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2012-01-10
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AN ANALYSIS OF THE HUMAN RESOURCE MANAGEMENT FUNCTION DURING THE DECENTRALISATION OF HOSPITAL MANAGEMENT: CASE OF NORTH WEST PROVINCE

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, in partial fulfilment of the requirements for the degree of Master of Public Health in the field of Hospital Management

Johannesburg, 2011

DECLARATION

"I, Mogale Philemon Mothoagae declare that this research report is my work. It is being submitted for the degree of Master of Public Health in the field of Hospital Management in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any another University".

……

22 day of May 2011

DEDICATION

This research is dedicated to my mother, Binang Magdeline Mothoagae, who raised me under very difficult circumstances and never gave up. She continued to be a pillar of strength, source of motivation and inspiration throughout this study.

ABSTRACT

Background: The National Department of Health adopted decentralisation of hospital management as a key policy in pursuit of a more efficient, effective, responsive and accountable public sector hospital system. The proposed decentralisation of hospital management represented a fundamental policy shift in the decision making processes between National, Provincial health departments and Hospitals. Provincial health departments were to "delegate significant decision making powers to hospital managers, including the authority to make decisions relating to personnel, procurement, and financial management"

Objective: To gain in-depth understanding of the decentralisation of hospital management processes between 1996 and 2007 as it relates to the Human Resource Management function in public hospitals.

Methodology: The study design was a descriptive qualitative comparative case study design.

Results: Decentralisation was promoted as a policy reform to improve efficiency, equity and effectiveness of hospitals in South Africa. There was no formal policy from the National Department of Health guiding the implementation of decentralisation of hospital management.

There was a shift of power over the control of HRM function between 1996 and 2007. Regional hospital gained more space and had more wide range of choices allowed in almost all HRM activities. District Hospital has gained some space and now has moderate choice allowed.

The experiences and understanding of health managers vary on what happened during the policy process.

Conclusion: The study found conclusive evidence that there are changes to HRM function during the ongoing debate on decentralisation of hospital management. More HRM functions were delegated to Hospitals.

ACKNOWLEDGEMENTS

Sincere thanks are extended to all my colleagues in the National Department of Health, and North West Province –Department of Health who contributed to the successful completion of this study. The assistance of the following deserves a special acknowledgement:

- DR D. Blaauw for your excellent guidance, assistance, and patience;
- Dr D. Basu –for your dedication and commitment to the development of hospital management as a profession;
- The Head of Department of Health-North West Province for allowing me to conduct the investigation;
- All those who spared their valuable time for interviews;
- My beautiful wife-Mathebe and two daughters-Malerato and Binang Rethabile who encouraged and supported me all the way;
- My parents, brothers and sisters, friends and colleagues for your continuous encouragement;
- Above all, to God Almighty for giving me the strength and guidance to complete this study.

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GLOSSARY OF TERMS

The following key terms will be used from time to time in the study;

Decentralisation: The transfer of formal responsibility and power to make decisions regarding the management, production, distribution, and /or financing of health services, usually from a smaller to a larger geographically or organisationally separate actors. Transfer can be within political levels (devolution), within administrative levels (deconcentration), from political to administrative level (bureaucratisation) or to relatively independent institutional levels (delegation/ automisation within the public sector) and transfer to private sector (privatization) (Saltman, 2007)

Delegation: Management responsibility is transferred to a semi autonomous entity such as a Health Board. The aim is to free national government from day-to-day management functions. The entity remains accountable to national government (Rondinelli, et al, 1983).

HRM function in this study is limited to the practice of the following four functions under observation which are:

- Determination of staff establishments.
- Recruitment, selection and appointment,
- Performance management and promotion,
- Discipline and grievance procedures

LIST OF ABBREVIATIONS

ANC	African National Congress
CEO	Chief Executive Officer
DHS	District Health System
DPSA	Department of Public Service and Administration
HRM	Human Resource Management
HSP	Hospital Strategy Project
HSR	Health Sector Reforms
NDoH	National Department of Health
NHS	National Health System
PFMA	Public Finance Management Act
PHC	Primary Health Care
PMA's	Performance Management Agreements
PSR	Public Sector Reforms
RDP	Reconstruction and Development Programme
UNICEF	United Nations Children Fund
WHO	World Health Organization
WPTHSD	White Paper on Transformation of Health Service Delivery
WPHRMP	White Paper on Human Resource Management in the Public

CHAPTER ONE
INTRODUCTION

The purpose of this study was to gain an in-depth understanding of the process of decentralisation of hospital management policy as it relates to the Human Resources Management function. This introductory chapter will cover the background to the study, statement of the problem, its aims and objectives and an outline of subsequent chapters.

1.1 INTRODUCTION

In South Africa the post-1994 era has been characterised by new legislative and policy reforms. The new democratic order and the change of the apartheid regime provided an opportunity for the introduction of Public Sector Reforms (PSR) in the Public Service and Health Sector Reforms (HSR) in the National Health System (NHS). The HSR in South Africa is a protracted process that already set before the change of government, gained momentum since 1994 and is still unfolding (Van Rensburg, 2004). As part of this wider reform the National Department of Health (NDoH) adopted decentralisation of hospital management as a key policy in pursuit of a more efficient, effective, responsive and accountable public sector hospital system (NDoH 1997; ANC 1994b. This was a key policy aimed at defining the functions, roles and responsibilities of the new cadre of hospital managers that were now taking over from the old hospital superintendents and hospital secretaries.

The World Health Organization (WHO) and United Nations Children Fund (UNICEF) consultants assisted the African National Congress (ANC) to develop a National Health Plan for South Africa which was later adopted as a key policy document of the ANC in 1994 (ANC 1994b). This plan was a detailed blueprint of how the ANC would develop and implement the National Health System if it became the ruling party. With regard to how the NHS system would be managed

the plan indicated that “the authority over, responsibility for and control over funds will be decentralised to the lowest level possible that is compatible with national planning and the maintenance of good quality care” (ANC 1994b). In 1994 a new democratic government was inaugurated and was led by the ANC. It is therefore not surprising that most of the ANC-adopted policies formed the basis of the new public sector reforms, and in the health sector the ANC National Health plan for South Africa became a cornerstone on which the Health Sector Reforms (HSR) are based.

In 1997, the NDoH produced a White Paper on Transformation of Health Service Delivery (WPTHSD) (NDoH 1997) which raised specific concerns relating to the management of public hospitals. These concerns related to the inefficient management of resources, inequitable and inaccessible services and poor management structures and systems. In addressing these concerns the WPTHSD proposed amongst others the following principles:

- The role of hospitals will be redefined to be consistent with the primary health care approach.
- Plans will be developed to rationalise hospital services, facilities, staffing and capital investment.
- Decentralised hospital management will be introduced to promote efficiency and cost effectiveness.
- Hospital boards will be established to increase local accountability and power.

The proposed decentralisation of hospital management represented a fundamental policy shift in the decision making processes among National, Provincial health departments and Hospitals. Provincial health departments were to “*delegate significant decision making powers to hospital managers, including the authority to make decisions relating to personnel, procurement, and financial management*” (NDoH, 1997). With regard to personnel administration, the WPTHSD proposed a fundamental shift from personnel administration to Human

Resource Management, and it in indicated that, "*authority for almost all line personnel management functions will be delegated to institutional level, hospital managers will decide on most appointments, performance appraisals, and promotions and will be responsible for disciplinary and grievance procedures*" (NDoH 1997).

Very little is known on what the experience of the NDoH on the decentralisation of hospital management is. This study aims to gain in-depth understanding of the decentralisation of hospital management processes between 1996 and 2007 as it relates to the Human Resource Management function in public hospitals.

1.2 STATEMENT OF THE PROBLEM

Developing countries are faced with serious challenges related to the management of health human resources and this includes poor staff motivation, lack of clear incentives, inequitable distribution of staff, instability in staffing, recruitment of poorly trained staff, and non-existent supervision (Wang, Collins, Tang, and Martineau 2002). Hospital managers in South African public hospitals are faced with similar challenges in managing their health human resources. The National Department of Health introduced the decentralisation of hospital management as part of the strategies to improve this situation .The overall aim of this strategy was to delegate authority and decision making powers from provincial departments to the new cadre of hospital managers (HSP, 1996).

Ten years after the introduction of this policy, the State President of South Africa in his State of the Nation Address in 2006 stated that "to improve service delivery in our hospitals, by September this year we will ensure that hospital managers are delegated authority and held accountable for the functioning of hospitals" (State of the Nation Address 2006). It is therefore important to understand the process of the decentralisation and the authority that is delegated to hospital managers in managing their hospitals in view of the Presidential call.

Decentralisation is sometimes seen as a single process of granting authority from the central national governments to other institutions of the periphery of the national system (Bossert and Beavais 2002). HSR reforms are politically problematic and the most powerful health sector actors are often satisfied with the status quo (Glassman, Reich, Laserson and Rojas, 1999, Collins, Omar, and Tarin, 2002). The problems of decentralisation range from a lack of robust system of policy formulation and implementation, political and bureaucratic resistance, and lack of managerial capacity at the district level (Collins et al 2002). It is therefore important, firstly, to understand the decentralisation of hospital management policy process and, secondly, the level of authority and decision making powers that are delegated to hospital managers as a result of the decentralisation. Due to time constraints and resource availability it was impossible to investigate all the different levels of authority and decision making powers of hospital managers in all line functions such as Human Resource Management, Financial Management, Procurement and etc. The study therefore focused on Human Resource Management function as is seen as the most critical function in hospital management and there are indications from other scholars that are easily neglected during reforms. The study question was therefore, what is happening to the HRM function in hospitals during the process of decentralisation?

1.3 JUSTIFICATION OF THE STUDY

This study aims to provide pivotal primary information on decentralisation and human resources management in South Africa and will also draw attention of policy makers to the HRM challenges, problems and advances in public sector hospitals. It is now over ten years since the decentralisation of hospital management was put on the policy agenda, and it is not clear whether the National Department of Health is achieving its intention of decentralising authority and decision making powers to hospital managers.

1.4 RESEARCH QUESTION

How is the process of decentralisation of hospital management policy related to the Human Resources Management function?

1.5 STUDY OBJECTIVES

1.5.1 BROAD OBJECTIVE

The overall aim of this study was to gain an in-depth understanding of the process of decentralisation of hospital management policy as it relates to the Human Resources Management function.

1.5.2 SPECIFIC RESEARCH OBJECTIVES

In order to achieve the overall aim of the study the following were specific objectives of this study.

I. To review existing legislation and policies on decentralisation of hospital management functions between 1994 and 2007
II. To document the changes in the formal Human Resource Management delegations of hospital managers in the North West Province between1996 and 2007.
III. To describe national, provincial and facility health manager's experiences of the implementation of the policy to decentralise Human Resource Management functions to hospital managers between 1996 and 2007.

1.6 PLAN OF THE REPORT

This study report was planned as follows:

Chapter 2: Literature Review: The aim of this chapter is to discuss, explain and define concepts that are related to this study and review the experience of other scholars on similar studies.

Chapter 3 Research Methodology This chapter describes the research methods, study design, the case study, data collection, management and analysis methods and techniques used in this study. It also deals with ethical considerations relating to this study.

Chapter 4: Results: This chapter presents the findings of the study.

Chapter 5: Discussion: This chapter analyses and discusses the results of the study.

Chapter 6: Conclusions and Recommendations: This is the final chapter of the study and it presents implications, recommendations and conclusions relating to the aims of the study.

CHAPTER TWO
LITERATURE REVIEW

This chapter covers the review of literature linked to human resources management with particular reference to decentralization of hospital management in South Africa and elsewhere.

2.1 INTRODUCTION

Hospitals are the largest, most visible, and costly operational units of a country's health system and account for a large portion of the health sector's financial, human and capital resources (Newbrander, 2006). Human resource costs in many health systems are estimated to be between 60 and 80% (Buchan, 2000). Given the large amounts that are spent in hospitals and Health Human Resources, health systems must pay a special attention to effective and efficient management of the human resources management (HRM) function in hospitals. Appropriate human resource management policies and practices can improve human resource outcomes and thus the effectiveness of the workforce, which in turn will contribute to improved organisational performance and health outcomes (Liu et al, 2006)

In 1995, the Ministry of Health commissioned a study on the serious problems of inefficiencies and inequities of the public hospitals system led by Hospital Strategy Project Consortium (Monitor Company, Health Partners International, Centre for Health Policy and National Labour and Economic Development Institute) This project came to be well known as the Hospital Strategy Project (HSP), and it ran between May, 1995 and June, 1996. Amongst others, the findings of the HSP (1996) included the following:

"Management of the hospital system is characterised by extreme over-centralisation, with hospital managers having almost no authority to manage their own hospitals. The effect of this is demoralisation of hospital managers and severe under management of hospitals, most of which are simply administered by provincial head offices rather than actively managed. Over-centralisation has also undermined the legitimacy and functioning of the hospital boards, diminishing public accountability and trust in the hospital system" (HSP, 1996)

Over-centralisation was blamed for inappropriate decision making, poor service delivery, poor management, inefficiencies and inequities in hospital sector. The HSP proposed that there was a need for national consensus on an approach to deal with all the critical problems identified. This had to be a comprehensive, strategic vision of a new approach to hospital management, rather than ad-hoc attempt to deal with crises as they arose (HSP 1996). There are conflicting views on the official status of the HSP report and on whether it was adopted by the National Department of Health. Sometimes some managers refer to this report as "policy on the decentralisation of hospital management". Even if it so, the HSP report served as a strong base and influence for formal discussions and approach on the decentralisation of hospital management in the Department. Of such discussions a policy position on the decentralisation of hospital management was adopted. The critical elements of this policy amongst others included delegation of substantial powers over personnel, finances, procurement and other critical management function to hospital managers; and a shift in the role of the provincial health administration from its current executive/administrative line managerial role to one which its main functions are to set guidelines and broad policy as well as to provide critical support for hospital management.

The finding of a study undertaken by Chabikuli, Blaauw, Gilson and Schneider, (2005) indicates that:

"district hospitals management teams have not been adequately prepared and supported in the implementation of reforms in the health sector. HR functions are still not decentralised and that there is anecdotal evidence that health care workers recruitment is hampered by a variety of organisational factors including the highly centralised recruitment process. Health district management structures are not yet able to create and advertise posts. The process of recruitment and appointment can take up to six months" (Chabikuli et al, 2005).

Appropriate human resources management policies and practices can improve human resource outcomes, which in turn will contribute to improved organisational performance. In large bureaucratic organisations HRM is often unresponsive to the need in terms of timelines and appropriateness of decisions to local context (Liu, Martineau, Chen, Zhan and Tang, 2006).Several studies on Decentralisation and Human Resource Management conclude that more than often human resource issues are forgotten or neglected during the HSR (Wang et al 2002).

The main aim of this Chapter is to discuss the three main bodies of literature relevant to this research, which are health sector reforms, decentralisation, and human resources management. It further discusses the analytical frame-works that are used in presenting the results of the study.

2.2 HEALTH SECTOR REFORMS

Health sector reform is defined as the sustained purposeful change to improve the efficiency, equity, and effectiveness of the health sector (Lethbridge, 2004). Some studies suggest that many reforms focus on a single macroeconomic objective, that of reducing the government's operating costs and cutting budget deficits, without paying much attention to their declared objectives of improving efficiency, equity, accessibility, quality of health service delivery, responsiveness to local needs, and the health of a country's population. (Rigoli and Dussault,

2003; Hutchinson and LaFond, 2004). Understanding the process of reform is important for understanding how changes have taken place and also to identify critical factors for successful policy implementation (Lethbridge, 2004).

2.3 DECENTRALISATION

The demands for decentralisation is strong with governments perceiving it as a way of ensuring more equitable and sustainable health care based on efficiency considerations (Saide and Stewart, 2001)

2.3.1 AIMS AND OBJECTIVES OF DECENTRALISATION

Decentralisation comes as part of a package of broader public sector and health sector reforms (Wang et al 2002). The process of decentralisation of decision making has generally been perceived with conventional theoretical framework as allowing action to be taken more quickly to solve problems, allowing more people to provide input into decisions and as reducing the sense of alienation typically felt by employee who have little say in the decision that affect their working lives (Saide and Stewart, 2001).

In many studies the following broad aims and objectives are stated for opting for decentralisation (Bossert et al, 2002; Saltman et al, 2007):

- Improved “allocative” efficiency by allowing the mix of services and expectations to be shaped by local user preference
- Improved “technical” efficiency through greater cost consciousness at local level.
- Service delivery innovation through experimentation and adaptation to local conditions.
- Improved quality, transparency, accountability and legitimacy owing to user oversight, and participation in decision making

2.3.2 TYPOLOGY OF DECENTRALISATION IN THE HEALTH SYSTEMS

Table 2.1 represents a typology of decentralisation illustrating the dynamic /process and static/structural nature of decentralisation. The vertical axis represents structural constructions of political/ administrative levels ranging from central to local levels and the horizontal axis represents the different institutional spheres.

Table 2.1 Structural and process dimensions of decentralisation

Decision making and responsibilities in health care functions				
	Political	**Administrative**	**Organisational;**	**Private**
		Bureaucratisation	*Delegation/ automisation*	*Privatisation*
Central/State	*Devolution*	*Deconcentration*	*Public Management Delegation*	*Management delegation*
Provincial/Regional				
Districts/Local/				
Group/individual				

Note: Structural dimensions in bold. Process dimensions in italics

Source: Saltman et al 2007

The following decentralisation types may be indentified by combining the two structural (vertical and horizontal) dimensions.

Devolution means decentralisation to lower level political authorities such as regions or municipalities.

Deconcentration refers to transfer of responsibility and power from a small number to a larger number of administrative actors within formal administrative structure or from central management to other managerial groups such as health professionals.

Bureaucratization refers to the transfer of responsibility and power from political levels to administrative levels.

Delegation and automisation refer to the transfer of selected functions to more or less autonomous public organisation management (Saltman et al 2007).

2.3.3 FACTORS FACILITATING DECENTRALISATION

Table 2.2 represents factors that facilitate the successful implementation of decentralisation.

Table 2.2 Factors facilitating decentralisation

Elements	Mechanisms
Consensus building	Highlights the importance of surveying the terrain and identifying actors in terms of the opponents and proponents of the reform.
Regulatory framework and	Enabling legislation is necessary but not sufficient for implementation of decentralisation.
Administration guidelines	Clear administrative guidelines defining roles and responsibilities are useful.
Policy champions	Establishing implementation units to drive the HSR process enables focus and dedicated attention to implementation.
Phasing and piloting	A gradual and deliberately well-planned approach, with incremental scaling-up as capacity develops.
Restructuring	This is often an overlooked process, but it is important to restructure and re-define roles for the levels to avoid confusion about their respective new roles.
Capacity-building	Must be appropriate to context and equip officials at all levels with wide-ranging skills for their new roles. Lack of management capacity undermines implementation.

Source: Gilson & Travis (1997)

2.3.4 CHALLENGES WITH DECENTRALISATION

Bossert (2002) argues that the issue is not whether or not to decentralise but rather how to design and implement better decentralisation policies to achieve

national policy objectives (Bossert, 2002). The national context and history, the bureaucratic and civil society infrastructure and capacity, the political institutions, and the broader value base in society will influence the appropriateness of structural choices in particular circumstances (Saltman, 2007). There is no consensus to decentralise as Bossert would like to argue. The following are some of the arguments that are advanced for centralization (Saltman et al, 2007):

- Decentralisation may lead to inequality in financing of health systems
- Risk of political capture by strong interest groups is greater in decentralised units.
- It may be difficult of attract qualified personnel to remote areas.
- Centralised planning creates more uniform standards.
- Decentralisation weakens coordination and creates situations of duplication of services
- Externalities from decisions of one unit may negatively affect the performance of other units, e.g. Competing for input factors such as personnel and patients.

Implementing decentralisation takes more than just rules and regulations, but new and creative management structures and processes are necessary to effectively and coordinate the activities of the government and the autonomous public hospitals, this would include new approaches for strategic planning, budgeting, financing, monitoring and evaluation and personnel management (Govindaraj & Chawla, 1996). With this intervention top management should also realise that the results will be a change in the internal organisational environment and therefore external and internal organisational arrangements to support autonomy should be designed and management training should be provided, so that a cadre of managerial staff equipped to handle all the key management functions at the hospitals is developed (Govindaraj et al, 1996). There must be a process of identifying the current administrative and financing structures and systems, and identify potential sources of tension, conflicts, capacity problems and political issues.

2.4 DECENTRALISATION OF HUMAN RESOURCE MANAGEMENT FUNCTIONS

Human Resource Management has been absent from the health sector reforms agendas. Changes are needed to strengthen institutional capacity in the health services so that HRM is adopted as an essential public health function (WHO, 2001). High performing organisations are characterised by the presence of an effective HR department (Teo and Rodwell, 2007).Decentralisation can be associated with a more adaptable, flexible, and appropriate management of health human resources, it can also generate problems when the decentralised authority lacks the required capacity and authority to take on these new management responsibilities (Wang et al, 2002). In case of HR inappropriate redistribution policies within the health sector will have a direct impact on the delivery of health care. Adequate management of human resources is therefore vital to ensure provision of good quality health care in an equitable manner (Saide and Stewart, 2001).

Personnel systems in the public sector have been highly regulated due to preoccupation with elimination of corruption and partisan abuses. They are described as reactive, with an emphasis on operational activities (Teo et al, 2007). HRM function is challenging in large bureaucratic organisation as decision-making is often remote from the workplace, unresponsive to the need in terms of timeliness and the appropriateness of decisions to the local context.(Liu et al 2006). The HRM reforms proposal around the world focus on: enhancing management discretion in personnel management, increasing flexibility and responsiveness of public personnel management systems, improving public sector reforms, and adopting private-sector staffing techniques (Teo et al, 2007). The following Table 2.3 summarises and represents the old and new agenda for the HRM function as proposed by WHO (WHO, 2001)

Table 2.3 Old and new agenda for HRM in the Health Services

Old Agenda	New Agenda
▪ Disequilibrium in the availability ,composition, and distribution of workforce ▪ Inadequate management and performance evaluation ▪ Ineffective management of the compensation and incentives systems ▪ Fragmentation of work process ▪ Repetitive centralised training with dubious impact ▪ Lack of motivation, coupled with absenteeism and low participation ▪ Outdated and rigid regulations ▪ Limited technical capacity ▪ Low visibility and lack of political priority	▪ Human resource management in the public sector, has ceased to administered exclusively by its own personnel ▪ Decentralised management ▪ Management of quality and productivity ▪ Rising trend toward flexible employment ▪ Complex management :coexistence of diverse types of labour contracts for similar occupational categories ▪ Trend toward cutbacks in public employment ▪ Competition for financial resources and personnel ▪ Need to adapt, modernize, and simplify personnel administration.

Source: WHO, 2001

2.5 COUNTRY EXPERIENCES

The following are relevant country experiences on HRM and decentralisation.

Mozambique

In Mozambique, Nampula Province the major objective of the decentralisation policies was that the central level institutions would not be overloaded with

routine HRM issues, as so, would be released to concentrate on broader strategic and policy issues (Saide and Stewart 2001) .Saide and Stewart, 2001 found that at the beginning of the health care reform process there were no clear guidelines to inform decision making and to allow better orientation of the process of decentralisation. Clear definition of the role of different management levels and the linkages between them were absent (Saide and Stewart 2001)

In the same study the impact of decentralisation were felt by the local HRM while provincial managers were critical and indicated that HRM skills were weak, with limited development of relevant administration procedure and coordination between the HR department and the financial sector in the provincial directorate (Saide and Stewart 2001).

China

Liu et al (2006) looked at the Chinese case study on whether decentralisation improves human resource management in the health sector. Their conclusions point to the complexity of decentralisation. Amongst others their findings indicate the following:

- that decentralisation will only work if sufficient capacity has been developed,
- that there was little evidence of any oversight of the decentralised management to check on and support managers,
- that in achieving the wider health goals sometimes the efforts of managers were misguided and led to other important areas of health care being neglected,
- that managers made logical HRM decisions that supported the immediate organisational pressure –mostly financial,
- that it led to difficulties in resource allocation and equity, and
- that there is a need for close monitoring linked with appropriate action to redress problems identified (Lieu et al , 2006)

Ghana, Zambia, Uganda and the Philippines

Bossert (2002) made a comparative analysis of decision space in the decentralisation of health systems in Ghana, Zambia, Uganda and the Philippines, and concluded that human resource policy is a contested area of local decision space and that the management of health sector personnel is a highly politicised issue and may have dramatic effects on the viability of decentralisation reform programmes (Bossert 2002).

Many developing countries experience similar problems with adequate policies not in place to inform the implementation of the decentralised system. Policies are established by decree, no one know what health policy really is, over the years it become an adhoc collection of declarations, rather than an integrated legal framework for government action (Saide and Stewart 2001)

2.6 ANALYTICAL FRAMEWORKS

It is difficult to measure decentralisation. The challenges involve identifying dependent and independent variables and the demonstrating the appropriate associations between them. Centralisation and decentralisation represents two ends of single a continuum. There are number of theoretical frameworks for decentralisation, few measure the scope and the extent of decentralisation (Saltman 2007).

2.6.1 POLICY TRIANGLE

Policy triangle is useful in measuring the process on decentralisation. It takes into account the context of the policy, process of policy making, influence of actors and content of a policy (Gilson 2000):

- **Context:** Collins identifies six categories of factors as the context of Health Sector Reform, namely, demographic and epidemiological change, processes

of social and economic change, economic and financial policy, politics and political regime, ideology, public policy and public sector and external factors (Collins et al 1999).

- **Content:** Refers to the nature and design of the specific reform of focus, the interaction between the health reforms of focus and the interaction between these reforms and parallel institutional changes
- **Actors:** These are factors that relate to the people involved, their interests, values, and roles in relation to developing and implementing the reform of focus.
- **Process:** The way in which the policies of focus are indentified, formulated, and implemented, including issues of consultation, timing and phasing.

2.6.2 DECISION SPACE APPROACH

Decision Space Approach is aimed at measuring the degree of decentralisation. However it does not consider decentralisation as a process (Saltman 2007). It measure whether or not changes were made. Decision space approach is chosen for its strength in measuring the degree of decentralisation and mechanisms that are used to influence and control decisions at local levels. Bossert (1998) proposed the concept of “decision space” as the range of effective choice that is allowed by the central authorities (the principal) to be utilised by local authorities (the agents). Space defines the specific rules of the game.

Decision space can be displayed in a map of functions and degrees of choice or discretion. It assists us to disaggregate the functions which local officials have a defined range of discretion, rather than seeing decentralisation as a single transfer of a block of authority and responsibility. It shows the functional areas in which choice is allowed to the agent by the mechanisms of central control (Bossert 1998).

2.7 SUMMARY OF THE LITERATURE REVIEW

Saltman et al (2007) pointed out the following key policy lessons on decentralisation:

- **Means not ends:** Decentralisation is policy mechanism intended as an instrument to achieve specific objectives .For decentralisation strategy to be successful; it should clearly specify the broader political, administrative or fiscal objectives it is designed to achieve. It is not a policy objective in and of itself.
- **Heterogeneously applied:** Decentralisation is hardly ever applied as a uniform universal strategy that cuts across all categories of health sector activity.
- **Dynamic and not static:** Decentralisation strategies are not etched in stone. Approaches which no longer meet constantly evolving political, administrative or fiscal objectives as defined by policy makers may need to be changed or eliminated.
- **Context counts:** Decentralisation occurs within a broader social and cultural context. How decentralisation strategies translate into institutional structure and process decisions will necessarily reflect composition, character, values, and norms on the broader social system in which they must operate.
- **Regulation remains essential:** Allocating political, administrative, or fiscal responsibility to lower levels of government does not involve abandoning all central government standards or accountability.
- **Outcomes vary:** Decentralisation strategies appear to be most stable when they pursue administrative objectives and volatile when targeted on political, particularly fiscal objectives.

Decentralisation as a management policy is not necessarily sufficient to guarantee desired health system reforms, other factors such as legislation to

guide the process and to assure uniform standards as well as adequate local management of both organisational change and the devolved services are important (Saide and Stewart, 2001).Human resource management function in public hospitals is an essential management function that needs to be elevated to a strategic level.

CHAPTER THREE
RESEARCH METHODOLOGY

The aim of this chapter is to discuss the study design, the case study, research techniques and data collection methods, data management and analysis, and ethical considerations.

3.1 SETTING OF THE STUDY

The study was conducted in the North West Department of Health.

3.2 SCOPE OF THE STUDY

The study was limited to a regional and a district hospital in the North West Province, and its findings, recommendations and conclusions are limited to these hospitals. It focuses on the decentralisation of hospital management policy with specific reference to HRM function between 1996 and 2007.

3.3 STUDY DESIGN

The aim of a study design was to plan and structure the research project in such a manner that the eventual validity of the research findings is maximised (Mounton and Marais, 1990).The study design was a descriptive qualitative comparative case study design. The case study design assisted the researcher in gaining an in-depth understanding of the policy experiences of local, provincial and national health managers on the implementation of decentralisation of hospital management policy, the powers and authority delegated to hospital managers in carrying out of HRM function and the formal changes that are happening in the HRM delegations. A comparative case study focusing on a district and a regional hospital was done over a period of a month. A comparative case study was chosen in this study because; departments sometimes delegate

authority and powers over certain functions such as HRM to a rank or level of an employee and not to a position being occupied. It is therefore possible that hospital managers may have different levels of authority and powers depending on their rank and level of a hospital being managed.

3.4 STRENGTHENING THE RESEARCH DESIGN

3.4.1 RELIABILITY

Reliability requires that the application of a valid measuring instrument to different groups under different set of circumstances should lead to the same observations. It can be influenced by four factors namely; researcher, participant, measuring instrument and research context (Mouton and Marais, 1990).With regard to the researcher the affiliation and orientation of the researcher are possible weaknesses that may have been inherent in the study. The researcher is an employee of the National Department of Health and a former hospital Chief Executive Officer in the North West Province.

Possible weaknesses with participants were memory decay relating to length of time, and omniscience syndrome as participants were senior managers and they may believe that they are capable of answering any question.

In dealing with all the mentioned possible weaknesses, the researcher used triangulation strategy by reviewing policy documents, and requesting to review previous records such as advertisements of posts, appointment offers, and database of misconduct and grievance cases relating to HRM functions. The researcher established rapport with each informant and ensured them of anonymity and confidentiality of their responses. The research protocol was developed and approved and the study can be easily repeated. The data relating to the study can be made available for anyone wanting to independently examine it.

3.4.2 VALIDITY

Validity on the on the other hand is concerned with just how accurately the observable measures actually represent the concept in question or whether they represent something else. Validity is concerned with what the instrument measure and the meaning of results (Bless 1999). The researcher is interested in two issues, firstly the changes in HRM delegation of hospital CEO's in carrying out their HRM responsibility and the policy experience of managers during the decentralisation of hospital management. The decision space map is used to measure the changes in powers while the policy triangle is used to understand the experience of managers. These two analytical frame works have been used widely to measure these two issues and are valid for this study.

3.5 RESEARCH TECHNIQUES AND DATA COLLECTION

The Table 3.1 indicates the methodological approach that was used for each for each study objective**.**

Table 3.1 Objectives and research methodologies

Objective	**Methodological approach**
To review existing legislation and policies on decentralisation of hospital management functions between 1994 and 2007	Document reviews
To document the changes in the formal Human Resource Management delegations of hospital managers in the North West Province between1996 and 2007.	Document reviews,
To describe national, provincial and facility health manager's experiences of the implementation of the policy to decentralise Human Resource Management functions to hospital managers between 1996 and 2007.	Key informants

3.5.1 DOCUMENT REVIEWS

In understanding the changes to HRM function and the formal powers delegated to hospital managers the researcher carried out document reviews. The following documents were reviewed (Table 3.2).

Table 3.2 List of Documents reviewed

Legislations and Regulations	**White Papers**	**Policies, Reports, Minutes, and others**
Constitution of the Republic of South Africa, Act 108 of 1996	White paper on Transformation of Health Service Delivery, 1996	Hospital Strategy Project Report
Public Service Act Proclamation 103 of 1994, and regulations	White Paper on Human Resources, 1997	Position paper on decentralised hospital management,
Public Finance Management Act (1&29 of 1999)		Policy document on decentralised hospital management,
National Health Act,, 61 0f 2003		MinMec reports on decentralisation of hospital management
		Ministers policy speech
		North West Department of Health 2001 delegations
		Delegations in terms of collective agreements
		North West Department of Health 2007 delegations-Draft

Documents were obtained from the NDOH, North West Provincial Department of Health, hospitals and from websites.

3.5.2 KEY INFORMANT INTERVIEWS

In-depth face-to-face interviews were conducted. The questions focused on two issues. Firstly, the experiences and understanding of the key informants on the context, content, process and the role of different actors during the formulation and implementation of the policy on decentralisation of hospital management with specific reference to HRM functions and secondly on their understanding of the current delegated authorities and powers of hospital managers in exercising HRM functions. The interview schedule that was used is attached as **Annexure G.**

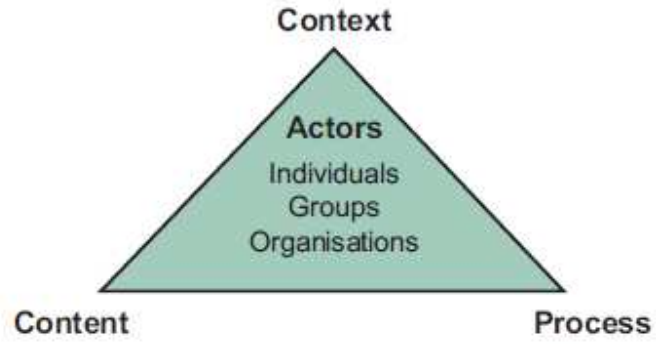
Key informants interviewed included, four experienced senior health managers at the National Department of Health, two senior provincial health managers, two Chief Executive officers and three Chief personnel officers at hospital level. Chief Executive officers are responsible for excising the delegated powers and authority and sometimes assume their positions without formal inductions and have to rely on the past experiences. Chief personnel officers are the officials responsible for the HRM in hospitals. They are usually highly experienced officers and may rely on previous experience and may continue with old practices without taking into consideration the new changes on the delegations.

All interviews were conducted in English after consent was obtained. For all informants who gave consent to be recorded, audio tapes are kept in a safe lockable drawers and will be destroyed after two years from the date of the completion of the study or five years if the study is published. A post-interview comment sheet was used to record the feelings of respondents about the interview

3.6 DATA MANAGEMENT AND ANALYSIS

The researcher took notes during interviews and later wrote interview reports. He also recorded the interviews in cases were consent for audio recording was obtained. If he was doubtful about any issues he referred to the recorded audio tapes. Due to resource constraints audio tapes were not transcribed but rather used as a reference for researcher's notes.

In analysing the policy experiences of key informants, the themes were categorised according to the policy triangle analytical framework as indicated in Figure 3.1.



Source: Walt & Gilson, 1994

Figure 3.1 Policy Triangle

This entailed categorising the experience of each key informant in terms of their understanding of the context, content, and role of different actors and implementation of the decentralisation of hospital management policy. The data were analysed by searching for possible underlying patterns and comparing these patterns with what is already contained in the policy documents and the literature. The views of key informants were classified according to areas of agreements and disagreements and effort were made to understand the underlying interests. The main interest of the study is on the design of the decentralisation reforms, the formulation of the decentralisation of hospital

management policy, the content of this policy and the implementation realities with regard to HRM functions. The study aimed to understand these experiences from three perspectives, those of local health managers, provincial health managers and national health managers. This is important because new roles and responsibilities in some studies were poorly communicated during the decentralisation process and led to conflicts between managers at different levels of the health care system (Kolehmainen-Aitken, 2004).

A decision space map analytical frame-work adapted from Bossert (2002) was used to determine the range of authorities and powers that are delegated to hospital managers in carrying out the HRM functions in their hospitals as indicated in Table 3.3. The researcher then classified range of local decisions allowed in carrying out HRM activities as narrow, moderate or wide. If the local decisions range is considered to be narrow it will indicates centralisation of that particular function and if wide it indicates decentralisation of that function. This was determined through analysing the formal HRM delegations and approval granted for a particular activity under observation. Views of all key informants were classified according to areas of agreements and disagreements and contrasted with formal delegations in order to determine any discrepancies in carrying out HRM functions.

Table3.3 Decision Space map

	Range of choice		
Function	**Narrow**	**Moderate**	**Wide**
Human Resources			
Recruitment, Selection and Appointments			
Performance Management and Promotions			
Discipline and Grievance procedures			
Determination of staff establishments			

Adapted from: Bossert, 2002

3.7 ETHICAL CONSIDERATIONS

Ethical clearance was obtained from the University of Witwatersrand, Committee for Research on Human Subjects (Medical) R14/49, (Annexure A) and the postgraduate committee (Annexure B). Research did not commence until the proposal was passed by the University Ethics Committee and the permission was granted by the Department of Health-North West Province (Annexure C).

A participation information sheet (Annexure D) was sent to all key informants requesting them to participate in the study. All key informants were requested to give written consent on the interviews (Annexure E) and a separate consent for audio recording the interview process (Annexure F). Participation was completely voluntary and no incentives were provided for participation in the study. Information obtained in the interview was kept confidential and the names of individuals will not be used when the results of the study are presented in the next chapter. All audio tapes and notes of the interviews were locked in safe

lockable cupboards at all times. The audio tapes will be destroyed after two years starting from the date of the report and will be kept for five years if the study is published. The results of the study will be shared with all participants, provincial, national departments, participating hospitals and will be presented at the relevant conferences and workshops.

CHAPTER FOUR
RESULTS

In the previous Chapters, the study question, literature review and methods were discussed. The aim of this study is to understand the decentralisation of hospital management policy process as it relates to the HRM function in public hospitals. The following Chapter presents the findings of the investigation. Two analytical frameworks are used, firstly the policy triangle to present the context, content, process and actors involved in the decentralisation. Secondly, they decision space map to disaggregate the HRM functions over which hospital managers have a defined range of decision.

4.1 REVIEW OF EXISTING LEGISLATION AND POLICIES ENACTED BETWEEN 1994 AND 2006

Health Sector Reforms in South Africa is a protracted process that already set before change of government in 1994, it gained momentum since 1994 and is still unfolding. The main reasons for reforms were to unify the fragmented health services into a comprehensive and integrated National Health System, reduce disparities and inequities in service delivery and health outcomes and extending access to an improved health services (van Rensburg, 2004). The post apartheid health sector reforms are based on the African National Congress pre election policy documents, such as the National Health Plan for South Africa (ANC, 1994b) and the. Reconstruction and Development Programme (ANC, 1994a).

4.1.1 NATIONAL HEALTH PLAN FOR SOUTH AFRICA-1994

The ANC developed a National Health Plan based on the Primary Health Care approach. The first draft of this plan was prepared by a team consisting of members of the ANC Health Department, and consultants appointed by the WHO and UNICEF. The second draft was released for public debate and discussions.

Organisations, institutions, and individuals were invited to present written submissions, and the response was enthusiastic and encouraging (ANC 1994b).

Principles and Vision

The ANC set the guiding principles and the new vision for Health in South Africa as follows:

> "Equity Right to health PHC Approach National Health System Coordination and Decentralisation Priorities Promotion of Health Respect for all Health information system" (ANC (b) 1994)
>
> On the decentralisation of management it stated the following:
>
> "Authority over, responsibility for, and control over funds will be decentralised to the lowest level possible that is compatible with rational planning , administration, and the maintenance of good quality care" (ANC(b) 1994).

4.1.2 THE RECONSTRUCTION AND DEVELOPMENT PROGRAMME - 1994

The Reconstruction and Development Programme (RDP) set the tone for the transformation and reconstruction of the health sector in the post apartheid South Africa. The ANC mobilised the electorate and every sector of society behind its first manifesto of a democratic South Africa based on the RDP. The RDP was widely consulted and represented the ideals of the majority of the previously marginalised and disadvantaged South Africans. With regard to the health sector it indicated that the reconstruction in the health sector will involve the complete transformation of the entire delivery system. This included review of all relevant legislatures, organisations, and institutions.

It promised to introduce management practices that promote efficient and compassionate delivery service, based on human rights and accountability to users, clients and public at large. On management arrangements, it advocated

for a single Minister of Health and a single National Health Authority (NHA). The responsibilities were to be shared between different Health Authorities established at, National (centre), Provincial and District (periphery) levels. The NHA was to be responsible for the development of national policies, standards, norms, and targets, allocate the health budget, coordinate the recruitment, training, distribution and condition of service of health workers and develop and implement a National Health Information System. The Provincial Health Authority was to support all District Health Authorities in its province, and ensure high-quality, efficient services through decentralised management and local accountability (ANC, 1994a).

The RDP formed a cornerstone of the HSR in the post apartheid South Africa. It propagated legislative, institutional, organisational, and management reforms. The underlying values of these reforms were to improve efficiency, local accountability and public participation which are often stated as objectives of many HSR and PSR programmes.

4.1.3 THE CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA -1996

The constitution of the Republic of South Africa is the supreme law of the country. Section 27 guarantees everyone the right to access of health care services including reproductive health services. The state must take reasonable legislative and other measures, within is available resources, to achieve the progressive realisation of each of this rights (Section 27 (2) (RSA, 1996)

On the principles governing public administration Section 195(1)(a) and (b) indicates that efficient, economic and effective use of resources must be promoted and that good human resource management and career development practices to maximise human potential must be activated.

On cooperative government and inter-governmental relations, Section 41 set the following principles for National, Provincial and Local governments: They must:

- assist and support one another
- (ii) inform one another of a consulting on another on, matter of common interest.
- (iv) coordinate their actions and legislation with one another
- (v) adhere to agreed procedures

4.1.4 PUBLIC SERVICE ACT, PROCLAMATION 103 OF 1994

The Public Service Act and its regulations apply to all persons employed in the public service. The Department of Public Service and Administration is the principal ministry that is charged with ensuring that Departments comply with the prescripts of this Act.

In terms of Part II (B) the Executing Authority or the Head of Department, she or he may, subject to this Act delegate the power to an employee or authorise an employee to perform the duty and set conditions for the exercise of the power or performance of the duty. An Executing authority shall record a delegation or authorisation in writing and the delegation of power by an executing authority or head of department does not prevent her or him from exercising the power personally.

4.1.5 THE WHITE PAPER FOR THE TRANSFORMATION OF HEALTH SYSTEM IN SOUTH AFRICA-1997

In 1997, the National Department of Health produced a White Paper for the Transformation of Health System in South Africa. Chapter 17 defines the roles and principles for hospitals. It set among others the following principles:

- The role of hospitals will be consistent with the PHC approach
- Plans will be developed to rationalise hospital services, facilities, staffing and capital investment
- Decentralised hospital management will be introduced to promote efficiency, and cost effectiveness.
- Hospital boards will be established to increase local accountability and power

On decentralisation of hospital management, it noted that most of public hospitals were under managed due to:

- Limited responsibility and authority accorded to hospital managers
- Ineffective and inappropriate structures and systems of management
- Limitations in the number of skills of managers
- Insufficient operational authority or incentives for managers to manager budgets efficiently, and
- The existing culture within hospitals.

In addressing the above challenges, substantial decentralisation of hospital management was proposed as a strategy. It involved the following:

- Provincial Departments delegating significant decision making powers relating to personnel, procurement and financial management to hospital managers.
- Introducing a system of general management to facilitate decentralisation.
- Reviewing existing systems and developing new ones to support decentralised management.

The following specific strategies relating to HRM were proposed (WPTHSD 1997):

- Authority for almost all line personnel management functions will be delegated to institutional level, subject to certain check and balances.
- Hospital managers will decide on most appointments, performance

appraisal and promotions, and will be responsible for disciplinary and grievance procedures.

- Within guidelines determine staff establishments and manage labour relations.
- Within national guidelines hospital managers will have the flexibility to determine competency grading, starting levels, and performance related rewards or bonuses.

The White Paper for the Transformation of the Health System with specific reference to hospitals was consistent with the spirit of the previous documents such as the RDP, National Health Plan for South Africa and the HSP report. This is a critical document that serves as blue print of the new health system in the post apartheid South Africa. It advocated and promoted decentralisation as a grand strategy in achieving hospital efficiency and accountability.

4.1.6 THE WHITE PAPER ON HUMAN RESOURCE MANAGEMENT IN THE PUBLIC SERVICE-1997

The WPHMPS promoted a fundamental shift from personnel administration to human resource management. In achieving this shift, it indicated the following management principles:

Increased delegation of managerial responsibility and authority to national departments and provincial administrations and, within departments, the delegation of day to day management decisions to line managers.

The WPHMPS noted that the existing personnel management practices were ineffective, discriminatory and inefficient. For example it noted that it took 3-12 months to recruit and appoint personnel. The proposed human resource management was to be managed in a decentralised manner.
(WPHMPS, 1997)

4.1.7 NATIONAL HEALTH ACT, 61 OF 2003

Section 48(1) indicates that “the National Health Council must develop policy and guidelines for, and monitor the provision, distributions, development, management and utilisation of, human resources within the national health system”

4.1.8 HOSPITAL STRATEGY PROJECT 1995-96

In 1995, The National Department of Health awarded the Hospital Strategy Project Consortium (Monitor Company, Health Partners International, Centre for Health Policy and National Labour and Economic Development Institute) a contract to analyse major issues and problems confronting the public hospital system, as well as providing possible strategies to address them. On the problems facing public hospitals the final report noted that over-centralisation leads to systematic underdevelopment of management skills and operational systems, especially in the areas such as personnel, financial and labour relations management and to a culture of action after permission, rather than to one in which individuals take initiative and are rewarded for doing so. The proposed strategy was to implement a National Policy on Decentralised Hospital Management. The following were important elements of this policy:

- Delegation of substantial powers over personnel, finances, procurement, and other critical management functions to hospital management ;
- A shift in the role of Provincial Health Administration forms its current executive /administrative line management role, to one in which its main functions are to set guidelines and broad policy, as well as to support critical support for hospital management;
- The establishment of representative, accountable Hospital Boards as statutory bodies, with clearly defined and important governance powers;
- Development of modern, efficient management structures and systems
- The recruitment, development and retention of skilled and motivated

hospital managers.

The HSP further proposed the following implementation strategies (HSP, 1996):

- A core package of essential measures to be put in place by the Department of Health and Provincial Health Administrations, constituting the minimum necessary requirements for decentralisation to be effective;
- Criteria for granting decentralised status that sets out the plans, systems, and capacities necessary before delegation for authority can be delegated;
- A staged timetable for implementation, with flexibility for provincial and hospital variation
- The National Department must negotiate legislative context in which the decentralised policy will be implemented, and provide support to Provincial Departments;
- Provincial Departments will be responsible for implementation of the decentralised hospital management. Provinces must produce detailed implementation plans covering, governance and accountability, general management, staffing and personnel management, labour relations, management capacity, systems development, management of clinical processes and communication strategy.

The HSP submitted volumes of modules as their final report to the National Department of Health. Some members of the HSP served in the initial Departmental Committees such as the Hospital Coordinating and National Hospital Policy Committees. Nine Drafts of Decentralisation of Hospital Management Policy were produced and presented to different committees and stakeholders. The 9th and final Draft was presented at the Hospital Coordinating Committee in May 1996. The contract of the HSP was due to expire at the end of June 2006, and there was hope that it will be renewed, something that was never to be.

During interviews Senior Managers were not aware of a written and approved policy called “The Decentralisation of Hospital Management Policy” instead kept on referring to the HSP report. It is therefore quite possible that the Draft policy as produced by the HSP was never adopted and approved.

There are differing views on the position of the Department with regard to this report, but what is absolutely clear is that any work or discussion that has since followed on decentralisation of hospital management is based on the HSP report. The HSP report was comprehensive on the prevailing situation and presented practical strategies and solutions going forward.

Decentralisation of hospital management policy was implemented concurrently with the establishments of the District Health System (DHS). There is no doubt that the policy priority of the Department was PHC and the DHS was seen as a critical step in achieving universal health care coverage. At this time many proponents of DHS argued for a move away from the hospital centric health system to a comprehensive PHC based on the DHS. During this period resources and focus were shifted from hospitals to PHC. This might have seriously undermined the momentum on the implementation of the decentralisation of hospital management policy.

Several strategies were clearly defined by the HSP and the WPTHSD, and what was required was detailed implementation plans to forge ahead with implementation. Specific structures and systems were put in place to coordinate and fast track the implementation process.

4.1.9 INTER-DEPARTMENTAL TASK TEAM FOR DECENTRALISATION OF HOSPITAL MANAGEMENT-1997

In 1997, number of local and International Technical Assistants were appointed to assist to drive the decentralisation of hospital management policy process. An

inter-departmental task team for decentralisation was set to coordinate the implementation of the decentralisation hospital management policy. The task team comprised of the representatives from the following stakeholders:

- National Department of Health –Chair and Convener
- EU.: Technical Assistant: National Department of Health
- Department of Public Service and Administration
- Department of State Expenditure
- Department of Finance
- Universitas Hospital
- Potchefstroom Hospital
- Western Cape Health
- Johannesburg Hospital
- Advisor to the Minister

Four stage process of decentralisation was proposed (NDOH, 2000a):

- National, Provincial and Hospital preparation
- Hospital application for decentralised status
- Provincial Assessments of hospitals preparedness for decentralised status
- If successfully assessed and the hospital meet the criteria for decentralisation a charter of interdepartmental delegation is conferred upon the hospital and key management posts.

The main focus areas were (DoH, Informative brochure on decentralisation of hospital management, no date):

- Corporate performance management agreements
- Business Planning
- Cost centre development and management and audit tools
- Personal and Team competency assessment and development
- Twinning “Provincial and Hospitals

4.1.10 CRITERIA FOR DETERMINING DECENTRALISATION APPROVAL

The Inter –Departmental Task team agreed on very extensive criteria for considering approval for decentralisation: An audit tool was developed and piloted at Johannesburg Hospital. Some areas of the criteria included the following (DOH 2000a):

- A defined period of in-budget service delivery
- Evidence of a strategic plan and the capacity to implement
- A business plan to include projected activity levels by cost centre and quality standards in place
- Monitoring and Evaluation tools for the implementation of the business plan
- Referral protocols in place
- The capacity to conduct HRM, and HRD plan in place
- A n operational structure in place
- Recruitment , performance management and disciplinary procedures in place with the capacity to effect
- All staff to have job descriptions
- A service delivery improvement plan with indicators and service standards
- Budget and Expenditure control mechanisms
- Union support
- Hospital board in place and etc

Provincial Departments were expected to constitute evaluation teams and use the above criteria to evaluate different hospitals for decentralisation. Functions that were lying with other Departments outside the Department of Health such as DPSA, Finance and Public Works were posing serious challenges with delegations. For example, DPSA is the principal Ministry for HRM functions in the Public Sector.

4.1.11 MINISTERIAL TASK TEAM ON DECENTRALISATION OF HOSPITAL MANAGEMENT-1999

In 1999, due to the slow progress on the implementation of the policy a Ministerial Task Team comprising of the DoH, Public and Private Hospitals representatives, Unions, and International Health experts was appointed to review progress and make further recommendations.

In August 1999, the Ministerial Task Team produced an interim report, which was presented to the newly formed MINMEC and PHRC and it was adopted. The report made the following recommendations:

- Review roles of National, Provincial and District Health Departments within a decentralised management framework.
- Launch Communication strategy
- Adopt cost centre management in public hospitals
- Put performance management agreements in all public hospitals
- Appoint CEO's/General Managers in all hospitals. Appointment must be based on competencies and open to competition and not doctors only

4.1.12 PERFORMANCE MANAGEMENT AGREEMENTS AND DECENTRALISATION-1999

In order to achieve safe decentralisation, the use of corporate Performance Management Agreements (PMA's) was introduced. The key areas of the PMA's were business planning, objective setting and delegations. In 1999, legal advice raised concerns about the use of PMA's specifically that they are legally unenforceable and cannot be used. In order for PMA's to be adopted complex legislative changes would be required (NDOH, 2000b) Based on this legal advice and the complexity of adopting new legislations allowing use of PMA's the Department silently abandoned the idea of PMA's.

4.1.13 SUMMARY OF KEY PROCESSES FOLLOWED DURING THE DECENTRALISATION OF HRM FUNCTION

The following Table 4.1 presents the summary of the key process followed during the decentralisation of hospital management between 1994 and 2007.

Table 4.1 Summary of Process during the decentralisation of HRM function

Period	Key Legislation/Policy decision
1994	National Health Plan for South Africa Reconstruction and Development Programme Public Service Act, Proclamation 103 of 1994
1995-1996	Hospital Strategy Project Constitution of the Republic of South Africa
1997	White Paper for the Transformation of Health System in South Africa White Paper for Human Resource Management in Public Service Inter-departmental Task Team for decentralisation of Hospital management
1999	9th and Final Draft of Decentralisation of Hospital Management Policy-Presentation to Hospital Coordinating Committee Ministerial Task Team on decentralisation of Hospital management MINMEC and PHRC interim report on decentralisation of hospital management First Performance Management Agreement between hospital CEO and Provincial Head of Department Legal advise against signing of PMA's between CEO's and Heads of Departments
2001	Public service regulations
2002	Formal HRM delegations-North West Province- effective 20 May 2002
2007	Revised HRM delegations- North West Province- Draft pending approval

4.2 ACTORS INVOLVED IN THE POLICY PROCESS DURING THE DECENTRALISATION OF HOSPITAL MANAGEMENT

The following Table 4.2 presents the summary of key actors involved in the policy process during the decentralisation of hospital management.

Table 4.2 Summary of key actors involved in the policy process during the decentralisation of HRM function

Main Categories of Actors	HSP-1996	Inter-Departmental Task Team (IDTT)-1997	Ministerial Task Team-1999
The State	NDOH, Provincial Health Departments-received and reviewed reports	NDOH-: Chair and Convener Minister advisor Other Departments DPSA Department of State Expenditure Department of Finance Department of Public Works	NDOH-: Chair and Convener
Private Hospitals	No	No	Yes
Academics	Yes	No	No
International Agencies	DFID, World Bank WHO, EU	DFID	Yes
Technical Assistants/ Consultants	EU Consultants	Yes	Yes
Unions	Not formally	No	Yes

The State was represented by top bureaucrats in the National Department of health or Ministers advisors in all the committees. Private hospitals were invited only on the Ministerial Task team in 1999. Academics were involved in the initial phase in 1996 through the HSP. International agencies were involved in all the

committed either through their representatives serving directly on committees or funding the activities of these committees. Consultant's mostly international ones served in all committees. Unions were only invited to the last committee in 1999.

4.3 DOCUMENTATION OF THE CHANGES IN THE FORMAL HUMAN RESOURCE MANAGEMENT DELEGATIONS OF HOSPITAL MANAGERS IN THE NORTH WEST PROVINCE

4.3.1 INSTITUTIONAL ARRANGEMENTS FOR HUMAN RESOURCE MANAGEMENT FUNCTION

The following Figure 4.1 represents the institutional arrangements for Human Resource Management during the decentralisation process. The DPSA has the overall responsibility for the Public Service Act and regulations which is the key legislature upon which HRM function in the public service is based. It places enormous responsibilities and powers on the MEC and the Head of Department.

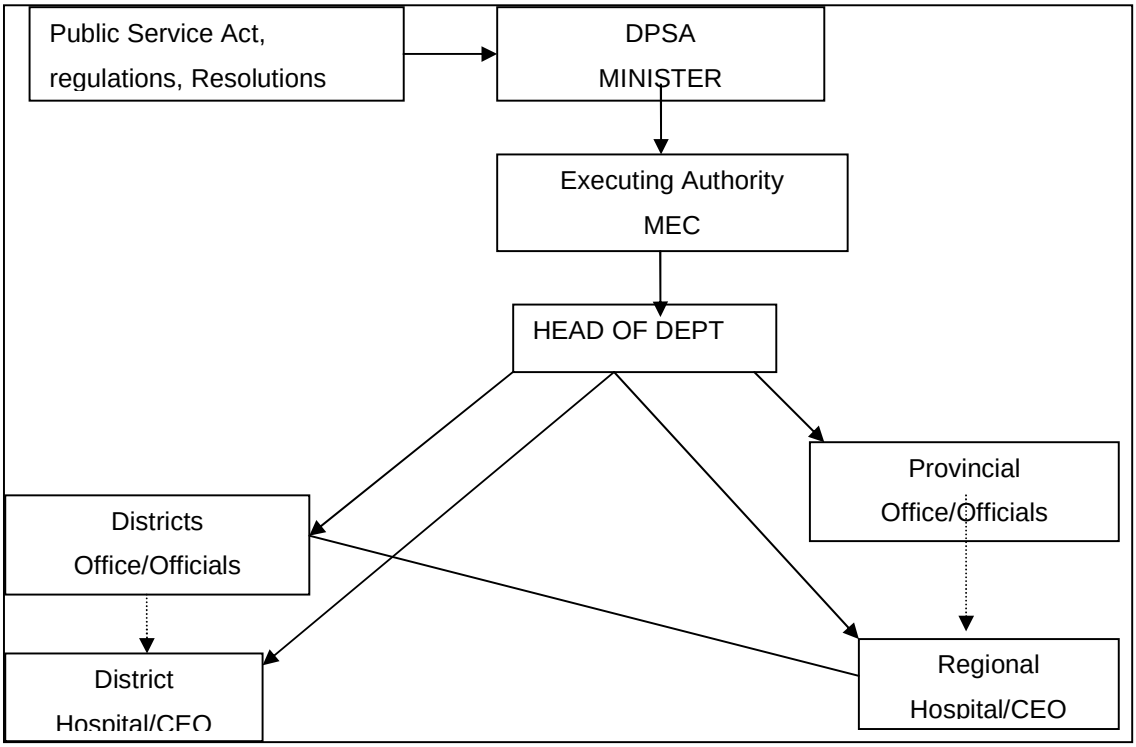


Figure 4.1 Institutional Arrangements for Human Resource Management Function

Keys

DPSA- Ministry –Responsible Authority on HRM function in Public Service

MEC-Executing Authority (Political Head)

HOD-Head of Department -Administrative Head

Provincial Office- Provincial Office Staff -activity carried out at Head office irrespective of levels of officials

District Office- Activity carried at District level irrespective of level

Hospital CEO-Activity carried at a hospital irrespective of the level

The MEC and or HOD may voluntarily delegate functions to officials in the provincial head office, district offices and hospitals.

4.3.2 HRM FUNCTIONS AND ACTIVITIES UNDER OBSERVATION

Based on the Public Service Act (103 of 1994) and Regulations, twenty three (23)

HRM activities were indentified and analysed as indicated in Table 4.3

Table 4.3 Summary of formal Human Resource Management Functions and Activities analysed

ID	FUNCTIONS	Number of activities
1	Determination of staff establishments	2
2	Recruitment, Selection and Appointments	7
3	Performance Management and Development	8
4	Discipline and Grievance Procedures	6
	Total	23

- On each function, number of activities that could be performed at that level were recorded
- The final decision (approval) for each function was recorded.

The Table 4.4 presents the detailed activities which were indentified.

Table 4.4 HRM FUNCTIONS AND ACTIVITIES UNDER OBSERVATION

1. Determination of Staff Establishments	**2. Recruitment, Selection and Appointments.**	**3. Performance Management and Development**	**4. Discipline and Grievance Procedures**
Organisation structure 1.1 Determine the Department's organisational structure in terms of its core and support functions and based on organisation development reports Creation and abolition of posts 1.2. Define posts necessary to perform the relevant functions, while	Recruitment 2.1 Ensure that vacant posts in the department are so advertised as to reach, as efficiently and effectively as possible, the entire pool of potential applicants, especially persons historically disadvantaged 2.2 An appropriate agency may be utilized	Performance Management 3.1 Determine a system for performance management and development for employees. 3.2 Designate in writing the particulars of each employee's assessment. 3.3 An employee's supervisor shall	Discipline 4.1 Suspension as a precautionary measure 4.2 To appoint an employee to investigate whether grounds exist to institute a charge of misconduct 4.3 To appoint a

remaining within the current MTEF OF his/her department, and the posts so defined, shall constitutes the Dept. approved establishments (including creation/abolition of posts)	to identify candidates for posts, as long as the advertising and selection procedures comply with regulations VII C and D. 2.3 In the case of a vacant post on grade 9 or higher, evaluate the job unless the specific job has been evaluated previously <u>Selections</u> 2.4 Appointment of selection committees to make recommendations on appointments to all posts subject to the prescribed conditions 2.5 Approval of a selection committee, recommendations for filling of posts. <u>Appointments</u> 2.6 Appoint employees on a permanent or temporary basis, either full-time or part-time 2.7 Non-acceptance of a selection committee's recommendation re a suitable candidate	monitor the employee's performance on a continuous basis and give the employee feedback on her/his performance. 3.4 Establishing of moderating committees to moderate assessment results 3.5 Approval of the recommendations of the Formal Moderating Committee 3.6 Communication of assessment results to employees 3.7 A financial incentive scheme may be established for employees or any category of those employees for rewarding good performance <u>Promotions</u> 3.8 Approve that an employee may be promoted to a vacant post on the establishment, subject to the prescribed conditions	presiding officer to preside over the disciplinary hearing 4.4 To charge an employee with misconduct. 4.5 Consider appeals against disciplinary actions excluding dismissals 4.6 Considering appeals against dismissals
NUMBER OF ACTIVITIES			
2	7	8	6

4.3.3 SUMMARY OF DECISION SPACE MAP FOR FORMAL HUMAN RESOURCE MANAGEMENT IN ACCORDANCE WITH THE PUBLIC SERVICE ACT AND REGULATIONS

The Public Service Act and Regulations places enormous HRM powers on the MEC and Head of Department. In terms of Part II (B) the Executing Authority or the Head of Department, she or he may, subject to this Act delegate the power to an employee or authorise an employee to perform the duty and set conditions for the exercise of the power or performance of the duty. An Executing authority shall record a delegation or authorisation in writing and the delegation of power by an executing authority or head of department does not prevent her or him from exercising the power personally. Table 4.5 present the decision space allowed in terms of the Public Service Regulations, 1999.

Table 4.5 Summary of decision space map for Human Resource Management in accordance with the Public Service Regulations, 1999

ID	FUNCTION	NARROW	MODERATE	WIDE
1	Determination of staff establishments	Hospitals		MEC, HOD
2	Recruitment, Selection and Appointments.	Hospitals		MEC, HOD
3	Performance Management and Development	Hospitals		MEC, HOD
4	Discipline and Grievance Procedures	Hospitals		MEC, HOD

All HRM functions were delegated to MEC and HOD at the provincial head office. Hospital CEO's had narrow decision space allowed on HRM functions.

4.3.4 SUMMARY OF DECISION SPACE MAP FOR HUMAN RESOURCE MANAGEMENT - NWP HRM DELEGATIONS 2002

In May 2002, the first formal HRM delegations in the North West Province were

approved by the MEC. Table 4.6 present the range of choices allowed for different HRM functions. Delegations were made to a level and not to a position being held. This is important to note because regional hospital CEO's were at Director level while District hospital CEO's levels differed from Assistant Director to Deputy Director.

Table 4.6 Summary of decision space map of Human Resource Management - NWP HRM Delegations 2002

ID	FUNCTION	NARROW	MODERATE	WIDE
1	Determination of staff establishments	District Hospital	Regional Hospital	Provincial Head Office
2	Recruitment, Selection and Appointments.		District Hospital Regional Hospital	Provincial Head Office
3	Performance Management and Development	District Hospital Regional Hospital		Provincial Head Office
4	Discipline and Grievance Procedures		District Hospital Regional Hospital Provincial Head Office	

Provincial head office had wide range of choice allowed on determination of staff establishments, recruitment, selection and appointment and performance management. Regional Hospital had moderate choice on most of the activities and this is due to post level of the regional hospital CEO. District hospital could only initiate activities and had no range of local decision space allowed.

4.3.5 SUMMARY OF DECISION SPACE MAP FORMAL HUMAN RESOURCE MANAGEMENT DELEGATIONS OF A REGIONAL HOSPITAL - 2002

The following Table 4.7 presents the local decision space allowed for a regional hospital in carrying our HRM function in 2002.

Table 4.7 Summary of decision space map of Human Resource Management function of a regional hospital -2002

ID	FUNCTION	NARROW	MODERATE	WIDE
1	Determination of staff establishments	←	—	
2	Recruitment, Selection and Appointments.		←	
3	Performance Management and Development	←		
4	Discipline and Grievance Procedures		←	

Regional Hospital had narrow local decision space allowed in determination of staff establishments and on performance management and development and moderate range of choices on recruitment, selection, appointment and discipline and grievance procedures.

4.3.6 SUMMARY OF DECISION SPACE MAP OF HUMAN RESOURCE MANAGEMENT FUNCTION OF A DISTRICT HOSPITAL - 2002

Table 4.8 is a summary of local decision space allowed for a district hospital in 2002.

Table 4.8 Summary of decision space map for Human Resource Management function of a district hospital -2002

ID	FUNCTION	NARROW	MODERATE	WIDE
1	Determination of staff establishments	←		
2	Recruitment, Selection and Appointments.	←		
3	Performance Management and Development	←		
4	Discipline and Grievance Procedures		←	

District hospital had a narrow local decision space allowed in almost all HRM activities allowed; it had moderate powers only on the discipline and grievance procedures.

4.3.7 SUMMARY OF DECISION SPACE MAP OF FORMAL HUMAN RESOURCE MANAGEMENT FUNCTION- 2007 (CURRENT)

Current local decision space allowed to local agents is presented in Table 4.9.In the 2007 delegations Hospital CEO's are recognised as a rank.

Table 4.9 Summary of decision space map of Human Resource Management function - 2007 (Current)

ID	FUNCTION	NARROW	MODERATE	WIDE
1	Determination of staff establishments		Regional Hospital District Hospital	Provincial Head Office
2	Recruitment, Selection and Appointments.		Provincial Head Office District Hospital	Regional Hospital
3	Performance Management and Development		Provincial Head Office District Hospital	Regional Hospital
4	Discipline and Grievance Procedures	Provincial Head Office		Regional Hospital District Hospital

Provincial office has wide range of choice allowed only in the determination staff establishments. Regional hospital gained more space and had more wide range of choices allowed in almost all HRM activities. District Hospital has gained some space and now has moderate choice allowed. District hospitals reports directly to District Office and most of the approvals happen here.

The following Table 4.10 represents a summary of decision space of a regional hospital in 2007 HRM delegations.

Table 4.10 Summary of decision space map Human Resource Management delegations of a regional hospital -2007 (Current)

ID	FUNCTION	NARROW	MODERATE	WIDE
1	Determination of staff establishments		←	
2	Recruitment, Selection and Appointments.			←
3	Performance Management and Development			←
4	Discipline and Grievance Procedures			←

Regional hospital has a wide local decision space allowed in almost HRM function allowed. Over the years the Regional Hospital has gained more powers, accountability and responsibility over the HRM function.

The following Table 4.11 represents a summary of decision space of a district hospital in 2007 HRM delegations.

Table 4.11 Summary of decision space map Human Resource Management Delegations of a district hospital -2007 (Current)

ID	FUNCTION	NARROW	MODERATE	WIDE
1	Determination of staff establishments		←	
2	Recruitment, Selection and Appointments.		←	
3	Performance Management and Development			←
4	Discipline and Grievance Procedures			←

District hospital has over time gained some wide range of choice on performance management and development and discipline. Almost all functions are approved at the District Office and very few activities are approved at provincial head office.

4.4 HEALTH MANAGERS' EXPERIENCE OF THE IMPLEMENTATION OF THE POLICIES FOR DECENTRALISATION OF HOSPITAL MANAGEMENT

4.4.1 CONTENT AND POLICY PROCESS

Understanding of decentralisation of hospital management policy

Respondents understanding decentralisation as giving more power and authority

to hospital CEO. Only one long serving senior manager at the NDoH could provide a more detail and sound answer.

"It can be delegation, deconcentration, privatization, and devolution. Central keeps accountability and responsibility but delegates certain functions and pull those functions at any time. In South Africa the form is delegation" long serving senior manager at NDoH

Availability and familiarity with the decentralisation of hospital management policy

There is no formal or approved policy on decentralisation of hospital management.

Experience with the changes to HRM function

Senior managers at NDOH indicated that changes are varying per province. Other respondents could not indicate the changes that had happened to HRM function since 1996. Determination of staff establishments and recruitment, selection and appointments are considered to be centralized at provincial head office by hospital staff. Over expenditure and withdrawal of financial delegations overrides all other delegations including HRM delegations. This result in many hospital staff not knowing when are they reinstated or even which delegations are in place. The provincial office is seen as having wide decision space on HRM function while; the role of the NDOH is unknown. There is a strong perception that HRM function is limited to appointment of staff.

"What can a CEO do, if he doesn't have the delegations to appoint cleaner and that decision have to be taken at the provincial office" senior manager at NDOH

“Every politician that comes into office wanted to take control of delegations” senior manager at provincial head office.

What worked well and did not work well

The main challenges indentified were lack of implementation plan and proper monitoring, political interference specifically with appointments, lack of local capacity and financial management in the public sector. The creation of new structures and appointments of managers in hospital is considered to have worked very well.

4.4.2 ACTORS

Respondents could not recall specific actors who were involved in the policy process but could only think that it should have been National and Provincial offices. Based on document reviewed actors who were indentified are listed in Table 4.2.

CHAPTER 5
DISCUSSION

In the previous Chapter, the result of the study was presented. The following Chapter discusses the result of the study.

5.1 REVIEW OF EXISTING LEGISLATION AND POLICIES ENACTED BETWEEN 1994 AND 2006

Key legislations and policies reviewed between 1994 and 2006 as per Table 4.1 point out to the fact that decentralisation is part of the health sector reform in South Africa. Decentralisation was promoted as a policy reform that will improve efficiency, equity and effectiveness of hospitals in South Africa. Lethbridge (Lethbridge 2004) argues that the main objectives of health sector reforms are improving efficiency, equity, accessibility, quality of health services delivery and responsiveness to local needs

Liu et al (Liu et al 2006) argues that HRM is often unresponsive to the need in terms of timelines and appropriateness of decisions to local context. The decentralisation of HRM in this study was driven by a need to be responsive in terms of timeliness and appropriateness of decisions to local context. There was a concern that decisions are centralized at provincial head offices and hospital CEO's had no powers to manage hospitals. As Wang (Wang et al 2002) concludes that decentralisation comes as part of broader public sector and health sectors reforms. The result of his study point out to similar conclusion.

There was no policy on the decentralisation of hospital management. A study by Saide et al made similar observation and conclude that "policies are established by decree, no one know what health policy really is, over the years it become an adhoc collection of declarations, rather than an integrated legal framework for government action" (Saide and Stewart 2001)

5.1.1 CHANGES IN THE FORMAL HUMAN RESOURCE MANAGEMENT DELEGATIONS OF HOSPITAL MANAGERS IN THE NORTH WEST PROVINCE

Decision space analytical frame work adapted from Bossert was used to analyse and present the results. Decision space is based on the principal- agent theory. An agent in this case hospital carries out HRM function on behalf of the principal which is the provincial head office. Bossert (2002) indicates that the principal have incentive or sanctions to guide the behaviour of the agent. Such mechanisms may include monitoring and reporting, inspections and audits, performance review, contract and grants. To this end the discussion on HRM delegations relates to the "decision space" allowed for a hospital to carry out HRM functions. In this case an activity is regarded as carried at the hospital if the hospital has a final decision or approval over it. As shown on the Figure 4.1 delegation of functions is a discretionary voluntary process. The MEC or HOD as principals decides which activity to delegate, to what level and or to whom. Furthermore combinations of mechanisms are used in the management of agent behaviour on carrying out the delegated HRM functions.

5.1.2 DETERMINATION OF STAFF ESTABLISHMENTS

Under determination of staff establishments two activities were observed, approval of organisational structure (staff establishment) and creation and abolition of posts. In 2002, the Executing Authority only delegated the creation and abolition of posts to Head of Department but the approval of the staff establishments was not delegated. Hospitals had no local decision space with regard to this function. It was highly centralized and bureaucratic.

In 2007, the approval of organisational structure remains highly centralised at provincial head office- can only be approved by the Executing Authority. Regional hospital will have wide range of local decision space in the creation and abolition

of posts, while district hospital will have moderate local decision space-the District Chief Directors will approve this activity excluding those for Senior Management Services. There are more HRM activities that are delegated to local agents during this period.

It is unclear whether the Executing Authority will approve all organisational structures-provincial and hospitals.

5.1.3 RECRUITMENT, SELECTION AND APPOINTMENT

Recruitment

Hospitals have a narrow decision space with regard to the recruitment process. They can only initiate and coordinate this activity but have no delegations to advertise or carry out job evaluations for posts levels. These activities are centralised at the Human Resource Management unit at the provincial head office, and they have been no changes since 2002.

Selection

In 2002, hospitals had narrow local decision space. Firstly, they had to seek approval for constituting a selection committee for all levels. Head of Department could only approve the selection committee for level 1-8 and 9 upwards were approved by the Executing Authority. In practice for example, this meant that for a hospital to appoint a doctor the Executing authority had to approve the selection committee and for any other employee ranging from a cleaner, administration clerks to professional nurses the hospital had to obtain an approval for a selection committee from the Head of Department. In cases where the HOD does not agree with the recommendations from the hospital on a selection committee the process had to be restarted.

In 2007, regional hospital and district chief directors had wide local decision

space as they could approve the constitution of the selection committee for posts up to level 12. District hospital had moderate decision space as they can now receive approval from district level.

Appointment

In 2002, appointment of employees on level 1 to 8 was delegated to Director level position, for level 9-12 to HOD and 13 to Executing Authority. Regional hospital could therefore appoint employees on level 1-8, while district hospital had to make recommendations to the district.

In 2007, there are no formal changes and the 2002 status quo remains.

5.1.4 PERFORMANCE MANAGEMENT AND DEVELOPMENT

In 2002, there was no approved policy on performance management and development. To this end activities under this function could not be delineated and delegated, but a reference was made to the HRM unit to develop a policy and system. In 2007, the provincial head office had a narrow decision space on performance management and development. They only activity that is approved at provincial head office is approval of the recommendations of the formal moderating committee-payments of performance incentives and rewards. Hospitals had a wide range of decision space on management of performance and development.

Discipline and Grievance Procedures

In 2002, hospitals had a moderate range of local decision space allowed in discipline and grievance procedures. Labour Relations officers appointed mainly at the provincial office and the role of hospitals in disciplinary positions was limited to informal disciplinary processes.

In 2007, Hospitals had a wide range of local decision space allowed on almost all activities relating to disciplining of employees. The only activity that was not delegated is the dismissal of employees and appeals for dismissals which are still carried out at provincial head office.

5.2 HEALTH MANAGERS' EXPERIENCE OF THE IMPLEMENTATION OF THE POLICIES FOR DECENTRALISATION OF HOSPITAL MANAGEMENT

The main challenges indentified were lack of implementation plan and proper monitoring, political interference specifically with appointments, lack of local capacity and financial management in the public sector.
Saide and Stewart, 2001 carried a study in Mozambique and had similar findings. They conclude that at the beginning of the health care reform process there were no clear guidelines to inform decision making and to allow better orientation of the process of decentralisation. Clear definition of the role of different management levels and the linkages between them were absent (Saide and Stewart 2001).

The respondents indicated that over expenditure and withdrawal of financial delegations overrides all other delegations including HRM delegations. This result in many hospital staff not knowing when are they reinstated or even which delegations are in place. This is done in order to comply with the requirements of the Public Finance Management Act (PFMA). This view is supported by a study by Liu et al (2006) which looked at the Chinese case study on whether decentralisation improves human resource management in the health sector. They conclude that decentralisation will only work if sufficient capacity has been developed, and that managers made logical HRM decisions that supported the immediate organisational pressure –mostly financial (Lieu et al, 2006).

5.3 CONCLUDING REMARKS

There was no policy on decentralisation of hospital management. Withdrawal of financial delegations mainly due to over expenditure results in the withdrawal of HRM delegations.

CHAPTER 6
CONCLUSION AND RECOMMENDATIONS

The following Chapter presents conclusions related to the aims of the study, limitation of the study, and recommendations. Decentralisation needs to be thoroughly planned, implemented and monitored in order to achieve the desired goals. Allocation of adequate resources, particularly financial and human resources and support from high levels of authority are instrumental for improvements (Saide and Stewart, 2001).

6.1 CONCLUSIONS RELATED TO THE AIMS OF THE STUDY

This was a descriptive qualitative comparative case study design that looked at broad issues pertaining to develop an in-depth understanding of the process of decentralisation of hospital management policy as it relates to the Human Resources Management function.

6.1.1 REVIEW EXISTING LEGISLATION AND POLICIES ON DECENTRALISATION OF HOSPITAL MANAGEMENT FUNCTIONS BETWEEN 1994 AND 2006

The findings of this study showed that decentralisation as a policy has been referred to in most of the legislation and policies that are aimed at the Health Sector Reforms in South Africa. It has been promoted as a policy to improve the efficiency and effectiveness of hospital management. It has been largely propagated by international consultants who on several stages of the policy process were involved with the drafting of key policy documents.

6.1.2 DOCUMENTATION OF THE CHANGES IN THE FORMAL HUMAN RESOURCE MANAGEMENT DELEGATIONS OF HOSPITAL MANAGERS IN THE NORTH WEST PROVINCE BETWEEN 1996 AND 2007

There was a shift of power over the control of HRM function. Over time provincial head office had delegated more HRM activities to Regional Hospital and District Office. District hospital managers depend on District Chief Directors for approvals. Although there was an attempt to recognise hospital CEO's as a critical cadre in the management of health service, district hospital management team were unaware of their delegated powers and functions. The real contention on HRM was on appointment of staff and sometimes on payments of performance incentives and rewards. The continued moratorium on filling of posts was down playing the enormous gains that hospitals made during the decentralisation of hospital management policy.

6.1.3 DESCRIPTION OF THE NATIONAL, PROVINCIAL AND FACILITY HEALTH MANAGER'S EXPERIENCES OF THE IMPLEMENTATION OF THE POLICY TO DECENTRALISE HUMAN RESOURCE MANAGEMENT FUNCTIONS TO HOSPITAL MANAGERS BETWEEN 1996 AND 2007

Long serving and experience managers had better understanding and experience of the policy process. Hospital staff was not aware of decentralisation of hospital management as policy and its implications to their daily operations. The main challenges indentified were lack of implementation plan and proper monitoring, political interference specifically with appointments, lack of local capacity and financial management in the public sector.

6.2. LIMITATIONS OF THE STUDY

The following are some of the possible limitations of the study.

- The study was only limited to the participating regional and district hospitals in the North West Province and the results may not be generalised to the entire country or hospitals.
- The Departments did not keep good records of policies, documents and Websites were not updated. There was a limitation in obtaining all relevant documents during the specified period. The researcher undertook visits to offices of the key informants and requested permission to search for the relevant documents in the archives.
- It was difficult to secure appointments with senior managers due to their busy schedules.

6.3. RECOMMENDATIONS

The following recommendations are made with regard to the findings of the study

6.1.4 USE OF FINDINGS OF THIS STUDY

The debate on decentralisation of hospital management is live in the National Department of Health. At any given time a new committee is set with the hope that this debate will be concluded. It is hoped that the findings of this study will enrich this protracted policy debate in the National Health System. The North West province may also start engaging with their HRM challenges with more vigour and understanding.

6.1.5 NATIONAL POLICY ON DECENTRALISATION AND AMENDMENT OF THE PUBLIC SERVICE ACT 103 OF 1994

The initial committees that worked on the decentralisation abandoned the idea of performance management agreement, citing the complexity of the required amendment to the public service act. This was a lost opportunity that could have allowed a legal recognition of hospital CEO's as new cadres with specific required authority to effectively and efficiently manage public hospitals. There is an opportunity in the current legislative frame work to designate hospitals as Service Delivery Units as a step towards a more matured model of hospital management. The NDOH should take a lead in the finalisation of a policy frame work on decentralisation with sound technical content and consider an amendment to the existing legislation to free hospitals of some of the bureaucratic processes and procedures common in the public sector.

6.1.6 FURTHER RESEARCH

The following areas are recommended for further research:

Impact of decentralisation on the efficiency and effectiveness of hospital management in all provinces at different levels of health establishments

6.4. CONCLUSION

The study found conclusive evidence that there were changes to HRM function during the ongoing debate on decentralisation of hospital management. More HRM functions were delegated to Hospitals, with regional hospital having a wider range of local decision space and district hospital with moderate local decision space. Managers at different levels have different understanding of the HRM function and activities that are delegated to hospitals.

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ANNEXURE

ANNEXURE A: ETHICS CLEARANCE CERTIFICATE

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Mothoagae

CLEARANCE CERTIFICATE	PROTOCOL NUMBER M080839
PROJECT	Human Resource Management in the Decentralisation of Hospital Management Case Study of the southern district in North West Province
INVESTIGATORS	Mr MP Mothoagae
DEPARTMENT	School of Public Health
DATE CONSIDERED	08.08.29
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 09.03.19 CHAIRPERSON .....
(Professor P E Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Dr D Blaauw

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and ONE COPY returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. I agree to a completion of a yearly progress report.

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

ANNEXURE B: APPROVAL FROM THE POSTGRADUATE COMMITTEE

Faculty of Health Sciences Medical School, 7 York Road, Parktown, 2193
Fax: (011) 717-2119 / Tel: (011)717-2125

Reference: Ms Helen Selolo

E-mail: monyai.selolo@ wits.ac.za
23 July 2008

Person No: 9211385K
PAG

Mr Mogale Mothcagae
P O Box 60170
Karen Park 2
Rosslyn
0118

Master of Public Health : Approval of Title

We have pleasure in advising that your proposal entitled *An analysis of the human resource management function during the decentralization of hospital management: case of North West Province* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

ANNEXURE C: APPROVAL FROM NORTH WEST PROVINCE DEPARTMENT OF HEALTH

Health & Soc Dev
Department
Health & Social Development
North West Provincial Government
REPUBLIC OF SOUTH AFRICA

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POLICY, PLANNING AND RESEARCH

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CHIEF DIRECTORATE
CORPORATE SERVICES
11 AUG 2009
RECEIVED

TO : **The Office of Superintendent- General**
North West Department of Health

FROM : **Mr K Rabanye**
Director: Policy, Planning and Research

DATE : **11 August 2009**

SUBJECT : **Analysis of the Human Resource management functions during decentralisation of hospital management: case of Dr Kenneth Kaunda district.**

The above subject matter refers

1. Purpose

To request a final approval for a research study to be undertaken in North West Province, Dr Kenneth Kauda district.

2. Background

Mr M Mothoagae the Principal Investigator of the above mentioned research study has requested permission to undertake a study in North West Province.

The researcher's protocol has been reviewed by the members of Provincial Health Research Committee and their ruling was that the researcher be granted an approval on condition he addresses certain issues. Comments were addressed as attached and they were accepted, a copy of ethics approval from University of Witwatersrand was submitted.

3. Aim and Objective

The objective of the study is to analyse the current Human Resource Management delegations of hospital managers.

4. Financial Implications

The researcher will receive funds from National Department of Health through European Union Funding.

ANNEXURE D: INFORMATION SHEET

Participant information sheet

STUDY TITLE: The decentralisation of hospital management. Case study of the Southern District in North West Province'

Researcher: M.P.Mothoagae

Institution: University of the Witwatersrand, Johannesburg

Telephone no: 012 312 3193

Email: mothom@health.gov.za

Part B

My name is M.P.Mothoagae, student from the University of Witwatersrand, Johannesburg. I am conducting a study on the analysis of human resource management function in district hospitals during the decentralisation of hospital management. This study is aimed at assessing progress on the policy on decentralisation of hospital management. Given the importance and challenges facing Human Resources for Health (HRH) the study is focusing only on the human resources issues. This study will involve interviews with participants on their experiences on the how human resources management function is being practiced during the period of 1996 to 2007. The main focus will on whether there is decentralisation or centralisation of the HRM functions during this period.

You are therefore invited to consider sharing you valued experiences with me in this study and give consent for the use of audio tapes during the interview. If in agreement the consent form is attached for your consideration. Your participation

in the study is entirely voluntary. Before agreeing to participate it is important that you read and understand the purpose and procedures of this study. You may withdraw from the study at any stage, although this is discouraged.

All information obtained during the study will be kept strictly confidential.

Kind regards,

M.P.Mothoagae

ANNEXURE E: INFORMED CONSENT

Informed Consent

I hereby confirm that I have been informed by the researcher, M.P.Mothoagae, about the nature, conduct, benefits and risks of the study. I have also received, read and understood the written participant sheet.

I am aware that the results of the study will be anonymously processed into a study report, and that I may at any stage without prejudice withdraw my consent and participation in the study. I have had sufficient opportunity to ask questions and declare myself prepared to participate in the study.

I herby give my written consent to be interviewed.
Participant

_____ _____

Print Name Signature

Date

I M.P Mothoagae herewith confirm that the above participant has been fully informed about the nature and conduct of the above study and consented freely to participate in the study.

Researcher

_____ _____

Print Name Signature

Date

ANNEXURE F: CONSENT FOR AUDIO TAPING

Consent for Audio Taping

I hereby confirm that I have been informed by the researcher, M.P. Mothoagae, about the nature, conduct, benefits and risks of the study. I have also received, read and understood the written participant sheet.

I understand that I can decide whether or not the interview will be tape recorded and that there will be no consequences for me if I do not want the interview to be recorded. I understand that if the interview is tape-recorded that the tape will be destroyed as soon as the interview has been transcribed.

I understand that I can ask the person interviewing me to stop tape recording, and to stop the interview altogether, at anytime.

I herby give my written consent to be tape recorded.

Participant

_____ _____

Print Name Signature

Date

I M.P Mothoagae herewith confirm that the above participant has been fully informed about the nature and conduct of the above study and freely consented to be tape recorded.

Researcher

_____ _____

Print Name Signature

Date

ANNEXURE G: QUESTIONNAIRE

Schedule of interviews

AIMS:

- To describe the experiences and understanding of key informants (context, content, implementation/process and role of actors) in the decentralisation of Hospital Management policy process, specific to HRM functions.
- Understand HRM delegations, powers and authorities of hospital CEO's.

These will form part of the questions that will be posed to key respondents.

PART A: INTRODUCTORY QUESTIONS

I. What is your current position?
II. How long have you been appointed in the current position?
III. Before this position, what were you doing?

PART B: POLICY PROCESS

1. Please describe to me, your own understanding of the "decentralisation of hospital management"?
2. Are you familiar with the decentralisation of hospital management policy?
3. Who has been involved in the development of this policy?
4. What is your experience with this policy, with specific reference to HRM?
    - Determination of staff establishments
    - Recruitments, Selections and Appointments
    - Performance Management and Promotions
    - Discipline and Grievance procedures
5. What do you consider to have worked well, did not work well and any obstacles in this policy? (Why). What it is required to make it work better?

PART C: HRM DELEGATIONS

6. Do you have formal /written HRM delegations of Hospital CEO's?
7. What are the current HRM delegations of hospital CEO's?
    - Determination of staff establishments
    - Recruitments, Selections and Appointments
    - Performance Management and Promotions
    - Discipline and Grievance procedures
8. How have they changed from 1996 to 2007?
9. What are the HRM powers of Provinces and National Departments? How will you describe the distribution of HRM powers between, Hospital, Provinces and National Departments?
10. Is hospital CEO's having enough HRM powers to carry out their functions effectively?
11. Can Hospital CEO's be delegated more HRM powers? What are the challenges with this?