



Role Play

DECENTRALISATION AND HUMAN RESOURCES DEVELOPMENT

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Objectives

By the end of the Role-Playing Exercise it is hoped that participants will achieve the following:

- Understand the importance of effective central government to a decentralisation programme.
- Understand that decentralisation is not just a once-off transfer of power but a process of continual development of a new system.
- Evaluate the appropriate roles and responsibilities of different levels of government in human resource development in the decentralised health sector.

Scenario¹

You have been called to a crisis meeting by the Chief Secretary to the President. A recent report alleges that the decentralised training and planning of health care human resources is ineffective and inequitable. You are one of the key stakeholders in human resources in the health sector. The meeting aims to resolve the problems that have arisen.

The following agenda has been given to you:

1. Welcome and Introduction
2. Assess what action is needed to improve the planning and training of health sector human resources under decentralisation.
3. Review roles and responsibilities
4. Agree next steps

You have also been provided with the controversial evaluation report (enclosed). Read through the **evaluation report** and your background **briefing notes** and prepare for the meeting. You will be given a period of **ten minutes** before the meeting where you can try and approach other teams for negotiations and **alliance formulation**. You will be expected to come to the meeting with **clear proposed roles and responsibilities** for the Ministry of Health, the Public Service Commission and the Provincial Governments. The debate about a possible reallocation of roles in health sector human resource planning and training will be the focus of the meeting.

¹ The material in this role playing exercise is derived from the decentralisation experience of Papua New Guinea. However, the stakeholders are purely fictitious. The source document is: Kolehmainen-Aitken R.L (1991), "Decentralization and health workforce development" in Thomason J. A., Newbrander W.C. & Kolehmainen-Aitken R.L (1991), *Decentralization in a developing country: The experience of Papua New Guinea and its health service*. National Centre for Development Studies, Research School of Pacific Studies, The Australian National University. Canberra.

INVESTIGATION OF THE EFFECTS OF DECENTRALISATION ON HUMAN RESOURCE DEVELOPMENT IN THE HEALTH SECTOR

Summary of an Evaluation Report

Summary

Decentralisation has proved to be a welcome change for the people of this country, in making government more responsive and flexible. Previous, hierarchical systems of central planning and unwieldy bureaucracy paid little heed to the demands of the provinces and municipalities and left communities feeling ignored and unimportant.

Nevertheless, decentralisation has had several unintended and unexpected consequences for the development of the country's health sector, particularly with respect to human resources. Some of the difficulties encountered were inherent in the manner in which decentralisation regulations structured power relationships between the national level and the provinces on the one hand, and between the Ministry of Health (MoH) and other central government Ministries on the other. Others arose as a result of the administrative confusion and conflict that accompanied the transfer of power over human resource planning and management from the MOH to the provinces.

Indeed, the transfer of executive powers to the provinces from a very reluctant MOH was followed by a period when the MOH seemed very unclear and hesitant about both its roles and its powers. Consequently, a lack of national level leadership has undermined an equitable and effective staffing of health services.

Human resource planning preceding and during decentralisation

National human resource planning commenced only in the mid-1980s as part of the production of the 2nd Health Plan. This plan identified the roles of the different health workers and estimated the numbers of health workers required and their availability over the entire plan period.

The second major effort in health human resource planning took place in 1991, just after decentralisation. The objective of the exercise was to obtain estimates of the number of health workers required by all provinces over the next ten years and to compare these requirements with estimates of projected supply. The data assembled by each provincial health office were used to make conservative projections of the numbers of health staff required to provide services and to make recommendations for improving the effectiveness of some categories of workers.

The provincial health officers were asked to scale their idealistic plans downward within the framework of local technical and administrative feasibility. Nevertheless, when the plan was sent to the Ministry of Finance (MOF) and the Public Service Commission (PSC) it was considered totally unrealistic and received no support from these central agencies. Its impact on a national human resource planning document and training policies was minimal. As a result provincial planners became demoralised and no further national human resource planning took place for several years.

Policy Formulation and Decentralisation

Upon decentralisation, each province was given the responsibility to develop its own provincial health policies within national guidelines. Nevertheless, the demarcation line between a “national” policy and a “provincial” one, was never defined, partly because the issue was new to central government.

Impact of decentralisation on the Planning of Human Resources

It was found that decentralisation had particularly affected three areas of human resource planning:

- the availability of data for monitoring, evaluating and planning
- the responsibility for planning
- MOH’s ability to implement planning decisions.

Data for planning human resources

The health human resource data base was weak prior to decentralisation; afterwards it became quite inadequate and unreliable. From 1991 to 1996, no attempt was made, whether at the national or at the provincial level, to relate the total number of health staff posts, future requirements and the numbers enrolling in and graduating from the training schools. This marked inactivity was due to several factors. Planning skills were clearly inadequate and staff turnover had been considerable. Furthermore, the MOH failed to give guidelines for health services and did not serve as a technical adviser to the provinces on HRD issues.

Since the MOH had no decision-making responsibility for provincial levels of staff, it kept few records of posts and vacancies. Personnel records at the PSC were also notoriously out of date and linked neither with establishment files in the same department nor with the payroll file in the MOF. Even existing databases of staff for whom the MOH were still responsible, such as training staff and students, were eroded as a result of the staff turnover that accompanied decentralisation.

Responsibility for Planning

Decentralisation also resulted in confusion regarding the responsibility of various government departments for health human resource planning. Many of the provincial health staff assumed that when the PSC reviewed provincial establishments, it did so according to a health human resource plan that it had undertaken on the basis of some clearly defined criteria. The PSC itself did not see health human resource planning as its responsibility, but instead as something belonging to the MOH. However, it failed to communicate this to the MOH for several years.

Even if the departmental roles had been clearly understood, the ability of the national MOH to accept an active role in human resource planning would still have been seriously affected by the uncertainty about the divisions of powers and responsibilities, aggravated by the emotionally charged atmosphere that accompanied decentralisation. In the provinces, the level of planning expertise remained totally inadequate.

Because the MOH was isolated from provincial staffing decisions, it had little opportunity to be kept informed of perceived staffing needs in the provinces. Given its weak planning capacity and the lack of any staffing or cost standards on which to base its arguments, the MOH failed to lobby for an active role in resource allocation

processes in the early days of decentralisation, when organisational structures and practices were still being moulded. The MOF and the PSC rapidly became accustomed to making their own planning decisions without consulting the MOH.

The exclusion of the MOH from provincial budget discussions, which take place between the individual provinces and the Ministries of Finance and Planning, left it unable to influence the overall funding levels either between provinces or between different sectors within a province. In reality, health care human resource planning was thus carried out by the Ministries of Finance and Planning and the PSC through the annual budgetary process of setting provincial financial limits and staff ceilings. Nowhere in this process was there any attempt to assess the health service needs of the country as a whole or one province in relation to another.

Ability to implement planning decisions

The Fourth Health Plan documented deep inequalities in staffing between provinces. The provincial population per nurse was found to range from 500 to 2,300 in 1995. The equivalent ratios of population per health extension officer ranged from 3,500 to 22,500.

Prior to decentralisation, the MOH had been able to decide what new posts were required in under-served provinces and to obtain PSC approval and funding for them. This was done taking account of existing vacancies and the estimated number of annual graduates. In fact, graduates of health training institutions came to expect a guaranteed job after finishing their training. With no formal linkages in place between the Ministries of Health, Finance and Planning and the PSC after decentralisation, the necessary mechanisms for regular assessment and adjustment of any identified imbalances in provincial staffing were non-existent. Furthermore, there were no incentives in place to attract health workers to provinces that were underserved. In addition, the MOH could no longer guarantee the creation of posts, and this led to considerable concern among the students, culminating in a strike by students training to be health extension workers.

Impact of decentralisation on training health care human resources

Lack of Planning

Lacking a long-term plan for the development of health care human resources, the MOH was unable to advise the training schools what types and level of intake it required. This lack of overall planning had a very demoralising effect on both students and teachers. Training programs were started and stopped and intakes fluctuated greatly.

Increasingly frustrated with the lack of human resource planning by the MOH, the Public Services Commission froze the health establishment for a year in 1985. This action was intended to encourage the MOH to undertake human resource planning. Instead it had the opposite effect. The department which had been pressured by health extension and health inspector students to guarantee employment after training, responded not by planning but by curtailing all training programs. Government nursing schools closed enrolments for a year and the intake of students to health extension and health inspector training programs was cut drastically. With no intakes for a year, potential nursing students lost confidence in courses and applications for subsequent years dropped. Furthermore, with falling intakes to

government nursing schools, church schools were training 75% of the country's nurses by the late 1980s.

Lack of human resource planning during decentralisation also seriously affected the ability of the MOH to influence those training programmes for which it was no longer responsible. The outputs from most training programs were insufficient to offset natural wastage from the human resource, and attrition during training was substantial.

Transfer of Training Functions

Decisions on the transfer of responsibilities at decentralisation had a particularly severe impact on the training of certain categories of health staff. While training in general was declared a national responsibility at decentralisation, medical assistant aide training was assigned to the provinces. Yet this was not backed up with the necessary funds. Most provinces found it impossible to fund this training out of their own budgets.

Need for capacity development

After decentralisation, the provinces did not have the necessary health systems to conduct effective financial management, budgeting and planning for the health sector. Provincial health administrators were, for the first time, forced to argue for adequate funding of health services in competition with other provincial sector priorities.

Strained administrative relationships over trainees and training institutions

While training remained a national responsibility at decentralisation, the training schools were physically located in the provinces. Following decentralisation, some of the provinces with a training institution insisted on a bigger voice in the selection of students and deployment of graduates to ensure that sufficient numbers of the province's own students were trained and graduates retained in the province.

Agreements had been drawn up between the national MOH and the provincial departments to allow the use of provincial health institutions and their staff in the training of health workers. In spite of such agreements, a conflict arose between a provincial government and a training school, with the provincial government refusing to allow any of its health facilities to be used for training purposes. This conflict was resolved only after threats by the Minister of Health to take the matter to the President's Office with a view to recentralising provincial health functions back to the MOH.

Decentralisation made it much more difficult for the MOH to rotate young doctors undertaking postgraduate training programs. When all establishment positions had been with the MOH, the Ministry had had authority to transfer staff and positions. By 1989, all provinces had created their own provincial establishments and filled their medical officer positions with doctors who were expected to remain on active service there, rather than undertake postgraduate training. This became an important constraint because the small numbers of specialist doctors who could supervise training no longer had a regular rotation of postgraduate trainees and therefore were unable to pass on their specialist skills.