen-Aitken, (1999) in the Philippines. The capacity (systems and skills) for dialogue between reformers needs to be developed as part of the change process (Martineau and Buchan, 2001).

## CONCLUDING REMARKS

The analysis presented so far leads to four concluding remarks.

Firstly, the contemporary interest in health sector decentralization in developing countries has not been sufficiently extended to the development of decentralised systems of human resources management, especially in the onset and process of decentralization. There is clearly a need for HR issues to be placed firmly on the policy agenda of decentralization in order to tackle the challenges and to exploit the opportunities presented by decentralization.

Secondly, to assist the process, this article has identified in Tables 1 and 2 key areas in which decentralization is having an important impact on HRM. These will help with the development of the particular HRM agenda for a country planning to decentralize health service provision.

Thirdly, underlying the problematic aspects of decentralization and human resources has been the lack of constructive policy dialogue between those responsible for the formulation and implementation of health sector reforms and stakeholders in the field of human resources. The analysis presented in this article provides a framework for policy dialogue between these policy actors. This could consist of two stages. The key aspects of decentralization can be identified under the decentralization categories set out in the left hand column of Table 1: policy context, policy content, policy formulation and implementation, and policy impact. It involves coming at the problem from the general process of health sector decentralization and allows policy-makers to identify key issues in the process of decentralization and draw out possible HR implications. The table is far from being comprehensive, but is illustrative of the types of issues that may emerge in a country context. The second phase requires policy-makers to identify the key themes in HR to draw out the changes, challenges and opportunities facing policy-makers. Table 2 shows the key themes and sub-themes discussed in this article, although different country contexts will produce different themes and sub-themes.

Lastly, the frameworks presented in Tables 1 and 2 provide a basis for developing policy analysis and applied research in the broad area of decentralization and human resources. Once again this will be country specific and should lead to developments in the framework presented here. The review carried out in this article shows the complex nature of change and how decentralization can have a wide range of different implications for HRM. If anything, we have underlined the importance of strengthening policy analysis in government as a basis for conducting health systems change. There is clearly a useful body of international literature that leads us to call for caution in the process of health systems change. This article also suggests that the research needs to adopt a multi-disciplinary character, given the close interweaving of managerial, social, economic, and political issues together

with those concerned with the technical aspects of health interventions. We have attempted to answer the question: what is happening to health HRM under decentralization? This has been answered using data collected after the decentralization process has taken place. For policy-makers responsible for introducing the process of decentralization, however, these retrospective findings have come too late. What is needed is to link such research to a monitoring process which identifies the impact of decentralization on HRM on an ongoing basis. Action may therefore be taken if the monitoring process identifies that, for example, the requisite authority to decide on staffing mix has not been decentralised as intended; or if decentralised recruitment is leading to an inequitable distribution of staff. Indicators for the monitoring process will depend on the situation in each country, but, again, Tables 1 and 2 provide a useful starting point for developing the indicators.

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