In the country case studies examined as part of this report as well as in other developing countries, several sources of inefficiency exist in the public sector in the way wage bill resources are used in the health sector. The main categories are administrative efficiency (for example, whether the wage bill budget is executed fully or the recruitment process is timely) and allocative efficiency (for example, whether additional wage bill resources are allocated to areas where staff are needed most and whether the remuneration policies and terms of work provide incentives for retention in underserved areas, low absenteeism, high productivity, and quality of care). In the country case studies, one major driver of inefficiency found was the high degree of centralization of human resources for health (HRH) management functions, coupled with low capacity in central agencies. One policy option to address this issue is to decentralize key HRH functions to subnational units such as provinces, districts, and facilities. This appendix summarizes the rationale behind decentralizing key functions and the available evidence and lessons learned about its effect.

Decentralization refers to transferring decision-making authority to subnational levels. It is a term that has many meanings, and distinguishing

This appendix was prepared by Andrew Mitchell with input from the core team.
among different types of decentralization is important. Decentralization can be defined as the transfer of authorities from central government bodies to lower levels within the public sector or to autonomous institutions (Rondinelli, Nellis, and Cheema 1984). Decentralization is often categorized along political, fiscal, and administrative lines. Political decentralization extends decision-making power governing public institutions to citizens at the local level. Fiscal decentralization relates to subnational ability to control financial resources, including revenue generation and allocation of funds. Administrative decentralization refers to relationships of authority that affect the managerial concerns. Often viewed along a continuum of lesser and greater degrees of decentralization, administrative decentralization may be characterized as deconcentration of authorities from the central to local levels within a ministry or department of health, delegation of authorities to semiautonomous bodies, and devolution of responsibilities to autonomous or separate local governments (Hutchinson and LaFond 2004).

In general, political, fiscal, and administrative decentralization may be applied to any number of distinct functions in the health sector. A ministry or department of health oversees several kinds of health functions, including those that relate to financing of services (for example, expenditures allocation); service organization (for example, provider payment mechanisms); governance (for example, facility oversight boards); and human resources (Bossert 1998). Decentralization within one function, such as financing for services through block grants, does not necessarily imply decentralization within other functions, such as ability to modify centrally determined program priorities. Indeed, human resource functions are often among the least decentralized, likely because of the large share (and therefore control) of the health sector budget generally allocated to personnel (Bossert and Beauvais 2002). In Ghana, for instance, despite devolution of provision of primary health care and complete delinking of health providers from the Ministry of Health, human resource functions remain highly centralized (Dovlo 1998).

**Rationale for Decentralization**

There is strong rationale for transferring decision making to subnational units as a means of improving efficiency of expenditure in the public sector. The rationale behind decentralization is relatively straightforward: smaller organizations that operate with autonomy and close to their clients are generally more agile, innovative, and responsive to local needs than large, centralized organizations (Saltman, Bankauskaite, and Vrangbaek
2007). More proximity between health sector decision makers and catchment populations, for instance, can better orient service provision to local health priorities and therefore increase use of and satisfaction with health services. Decentralized units with greater autonomy may also more innovatively face challenges in HRH financing, allocation, and management. Table C.1 summarizes common objectives of decentralization, the mechanisms by which decentralization may achieve those objectives, and reasons that decentralization might not meet objectives.

In the area of HRH, decentralization can mean many different things. It is important to distinguish which particular decision-making powers are transferred to local authorities. Table C.2 lists the major human resource functions that might be decentralized independently or in concert. They include functions related to employment (hiring and firing, nature of tenure, defining the compensation package); management (transfers, promotions, and sanctions); skills mix; and training. Transferring authority to the local level for these functions may help governments be more responsive to local conditions, including market conditions, citizen preferences, patient needs, staff availability, and available resources.

There is a strong rationale for why transferring certain functions to local units might improve administrative and allocative efficiency, but potential negative effects also exist. In terms of administrative efficiency, allowing local recruitment could shorten the time to fill a position, eliminating the many steps involved with central-level approval. It may also lead to a better match of candidates with the appropriate

<table>
<thead>
<tr>
<th>Objective</th>
<th>Mechanism</th>
<th>Potential drawbacks</th>
</tr>
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<tbody>
<tr>
<td>Improved administrative efficiency</td>
<td>• Less bureaucratic red tape and more experimentation&lt;br&gt;• Greater local-level cost consciousness</td>
<td>• Higher national-level transaction costs from local-level administrative redundancies</td>
</tr>
<tr>
<td>Improved allocative efficiency</td>
<td>• Greater responsiveness to local-level priorities and preferences</td>
<td>• Heightened inequities at the national level</td>
</tr>
<tr>
<td>Greater accountability</td>
<td>• Heightened local-level involvement and civic participation</td>
<td>• Minimum level of local-level capacity required&lt;br&gt;• Open to local-level capture</td>
</tr>
<tr>
<td>Improved quality of services</td>
<td>• Improvements in efficiency and accountability&lt;br&gt;• Greater innovation from increased autonomy</td>
<td>• All of the above</td>
</tr>
</tbody>
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*Source: Authors’ compilation.*
position, because the final selection of candidates would be done locally. The same holds for firing, because dismissal and sanctioning could be conducted much more quickly. Similarly, letting local units set salaries and allowances allows them to take into account local labor market conditions. For example, salaries for certain areas may need to be much higher to attract staff members, but common national pay scales may prevent such local discretion. However, these potential

<table>
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<tr>
<th>Function</th>
<th>Specific elements</th>
<th>Rationale for decentralization</th>
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| Hiring and firing               | • Selection of candidates, development of job descriptions, and termination of staff members | • Reduces time to fill vacant positions  
• Matches candidates to job profiles better |
| Tenure                          | • Determination of terms of employment (for example, permanent versus contracted staff members) | • Responds to local market conditions  
• Allows more flexibility in types of personnel hired |
| Salary                          | • Determination of base salary                                                   | • Responds to local market conditions in recruiting health workers |
| Nonsalary compensation          | • Determination of allowances, bonuses, and pensions                              | • Responds to local market conditions in recruiting health workers |
| Transfers                       | • Transfer of staff members within and between localities  
• Horizontal mobility          | • Increases flexibility in deploying staff members  
• Responds to local preferences, patient needs, and staff availability |
| Promotions and sanctioning      | • Promotion, performance review, grievances, and termination                      | • Makes promotions more timely |
| Skills mix                      | • Determination of overall staff establishment  
• Determination of facility staffing patterns  
• Accreditation and licensing standards | • Responds to local market conditions, local preferences, patient needs, staff availability, and staffing resources |
| Training                        | • Central or local division of preservice and in-service training responsibilities | • Responds to local preferences, patient needs, staff availability, and staffing resources |

Source: Authors’ compilation
gains in efficiency are threatened by negative repercussions if proper oversight and monitoring are not in place. Allowing local hiring and firing may increase the likelihood of corruption and nepotism, as has been reported in China, Indonesia, Tanzania, and Uganda (for example, favoritism in employment toward “sons and daughters of the soil,” a form of nepotism) (Ssengooba 2005; Tang and Bloom 2000; Turner and others 2003). Decentralizing wage-setting could exacerbate distributitional inequities if historically advantaged localities are better able to attract and retain personnel than are relatively disadvantaged areas. It might also lead to wage inflation as districts and provinces compete for scarce personnel and escalation in the overall wage bill if controls are lacking or not all local-level workers are under local contracts (a common occurrence). This has been the experience of such countries as the Philippines and Mexico, where local government units have felt fiscal pressure to raise compensation of locally employed personnel to the higher pay scales enjoyed by workers who continue to be centrally employed (Homedes and Ugalde 2005; World Bank and Asian Development Bank 2005).

For decentralization to work, careful thought must be given to what functions need to be matched. For example, transferring authority to hire and fire workers may have less of an effect if authority on setting the skill mix is not transferred as well (that is, the local government may be able to select which individual to hire but not whether to hire a doctor or a nurse because of fixed staffing norms). Authority to set salaries might not be useful unless either facilities have flexibility in how much of their budget can be used to pay health workers, or facility budgets are adjusted based on local salary levels. In other words, an appropriate match needs to be made between fiscal and administrative functions.

Decentralization in Practice
The scope of decentralization of HRH functions has been limited in developing countries. Although examples exist of countries that have undergone a process of human resource decentralization, governments often decentralize only some elements of certain human resource functions. Under less expansive forms of decentralization (for example, deconcentration or delegation), the most commonly decentralized functions appear to relate to human resource management, whereas functions related to terms of employment for HRH (for example, determination of local-level wage bill or HRH salaries) tend to remain under centralized control. Furthermore, the degree of decentralization within a specific functional element can vary. In Tanzania, for example, recruitment and
selection procedures for junior staff fall under district-level auspices while the same functions for senior-level staff remain centralized. Even under more expansive forms of decentralization (for example, devolution), salary determination may be specifically delinked from the decentralization process to ensure continued central control, as is the case in the Philippines. Public sector decentralization experiences in East Asia are typical of this pattern. Among the six countries analyzed (Cambodia, China, Indonesia, the Philippines, Thailand, and Vietnam), none is able to determine salaries at the local level (though top-ups are allowed), whereas all but one handle recruitment at the local level (Green 2005: ix, 135).

For many administrative, political, and policy-related reasons, most countries have limited the scope of decentralization of HRH functions. Administratively, a “big bang” approach to decentralization of HRH functions is costly and may require fundamental organizational changes of national health ministries. Terms of employment and terms of reference for posts—existing and planned—may need to be redesigned to incorporate new administrative responsibilities, skill requirements, and resources available at different levels of the system. Although such reform was possible in a country such as Indonesia, which has a highly capable civil service commission at the national level, such capacities may not exist elsewhere. Even where they do, the financial implications of decentralization can be significant: Mexico spent an estimated US$452 million in administrative costs to transfer its federal health employees to the state level (Homedes and Ugalde 2005).

The required local-level capacity to implement these changes might be lacking and cause hesitation to decentralize human resource functions. Indeed, the quality of Papua New Guinea’s personnel management database rapidly deteriorated following provincial-level devolution (Kolehmainen-Aitken 2001). Additionally, the associated costs of ensuring that newly decentralized systems work efficiently could be exorbitant and meet with resistance. Chief executives of local governments in the Philippines, for example, initially refused to absorb over 4 percent of devolved health staff (Kolehmainen-Aitken 2001).

Political pressure may prevent decentralization. Politically, human resource decentralization involves a wide variety of institutional actors, both within the government (for example, health managers, civil service officials, elected politicians) and in the private sector (for example, professional associations, unions). These stakeholders may manifest resistance to decentralization of HRH functions for any number of reasons. Bolivia,
for example, has twice failed to decentralize HRH functions despite fiscal decentralization because of resistance both from within the government and from most unions and professional associations (World Bank 2004). Similar resistance has been manifested in Burkina Faso (Bodart and others 2001) and elsewhere. Furthermore, ministries of health often do not have the ability to alter key HRH functions such as civil service–wide terms of employment.

Finally, central authorities may limit decentralization of human resource functions in light of certain policy objectives. Although decentralization may improve local-level responsiveness to needs, it may neglect national-level concerns, such as equity in HRH distribution or standards of compensation. In Uganda, for instance, district governments must adhere to a national pay scale even if benefits and allowances are left to their discretion (Bossert and Beauvais 2002). The government explicitly developed this system to ensure equity in deployment of personnel among local governments (Ssengooba 2005). In Brazil, an important federally supported primary health care program specifically retains many staffing concerns (for example, composition of teams, personnel job descriptions) even while program implementation has been devolved to the municipal level. This design was reportedly used specifically to ensure that local implementation met national objectives as well as to avoid political program capture (Guanais de Aguiar 2006).

**Evidence of the Impact of Decentralization**

What does the evidence say? The following evidence is informed by a literature review, conducted in March and April 2008. Documents consulted include peer-reviewed journal articles; other published works (for example, books, official reports); and public domain “gray literature” (that is, unpublished or nonreviewed literature). All sources or relevant citations were accessed over the Internet. Primary search engines included PubMed (for peer-reviewed sources), Google (for gray literature), and site-specific searches (for example, USAID Development Experience Clearinghouse). Manual searches of bibliographic references contained within the documents retrieved were also made to identify further instances of relevant literature. The research strategy was not designed as a reproducible systematic review of the literature.

Discussion of the evidence base focuses primarily on links between decentralization of management-oriented human resource functions and efficiency or performance. Although insights on the role that decentralized salary determination might play in these outcomes is of great interest,
the general lack of experience with decentralization of salary setting in developing countries precludes such an analysis.

Improved administrative efficiency is context-specific and requires adequate capacity at local levels. Instances exist in which decentralization of hiring and firing appears to improve administrative efficiency. Delegation of recruitment procedures in Thailand from the central civil service commission to line ministries is reported to have reduced this process by over 50 percent—from 68 to 31 days (Simananta and Aramkul n.d.). In China, devolution to the township level of recruitment for health facility personnel enabled health centers to better match demand with supply costs and to reduce employment by 70 percent (Liu and others 2006). In Uganda, three-quarters of health workers interviewed in one study felt that salary disbursement is more rapid following district-level decentralization of human resource functions related to recruitment, selection, performance evaluation, and promotion (Ssengooba 2005; also box C.1). In other instances, however, drawbacks to decentralization

Box C.1

A Tale of Two Ugandas: Successes and Failures in Administrative Efficiency under Decentralized Human Resource Management

The framework of decentralization of human resource functions in Uganda is typical of that of many countries. Most human resource management functions—recruitment, appointment, allowance and benefit setting, performance evaluation, and promotion—are under the authority of district service commissions (DSCs), whereas salary scales and payroll management remain under centralized control by the Ministry of Public Service. Before this decentralized framework, administrative inefficiencies clearly abounded in human resource management. Many employees worked without ever receiving formal letters of appointment, for example, while others remained indefinitely on probation for no apparent reasons. Decentralization has been able to address some of these problems, but challenges remain.

Successes

Interviews with 800 health workers carried out in 2005 suggest that, in many ways, decentralization has improved human resource management:

(continued)
Under demand-driven recruitment, employment processes are generally much faster, owing to the ability of DSCs to conduct selection. Furthermore, decentralized recruitment may have allowed districts to better match needs with resources: poorer districts generally had higher levels of workers working in their home district than did wealthier districts.

Around half of study respondents felt that performance appraisals were more objective after decentralization than previously, and most felt that heightened local-level supervision and accountability were beneficial.

Almost three-quarters of respondents receive salaries more quickly under decentralization and expressed satisfaction that, under decentralization, the date of monthly payments was simply predictable.

District facilities were able to employ some cadres of personnel at significantly higher rates than nationally established minimum staffing standards.

Failures
For each success, there is a flip side. Additionally, decentralization of human resource management has introduced new challenges not of previous concern:

- The change from centralized supply-driven recruitment to decentralized demand-driven recruitment—coupled with broader national-level policies to contain the public sector wage bill (wage ceiling; freeze on recruitment)—left many job seekers feeling frustrated about not being able to find employment. Although some districts increased the level of locally employed workers, this action may have been driven by nepotism as much as by taking advantage of market conditions. Health workers working in their home districts generally reported expedient recruitment, whereas those from other home districts often perceived the recruitment process as biased against them.
- Though performance evaluations are more objective, many respondents felt that these evaluations were not used in employment and promotion decisions. Furthermore, 75 percent of respondents did not feel secure in their jobs because of the power of local authorities to dismiss workers and the perception that these authorities often base employment decisions on nontechnical or non-job-related grounds.
- Although satisfaction has increased with more efficient salary disbursement, it is in some ways overshadowed by low salary levels: for only one in five respondents does salary make up even one-half of total earnings; the remainder comes from subsistence cultivation, private practice, other business, and the like.

(continued)
Box C.1 (Continued)

- Employees expressed a widespread sense of entrapment because of new obstacles to cross-district transfer under decentralization. (Workers effectively have to resign from their post in one district before taking another job in a different district.)
- Employment of health workers above minimum standards was confined almost exclusively to nontechnical personnel. For technical personnel, shortfalls from minimum standards ranged from 25 to 50 percent.

Lessons Learned

Uganda’s experience with decentralization and HRH provides useful insights to countries considering decentralization of human resource functions. Uganda’s successes and failures suggest that to achieve improvements in administrative efficiency under decentralization, the following conditions should apply:

- Adequate local capacity and accountability need to accompany increased local-level authority. Heightened efficiency in recruitment means little if overall salary levels are not adequate to attract and retain workers. Accountability can be effective, but only if it is not subject to local political capture.
- An appropriate balance must be struck between degrees of decentralization and centralization. Although local and demand-driven recruitment is in some ways more efficient than centralized and supply-driven recruitment, the absence of centralized coordination of information about job availability—as well as new obstacles to cross-district transfers and promotions—has resulted in an expensive system for job seekers and an entrapping system for workers.
- Effectiveness of HR decentralization is greatly affected by broader constraints. Financial limitations imposed by national-level policies to contain the country’s civil service wage bill became the overriding criterion for determining staffing patterns and inhibited the ability of DSCs to respond to local conditions.

Source: Ssengooba 2005.

described in table C.1 have prevented efficiency gains. District-level decentralization of certain human resource management functions in Pakistan is said to have resulted in long-term vacancies of posts, in part caused by multiple and overlapping lines of authority over posting of officials (Nayyar-Stone and others 2006). Despite decentralization of recruitment and contracting procedures in Tanzania to the district level for lower-level personnel, employment procedures remain lengthy, and delays in hiring continue as before. A lack of local-level awareness of procedures
Decentralization generally does not narrow—or even accentuates—inequities in geographic distribution of personnel. Country experiences suggest that inabilities to guide the decentralization process with national-level objectives—as well as increased local-level transaction costs—inhibit equity in distribution of personnel. Geographic inequities in HRH distribution have been perpetuated where the central ministry of health no longer has the authority to establish staffing establishments (for example, China, Papua New Guinea) or the capacity to fulfill such establishments, despite decentralization of human resource management functions. For example, one-third of Mozambique’s health facilities—for which selection, recruitment, posting, administrative procedures on salaries, and retirement are handled by provincial governors—do not meet nationally determined staffing patterns (Ferrinho and Omar 2006; Kolehmainen-Aitken and Shipp 1990; Tang and Bloom 2000). At the same time, increased bureaucratic hurdles at the local level can further perpetuate geographic imbalances. Devolution of human resource functions in Indonesia to provincial, regional, and city governments, for example, has not mitigated existing inequities in distribution (in the health sector, the ratio of HRH to 1,000 population ranges from 0.5 to 5.5 at the regional level, with one- to fivefold differences at the city or district level). The lack of a formal process to transfer staff members between regions—as well as no national downsizing plan to meet equity concerns—may help perpetuate these imbalances (Thabrany 2006; Turner and others 2003). Difficulties in transferring staff members between local governmental units endowed with devolved human resource powers have also been reported in China, Papua New Guinea, and Tanzania (Campos-Outcalt, Kewa, and Thomason 1995; Dominick and Kurowski 2004; Liu and others 2006). Additionally, HRH decentralization can heighten or even create horizontal inequities among personnel. Reports from China, the Philippines, and Uganda indicate that staff members who perform similar functions are paid differently because some continue to be administered centrally while others are paid locally (Kolehmainen-Aitken 2004).

Evidence on quality of care is scant, mixed, and of limited generalizability. On the quality side, a particularly interesting account from Tanzania suggests that decentralization of human resource functions is positively associated with quality of care. Analyzing the degree of decentralization in governmental and nongovernmental health facilities—measured by ability to fire personnel, set salary levels, pay workers from local resources,
and determine staffing patterns—the author finds greater decentralization to be associated with better quality of care (including metrics on clinical and diagnostic procedures, health education, and client responsiveness) (Mliga 2003). Though provocative, this study is plagued with methodological limitations that make the influence of decentralization impossible to isolate from other factors (such as different quality of personnel by institution ownership type).

Similarly, little or conflicting evidence is available related to absenteeism or turnover. One study states that assumption of recruitment and appointment powers for contracted physicians by divisional-level authorities in Pakistan has reduced absenteeism (Collins, Omar, and Tarin 2002), although another indicates findings to the contrary (Nayyar-Stone and others 2006). In Nigeria, relatively elevated rates of facility turnover suggest that the national civil service incentive structure is not meeting its objectives of heightened facility-level teamwork and stability despite human resource management having been fully devolved to local governments (Das Gupta, Gauri, and Khemani 2004).

In summary, there are both success and failure stories in the literature, clearly showing no magic bullets are available for improving HRH performance through decentralization. Moreover, the evidence base is fairly weak. It is increasingly clear that health sector decentralization is not an automatic prescription for improved efficiency or performance. This applies equally to decentralization of human resource functions and to health functions more generally. Although connections may exist between decentralization of human resource functions and efficiency and performance, evidence from the previous literature is not strong. A major reason is a lack of research on the effect of decentralization on outcomes. This knowledge gap is particularly deep for outcomes related to administrative efficiency. Of the examples cited previously, only the China and Thailand accounts provide quantitative data to support their conclusions, making evaluation of the accuracy of claims made by these reports generally impossible. More generally, rigorously evaluating the effects of decentralization on administrative efficiency does not appear to be on anyone’s agenda.

Even with more rigorous studies, a second reason has to do with the difficulty in attributing decentralization of human resource functions per se to outcomes. On the one hand, the multifaceted nature of decentralization makes isolating the effect of decentralizing any one element of a given function difficult. For instance, the precise role that decentralization of human resource functions has played in geographic distribution of
HRH—as opposed to other factors, such as the capacity of regions to effectively finance HRH under fiscal decentralization—is not documented. On the other hand, decentralization is almost always but one component of a larger package of health reforms, any of which might affect efficiency and quality concerns related to HRH. In China, for instance, loosening of HRH rural service requirement rules occurred at the same time that human resource management functions were devolved to townships. The subsequent reported increase in employment of “unskilled staff members” and suboptimal facility staffing patterns may have had as much to do with decreased incentives to locate in certain facilities as human resource management decentralization.

The evidence suggests several key issues that need to be considered in undertaking decentralization of human resource functions to achieve intended aims. At the local level, adequate capacity and accountability are key ingredients. Where decentralization has failed to meet desired goals, many previous studies have pointed to the lack of adequate financial resources made available to local authorities to carry out human resource functions as a major factor. In essence, decentralization of management functions cannot be expected to improve service delivery without accompanying ability to fund those functions. Similarly, several analyses point to lack of local-level accountability in thwarting goals of decentralization. In China, Indonesia, Tanzania, and Uganda, for example, favoritism in employment toward “sons and daughters of the soil” is reportedly common because of local political capture of the decentralization process (Ssengooba 2005; Tang and Bloom 2000; Turner and others 2003).

Both constraints and opportunities to effective human resource decentralization also exist at the national level. Constraints often come in the form of policies that supersede a country’s national health policy-making body. Many of the countries analyzed have rigid civil service employment structures, have imposed wage ceilings, or are in the process of downsizing the public sector workforce. Such constraints may inherently inhibit the range of human resource functions that can be decentralized and thus the likely effect of decentralization. At the same time, a ministry of health or relevant policy-making body needs to take advantage of opportunities to steer the course of decentralization. First and foremost, clarity in the objectives and divisions of responsibilities under decentralization are prerequisites. Confusion in lines of authority is often cited as a challenge to effective human resource decentralization. Districts in Kenya, for instance, are expected to manage public sector HRH performance but are not legally granted this function (Steffensen and others 2004). Additionally,
there is no reason to expect local-level authorities to develop innovative ways to improve efficiency or performance without national-level incentives to do so. The experience of primary health care in Nigeria—in which most local governments continue to abide by national civil service standards in setting pay rather than use performance or other locally relevant criteria—is a case in point (Das Gupta, Gauri, and Khemani 2004).

**Key Messages**

In summary, decentralizing human resource functions is a complex affair requiring a program of functional transfer of powers that matches national- and local-level capacities, resources, and accountability. When one is designing a program of human resource decentralization, considering the following points could help:

- **Objectives of human resource decentralization at the local and national levels need to be explicitly formulated and prioritized.** Given limited health sector budgets and capacities, it is doubtful that most countries will be able to register across-the-board improvements in efficiency and performance that could be realized under decentralization. Additionally, national-level priorities are not always in line with those at the local level. A program of human resource decentralization therefore needs to balance and prioritize local-level discretion in addressing the most pressing concerns at that level with national-level concerns.

- **Mechanisms by which human resource decentralization can achieve objectives need to be clearly articulated.** Decentralization is often thwarted by conflicting policies of centralization along one function, decentralization along another, lack of capacities to implement either, and lack of accountability to oversee implementation. In large part, this problem arises because objectives have not been clearly defined, nor have the tensions between local and national levels inherent in decentralization been addressed. Mapping out the mechanisms by which human resource decentralization is expected to meet objectives would go a long way toward developing more coherent and successful programs of decentralization. If improving administrative efficiency is the highest priority, for example, decentralizing management functions (for example, recruitment and selection) might be enough without necessarily decentralizing salary determination for those positions. If, however, such allocative efficiencies as inequitable geographic distribution dominate, giving lower levels greater authority in setting salaries to attract HRH to underserved areas might be more effective, whether
recruitment or selection takes place at the central or peripheral levels. Similarly, although minimum national facility staffing standards may help to ensure equity in HRH distribution, they come at the expense of flexibility to adapt to local conditions. Whether such standards are worthwhile requires prioritizing objectives and thinking through which package of minimum standards will actually achieve those objectives.

• **Policy makers should address capacity constraints and create incentives in line with objectives.** Time and again, inadequate central-level support (technically, financially, administratively) has been cited as a major roadblock for effectively decentralizing human resource functions. A program of decentralization needs to be realistic about what gains can be expected, given existing capacities, as well as ways in which those capacities can be improved. Additionally, capacities may be necessary for human resource decentralization, but they are not necessarily sufficient. Incentives are needed to encourage local decision makers to make the most of opportunities afforded by greater control of human resource functions.

• **The effect of human resource decentralization on efficiency and performance needs to be monitored.** Improving the balance sheet of decentralization and HRH requires a much better understanding of the links between (a) human resource decentralization and (b) efficiency and performance. This understanding can be developed only through a concerted program of research to evaluate the effects of human resource decentralization on outcomes.

**References**


