Decentralised Human Resource Management in a District Health System: case studies in the Western Cape Province, South Africa

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Keywords

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Role theory

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Legitimacy

Capacity

Declaration

I declare that *Decentralised Human Resource Management in a District Health System: case studies in the Western Cape Province, South Africa* is my work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full name: Verona Elizabeth Mathews

Signed: 

Date: 9 November 2017

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Dedication

To my mother, Ada Phillips, who has sacrificed so much for me especially to attain an education, instilled a set of values and principles that amalgamated into a set of personal characteristics such as: integrity, perseverance and courage.

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Abstract

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Submitted for Doctor of Philosophy, School of Public Health, Faculty of Community and Health Sciences, University of the Western Cape.

The effective management of the public health workforce, in the context of decentralisation and the District Health System, is pivotal to the delivery of primary health care and, ultimately, improved health. This research investigates the phenomena of human resource management in the public health sector, focussing on the factors influencing human resource management (HRM), the internal alignment within the HRM Programme and external alignment with the strategic objectives of the organisation. It takes a frontline perspective to understand how the phenomenon is experienced in a decentralised District Health System.

This research is located in the field of Health Policy and Systems Research. The specific research design adopted in this thesis was a case study approach using an embedded, multiple-case study consisting of two district cases studies, representing an urban and rural district in one province, with two embedded units of analysis (appointments and leave application) in each of the two cases. Data collection consisted of document review, face-to-face interviews, questionnaire and focus group discussions.

The research yielded the following key insights on human resource management in the public health sector districts in the Western Cape Province: firstly, HRM is performed by two key role players (HR Manager and Line Manager) ostensibly in partnership. The application of Ulrich's framework of roles and competencies required for an internally and externally aligned HRM system identified key gaps in the roles and competencies of both Line and HR Manager. In addition, the research found that an absence of clear roles and responsibilities in performing human resource management, different orientations, backgrounds, and priorities of Line and HR managers, caused role confusion in the shared role of human resource management. Secondly, the study found that the shared role for human resource management was undermined by the absence of reliable up to date information where Line Managers developed duplicate information systems to provide the information they needed to manage

the public health workforce. Thirdly, the study identified the key strengths and weaknesses of the HRM system by analysing the internal and external alignment of the HRM Programme. The analysis provided insight into the factors influencing district HRM and the implications thereof.

Though favourable conditions for alignment were found, the research concluded that internal or vertical and external or strategic alignment was not observed in the districts. To strengthen the human resource management system in a District Health System a partnership between the HR Manager and Line Manager has to be fostered starting with a shared vision and objectives for human resource management, improving alignment through coordination within HR components, role clarification, capacity building, improving the human resource information system and positioning an accountability framework for the partnership.

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List of acronyms and abbreviations

ART	Antiretroviral therapy
ASD	Assistant Director
CEO	Chief Executive Officer
CHC	Community Health Centre
CHSO	Community Health Services Organisation
CMI	compliance management instrument
CoCT	City of Cape Town
DD	Deputy Director
DHS	district health system
DMT	district management team
DPSA	Department of Public Service Administration
HR	human resources
HRD	human resource development
HRH	human resource for health
HRM	human resource management
HPSR	Health Policy and Systems Research
MCH/HIV/TB	maternal and child health/ human immune virus/ tuberculosis
MDG	Millennium Development Goals
MDHS	Metro District Health Services
MFMA	Municipal Finance Management Act
NHA	National Health Act
Persal	Personnel Salaries
PFMA	Public Finance Management Act
PHC	primary health care
SHRM	Strategic Human Resource Management
WHO	World Health Organisation
WPHRM	White Paper on Human Resource Management
WPTPS	White Paper on the Transformation of the Public Service

1. INTRODUCTION

The introductory chapter describes the background of the thesis as a study of human resource management in the context of a decentralising District Health System. It summarises the key issues accompanying decentralisation, with particular reference to the human resource dimensions of decentralisation. It highlights the overall neglect of human resources for health, specifically human resource management, in health sector reforms.

The overall framework adopted is then outlined, followed by the introduction of the concept of alignment, a core idea in the thesis. Alignment is used in two ways: firstly, analytically, to assess the alignment of human resource management functions with each other, as well as with the strategic objectives of the organisation; and secondly, as a strategy to enhance the functioning of the health system. This is followed by a description of the problem statement, research setting, aim, objectives, and research questions. The chapter concludes with an outline of the thesis.

1.1. Background

This thesis addresses the theme of human resource management in decentralised or decentralising health systems, specifically the District Health System, in South Africa. Human resources for health have been a pre-occupation in health systems for a long time. However, the focus has tended to be on the availability, planning and training of health workers, often centred on national policy and processes, rather than the local systems required in the day-to-day management and deployment of human resources for health. There is a gap in the understanding of what is entailed in comprehensive human resource management functions at district level. This thesis seeks to contribute to filling this gap.

District health systems and decentralisation

In most health systems, the most decentralised unit of governance is a district. A district health system is defined by the World Health Organization as follows:

> *A district health system based on Primary Health Care is a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private, or traditional. A district health system, therefore, consists of a large variety of interrelated elements that contribute to health in homes, schools, work places, and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level and the appropriate laboratory, other diagnostic, and logistic support services. Its component elements need to be well coordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities* (WHO, 1988: 9).

The development of District Health Systems in South Africa and other low and middle-income countries has to be understood in the context of wider health sector reforms, most notably decentralisation.

Health sector decentralisation, the transfer of authority and responsibility for decision-making from the centre to the periphery (Saltman, Bankauskaite, & Vrangbaek, 2007), has been implemented as part of health sector reforms in many countries of the developing world (Bossert & Beauvais, 2002). However, the rationale for decentralisation has varied. A development perspective would see decentralisation as promoting good governance by "increasing people's opportunities for participation in economic, social and political decisions; assisting in developing people's capacities; and enhancing government responsiveness, transparency and accountability" (UNDP-government 1999: 2). An influential proponent of health sector decentralisation in the early 1990s, the World Bank, promoted decentralisation with other measures such as user fees, in its World Development Report as a key means of improving health sector performance (World Bank, 1993). Coming from an economic perspective, it is argued that bringing decision-making and oversight

closer to the point of service delivery would lead to improved allocative and technical efficiency and service delivery innovation, as well as improved quality, transparency, accountability, and legitimacy. Decentralisation was a key feature of the "health sector reform" movement in the 1980s and 1990s. Gilson and Mills (1995) in their review of health sector reforms in sub-Saharan Africa in this period, highlighted two specific types of strategy initiated by governments: reform of financing strategies, and reform of public sector organisation and procedures.

Decentralisation can take different forms. The classic four-fold typology of decentralisation - deconcentration, delegation, devolution and privatisation – involves different institutional arrangements and degrees of transfer of authority. The two forms relevant to thinking about District Health Systems – deconcentration and devolution – are defined by Bossert (1998: 1515) as follows: "Deconcentration is … shifting power from the central offices to the peripheral offices of the same administrative structure (e.g. Ministry of Health and its district offices)" whereas "Devolution shifts responsibility from the central offices of the Ministry of Health to separate structures still within the public administration (e.g. local governments in provinces)".

Notwithstanding common drivers and forms, the specific manifestations and impacts of decentralisation have varied. Gilson and Mills (1995) conclude that to assess the success of reforms, the implementation of reforms – specifically the influence of context, actors, and processes – has to be investigated.

District health system in South Africa

The health system in South Africa is made up of one national and nine provincial health departments, with fifty-two districts demarcated along political district and municipal boundary lines, mandated by the National Health Act (61 of 2003) (National Department of Health, 2014).

In 1997, The White Paper for the Transformation of the Health System in South Africa, set a framework for the establishment of the District Health System. The White Paper proposed three governance options: the provincial option, the statutory district health authority option and the local government option (National Department of Health, 1997). District

management teams were subsequently appointed for the day-to-day management of the primary health care (PHC) system, mostly as units of a de-concentrated provincial system, rather than management entities with delegated authority and significant capacity (Harrison, 2009). Several metropolitan municipalities have retained a significant parallel role in the delivery of PHC services (National Department of Health, 2014).

The appointment of District Health Councils, as an oversight governance structure charged with coordinating the planning, budgeting, provision and monitoring of all services for the health district, was stipulated in the National Health Act of 2003. However, the implementation of this stipulation required provinces to legislate for the functioning of the District Health Council and to enter into agreements with municipalities providing PHC services. By 2009, this had been achieved to a very limited extent, with only one province having passed the required subordinate legislation (Harrison, 2009).

In 2011, the National Health Insurance Green Paper was launched, proposing an alternative option for the District Health Council, namely, the District Health Authority, with new roles in relation to other spheres of government. In a purchaser-provider split arrangement, the District Health Authority would have responsibility for contracting and purchasing decisions, together with the National Health Insurance Fund, to ensure health service provision for populations located within a defined health district (National Department of Health, 2011).

Despite the policy intentions, the District Health System in South Africa is still undeveloped and highly uneven in respect of key issues such as decisions space, capacity, and financing. Decision space refers to how much choice the districts are able to exercise regarding health service functions such as financing (budgets and expenditure), logistical arrangements and payments, human resources and service provision (National Department of Health, 2014). Although several initiatives have been put in place to strengthen them, management capacity and systems at district level remain weak and decision-making on staffing, budgeting and expenditure control is still mostly centralised at provincial level (Harrison, 2009).

The human resource dimensions of decentralisation in South Africa were studied by Martineau and colleagues (Martineau et al., 2003) and Kolehmainen-Aitken (2004). Kolehmainen-Aitken (2004) noted the constraints on District Health System development

exercised by the differences among health workers working in local government and provincial health departments, specifically the different remuneration packages and service conditions, legislation governing their work, as well as their organisational cultures and management styles. The human resource challenges to decentralisation identified by the authors were the lack of accurate information, lack of authority of managers in staff allocation and poor morale and performance arising from staff concerns (Kolehmainen-Aitken, 2004). Martineau et al. (2003) found that decentralisation of the district had been limited and noted a lack of indicators to monitor the impact of decentralisation on human resource management. The authors highlighted the high staff vacancy rate, as well as the unpreparedness of managers at a district level to perform decentralised human resource (HR) functions, and manage the process of change.

Human resource management functions at a district level are heavily influenced by the degree and processes of decentralisation of both the budget and the HRM responsibilities of district and sub-district authorities (WHO, 1988). In 2009, Harrison identified the devolution of staffing, budgeting and expenditure control to the peripheral level as an urgent priority (Harrison, 2009). Furthermore, the HRH Strategy for the Health Sector: 2012/13 – 2016/17, found that information for planning and managing the health workforce was not available, posing hindrances to determining the impact of decentralisation, monitoring and evaluating of human resources for health, and evidence-based decision-making and planning (Department of Health South Africa, 2011).

Health system strengthening and human resources for health

The adoption of the Millennium Development Goals in 2000 signalled a new era in health systems globally. It led to a series of global health initiatives providing increased funding for disease- orientated programmes and health systems, strengthening low and middle-income countries (Warren, Wyss, Shakarishvili, Atun, & De Savigny, 2013).

Although focused on MCH/HIV/TB, it became clear that without strengthened health system capacity generally, the new global health initiatives would be difficult to scale up. Initially, the spotlight was placed on the health workforce crisis. For example, financial resources were not considered the main constraint to scaling up national treatment plans for Antiretroviral Therapy (ART) in sub-Saharan Africa, but rather the lack of human resources for health

(Kober & van Damme, 2004). The theme of the 2006 World Health Report was the global health workforce crisis. The subsequent publication in 2007 of WHO's "Building Blocks" model of the health system (WHO, 2007) recommended the integration of health workforce issues into a comprehensive approach to health systems. This was in the light of some authors suggesting that while these global health initiatives supported health systems, they actually remained selective and disease specific (Marchal, Cavalli, & Kegels, 2009).

Health system strengthening is now recognised as key to improving health outcomes and attaining the Millennium Development Goals (Warren et al., 2013). The WHO's health systems model consists of eight health system building blocks, which through their multiple relationships and interactions constitute a system (WHO, 2007). The building blocks are: leadership/governance, information, financing, service delivery, health workforce, medical products, vaccines and technology (WHO, 2007). Health system strengthening aims at improving these elements and their interactions, with the objective of achieving more equitable and sustained improvements to health services and health outcomes (WHO, 2007).

Over the last decade-and-a-half, awareness of the critical importance of human resources for health worldwide has been created, through a cluster of international activities, prompted especially by the human resource crisis in sub-Saharan Africa (WHO, 2009). These activities have included, amongst others, high level forums on the health Millennium Development Goals, the Human Resources for Health Strategy Report of the Joint Learning Initiative, the publication of the World Health Report 2006: Working Together for Health, the resolutions of World Health Assemblies on health workforce development and the establishment of the Global Health Workforce Alliance (Dal Poz et al., 2009).

The 2006 World Health Report defines the health workforce as "all people engaged in actions whose primary intent is to enhance health" (WHO, 2006: 2), also often referred to as "health workers" or human resources for health (HRH). They include those responsible for delivering health services to the health system, as well as those who enable health system functioning. They include doctors, nurses, allied health professionals, dentists, social workers, community health workers, health information officers, health managers and support personnel. Health systems' performance depends on the size, composition and distribution, knowledge, skills and motivation of those responsible for delivering health services (WHO, 2006).

Despite the turn to "system level interventions", and the commendable progress made in achieving the MDG's (Warren et al., 2013; United Nations, 2015), strengthening the human resources of health component of systems remains a challenge. In many countries, there are still insufficient human resources to absorb, deploy and use the finance provided by global health initiatives to scale up health service delivery (WHO, 2009).

There is an estimated global deficit of 7.2 million health workers, with a projected 12.9 million shortage of skilled health professionals by 2035 (Campbell et al., 2013). In previous years, the human resource crisis was found to be greater in sub-Saharan Africa and low- and middle-income countries. These countries were especially constrained in the achievement of the health-related Millennium Development Goals (MDGs) since, globally, they hosted 4% of health workers, but carried 25% of the disease burden (WHO, 2006). The World Health Report (2006) found that 36 of the 46 African countries had critical shortages of doctors, nurses and midwives. The WHO Health Statistics Report (2015) depicts a grave picture, with only 2.7 physicians per 10,000 of the population in the WHO African Region, compared to 13.9 globally, and 12.4 nurses/midwives per 10,000 of the population in the WHO African Region, compared to 28.6 globally; the WHO African Region also has a much lower density of health workers overall (WHO, 2015). Indeed, the shortages of critical staff to implement policies, strategies and interventions are regarded as seriously impeding progress towards reaching MDGs (WHO, 2015).

As outlined in the 2006 World Health Report, HRH constraints on health systems are wide-ranging, of which the availability of health workers is just one. They include:

> *inappropriate or inadequate training, poor access to information and knowledge resources; inadequate numbers and skills of health workers; uneven distribution of workers at different levels of service delivery, low morale and motivation; unsafe conditions in the workplace; poor policies and practices for human resource development; lack of supportive supervision; lack of integration of services with the private sector and high attrition of health workers* (WHO, 2006: 21).

Despite a global health workforce crisis, skills training remains neglected and is often low on government policy agendas. As pointed out in 2003, "workforce issues are still considered to

be relatively unimportant by both national governments and international agencies" (WHO, 2003: 110). Health sector reforms prioritise aspects such as financing and access to medicines, and there is an underlying mistaken assumption that health workers will be available, motivated and able to undertake newly-assigned roles (Martinez & Martineau, 1998; Rigoli & Dussault, 2003; Narasimhan et al., 2004). Compounding this is the lack of technical capacity to identify and assess crucial policy issues related to the health workforce, as well as a paucity of comprehensive and reliable up-to-date data for informed decision-making and planning (WHO, 2009). In South Africa, the National Human Resource Plan for Health 2006 states: "It is evident that there are many challenges related to HR management and development. However, the major concern is the production of human resources in sufficient quantities to cater for the country's needs" (National Department of Health South Africa, 2006: 50).

Furthermore, emphasis is placed on the production of health workers and not on the management of these health workers, once they are working in the public health sector:

> *Human resources are arguably the single most valuable asset within health systems and this may explain the emphasis that traditional HR analyses place on looking at individual cadres of health workers: their numbers, their flows, their career structures and so forth. However, from a health systems development perspective, analysis of health cadres per se contributes little to understanding how these cadres are organized and managed in accordance with institutional arrangements* (Martinez & Martineau, 1998).

1.2. **Human Resource Management**

To date, research on HRM has focused more on the implementation of and impact on specific human resource (HR) policies, as well as interventions on availability, retention, performance, motivation and job satisfaction of frontline providers, with less focus on human resource management as a comprehensive *system* consisting of functions, actors, processes and a context responsible for these outcomes. In 2009, a review of the 10 best resources for health workers in developing countries provided an overview of recent studies, classified into three categories: human resource requirements in health, financial and non-financial incentives and health worker migration (Grepin & Savedoff, 2009). The review was silent on the holistic approach and practices to be adopted in managing a public health workforce,

whilst viewing human resource management as a system, specifically for the process of decentralisation and alignment with organisational performance.

Human resource management is "the integrated use of procedures, policies, and management practices to plan for necessary staff, and to recruit, motivate, develop, and retain staff so that the organization can meet its desired goals" (Mwita, Nyagero, O'Neil, & Elqura, 2009: 2). An HRM system is "a system representing a set of distinct but interrelated activities, functions, and processes that are directed at attracting, developing, and maintaining (or disposing of) a firm's human resources" (Lado and Wilson, 1994: 701). It has been characterised as consisting of three key elements: administrative systems, policies, and management and leadership practices (Management Sciences for Health, 2009). Bowen and Ostroff (2004), alternatively, describe two interrelated features of an HRM system: content and process. The content of the HRM system refers to the set of practices driven by the strategic goals and values of the organisation; and the process refers to how the HRM can be designed and administered effectively, creating shared meaning about the content and leading to better organisational performance (Bowen & Ostroff, 2004).

In their typology, Martinez and Martineau (1998) propose three key dimensions of HRM.

- The first dimension consists of the mechanisms referred to as Human Resource Development (HRD) functions (or HRM systems). While there is no agreed agenda or one way of categorising HRD functions (Martinez & Martineau, 1998), these generally include some combination of the following: HRM Capacity (HRM budget, HRM staff, HR planning), personnel policy and practice, HRM Data, Performance Management and Training (Neil & Reimann, 2010).
- The second dimension consists of the set of institutional actors who are "those groups or individuals who influence, or have the potential to influence, changes in the human resource domain because of their control or influence over one or more human resource functions" (Martinez & Martineau, 1998: 355). In the public health sector, there is a dispersal of accountability for HRM, with human resource management functions performed by two main role players: human resource managers (they are considered the administrators of HR) and line or operational managers (they usually perform the dual role of health professional and manager). However, human resource managers tend to have a focus that is limited to "personnel administration", which fails to encompass all

the aspects of HRM (Dussault and Dubois, 2003) and, conversely, the line or operational managers have a limited capacity to perform human resource management functions (Mwita et al., 2009).

- The third and final dimension is the general direction of change referred to as the policy context. This refers to the HR domain, which at the time when this typology was developed, was embedded within a broader policy context increasingly dominated by programmatic, disease-specific interventions and various health sector reforms, including decentralisation (Martinez & Martineau, 1998).

A realist review of human resource management interventions to improve health workers' performance in low and middle-income countries, one of the few studies on this theme, found that human resource management interventions could improve health workers' performance, but that different contexts produce different outcomes (Dieleman, Gerretsen, & van der Wilt, 2009). In Brazil health sector reform processes have emphasized decentralisation. A study assessing the process of decentralising human resources for health management and organisation found that though the HRH area has been developed beyond the field of personnel administration a low level of institutionalization of new approaches still remained (Pierantoni & Garcia, 2011). It found that 76.3% of health departments had an HRH unit, while 63.2% had an HRH information system using only the payroll and administrative records as data sources (Pierantoni & Garcia, 2011).

While there is relatively little literature addressing HRM in low and middle income countries' health systems, there is a considerable body of literature on HRM and organisational performance in the corporate environment (Wood, 1999; Youndt, Snell, Dean, Lepak, & Snell, 1996; Huselid, Jackson, & Schuler, 1997; Wright & Gardner, 2000; Rogg, Schmidt, Shull, & Schmitt, 2001; Paul & Anantharaman, 2003; Bowen & Ostroff, 2004). Although conducted in very different organisational environments, they provide useful conceptual tools for considering the public health sector in developing countries. For example, Zairi (1998) applied generic international best practices to the health care context and claimed that because the practices were rich in analysis, and generic, the health care environment could benefit from them.

1.3. **The Concept of Fit/Alignment**

A key concept in the literature on human resources from the private corporate sector is that of *fit*. Studies have shown a strong relationship between human resource management and organizational performance, where the concept of fit is used to measure HRM factors affecting organizational performance (Feyter & Guerry, 2010; Collins, Ericksen, & Collins, 2005; Erdil & Günsel, 2001; Gelade & Ivery, 2003). Studies using fit to measure HRM and organisational performance have also been conducted in public sectors in the global north (Järvalt, 2012; Boon, 2008; Loon, Vandenabeele, & Leisink, 2015).

Nadler and Tushman (1980: 45, in Wright & Snell, 1997) define congruence or fit as "the degree to which the needs, demands, goals, objectives, and/or structure of one component are consistent with the needs, demands, goals, objectives, and/or structure of another component". Becker, Huselid, and Ulrich (2001) posit that measuring human resource alignment is important in striving towards improving organisational performance. Wright and Snell (1997: 3) concur and link HRM with fit, by defining strategic HRM as "the pattern of planned human resource deployments and activities intended to enable the firm to achieve its goal", emphasising congruence or fit between HR and strategy. For example, organisational strategies require different role behaviours from their employees, thus HRM practices would be chosen based on the behaviours required to implement strategies (Wright & Snell, 1997).

The term, *fit* is used interchangeably with *alignment*. Two main types of alignment are identified: internal and external alignment (Becker et al., 2001). Internal alignment is the extent to which human resource management functions are integrated with each other and external alignment is the extent to which the HRM system is aligned with the objectives of the organisation (Becker et al., 2001). The measurement of internal and external HR alignment provides a platform for investigating the human resource management functions, by assessing the linkages between the HRM functions performed, and between the HRM system and the operational and strategic objectives of the organisation.

Following Martinez and Martineau's framework, internal alignment can be understood as the extent to which the different human resource components/functions are aligned with each other within the HRM system, with the HR professionals as key actors in this type of alignment. External alignment is understood as the extent to which the human resource

management components/functions are aligned with the strategic objectives of the HRM Programme, the health organisation's objectives, HR deliverables and the strategies implemented by the organisation. External alignment involves two actors, the HR professional and the line manager. In this case, actors refer to the key role players involved in the implementation of human resource management. External alignment, like internal alignment, is influenced by the context in which human resource management takes place and, specifically, factors such as the role and competencies of the HR professionals and the line manager, budget allocations, the technology utilised, prescribed priorities, and the implementation of HR strategies.

In summary, human resources for health are pivotal to the performance of health systems, although they have been neglected in health system strengthening endeavours. Even more neglected has been the human resource management function in the field of human resources for health. The appropriate management of the public health workforce, in the context of decentralisation and the District Health System, is pivotal to the delivery of primary health care and ultimately, improved health. Human resource management is the combination of mechanisms, actors and contexts forming a system. The concept of alignment provides the acumen for understanding the relationship between these dimensions.

1.4. The Human Resource Context in South Africa

Compared to other African countries, South Africa has a relatively good aggregate availability of HRH. In 2004, the Africa Health Workforce Observatory found that the health worker density of 7.078 per 1,000 of the population in South Africa compared favourably to the density of the entire African region of 2.626 per 1,000 of the population (WHO AFRO, 2006). A recent study in five countries – Mali, Sudan, Uganda, Botswana and South Africa – found that health worker density in Mali, Uganda and Sudan all fell short of WHO's recommended target of 2.28 health workers per 1,000 of the population, whereas South Africa and Botswana both exceeded it (Willcox et al., 2015).

However, the data on South Africa are misleading, in that approximately 79% of doctors work in an insurance-based private sector (Akazili & Ataguba, 2010), servicing on a regular basis only 16% of the population (National Department of Health South Africa, 2015). The public health sector in South Africa has a wide range of health workforce challenges,

including a shortage of professional health workers, a maldistribution of the current health workforce and recruitment and retention problems (Department of Health South Africa, 2011) .

The maldistribution of the health workforce occurs not just between the public and private sectors, but also between urban and rural areas, and tertiary and primary levels of care (Department of Health South Africa, 2011). South Africa's public health system, with its human resource shortages, has been weakened by an increased demand for care associated with HIV (Van Rensburg, Steyn, Schneider and Loffstadt, 2008). Furthermore, "the leadership, structures, processes and data systems have not been in place for effective health workforce planning and management. The lack of planning results in an 'unmanaged' health workforce, where attrition, shortages, poor access, and dissatisfaction become part of the culture of Human Resources for Health in the South African health system" (Department of Health, 2007: 27).

In 2007, a national assessment of existing district management structures, competencies and current training programmes was undertaken, in order to inform a national strategy and plan to strengthen district management capacity to ensure effective delivery of Primary Health Care in South Africa. One of the key findings of the national assessment was the variance in the delegation of authority amongst the nine provinces in the country: delegation of authority is depicted on two levels, financial delegation and human resource delegation (Byleveld, Haynes, & Bhana, 2008). The constraints and challenges experienced by District Health Management Teams in urban and rural districts include: inadequate delegation of authority, defective budgeting processes, staffing issues, lack of managerial skills, vacancies in key managerial positions and ineffective use or absence of quality management information systems to support decision-making (Wolvaardt et al., 2014: 81).

1.5. **South Africa's Public Health System**

The National Health Act 2004 (No 61 of 2003) provides the legislative framework for the South African health system and delineates three tiers: national, provincial, and district (Republic of South Africa, 2004). The three tiers can be described as follows:

- National - identifying national goals and priorities, and developing norms and standards for the provision of health services
- Provincial – taking care of public and private hospitals, ensuring that systems are in place to maintain quality control, and supporting districts
- District – at the centre of health care service delivery (Hassim, Heywood, & Berger, 2007).

The 1997 White Paper for Transformation of the Health System emphasised that primary health care, which is the focus of the national health system, will be delivered through a District Health System (National Department of Health, 1997). The National Health Act (2004) established the District Health System in 2004 as the delivery system of primary health care whose role, according to the White Paper for Transformation of the Health System (1997), was "the overall management and control of its health budget, and the provision and/or purchase of a full range of comprehensive primary health care services within its area of jurisdiction. Effective referral networks and systems will be ensured through co-operation with the other health districts. All services will be rendered in collaboration with other governmental, non-governmental and private structures" (National Department of Health, 1997: 30). Although the White Paper proposed that the primary health care services be devolved to local government, responsibility for the DHS and PHC was ultimately located at provincial level in the National Health Act[1].

1.6. **Problem Statement**

Research to date on human resources for health has focused on individual strategies and interventions in human resource management, and has not viewed HRM as a system aligned with the organisational objectives to improve organisational performance. Thus far, research on alignment has been limited to the corporate sector, with a dearth of research on alignment in the public health sector and, specifically, human resource management. Furthermore, little attention is given to the HRM functions performed by the role players in a District Health System in the process of decentralisation, and how HRM functions are aligned within the HRM system and the strategic objectives of the organisation. This neglect could lead to ineffective human resource management, influencing service delivery and affecting the health

[1] This issue is subject to considerable debate and contestation.

outcomes of populations. The alignment of human resource management in a decentralised District Health System with the strategic objectives of the organisation would improve health worker performance, and strengthen both the health system and health outcomes in the health districts.

1.7. **Aim of the Study**

The aim of this study is to describe and analyse human resource management in the public health sector, through assessing the internal and strategic alignment of human resource management within the Human Resource Programme, and with the strategic objectives of the organisation. An analysis of human resource management in a District Health System will illuminate the factors influencing alignment, whilst identifying opportunities for health systems to be strengthened.

1.8. **Objectives of the Study**

1. To describe the challenges experienced in human resource management in a district health system.
2. To describe and analyse the human resource managers' roles and functions in human resource management.
3. To describe and analyse the operational or line managers' roles and functions in human resource management.
4. To assess the internal alignment of human resource management functions within the human resource management system.
5. To assess the strategic alignment of the human resource management system with the operational and strategic objectives of the organisation.
6. To explore the factors which hinder or strengthen the district-based human resource management of the public health workforce.

1.9. **Research Questions**

1. Who are the different role players and what is their relationship with each other in the human resource management of the public health workforce?
2. What are the roles and functions of the role players in the human resource management of the public health workforce?
3. What are the structures, functions and procedures for managing the public health workforce?
4. What are the relationships and communication structures for human resource management in the public health sector?
5. What are the challenges experienced in the human resource management of the public health workforce?
6. How are the human resource management functions aligned within the Human Resource Management Programme?
7. How are the human resource management functions aligned with the objectives of the organisation?
8. What are the enablers and hindrances in strengthening or weakening the human resource management of the public health workforce?

1.10. **Study Setting**

This research was conducted in one of South Africa's provinces in two districts in the Western Cape Province. As with the rest of South Africa, the Western Cape Province's population suffers from a complex, quadruple burden of disease, consisting of high levels of HIV and TB; a traditional burden of infectious, neonatal, child and maternal ill-health; a growing burden of non-communicable diseases; and injuries and violence. The Mortality and Causes of Death in South Africa (2014) report highlights "an epidemiological shift in the main causes of death and disease, specifically away from communicable diseases towards non-communicable diseases" (Statistics South Africa, 2016:27). In addition, deaths arising from injuries from 2010 – 2014 showed a consistent increase from 8.9% in 2010 to 10.5% in 2014 (Statistics South Africa, 2016).

According to the District Health System Policy Framework and Strategy (2014-2019), the Western Cape Province has a population of 5,641,880, distributed among five rural and one

urban district (National Department of Health, 2014). The table below illustrates the variance between the six districts in the province, highlighting that the City of Cape Town district serves 64% of the total population of the Western Cape Province. The public health system serves approximately 80% of this population. Furthermore, in the Western Cape Province, there are 346 primary health care facilities: 280 fixed clinics, 56 community day centres and 10 community health centres. There are 113 clinics under the authority of the City of Cape Town (CoCT) (Western Cape Provincial Department of Health, 2016).

Table 1.1. Western Cape Province Population Distribution by District

District	Total population 2012 (DHIS)	% of total population	Population Density	Access to piped water within 200m
Cape Winelands	764 816	13.6	35.6	97.7
Overberg	259 065	4.6	21.2	97.3
Eden	567 988	10.1	24.3	95.5
Central Karoo	66 328	1.2	1.7	98.1
West Coast	353 411	6.3	11.4	97.3
City of Cape Town	3630 272	64.3	1488.0	97.3
Western Cape	5 641 880	100		97.65

Source: District Health System Policy Framework and Strategy (2014 - 2019) (National Department of Health, 2014)

The Department of Health in the Western Cape Province employs 31,267 staff members, comprising 63% health professionals and 37% administrative support staff (Western Cape Government: Health, 2015). The overall vacancy rate in the financial year 2015/2016 for health professionals was 5.4% and the availability of medical officers was 44 per 100,000 uninsured members of the population (Western Cape Provincial Department of Health, 2016).

The research was conducted in two of the health districts in the Western Cape Province: City of Cape Town District (urban district) and West Coast District (rural district). The justification for selecting these two districts as case studies are: they represent an urban and rural district; they share the same a policy and provincial management structure; represent contrasting staff establishments, population size and management structures. Finally, the

researcher was familiar with structure and context of these two districts, which enabled her to describe and analyse the different decentralisation processes within the two districts.

In the City of Cape Town district, there are two authorities providing primary health care services: City Health and Metro District Health Services (MDHS). The two authorities collaborate on a district and sub-district level to plan and monitor primary health care service delivery. They are, however, independent authorities and thus have separate management structures for their facilities, even if they share the same geographical area. The MDHS reports to the Western Cape Department of Health (provincial government) and City Health to the City of Cape Town (local government). This research was conducted with one of the two authorities - the MDHS – providing services in Cape Town. The MDHS is divided into four substructures: Klipfontein/Mitchell's Plain, Tygerberg/Northern, Southern/Western, Khayelitsha/Eastern.

In the West Coast District, all the municipal facilities were amalgamated with provincial services in 2005 and thus report to the provincial authority of the Western Cape Department of Health. The West Coast District consists of five sub-districts: Matzikama, Cederberg, Bergriver, Saldanha Bay and Swartland.

Table 1.2 describes the staff establishment per type of primary health care facilities in each of the two district case studies.

Table 1.2. Staff Establishment and PHC Facilities

	MDHS	**West Coast District**
Population	3 895 123	31 4926
Public health workforce	6 095	1210
Fixed public health facilities	87	27
Non-fixed public health facilities	26	42
District hospitals	9	7

As outlined in Table 1.2, the size of the MDHS in terms of population and health workforce is significantly larger than that of the West Coast District. Secondly, the two health districts represent different degrees of decentralised decision-making from province to district, with

the MDHS considered more decentralised than the West Coast District. Thirdly, the two district management structures are different, even though they both report to the same governing authority, the Western Cape Department of Health. Finally, in terms of human resource management, their functions are decentralised from district to sub-structure in the case of the MDHS, whereas the West Coast District has a more complex pattern of delegated decision-making: from district to hospital level, accompanied by a greater devolution of the functions to line management.

1.11. **Outline of the Thesis**

The remainder of this thesis is organized into five chapters, as follows:

Chapter Two reviews the literature on human resource management, providing an overview of both the private sector and public health care sector. The chapter describes the paradigm shifts in human resource management and continues by describing the elements of an HRM system. The chapter concludes by seeking strengthening mechanisms to improve the health outcomes of the public health sector.

Chapter Three describes the methodology utilised in the study, which is a comparative case study approach using both quantitative and qualitative techniques for data collection. The methodology chapter describes the iterative process undertaken in data collection and the two phases of data analysis. This chapter concludes with a review of the strategies for rigour employed in the process of data collection and data analysis.

Chapter Four presents the findings of the study in four subsections, to create a holistic picture of the comparative case study approach employed. The first subsection situates the two case studies in their policy, environmental and situational contexts in which human resource management takes place. The following two subsections provide a detailed description of each case study, and the final subsection is a comparison between the two case studies, resulting in a comparative case analysis.

In Chapter Five the comparative case analysis is used as a basis for the discussion of the findings in relation to the context described in the first subsection.

In the final chapter of the thesis, Chapter Six, conclusions are drawn from the discussion and recommendations are presented, with the objective of strengthening the health outcomes of the public health sector through creating alignment in human resource management.

2. LITERATURE REVIEW

The literature review focusses on four parts: an understanding of HRM, the elements of HRM systems, the state of HRM systems, and in particular in South Africa, and HRM strengthening mechanisms. In the first part of the literature review, the focus is developing an understanding by providing an overview of the evolution of HRM and the paradigm shifts that has taken place. This chapter presents the literature addressing different perspectives applied in Human Resource Management (HRM): these ranges from the organisation being a simple production system to being a social and cultural system. It highlights the paradigm shift from personnel management to strategic HRM. The second part uses the three dimensions institutional actors, context and mechanism to describe the elements of an HRM system and by providing alignment as an element presents the conceptual framework of the research. The third part, the state of HRM systems, draws on private sector and public sector literature to yield the recent developments in HRM with a specific focus on South Africa. Finally, the chapter concludes with the proposed HRM strengthening mechanisms drawn from the literature.

This literature review on HRM has drawn on literature published on the private sector and in private health care, which has helped to identify the research focus for this study, and certain gaps in the literature on public health sectors and care. The review also found more literature on Western and high income countries compared to low and middle-income countries, especially from Africa. Special efforts were thus made to search for and include grey literature on HRM Africa.

Together, the four parts of the literature review illuminate and review the various factors involved in human resource management and their relationship to each other. These factors also start to frame the answers to the research questions posed.

2.1 **Understanding Human Resource Management (HRM)**

Evolution of HRM

The field of Human Resource Management (HRM) has its roots in the industrial revolution and the emergence of organised work places in the 19th century. Over the ensuing centuries, different schools of HRM evolved, leading to the emergence of specialised human resource

departments and a common preoccupation with the relationship of people with an organisation.

Writing on health sector reform in the early 2000's, Blaauw, Gilson, Penn-Kekana, and Schneider (2003), describe three main perspectives for understanding people within organisations: the machine perspective; the economic perspective; and the socio-cultural perspective (Figure 2.1) For each perspective there is a close relationship between the desired organisational form, the main coordinating mechanism and the underlying assumptions about human behaviour (Blaauw et al., 2003).

Management perspectives within organisations

	Machine Perspective	**Economic Perspective**	**Socio-cultural Perspective**
View of organisation	Clearly defined parts working efficiently together in routinised ways	Atomistic economic actors engaged in market relations	Reflective, responsive people forming a complex social system
View of human behaviour	Compliant : Humans simply comply with organisational changes	Calculating : Humans are individualistic & motivated by self-interest	Social : Human behaviour is influenced by social networks and relationships
Coordinating mechanisms	Formal rules & procedures Authority	Prices Competition Financial incentives	Norms Values Trust Shared meanings

Figure 2.1. Management perspectives within organisations (Source: Adapted from Blaauw et al, 2003)

The machine perspective is a very common way of understanding and managing organisations, where the organisation is viewed as the ordered arrangement of clearly defined

components, which then work together efficiently and through clear lines of command, structured in a formal organisational organogram (Blaauw et al., 2003).

The economic perspective is driven by its view of human behaviour: "humans are rational and individualistic and can be expected to act in their economic self-interest, and social influences on human behaviour can be ignored as it is considered exogenous and irrelevant" (Blaauw et al., 2003: 15). In addition, market mechanisms such as price, competition, and financial incentives set organisational form and activities (Blaauw et al., 2003).

The socio-cultural perspective recognises that human organisational behaviour is fundamentally shaped by social interactions and relationships (Blaauw et al., 2003). Arising from the Hawthorne Studies, Maslow's Hierarchy of Human Needs, and McGregor's Theory X and Theory Y, the social side of workers and the effect of social factors on their performance was recognised (Bal, 2011). Maslow's 1943 Hierarchy of Human Needs and McGregor's 1960 Theory X and Theory Y posit that if all human needs are met, individuals will be more productive; contributing further to this understanding, the Hawthorne Studies demonstrated the impact of social phenomena on human organisational behaviour, notably:

- the importance of informal social groups on increasing or limiting workplace motivation and performance;
- the relationship between group standards and broader societal norms, customs and routines;
- the importance of relationships with supervisors;
- and that simple communication and interaction with workers can result in increased motivation and performance (the famous Hawthorne Effect) (Blaauw et al., 2003).

In the socio-cultural perspective, there is shift in focus from viewing an individual in isolation to viewing an individual as shaped by the social interactions and relationships within an organisation. These different perspectives have underpinned the paradigm shifts in HRM described in the next section.

Paradigm shifts in HRM

In this section, HRM is defined with its accompanying philosophical underpinnings, followed by a description of the paradigm shifts from personnel management to strategic HRM.

HRM is defined as: “a strategic and coherent approach to the management of an organization’s most valued assets – the people working there who individually and collectively contribute to the achievement of its objectives” Armstrong (2006: 3).

Armstrong further outlines a set of philosophical underpinnings of HRM:

1. HRM is distinctive approach as it is based on a particular constellation of beliefs and assumptions which includes a belief that human resources are valuable assets and the employment relationship is based on commitment and not compliance
2. HRM is a strategic thrust informing decisions about people management.
3. The central involvement of Line Managers plays an important role in HRM due to the relationship between them and their subordinates or employees.
4. HRM relies upon a set of levers to shape the employment relationship that emphasises the importance of culture management.

Box 2.1. HRM Philosophical Underpinnings

(Source: Storey1989 in Armstrong, 2006: 4)

One of key critiques of the definition of HRM as outlined above is in relation to the proposition that HRM promises more than it can deliver. In general, the literature supports this view, with Guest (1991) positing that HRM is an optimistic but ambiguous concept. This is further supported by Gratton, Haily, Stiles, and Truss (1999) whose study found that there is a disjuncture between the rhetoric and reality, specifically between what the HR function says it is doing, and the practice as perceived by employees.

There are two widely adopted models of HRM: the *hard* and *soft* models. These models are different in two ways: first, they are based on opposing views of human nature and managerial control strategies: in the case of the hard model, it is based on tight strategic control, while in contrast, the soft model is based on control through commitment (Truss, Gratton, Hope-Haily, McGovern, & Stiles, 1997). The second important point is that the hard model emphasises acquiring, developing and deploying human resources to achieve competitive advantage, while the soft model is rooted in the human relations school, which emphasises communication, motivation and leadership (Armstrong, 2006). Interestingly, Truss et al. (1997) found that not a single organisation studied adopted either a pure soft or hard model of HRM.

The paradigm referred to as personnel management can be associated with the hard model of HRM, as well as the machine perspective, concerned with tight control of formal rules and regulations within the organisation. The paradigm referred to as strategic HRM is associated with the soft model and human relations school, viewing human resources as a complex system. Strategic HRM is "an approach to making decisions on the intentions and plans of the organization in the shape of the policies, programmes and practices concerning the employment relationship, resourcing, learning and development, performance management, reward, and employee relations" (Armstrong, 2006: 115) and is considered a soft model to HRM, associated with the socio cultural perspective.

Strategic HRM (SHRM) is a distinctive approach premised on the assumption that personnel decisions are most effective when linked strategically to the organisation's mission and strategy (Wright & McMahan, 1992). Strategic HRM claims that human resources can contribute to and create sustainable competitive advantage when activities are managed from a strategic perspective (Becker & Gerhart, 1996; Wright & Mcmahan, 1992; Lado & Wilson, 1994; Lengnick-Hall & Lengnick-Hall, 1999).

Table 2.1 provides an overview of the distinction between Personnel Management, HRM and strategic HRM, illustrating a paradigm shift from traditional personnel administration to strategic people management.

Table 2.1. Paradigm Shifts from Personnel Management to Strategic HRM

	Personnel Management	**HRM**	**Strategic HRM**
Time and planning perspective	Short term Re-active Ad hoc Marginal	Long term Proactive Strategic Integrated	Long term Proactive Strategic intent Aligned/Coherent
Psychological contract	Compliance	Commitment	Performance
Control systems	Compliance	Internal controls	Monitoring and Evaluation
Employee relations perspective	Pluralist Collective Low trust	Unitarist Individual High trust	Unitarist Individual High trust
Preferred structures/systems	Bureaucratic/mechanistic Centralised Formal defined roles	Organic Devolved Flexible roles	Devolved Flexible roles Strategic Fit

Roles	Specialist/Professional	Largely integrated into line management	Devolved to Line Management
Evaluation criteria	Cost minimisation	Maximise utilisation Human asset accounting	Added Value Competitive Advantage

(Source: Adapted from Guest, 1987: 507; Armstrong, 2006)

The paradigm shift from personnel to Strategic HRM redefines the role of HRM in the organisation from personnel administration to being a strategic partner (Ferris, Hochwarter, Buckley, Harrell-Cook, & Frink, 1999; Becker, Huselid, & Ulrich, 2001; Burke & Cooper, 2005). The main difference between HRM and Strategic HRM is moving away from internal control to monitoring and evaluation, as well providing the added value of the HR Unit/Department/Manager being a more strategic player. Strategic HRM is considered the end point and most organisations, specifically in the public health system, are in the process of transitioning from HRM to Strategic HRM.

2.2 **Elements of HRM Systems**

HRM is a system, as it represents a complex of interdependent parts with a network of unique, interlocking relationships, as well as being a sub-system of the larger health system. General systems theory provides the framework to unpack the elements, structures, processes and interactions in HRM within the district. In addition, a systems perspective on HRM is important to successfully transition to Strategic HRM.

The framework for analysing HRM outlined by Martinez and Martineau (1998) described in the Introduction chapter, introduces three dimensions of HRM: institutional actors, mechanisms, and context. These dimensions and other elements of the HRM system informs the development of a new framework for optimising HRM in public health care, unpacked below and presented at the end of this sub section as Figure 2.7. Framework for Optimising HRM in Public Health Care.

2.2.1 **Key actors and roles in HRM**

Two key role players perform HRM in the public health sector: the HR Manager and line manager. It is important to note that though this research focusses on these two key role players, the omitted role player that forms the HR triad is the employee.

HR managers' roles

The HR Manager's roles in HRM, depicted in the Ulrich HRM Four-Roles Model, consists of two main dimensions of which the first reflects the continuum from an operational to a strategic focus, while the second reflects the conflicting demands of people and processes (Ulrich, 1997; Connor & Ulrich, 1996).

Ulrich's model proposes that the HR Manager performs the following four roles (Long & Ismail, 2008: 89-90):

a. The Role of Strategic Partner

In this role, HR professionals become strategic partners by asking questions and designing HR practices that effectively and efficiently align themselves with the strategy of the organisation. In addition, HR managers are expected to align HR initiatives with strategic organisational goals, and thus require the capacity of organisational and financial knowledge, in addition to being knowledgeable in business. Consequently, if HRM practices align with line management objectives, it will place HR managers *at the leadership table* in other organisational functions.

b. The Role of Administrative Expert

This role described as the management of the organisation's infrastructure, through developing and delivering efficient HR processes (e.g. recruitment, selection, training, compensation, benefits, work force planning, and performance management) that utilise new technologies and improved information systems). However, a warning has been noted that moving to a strategic role cannot be performed at the cost of neglecting the basics of good HRM practices.

c. The Role of Employee Champion

The role of the employee champion entails an HR professional striving to meet the needs of the employees, and creating opportunities to increase employee commitment. In addition, to add value to HRM, the HR Manager performs the relationship role, by being an outspoken advocate of employee interests, with a balance towards the needs of the organisation (Ehrlich, 1997).

d. The Role of Change Agent

In Ulrich's view, the management of transformation and change falls squarely in the HR role of change agent. In addition, HR managers are expected to help managers develop and communicate clear visions of the future, develop procedures that motivate and reward behavior consistent with goal achievement, and overcome employee resistance to change (Friedman, 2007). This suggests that HR managers can add value through management of the change process, based on their advisory role to management.

The four roles presented by Ulrich in Long and Ismail (2008) suggest that HR managers can add value by being strategic, but not neglecting administrative procedures; they should manage change through balancing the needs of all role players and the unique advisory role of the HR Manager to both employee and management. However, to be able to perform these roles, the HR Manager needs to acquire certain competencies.

HR managers' competencies

Competency frameworks have been used to measure internal fit in several HR research studies specifically on how the competencies of HR staff integrates with each other, where competency is defined as the work related personal attributes, knowledge, skills and values used to perform the required work duties (Selmer & Chiu, 2004). Ulrich contributes an additional dimension to the competency framework, suggesting that HR managers should have the ability to *add value* to the organisation referring to their ability to improve organisational performance. Wei's belief is that the capability of the HR Manager is important for the effectiveness of both the design and implementation of the HRM system, requiring the utilisation of business knowledge to facilitate and coordinate HR redirection, initiate change, or strategic changes in the organisation (Wei, 2006).

Ulrich and colleagues (Brockbank & Ulrich, 2003; Ulrich et al., 2005) developed a HR competency model, outlining competency domains, which they tested in private businesses on HR professionals, their peers, Line Managers, and clients. Their model was developed through an ongoing study, in cooperation with the Ross School of Business and The RBL Group. Called the Human Resource Competency Study (HRCS), it was developed in six 5-yearly waves, between 1987 and 2012. The study had a twofold purpose: firstly, to identify

the major competencies required for HR professionals and secondly to monitor the major trends in the field of HRM. The resultant HRCS contains data from over 40,000 HR professionals in hundreds of companies, collected over 20 years.

The Human Resource Competency Study (HRCS) identified five domain factors, referred to as the *Brockbank and Ulrich Model*. These five domain factors, Strategic Contribution, Personal Credibility, HR Delivery, Business Knowledge and HR Technology were regarded as making a difference in organisational performance (Brockbank & Ulrich, 2003):

Strategic Contribution
This includes competency areas of culture management, rapid change efforts, and a business partner role, along with customer focus; these emerged as important factors for HR professionals (Brockbank & Ulrich, 2003). Boselie and Paauwe (2005) also pick out professional involvement in strategic decision making and creating market-driven connectivity of the operation.
Personal Credibility
Personal credibility refers to HR professionals being credible to both their HR counterparts and business Line Managers (Long & Ismail, 2008). This credibility requires the HR professional to work well with others by building good relationships, and having effective writing and verbal communication skills (Boselie & Paauwe, 2005).
HR Delivery
HR delivery encompasses both traditional and operational HR activities performed by HR professionals, which include: career planning; internal communication processes; structuring HR activities and HR measurement, e.g. restructuring the organisation, measuring impact of HR practices, and managing global implications of HR practices; in addition it includes attracting, promoting, retaining, and out-placing appropriate people (moving people where they are needed), and finally performance management (Long & Ismail, 2008).
Business Knowledge
In this competency area, HR professionals are considered key players in the organisation; thus they should have an understanding of how their organisation operates in terms of its organisation's strategy, technological processes and organisational capabilities, finance, marketing, as well as general management (Long & Ismail, 2008).
HR Technology
HR professionals need to be able to leverage technology for HR practices, by using electronic or web-based channels, and by automating HR processes to become more efficient (Long & Ismail, 2008).

Box 2.2. Brockbank and Ulrich Model of HR Competency Domains Factors

The relationship between the HR roles and these competency domain factors is illustrated in Table 2.2 below, illuminating the competency roles as part of the HR Manager roles within the five competency domains.

Table 2.2. Relationship between HR Roles and Competencies

HR Manager Role	Competency Domain	Competency Role
Strategic Partner	Strategic Contribution	Strategy Architect
Administrative Expert	Personal Credibility	Operational Executor
	HR Technology	
Employee Champion	HR Delivery	Credible Activist
		Talent Manager/Organisational Designer
Change Agent	Business Knowledge	Culture and Change Agent
		Business Ally

(Source: Brockbank & Ulrich, 2003)

In 2013, Ulrich, Younger, Brockbank, and Ulrich revisited the model: they retained the roles approach to defining the competencies, but changed the names of the domains; the scope of the competencies remained relatively similar for the three significant stages in the model's development.

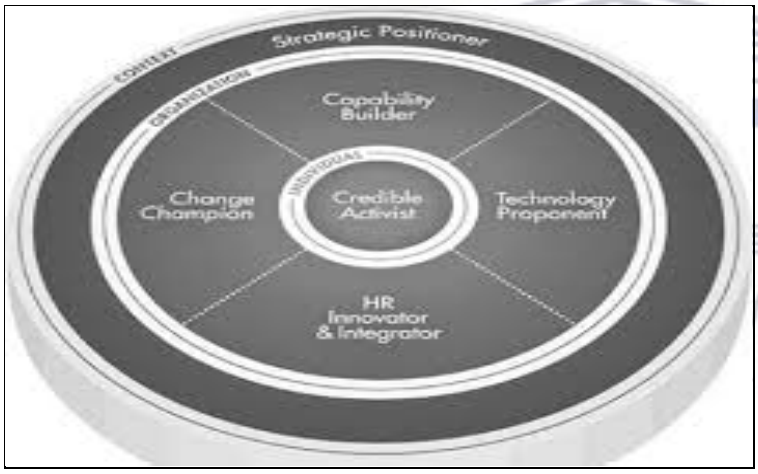


Figure 2.2. Future HR competencies

It is noteworthy that the most recent model looks at the future of HR and focusses on what would be the required competencies. The future competencies are classified into three spheres of influence illustrating the different levels within which HR managers would be expected to operate: context, organisation, and individual (Figure 2.2) (Ulrich et al., 2013). In the central individual sphere is the competency role of *credible activist;* the organisation sphere contains the *change champion*, *capacity builder*, *HR innovator and integrator,* as well as *technology proponent*; finally is the *strategic positioner* is located in the last sphere, the context, (Ulrich et al., 2013).

In applying the HR Competency Model, the roles and competencies of HR professionals in manufacturing companies in Malaysia were examined: this included business knowledge, strategic contribution, HR delivery, personal credibility, and HR technology (Long & Ismail, 2008). The main findings yielded that the HR professionals' competencies ranked the highest in the domains of *strategic positioner, personal credibility* and *HR delivery*, but that they lacked the capacity to perform the roles of the *strategic partner* and *agent for change* (Long & Ismail, 2008).

In addition, an exploratory study, with a cross sectional study design, conducted in the health sector of four East African countries (Ethiopia, Kenya, Tanzania, and Uganda) explored the challenges faced by staff with significant HRM responsibilities (Mwita et al., 2009). The study, in line with the situation in South Africa, found that HRM responsibilities reside with the HR Manager and the Line Manager. Similar to South Africa, the responsibility for HRM in health is more often assigned to managers with other roles, as most of the study respondents are managers with dual roles, both clinical and managerial (Mwita et al., 2009). One of the key findings of the study was that 68 to 75 percent of the respondents indicated that they lacked the knowledge and skills to carry out many of their HR functions, to address the many challenges in their work such as:

- understaffing,
- lack of employee satisfaction,
- lack of skilled clinical staff,
- poor working conditions,
- and inadequate mechanisms for dealing with staff grievances (Mwita et al., 2009).

Line Managers' role and competencies

Line Managers' involvement in HRM has increasingly come to be researched, on account of their role being regarded as increasingly pivotal for effective HRM. Line Managers have always been responsible for people management, with the HR department performing the formal HR activities, functions, and processes. This situation has changed as Line Managers in both public and private sectors are expected to perform more formal HR activities and functions.

This change in the situation is depicted as a responsibility shift, commonly referred to in the literature as "the devolution of HRM responsibilities to the Line Managers" including the transfer of particular formal HR functions/activities/practices from the HR Manager to the Line Managers. In addition to the transfer of formal HR practices, Top and Line Managers' strategic and business perspectives are pivotal to the implementation of business strategy; thus their role becomes critical in the design of the HR System as they impose their influence on various functional activities (Wei, 2006).

The rationale for involving Line Managers has been discussed by various authors (McConville, 1994; Purcell & Hutchinson, 2007; Renwick, 2002). In brief, the rationale for involving the Line Managers in HRM can be summarised in five main elements: to reduce costs; to provide a more comprehensive approach to HRM; to place responsibility for HRM with the managers most responsible for it; to expedite decision making; and as an alternative to outsourcing the HR function (Brewster and Larsen, 2000, in Renwick, 2003).

In the health sector, the devolution of HRM to Line Managers is the filling in the sandwich as HR work is dumped on them via devolution (McConville & Holden, 1999). However, through an operational management lens, the devolution of HRM to Line Managers is "heavily dependent on the capability and motivation of individual managers to engage with HR issues" (Hope-Hailey et al., 2005 in Harris, 2007: 44), and Line Managers' knowledge of organisational HR policies (Bond and Wise, 2003 in Watson, Maxwell, & Farquharson, 2007).

Furthermore, the devolution of HRM to the Line Managers competes with their other responsibilities, resulting in competing priorities for the Line Managers. In the private sector, HR responsibilities took second place in relation to other business needs - of sales and marketing and finance (Whitaker and Marchington 2003 in Watson et al., 2007). In addition, issues around lack of time, inadequacies in ability, distraction from general managerial focus and tensions between HR specialists' expectations in relation to completion schedules of HR tasks, resulted in competing priorities (Renwick, 2003). Moreover, Line Managers felt that the additional HR responsibilities that had been *dumped* on them would be better addressed by HR professionals, as these additional responsibilities could distract them from their own service priorities and be a source of frustration (Harris, 2007).

The devolution of HRM responsibilities to the Line Managers has brought about about a changing HR environment, and challenges for both HR Manager and Line Managers. For example, Renwick (2003) conducted 40 interviews with Line Managers from three different United Kingdom work organisations, on their experiences of handling HR work that had been devolved to them; it was concluded that line management involvement in HRM is problematic for organisations to adopt. The author found that the challenges lie in the relationship between line managers and HRM specialists, the ability and willingness of line managers to carry out HR tasks properly, and Line Managers' knowledge of HR policies (Renwick, 2003).

The author provides a summary of the Line Managers' positive and negative experiences in handling the HR work devolved to them (Renwick, 2003: 271-272):

- Positive experiences:
    - The Line Manager takes on responsibility and accountability in HR work.
    - Flexibility is forthcoming from the Line Managers to do HR work.
    - The Line Manager is keen to take part on doing HR work.
    - The Line Manager manages large numbers of employees.
    - The Line Managers takes a professional and serious attitude to doing HR work.
    - Line Managers are relatively happy doing some HR work.
    - The Line Manager is considerate of employee needs and wishes.
    - The Line Manager sees HR as positive helpers in HR work.
    - The Line Managers sees career benefits for them in doing HR work.

- Negative experiences:
    - The Line Manager has many duties, and lacks time to do HR work well.
    - The Line Managers do not see themselves as experts in HRM.
    - Doing HR work dilutes the Line Manager's generalist managerial focus.
    - There are significant Line Manager inadequacies in handling HR work.
    - There are tensions between Line Managers and HR, over transfer and completion of HR duties.
    - The Line Managers needs to reflect and be critical of their performance in HR work.
    - The Line Managers are reliant on HR to do HR work properly.
    - There are differing Line Manager commitment and discipline levels in doing HRM.
    - The Line Manager has responsibility and accountability in HRM, but little authority.
    - There is little appreciation of Line Managers' flexibility in doing HR tasks.

Several important factors influencing the performance of Line Managers are highlighted around their capacity to perform these devolved roles and responsibilities. The factors influencing Line Managers' performance are: the time allocated to the specific expected tasks and duties, the accompanying limited authority yet responsibility and accountability, and finally the tensions between line management and HR in terms of transfer and completion of HR duties (Renwick, 2003). In addition, Line Managers face pressure to introduce new HR practices which are time consuming or difficult to apply, and this is coupled with the fear of disputes with subordinates, especially in decisions about performance related to pay and career development (Papalexandris & Panayotopoulou, 2005).

In the case of the HR Manager, a concern was identified, about their reduced influence or even redundancy if HR work is done by Line Managers, and of being replaced by HRIS, arising from cost-reduction efforts and improvements in technology (Papalexandris & Panayotopoulou, 2005). Furthermore, the difficulty of training Line Managers to participate and adopt appropriate ways of handling employee matters was noted. Finally, through constant auditing and the Line Managers' lack of competencies or willingness to assist in HR designed activities, such as career development and training performance appraisal were identified as challenges in the changing HRM environment.

To summarise, the devolution of HRM to the line managers competes with their other responsibilities, puts pressure on the willingness and capacity of line managers to perform HRM responsibilities previously assigned to HR managers thus creating tension between the two role players, and brings forth a variety of challenges including fear to deal with disputes and fear of redundancy. The challenges in the devolution of HRM responsibilities and how both HR manager and line managers perform HRM as a shared responsibility have not been fully explored and described.

2.2.2 **Context**

The literature review yielded three categories to describe the context of HRM: institutional context, organisational context, and factors meaning, conditional or provisional factors that affect effective HRM.

Institutional context

The institutional context refers to economic, social, cultural, and professional environments within surrounding HRM functions. This includes the pressure on HRM functions from external agencies and the international context (Friedman, 2007), the role of professional bodies, especially relevant in health systems that predominantly employ health professionals, and national culture. The international context and the role of professional bodies are broad and varied and could not be given the detailed coverage it would deserve. Thus for the purpose of this literature review these factors are acknowledged as important but not further explored. However, national culture has shown to be have a significant influence on the HRM in the public health sector and thus were further explored.

National culture constitutes:

> *the influence of values and culture on vertical fit [and] is mainly reflected in how quick or good the strategy can be merged into the designing of HR practices that are compatible with the strategy* (Wei, 2006: 56).

National culture is influenced by three factors: socialisation, assumptions, and management logics (Budhwar & Sparrow, 2002). The socialisation process refers to the manner through which managers are "made" and how the managerial role is defined. This process varies between and within countries influenced by additional factors. The assumptions refer to the basic assumptions, which shape managers' behaviour. This could be that managers think that HRM is not their priority or responsibility. Finally, under national culture, is understood the unique ways of doing things and management logics in a particular country, which is the reflected in how managers are formed in different countries (Budhwar & Sparrow, 2002). In this regard, the formation of managers in the public health sector is unique; in addition to that, Line Managers with dual roles, both clinical and managerial, are assigned responsibility for HRM in health.

Organisational context

The organisational context encompasses what is structural, administrative, legislative, governmental, or managerial. The organisational context locates HRM within the government and legislative context of the country. For example, in this research health care governed by

the public sector is influenced by common strategies, business logic, and goals of the public sector and thus framed within the public service regulations and standards. One of the key organisational factors influencing HRM in the public sector is that of decentralisation.

Decentralisation in the public sector has led to several restructuring activities. However, the four fold typology of decentralisation (deconcentration, delegation, devolution, and privatisation) does not address the issue of decision making, specifically the range of choices that is granted to the decision makers at the decentralised level (Bossert & Beauvais, 2002). The concept of decision space provides the range of effective choice that is allowed by the central authorities, to be utilised by the local authorities (Bossert, 1998).

The advanced technological era where new technology is constantly being developed and introduced to improve efficiency and productivity, affects HRM in the public health sector (Papalexandris & Panayotopoulou, 2005). Technology and specifically the automation of information systems has a great impact on systems and procedures in HRM. For example, the use of organisational intranets, the internet, and sophisticated human resource information systems (HRIS) can provide excellent services, making it possible for line managers to handle some of the HR work, without the help of the HR department (Renwick and MacNeil, 2003 in Papalexandris & Panayotopoulou, 2005).

Factors

The factors represent conditional or provisional factors that affect effective HRM. The first factor identified is the size and structure of the organisation (Boselie et al., 2005; Budhwar & Sparrow, 2002). The size and structure implies the number of health workforce, formal and informal structures, reporting lines, and forums. Secondly, the existence of training units in the HR department is an important variable for aligning HR functions with each other (Budhwar & Sparrow, 2002).

Furthermore, the budget allocated to HRM determines human and material resources devoted to HRM, affecting the quality of the HR practices and operations as well as the overall performance of the department. In addition, the budget allocation indicates the value of the department to the institution, suggesting, the importance of HR to the institution (Budhwar & Sparrow, 2002).

However, Dubois and Singh (2009) place HRM strategies as a mechanism in the centre of Figure 2.3. A Framework for Optimising Human Resources in Health Care; at the same time, they recognise the importance of context (institutional and organisational), and translate performance to organisational outcomes, staff outcomes, and patient outcomes, more in line with measuring health care performance.

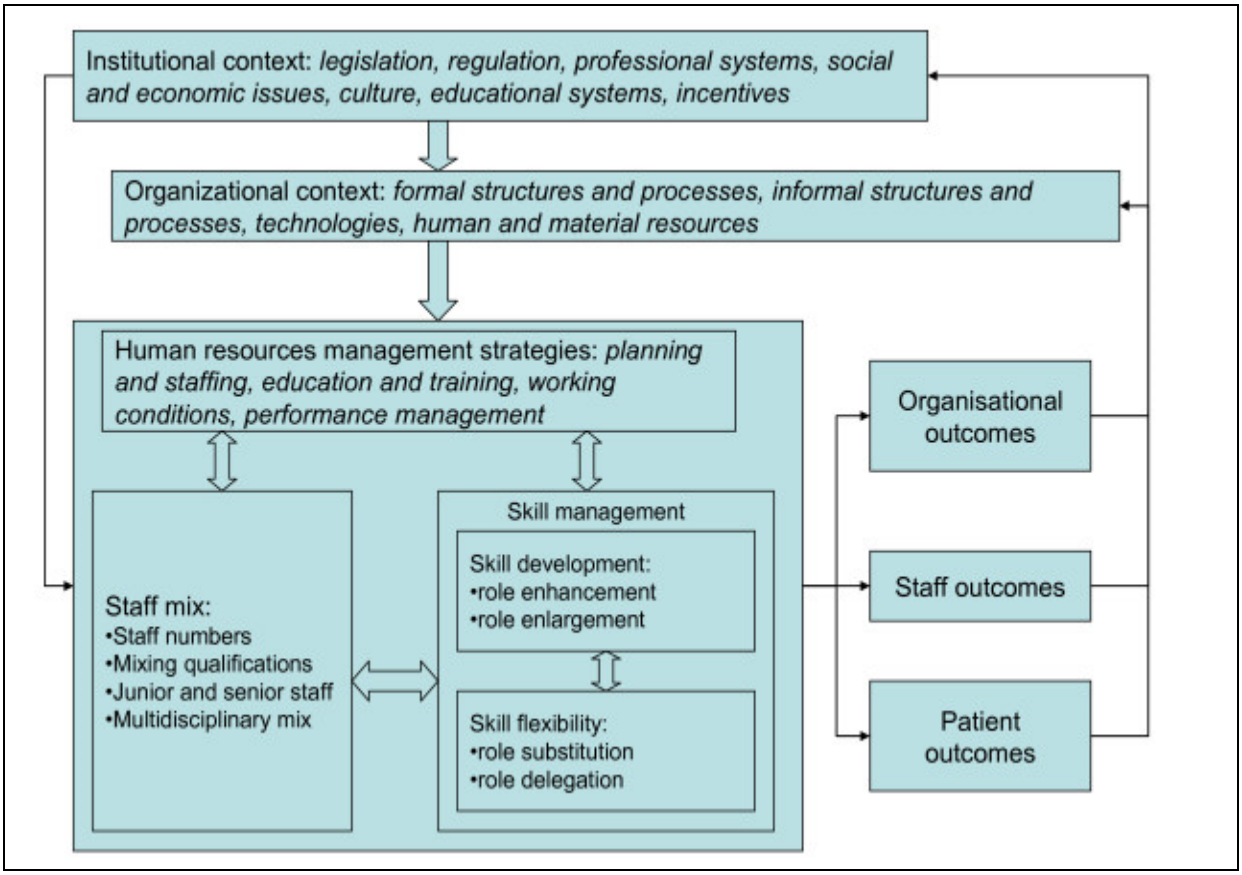


Figure 2.3. A Framework for Optimising Human Resources in Health Care
(Source: Dubois & Singh, 2009: 97)

2.2.3 Mechanisms

Martinez and Martineau (1998) refer to mechanisms as a list of HRD functions. These include HRM capacity (HRM budget, HRM staff, HR Planning), personnel policy and practice, HRM data, performance management, and training.

Armstrong (2006) provides an expanded view on the mechanisms that goes beyond a list of HRD functions, by introducing the concept of *HR Systems*. The author claims that HRM

operates through different human resource systems and thus is not limited to HRD functions, as referred to by Martinez and Martineau (1998).

A description of the different types of HR systems outlined in Table 2.3. Description of HR Systems below, provides an overview of the mechanisms within a HRM system. At this point, it is important to point out that these HR Systems are sub-systems within the HRM system, representing complex interdependent parts with interlocking relationships.

Table 2.3. Description of HR Systems

HR System	Description
HR philosophies	Describing the overarching values and guiding principles adopted in managing people
HR strategies	Defining the direction in which HRM intends to go
HR policies	The guidelines defining how these values, principles and strategies should be applied and implemented in specific areas of HRM
HR practices	HR activities, functions, and processes - the formal procedures and methods used to put HR strategic plans and policies into effect
	The informal approaches used in managing people
HR Programmes	Enabling HR strategies, policies and practices to be implemented according to plans

(Source: Adapted from Armstrong, 2006: 4)

The literature related to these systems is discussed in the context chapter of this thesis which forms part of the Results chapter; the focus is on HR strategies and policies in the South African context, highlighting their implications and implementation. The HR programmes established in South Africa are also described in detail in the Results chapter of each district case study. For the purpose of the literature review, the HR philosophy and practices systems are further discussed, identifying the international trends for HR philosophy and HR practices whilst locating these two specific HR Systems in the public health sector.

HR practices and philosophy

In the case of HR practices, the review of the literature yielded several different descriptions or lists of the *formal* HR practices: they include HR activities, functions, and processes but very little on the *informal* practices. Thus for the purpose of the literature review, the formal approaches in managing people will form the focus as HR practices.

The majority of the studies define HRM in terms of *bundles* (a collection or selection) of HR practices (Paauwe & Boselie, 2005). In the table below, HR practices are those functions and activities necessary for the effective management of the organisation's human resources (Schuler & Macmillan, 1984).

List 1 represents a traditional approach to HRM, namely to attract, retain, and motivate employees. Moving away from these traditional purposes, List 2 proposes seven HRM practices expected to enhance organisational performance. The most distinguishable feature of the seven is the addition of specific practices aimed at enhancing performance, offering a more directive approach to HRM. For example: extensive training implying a huge investment; and selective hiring of new personnel curtailing the approach taken by the organisation (Pfeffer, 1998).

In contrast, List 3 represents a synthesis of the different HR practices by Boselie et al. (2005), yielding 26 HR practices. Interestingly, in List 3 there are a few HR practices that are different from List 1 and 2, which specifically focusses on the development and maintenance of the social aspects of the employee, for example, socialisation, work-life balance, and social responsibility practices. The HR practices that are relevant for this research from List 3 are firstly, autonomy and decentralised decision making, and secondly professionalisation and effectiveness of HR function/department.

Another variation developed by Mwita et al. (2009) identified HR practices in the public health sector as recruitment, deployment, personnel policy, HR Planning, performance management, training, HR data systems, HR strategy development, and general leadership and management; this is in line with Schuler and Macmillan's traditional purpose of HRM (1984), to attract, retain and motivate. On reflection, List 1 would best represent the list of HR practices in the public health sector.

Table 2.4. Comparison of Lists of HR Practices

	List 1	**List 2**	**List 3**
Philosophy	**Traditionally described as *to attract, retain, and motivate employees***	**Expected to enhance organisational performance**	**Synthesis of the different HR practices**
List of HR	1. Human resource	1. Employment security	1. Training and

practices	planning 2. Staffing, including recruitment, selection, and socialisation 3. Appraising 4. Compensation 5. Training and development 6. Union-management relationships (Schuler & Macmillan, 1984: 242)	2. Selective hiring of new personnel 3. Self-managed teams and decentralisation of decision making as the basic principles of organisational design 4. Comparatively high compensation contingent on organisational performance 5. Extensive training 6. Reduced status distinctions and barriers, including dress, language, office arrangements, and wage differences across levels 7. Extensive sharing of financial and performance information throughout the organisation (Pfeffer, 1998: 96)	development 2. Contingent pay and rewards (PRP, bonuses, profit-sharing) 3. Performance management (also appraisal and performance metrics) 4. Recruitment and selection (also staffing) 5. Team working and collaboration 6. Direct participation (e.g. empowerment, employee involvement, suggestion schemes) 7. 'Good' wages (e.g. high, or above market rate remuneration; also fair pay) 8. Communication and information sharing 9. Internal promotion opportunities and labour market 10. Job design (also job rotation, job enrichment) 11. Autonomy and decentralised decision-making 12. Employment security 13. Benefits packages 14. Formal procedures (grievances) 15. HR Planning (e.g. career and succession planning) 16. Financial participation (e.g. employee stock/shares) 17. Symbolic egalitarianism (e.g. single status/ harmonisation) 18. Attitude survey 19. Indirect participation (e.g. consultation with trade unions, consultation committees, voice mechanisms) 20. Diversity and equal opportunities 21. Job analysis 22. Socialisation, induction and social activities 23. Family-friendly policies and work-life balance (WLB)

			24. Employee exit management (e.g. layoffs, redundancy policy) 25. Professionalisation and effectiveness of the HR function/department 26. Social responsibility practices (Boselie et al., 2005: 94)

Debates on HR practices

One of the key debates in the field of HRM centres around the best approach to HRM and focuses on HR practices. The debate takes place between the *best* practice and the *best fit* approaches. There are two basic arguments: first, some authors support the viewpoint that there are universalistic best practices in HRM (Pfeffer, 1994; Patterson et al., 1997; Guest, 1999a in Armstrong, 2006), whilst others argue that there are no universalistic best practices but in fact there are only best fit practices (Wood, 1999; Bach, 2001; Baird & Meshoulam, 1988).

The universalistic perspective argues that HR practices are universally effective, regardless of the context, aligning itself with the *best practice appro*ach (Delery & Doty, 1996). The perspective asserts that certain independent-dependent variable relationships hold across whole populations of organisations, and that some HR practices are always better than others, suggesting that all organisations should adopt these best practices (Colbert, 2004). Seven consistent strategic HR practices were identified: internal career opportunities, formal training systems, appraisal measures, profit sharing, employment security, voice mechanisms, and job definition (Delery & Doty, 1996).

The majority of these strategic HR practices are listed amongst Pfeffer's seven most effective practices for managing people (Pfeffer, 1994). The universalistic perspectives proposes that bundles of human resource practices had more influence on performance than discrete individual practices aimed at creating a high degree of internal consistency or fit among their HR activities, and to link with a firm's competitive strategy (Pfeffer, 1994).

The best fit practice claims that the effect of HR practices depends on the specific (internal and external) context (Wood, 1999), supporting the notion that "context matters". However, there is no one fixed list of generally applicable HR practices or system of practices that

defines or constructs HRM (Boselie et al., 2005). This throws into doubt the best practice argument, that there is a universal list of best practices.

Relationship between HR practices and performance

In addition to identifying HR practices, Boselie et al. (2005) illuminate the relationship between HRM practices in achieving outcomes and ultimately organisational performance. Despite not acknowledging the importance of context to HRM, the authors take into consideration contingency variables, for example size and structure of the organisation. The authors depict the relationship between HR activities and performance in Figure 2.4. HRM and Performance Linkage below.

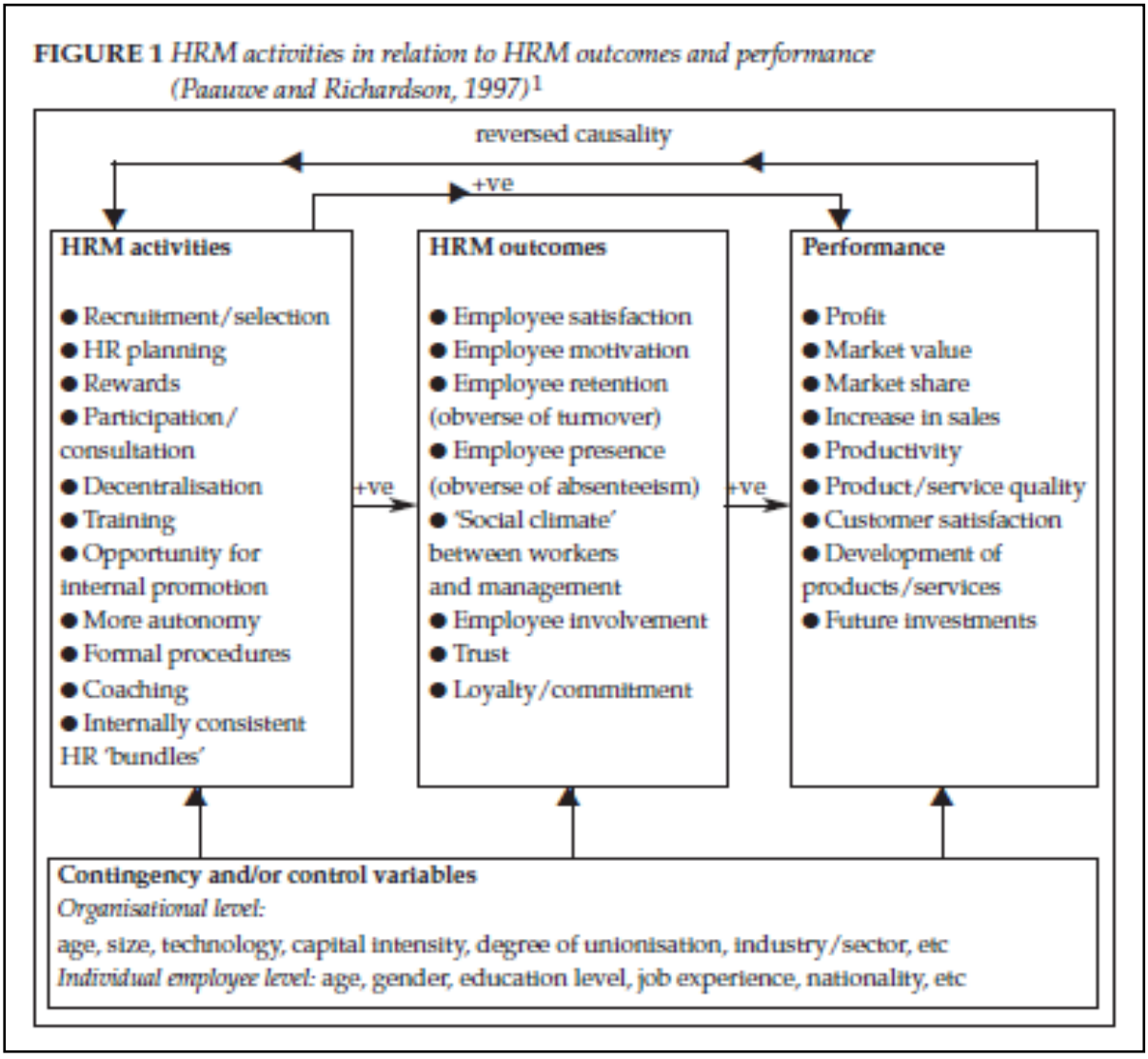


Figure 2.4. HRM and Performance Linkage (Source: Boselie et al., 2005: 68)

Purcell and Hutchinson (2007) posit, through the people management-performance causal chain, that employee responses to HR practices are key to HRM and performance models (Figure 2.5). This casual chain supports the core justification of this research, namely, that ineffective human resource management could lead to poor health outcomes.

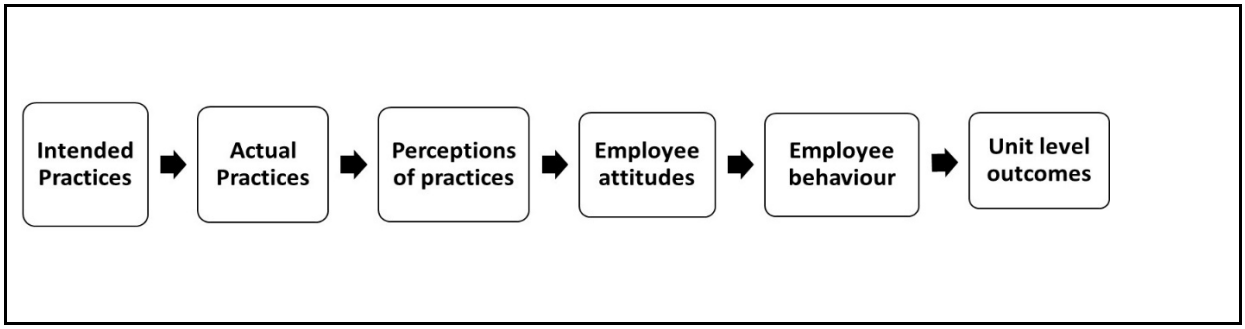


Figure 2.5 The people management-performance causal chain (Source: Purcell & Hutchinson, 2007: 7)

2.3 Alignment

One of the key concepts in HRM which is drawn on in this research, is that of alignment or fit, defined as "*the degree to which the needs, demands, goals, objectives, and/or structure of one component are consistent with the needs, demands, goals, objectives, and/or structure of another component*" (Nadler and Tushman, 1980: 45, in Wright & Snell, 1997).

The HR Alignment Framework (Figure 2.6) described by Becker et al. (2001), originating from the balanced scorecard approach contributes to the development of the conceptual framework for the research: it is relevant because it identifies the analytic concepts and the relationship between the concepts in understanding the nature of HRM in a district health system. Horizontal fit between HR practices and vertical fit between HR practices and organisational strategy is pivotal for effective human resources for health care (Dubois & Singh, 2009). As previously mentioned, the concepts, *alignment* and *fit* are interchangeable.

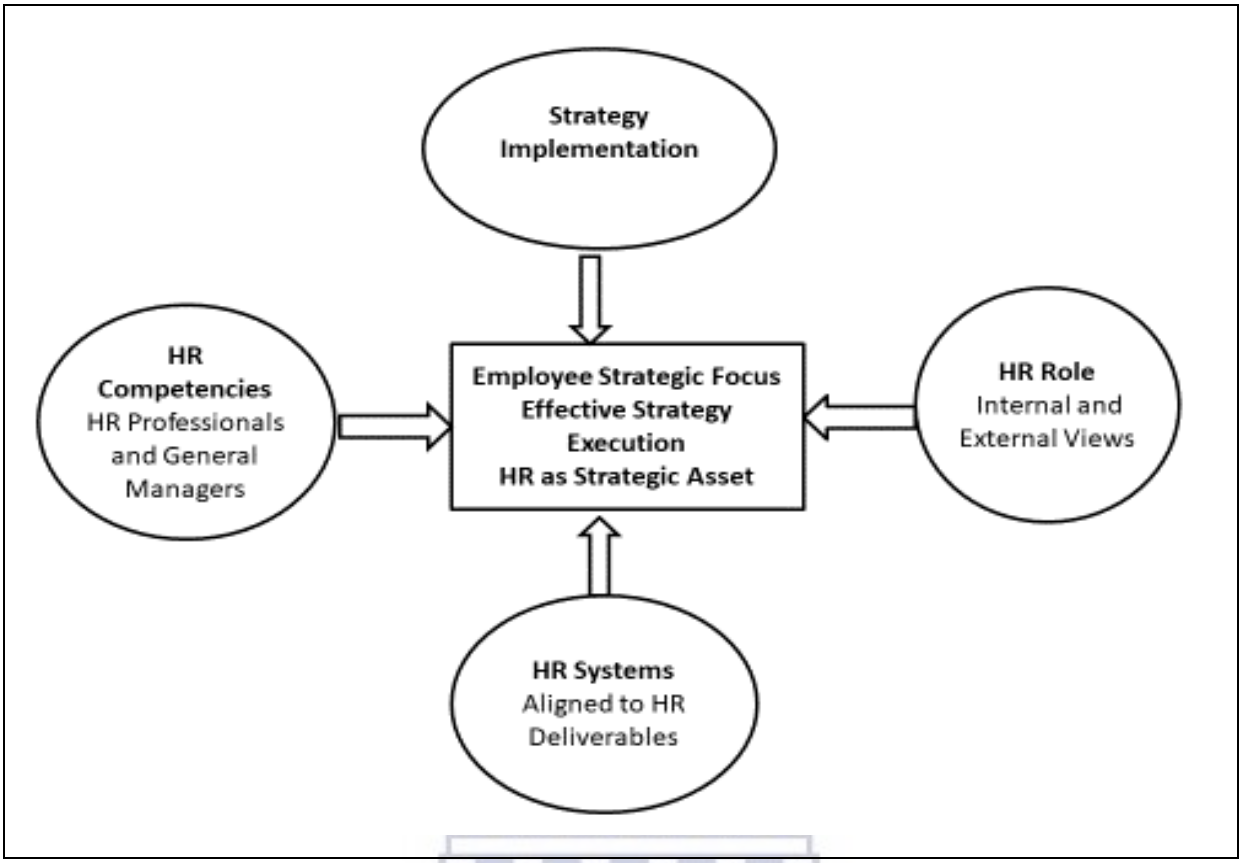


Figure 2.6. HR Alignment Framework

(Source: Becker et al., 2001)

Internal alignment is the extent to which HRM functions are integrated with each other (Becker et al., 2001). It is important to align HR practices with each other into a coherent and consistent system; for the HR System to be effective, the HR practices not only have to fit with, but also support each other (Baird & Meshoulam, 1988).

External alignment is the extent to which the HRM system is aligned with the objectives of the organisation (Becker et al., 2001). Furthermore, external alignment aims to align health policy with HR policy, to ensure that the organisation's policies support the behaviours and competencies required for it to be effective (Bach, 2001). In addition, it is important to take the broader context, external environment, the workforce, organisational culture, organisational strategy, technology, production, and organisation of work into consideration, to achieve vertical alignment or strategic fit (Baron & Kreps, 1999).

In addition, acknowledging the importance of context, Wood (1999) describes four types of fits or alignments: internal, strategic, organisational and environmental. Internal/vertical

alignment refers to the link between the different HR practices within the HR System; strategic/external alignment refers to the link between the HR System and the organisational operational and strategic objectives. Organisational alignment refers to the link between the HR System and other relevant systems in the organisation; and finally environmental alignment refers to the linkage between the HR System and the external environments (Wood, 1999). Contextual factors such as country, sector, strategy, systems, and employee groups influence the effectiveness of HR practices, supporting the environmental and organisational alignment of the HR System with the internal and external environments (Boxall & Purcell, 2008).

Taking the concept of alignment into consideration and relating it to the best-fit approach mentioned earlier seems to be in line with the configurational perspective to HRM. The configurational perspective follows a more holistic approach of inquiry and is concerned with how patterns of multiple interdependent variables relate to a given dependant variable in order to identify configurations or unique patterns of factors (Colbert, 2004; Delery & Doty, 1996). First, the configurational perspective construes that HR practices should be bundled to be most effective as the effectiveness of any HR practice depends on its interrelationship with others (Delery & Doty, 1996). Secondly configurational theorists working in Strategic HRM aim to derive internally consistent configurations of HR practices, that maximise horizontal fit, and then link the HR practice configurations to external configurations to maximise vertical fit (Delery & Doty, 1996). Thus, the perspective is concerned with both vertical and horizontal fit. Finally, the configurational perspective acknowledges system interaction effects, where the whole may be more or less than the sum of its parts (Colbert, 2004).

As a result, this research undertakes a configurational perspective, as it is concerned with both vertical and horizontal fit. The configurational perspective is in line with the system perspective, as it acknowledges the interrelatedness of the different components in a system and that the system is more than the sum of its parts.

2.4 Conceptual framework for optimising HRM in public health care

The model below draws together the various concepts and approaches discussed in the elements in a HRM system: context, mechanisms, actors, alignment and outcomes.

The model presents a framework for optimising HRM in public health care. The framework places the concepts of strategic HRM and alignment at the centre stage of HRM, with the addition of the context of institutional, organisational, and contingent factors, illustrating their relationship and impact on the HRM outcomes and organisational performance.

The model draws on Dubois and Singh's approach (2009) to highlight the context (institutional and organisational), and link from performance to organisational outcomes, staff outcomes, and patient outcomes, whilst identifying HR strategies as mechanisms. Purcell and Hutchinson (2007) and Boselie et al. (2005) depict the relationship, linkage or chain between HRM and organisational performance, whilst Becker et al., 2001 provide the frame for the model – alignment. Becker et al., 2001 posit that internal and external alignment could lead to effective organisational strategy execution and thus ultimately improved organisational performance.

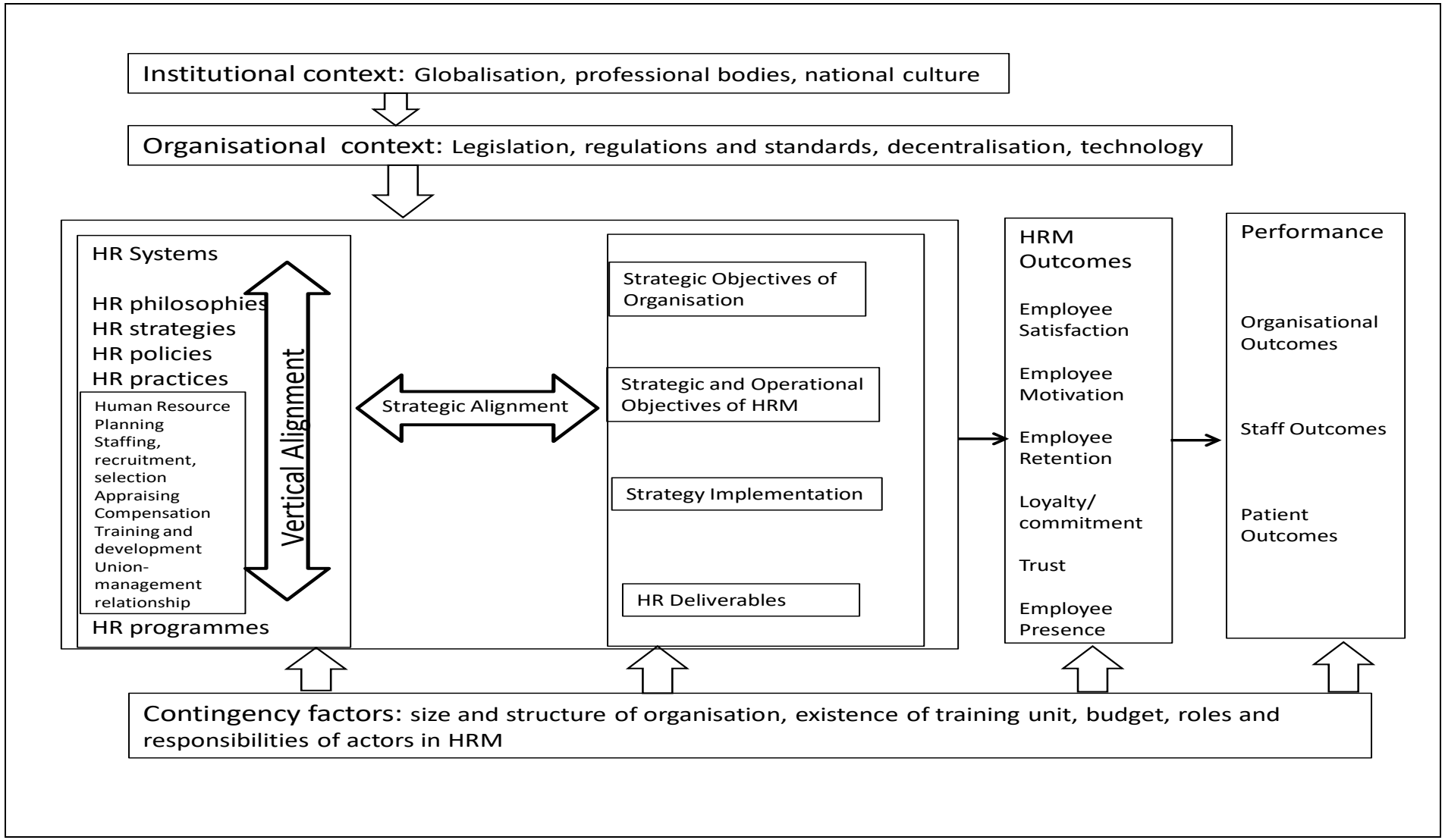


Figure 2.7. Framework for Optimising HRM in Public Health Care

2.5 The State of Human Resource Management

The search for literature on the current state of HRM in the public sector was expanded to the include literature on the private sector to gain deeper insights and understanding on alignment in HRM.

2.5.1 Research on HRM in the private sector

The review of literature on HRM in the private sector, outside of the health sector, provides useful insights and approaches to studying HRM that are relevant to the health and public sectors. Several authors have synthesised research studies conducted on HRM in the private sector, making four key contributions (Wright & Boswell, 2002; Boselie et al., 2005; Truss, 2001):

- a typology of HRM research;
- the importance of the role of the line manager;
- the lack of focus on the softer issues in HRM; and
- the recognition that research conducted is more quantitatively orientated.

The typology of HRM research identifies four sub-areas: multiple numbers of HRM practices; single HRM practices; individual level of analysis; and organisational level of analysis. Within two of these sub-areas, it was found that research conducted on multiple HRM practices and HRM systems at the organisational level highlighted two important contributions to the field of study (Wright & Boswell, 2002). First, is the reaffirmation of the relationship between HR practices and organisational performances, emphasising the importance of classifications or configurations of HR practices; the second observation is that the assessment of horizontal fit was done using a single HR practice to measure effectiveness.

The review of 104 articles focusing on the private sector in the period 1994 - 2003 conducted by Boselie et al. (2005) revealed two important insights relevant to the public sector; first, limited research attention was given in the area of investigating the quality of the implementation of HRM, as a necessary condition for its effectiveness; second, there is a dearth of research studies examining leadership and the change delivery role of immediate Line Managers or supervisors in HRM in the private sector (Boselie et al., 2005).

Finally, the critiques revealed a dependence on quantitative research methods, specifically survey. Truss's 2001 critique of HRM research studies reveals flawed findings based on a single respondent per organisation as well as no qualitative inquiry into process, practice and implementation. In response, the author embarked for her doctoral dissertation on an exploratory approach using a case study approach on the actual practices, highlighting the rhetoric of HR polices and HR practice.

2.5.2 Research on HRM in public and private health care

This section describes the relationship between HRM and organisational performance in the health sector. It highlights that although HR policies are considered crucial to improved health service delivery and thus organisational performance, the evidence shows that other HR Systems, for example HR strategies, play a pivotal role as well.

The factors identified as influencing HRM are the role of the HR Department and the role of Line Managers, highlighting the importance of the actors in HRM in improving organisational performance.

Relationship of HRM and organisational performance

There is limited literature on the relationship of HRM and organisational performance in the health sector. From several research studies, it was found that HRM conveys the perception of quality of health care (Loi, Lam, Ngo, & Cheong, 2011). The difficulty in illustrating the link between HRM and organisational performance lies in establishing unequivocal links between single or multiple practices and performance outcomes (Harris, Cortvriend, & Hyde, 2007). Relationships between a range of HRM practices, policies systems and performance have been established for the private health sector but not in the public health sector (Harris et al., 2007).

Several studies have tried to address this difficulty of linking HRM and organisational performance. One study found that it is generally believed that human resource policies will lead to improving health service delivery, health outcomes, and overall organisational performance (Dussault & Dubois, 2003). These authors make specific reference to a possible linkage between decentralisation and its impact on human resources implementing human

resource policies. For example, they argue that the absence of appropriate human resource policies could be the reason for a chronic imbalance in the health workforce, with multifaceted effects, including quantitative mismatch, qualitative disparity, unequal distribution and a lack of coordination between HRM actions and health policy needs (Dussault & Dubois, 2003). In another study, a typology of health workforce imbalances is presented, with the objective of facilitating the development of policy tools and assessments (Zurn, Poz, Stilwell, & Adams, 2004) supporting the notion that human resource policies will improve organisational performance.

Similarly, a study by Nasiripour and Izadi (2012), the effect of HRM policies on the Potential of Employee Productivity (PEP) in a healthcare organisation is analysed through an adaptive and descriptive research, using Vensim software. Causal loop diagrams, and stock and flow diagrams highlight that management practices are multi-dimensional constructs that generally do not demonstrate a straightforward relationship with productivity variables. The research demonstrates that the relationship between HRM policies and PEP in a healthcare organisation is non-linear, dynamic and affected by the qualities of the policies.

In addition, an analysis of systematic reviews to identify and assess available policy options to address human resources for health found that most evidence focused on organisational mechanisms for addressing the human resources for health challenges, and not policy options (Chopra, Munro, Lavis, Vist, & Bennett, 2008); these organisational mechanisms include substitution or task shifting between different types of health workers, role extension, performance-enhancing strategies such as quality improvement or continuing education strategies, promotion of teamwork, and changes to workflow (Chopra et al., 2008). Hence, they reach the conclusion that human resource policies are not the solution to addressing the human resources for health challenges in low- and middle-income countries.

Impact of individual HR strategies on organisational performance

The literature review identified the types of individual HR strategies implemented that impacted organisational performance. Individual strategies were considered effective only to some extent, as the challenge remained with the HRM of the health workforces specifically to retain, equally distribute, motivate, and manage performance. For example, the creation of the Emergency HR Plan in Liberia to quickly increase workforce numbers, improved equitable distribution of workers and enhanced performance, and demonstrated significant

improvement in the nursing cadre numbers; yet they remained challenged by equitable distribution, retention and performance management (Varpilah et al., 2011).

A case study in China found that whilst decentralisation gave health service managers more control over managing their staff, the complexity of decentralisation, coupled with inadequate capacity building and other pressures, influenced the alignment of HRM actions with health service objectives (Liu, Martineau, Chen, Zhan, & Tang, 2006). The authors suggest that to increase the chance of decentralisation leading to improved HRM and health service delivery, the following factors should be taken into consideration and addressed:

- capacity building for managers to support them in their new role;
- the complexity of decentralisation;
- recognising the external influences in decision making;
- and finally competition for resources, which could exacerbate inequities in health service provision (Liu et al., 2006).

Other literature points to the neglect of HRM issues, as in a study of costing interventions focused on financing sources and mechanisms to improve health workforce recruitment and retention in remote and rural areas (Zurn et al., 2011). A realist review on how HRM interventions impact on health worker performance teased out three mechanisms that were triggered by HRM interventions and brought about change in health workers' performance: increased knowledge and skills, improved motivation and the feeling of being obliged to change (Dieleman et al., 2009). The authors conclude that none of the studies reported explicitly how staff motivation was meant to be achieved or on which motivation theories HRM interventions were based, but found that the studies provided some insights into mechanisms contributing to motivation.

However, a wide range of research conducted on the motivation of health workers relating it to job satisfaction and performance were found, ranging from perceptions of job satisfaction (Peters, Chakraborty, Mahapatra, & Steinhardt, 2010), to financial and non-financial predictors of motivation (Adzei & Atinga, 2012; Mathauer & Imhoff, 2006). Understanding motivation and job satisfaction is highly dependent on the local context and requires plans to be developed locally, focussing on locally assessed conditions, and managing incentives to ensure health workers are motivated in their work (Peters et al., 2010). Furthermore, though

financial incentives significantly influence motivation and retention, the non-financial incentive predictors of motivation and retention identified included: leadership skill and supervision, opportunities for continuing professional development and availability of infrastructure and resources (Adzei & Atinga, 2012: Mathauer & Imhoff, 2006). The inadequate or inappropriately applied HRM tools may adversely affect the motivation of health workers (Mathauer & Imhoff, 2006).

In some instances, individual strategies, for example task shifting, appeared to be a promising policy option to increase the productive efficiency of the delivery of health care services, but challenges in sustaining motivation and performance were identified (Fulton et al., 2011). In addition, the implementation of HR strategies such as task shifting hinges on serious political and financial commitments (Lehmann, Van Damme, Barten, & Sanders, 2009).

Factors influencing HRM

The review on research studies on HRM in health care revealed a range of factors influencing HRM in health care:

- migration (Kabene, Orchard, Howard, Soriano, & Leduc, 2006);
- adequate resourcing of HRM (Stanton, Bartram, & Harbridge, 2004);
- the role of the HR Department (Rosman, Shah, Hussain, & Hussain, 2013; Mcdermott & Keating, 2011);
- the role of Line Managers (Buchan & Seccombe, 1995);
- the competency of line managers to perform HRM (Mwita, Nyagero, O'Neil, & Elqura, 2009; Singh, Singh, & Singh, 2012).

Migration of health workers to more affluent regions or countries is one of the challenges identified in developing countries, which may be addressed through the proper implementation of HRM practices (Kabene et al., 2006). However, HRM faces critical issues at the health workplace. First is the adequate resourcing of the HRM function which requires a strategic government response to HRM; second is the need to recognise the potential of HRM to add value to the public health sector. Third, the need for effective management skills, and finally managing the complex relationship and political processes of the three main actors within the health care system (Stanton et al., 2004).

For instance, the role of the HR Department is crucial, as currently it performs the role of administrative expert, neglecting the roles of change agent, strategic partner, and employee champion (Rosman, Shah, Hussain, & Hussain, 2013; Mcdermott & Keating, 2011).
In the case of the role of the Line Manager, the review yielded that the role of the Line Manager is crucial in developing good practice in managing absence (Buchan & Seccombe, 1995) and that Line Managers are often unclear on the tasks that are expected to be performed in HRM (Singh et al., 2012). For example, an exploratory study of managers with significant responsibility for HRM in health institutions was undertaken in Ethiopia, Kenya, Tanzania, and Uganda, to determine the needs of staff in HRM roles (Mwita et al., 2009). Some of the key findings from the study included: that more than 70 percent of the respondents stated that they need additional skills and knowledge to carry out personnel policy functions (compensation of benefits, HR Planning, recruitment, transfer and promotion of staff, termination, grievances). In addition, an average of 75 percent of the respondents needed improved capacity to use HR data systems in order to maintain an employee tracking system and provide personnel files to staff (Mwita et al., 2009).

Furthermore, to achieve effective HRM, it was suggested that health care organisations must consider a more systemic approach - one that accounts for factors beyond narrowly defined HRM practices, which includes organisational and institutional conditions (Dubois & Singh, 2009). Bach (2011) also suggests that a more strategic approach could be developed in the health sector, emphasising the importance of ownership, external and internal fit, and the vital role of the specialist HR function. Aligning people management with business strategy and integrating high performance work systems into the strategic management process is crucial for improving performance and health service delivery, in addition to a new perspective of the HRM system (Mugo, Nyandika, & Okibo, 2014).

The review of the literature in the public health sector found similar insights to the private sector on two points: there is a lesser research focus on the *soft* issues in HRM and there is a dearth of research on the role of Line Managers in managing the workforce. Interestingly, the research techniques employed in the private sector were predominantly quantitative in methodology. The literature on HRM in health care yielded a range of research techniques, from the preferred quantitative and qualitative methodologies, but also case study research, action research, systematic reviews, realist reviews, and using Vensim Software to demonstrate relationships through diagrams and loops.

2.6 HRM in South Africa

South Africa's public health system human resource shortages are exacerbated by an increased demand of HIV care (van Rensburg, Steyn, Schneider, & Loffstadt, 2008) coupled with maldistribution (geographical and institutional) of HR (Wadee & Khan, 2007). The maldisdistribution of the health workforce occurs between the public and private sector, urban and rural areas, and tertiary and primary levels of care (Department of Health South Africa, 2011). In South Africa, the distribution of health professionals is skewed towards private, urban and tertiary levels of care.

In the public sector, the Public Service Act of 1994 sets the legislative framework for the public service; it states the functions of the organisation and staff supported by the Public Service Regulations, which provide the regulatory framework to implement the Public Service Act, setting out regulations for conduct, financial disclosure, anti-corruption and ethics management.

In 2010, an assessment of the state of HRM in the public service of South Africa by the Public Service Commission (PSC), revealed the extent of HRM policy implementation. The assessment utilised a desktop review of reports published by the Public Service Commission and other organisations. The PSC used five key areas of HRM, as identified by the Department of Public Service and Administration (DPSA) in the *Circular on Interventions to Improve the HRM Function in the Public Service,* as the framework for the assessment. They are:

1. Human resource and organisational strategy and planning
2. Human resource practice
3. Human resource utilisation and development
4. Employee health and wellness
5. Employee relations.

The assessment determined the extent to which HRM policy implementation took place, and identified the challenges experienced, utilising indicators developed for each of the five HRM areas. The assessment found that the human resource practices deal with the human resource administration services within a department, which include the management of recruitment, selection, compensation, conditions of service and human resource personnel records (The

Public Service Commission, 2010). One of the assessment's main findings is the "disregard of elementary processes such as compiling job descriptions, conducting job evaluations and obtaining approval of job adverts prior to their placement in the media" (The Public Service Commission, 2010: vii). The report acknowledges that some procedural omissions undermine the credibility of the selection process and create challenges for the Public Service.

The key human resource (HR) practices affecting doctors' retention in a medical complex were explored in the Eastern Cape, South Africa (Longmore & Ronnie, 2014). The most important HR practices identified which affect doctors' retention were: paying salaries on time and accurately, the management of documentation, communication, HR staff showing that they respected and valued the doctors, and reimbursement for conferences and special leave requests (Longmore & Ronnie, 2014). The study revealed that the most important HR practices perpetuated the shortages, and adversely affected the retention of doctors. Overall, the research found that the administering of HR practices was deemed "*poor in nature*" (Longmore & Ronnie, 2014). In addition, HR performance characteristics were ranked by the respondents in the following order of importance: task competence of HR staff, accountability, general HR efficiency, occupation-specific dispensation adjustments and performance management and development system efficiency, and finally the availability of HR staff (Longmore & Ronnie, 2014). This research is one of the few studies linking HR practices to a HR outcome, in this case retention of doctors.

However, good HRM is a solution to most of the challenges experienced by the human resources for health. The literature review identified two strategies being implemented to improve HRM of the public health workforce in South Africa: professionalising HR and devolving HRM responsibilities to Line Managers.

The first strategy is aimed at improving the human resource practices in the public health sector, and is suggested by the HRH Strategy for the Health Sector, 2012/13 – 2016/17; the professional HR function for the health sector requires, in addition to general health care management skills, that all public sector health care human resource managers should:

- possess formal general management qualifications, including training in best practice human resource (HR) management;

- undergo training in specific government policies and procedures relating to HR, recruitment, induction, procurement and finance and have competencies in soft leadership skills, fostered through mentorship and training, and assessed through upward feedback mechanisms;
- be managed against performance targets that include key performance indicators in HR;
- ensure clear succession planning for managers who are successful and who are consequently promoted, in order to ensure sustainable services (Department of Health South Africa, 2011: 61).

The second strategy is proposed by the White Paper on HRM in the Public Sector, which is to decentralise and align HRM responsibilities with the line function (Department of Public Service and Administration, 1997a). In Primary Health Care, the implication of the devolvement of HRM responsibilities to Line Managers is that Line Managers will acquire formal HR responsibilities, previously performed by HR managers in the district or provincial offices (Chabikuli, Blaauw, Gilson, & Schneider, 2005).

Health sector decentralisation policies have been implemented on a broad scale as part of health sector reforms in the developing world (Bossert & Beauvais, 2002) including South Africa. Decentralisation influences the implementation and effectiveness of HRM. The effects of the extent of decentralisation of both the budget and HRM responsibilities to district and sub-district authorities influences the HRM functions at a district level (WHO, 1988).

The district health system has been recognised as the main mechanism for implementation of Primary Health Care, with district management teams responsible for day-to-day management of primary health facilities and community outreach (Harrison, 2009). The key features of functional administrative decentralisation are clearly defined: staff can be allocated across functions as needed; employers should be able to attract and retain qualified individuals; and lastly, there should be flexibility in managing financial resources (Green, 2005). These key features require a degree of autonomy, influence and power in decision-making. However, in South Africa, the District Management Teams act as units of a

de-concentrated provincial system, rather than as management entities with delegated authority (Harrison, 2009).

In South Africa, the decision space of a decentralised district health system is determined by looking at financial and HR delegation authority. The HR delegation of authority can be categorised as follows: two provinces have no HR delegation authority; six provinces have limited and varied HR delegation authority; and only one province has complete HR delegation authority (Byleveld et al., 2008).

In the South African Department of Health there is a general agreement that information for planning and managing the public health workforce is insufficient (Department of Health Republic of South Africa, 2006: Department of Health South Africa, 2011). The available information system, Personnel Salaries (Persal), is criticised for not being up to date and not collecting the information required for evidence-based decision-making, planning and management.

The Persal database is the human resource information system used by all public services in South Africa, linked to a shared mainframe computer system to manage personnel and financial data. Persal is a human resource information system hosting data in the following categories: Individual Member Data, Job Information, Organisational Structure and Salary Information. However, Herbst, Burn and Nzimande (2002) found that the main weakness of Persal as an information system is that its primary function is to manage salary payments, which dominates the use of the system to the detriment of the accuracy of the non-salary information in the system. (Mathews, 2005) concurred and identified two critical challenges: there is no routine aggregation of data, limiting the analysis and use of information for monitoring the public health workforce; and there is no district based monitoring system for managing the public health workforce.

The lack of accurate information on the health workforce in South Africa is reiterated by *HRH SA 2030, the Draft HR Strategy for the Health Sector: 2012/13 – 2016/17.* It suggests the utilisation of monitoring and evaluation of the public health workforce as a strategy to address the problems experienced in the health sector:

> *Information for planning and managing the health workforce is very problematic. The use of public service information system, Persal, is not accurate and various*

professional categories for example medical specialists by category are not captured. A reason for the significant health workforce problems identified in this HR Strategy development process is that trends in the workforce are not monitored, evaluated and acted upon (Department of Health South Africa, 2011).

To summarise, the public health sector in South Africa experiences a shortage of professional health workers, a maldistribution of the health workforce, and recruitment and retention challenges. The ineffective delivery of HR practices, and poor HRM perpetuates the already HR constrained and challenged environment. As a result, two strategies: Professionalising HR and Devolving HRM responsibilities to the Line Managers are aimed at improving the HRM of the public health workforce, within a limited decentralised context, accompanied by accountability but not necessarily authority. The review of the South African document indicated support for a partnership approach and the need to improve the evidence base for the monitoring and evaluating of the public health workforce.

2.7 HRM Strengthening Mechanisms

The relationship between HRM and organisational performance has been established, where effective HRM in the public health sector depends on both HR manager and Line Managers. The review of the literature suggests that the devolution of HRM to the Line Managers requires a partnership approach, and information on the human resources for health to manage the public health workforce.

Several authors have advocated for a partnership approach to strategic HRM (Jackson & Schuler, 2000; Jackson & Schuler, 2003; Purcell & Hutchinson, 2007; Papalexandris & Panayotopoulou, 2005). A partnership approach is advocated between HR managers, line or operational managers and employees, to manage HR issues (Jackson & Schuler, 2000; Purcell & Hutchinson, 2007) which is also referred to as "an HR triad" (Jackson & Schuler, 2000: 25). The main purpose of the partnership would be to "add value" and "deliver results" for organisations (Ulrich, 1997, 1998 in Jackson & Schuler, 2000).

However, the partnership could prove to be challenging as it adds to the already exhaustive lists described by Papalexandris and Panayotopoulou (2005) and Renwick (2003), creating conflicts and tensions. Renwick (2003) highlights that line managers did not consider the advice provided by the HR manager as helpful (Brewster and Larsen, 2000) and they felt that

they were being “policed by the rule book” (Guest et al. 2001: 67). Similarly, the Line Manager thought that doing HR work was time consuming when other priorities were pressing (customers, time, quality of product), but they saw the value of having HR, for “advice, comment and support”, but not to be subject to their direction. “HR give you the implications of the options”, but “the decision’s mine” (Marsh and Gillies, 1983 in Renwick, 2003). Thus it appears that the exploration and development of the partnership between the HR manager and Line Managers is required to meet the expectations of both role players. In addition, the HR manager needs information to advise, and Line Managers would require information to make evidence based decisions for managing the public health workforce.

HR information for evidence based decision-making and planning is important for two reasons: to monitor the human resources for health and to measure organisational performance. A review of the literature suggests that different data sources monitored and evaluated the human resources for health. The main data sources for the monitoring and evaluation of human resources in countries are: professional registration bodies, labour force and income surveys, population census data, health facility reviews and administrative data (WHO, 2009).

Although labour force and income surveys are not health sector specific, they provide data on the complete range of employment sectors, both private and public services in a country, which could be used to develop additional insight and trends in the health workforce (Gupta, Diallo, Zurn, & Poz, 2003). Population census data is limited to information on the stock and composition of the health workforce, disaggregated by sex (Lavallee et al. in Dal Poz et al., 2009).

Human resource information systems are also developed through administrative data sources. An example of developing an administrative data source is when a human resource information system using a participatory approach involving various stakeholders, a mature software solution and an emphasis on capacity building was developed in three low-middle income countries: Uganda, Sudan and Brazil (McQuide et al. in Dal Poz et al., 2009). In the case where there is no information system to monitor changes in human resource information the data collection of human resource information at the health facility would be required (Heywood, Harahap, & Aryani, 2011). Facility based records proved to be very useful in

providing information on qualifications, skills mix, training and performance (Fapohunda et al. in Dal Poz et al., 2009).

In summary, this section has described the rationalisation and challenges of the devolution of HRM functions; in addition, it has identified the dearth of research studies in both the private and public health sector, on how HRM is performed by the two sets of role players, and how this relationship can be strengthened. Two strengthening mechanisms identified in the review from existing data sources on monitoring and evaluating the human resources for health are: a partnership approach and developing an evidence base for decision-making and planning. The review continues to describe HRM in South Africa providing the background on the HR situation and finally the data sources used for evidence based decision-making and planning. In conclusion, paradigm shifts from personnel management to strategic HRM requires specific skills and competencies. In this literature review, it was found that HR practices in the public sector epitomise the traditional purpose of HRM - to attract, retain and motivate. The description of the elements of a HRM system led to the development of a framework to optimise HRM in health care. The devolution of HRM responsibilities to the Line Managers has a tremendous impact on the effectiveness of HRM. The review on the literature in both private and public sector revealed two research gaps: research on the softer issues in HRM, and on the role of leadership specifically of the line managers in managing the workforce. The chapter was concluded with a description of HRM in South Africa. The chapter on the research methodology follows, outlining the research process, the strategies for rigour which were applied, and ethical considerations of this study.

3. METHODOLOGY

This chapter begins by outlining the overall research strategy adopted in the study, namely that of the comparative case study of district human resource management (HRM) in the rural and urban Western Cape. It describes criteria for selection of cases, the embedded units of analysis, multiple sources of data (document review, interviews, surveys, focus groups, observations) and the iterative process of data collection, involving phases of analysis from individual case study description to comparative case analysis, as well as the strategies adopted to ensure rigour in this research.

3.1. **Research Strategy**

The research strategy selected is a case study. The scope of a case study is an empirical inquiry that "investigates a contemporary phenomenon (the 'case') in depth and within its real-world context, especially when the boundaries between the phenomenon and context are not clearly evident" (Yin, 2014: 16). As described in the Literature Review, the phenomenon under investigation is the HRM system in a district health system. A conceptual framework for optimising HRM in public health systems is presented in this chapter, depicting the complexities and context influencing this phenomenon. In order to study the phenomenon of HRM in depth using this conceptual framework, a case study approach was felt to be appropriate for this research inquiry. In addition, the case study approach lends itself to answering *what*, *how* and *why* questions of a contemporary set of events (Yin, 2014).

Within these parameters, this research design is comparative: a rural case of district HRM is compared to an urban case, encompassing a range of descriptive/exploratory (what and how) and explanatory (why) questions. The study explores how HRM functions are performed; it describes the HRM system, and explains why alignment is poor, as well as the factors influencing HRM in a district health system. The researcher has adopted a multi-method, flexible and iterative approach to data collection whilst being systematic and rigorous, which is fitting for the case study methodology.

The case study is well established as a methodology for researching human resources for health (Dieleman, Shaw, & Zwanikken, 2011; Fulton et al., 2011; El-jardali, Jamal, Abdallah,

& Kassak, 2007; Munga & Mæstad, 2009). This research forms part of the broader field of health policy and systems research (HPSR), which investigates real-world situations and issues, drawing on methods and perspectives from a range of disciplines (Gilson, 2012). The field of health policy and systems research:

> … *seeks to understand and improve how societies organise themselves in achieving collective health goals, and how different actors interact in the policy and implementation process to contribute to policy outcomes. By nature, it is interdisciplinary, a blend of economics, sociology, anthropology, political science, public health and epidemiology that together draw a comprehensive picture of how health systems respond and adapt to health policies, and how health policies can shape – and be shaped by – health systems and the broader determinants of health* (Gilson, 2012: 21).

In the field of HPSR, a wide range of research strategies are utilised, covering dominant and emerging approaches in the field, one of which is the case study approach. Case study research is widely used in HPSR because firstly it acknowledges the importance of context and how health policy and systems are influenced by contextual factors; secondly, the types of questions posed in HPSR require investigation into the complex behaviours and relationships of actors, and how those relationships influence change; and finally, the case study approach can be used to support and analyse policy development (Gilson, 2012).

The specific design adopted in this thesis was an embedded, multiple-case study consisting of two cases and two embedded units of analysis in each of the two cases (Figure 3.1). In this research, the case was the HRM system in the context of the district health system, and the embedded unit of analysis was the particular HRM functions, for example appointments.

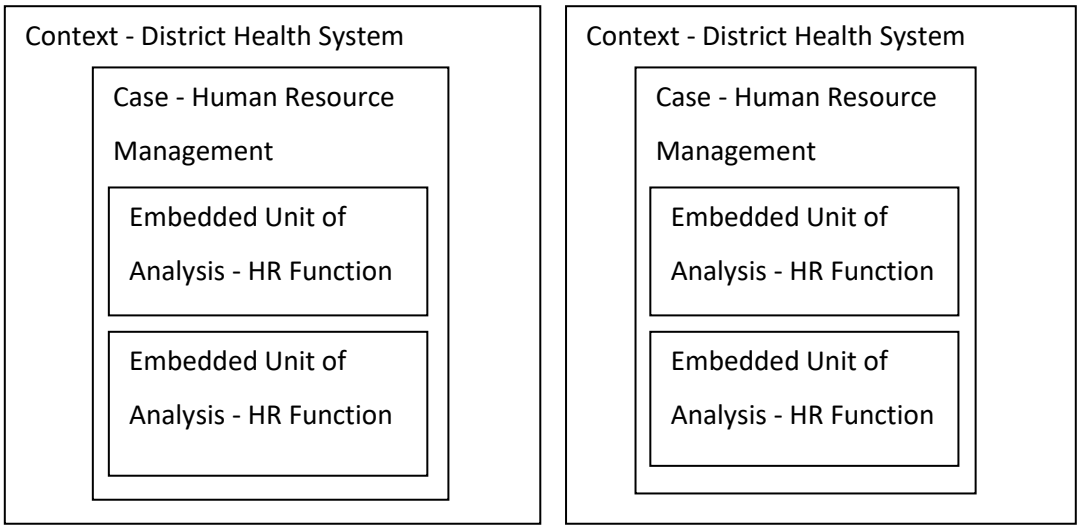


Figure 3.1. Multiple case study design

This multiple case study design was selected to follow a replication logic, selecting cases predicted to have similar results, referred to as "literal replication" (Yin, 2014).

Selection of districts, units of analysis, and participants

Neuman (2011) correctly asserts that sampling in qualitative research aims to deepen understanding of a larger process, relationship, or social setting, and that the people to be studied are selected based on their relevance to the topic rather than their numerical representativeness of a population. This is referred to as purposive sampling, and is employed in this research inquiry (Neuman, 2011).

Miles and Huberman (1994) propose four sampling parameters to bound the collection of data; the setting (where the research will take place); the actors (who will be observed or interviewed); the events (what actors will be observed or interviewed doing); and the process (the nature of events undertaken by the actors within the setting). In this research, the setting constituted two districts, purposively selected for their urban and rural status, representing different degrees of decentralised and centralised decision making on human resources, in the overall context of a province with a decentralised district health system. The actors were selected based on their specific contribution of being experts in the field and providing in-depth understanding of how human resources are being managed in a district. The events were the embedded cases which served as the units of analysis, the HRM functions emerging

from the interviews. The processes were relationships, communication, and meetings of the actors.

The actors included in the study (study population) were the line, operational and human resource managers involved in decision making on human resources (Table 1). Human resource managers comprised a multitude of different job titles which included: Human Resource Practitioner, Personnel Administrator, Assistant Director Human Resource, and Deputy Director Human Resource. Participants were selected from the Line Managers and HR Managers at the different levels of the district health system.

Table 3.1. Study Population

Levels in the Public Health System	Human Resource Managers/Practitioners Cluster	Operational or Line Manager Cluster	Senior Management Cluster
District	Deputy Director HRM Human Resource Managers, Practitioners and Clerks (HRM Components)	Primary Health Care Manager Programme Managers	District Manager
Sub-District	Human Resource Managers, Practitioners and Clerks (HRM Components)	Primary Health Care Manager Programme Managers	Sub-district/ Structure Manager
Facility		Facility Manager	

The actors from the HR manager cluster were purposively selected using the following criteria:

a. more than 5 years' experience in HRM
b. authority and responsibility for HRM
c. authority and responsibility in monitoring human resources

Though interviews with both the Line Manager and senior manager cluster were planned, it emerged that the Line Manager cluster was the most knowledgeable on HRM and therefore the most appropriate as respondents. Four to six Programme Managers, Sub-district Managers and Facility Managers were selected in each district, based on their experience and knowledge in the public health sector, and on their having to perform both HRM functions and health service management. The following criteria were used to purposively select the Line Managers:

a. The manager must have been in this position for more than five (5) years
b. The manager must have been performing HRM functions and monitoring for more than three (3) years
c. The manager has to have more than five (5) subordinates with direct accountability to the manager

d. The manager must have had training in HRM or general management in the last five (5) years.

3.2. **Data Collection Strategy**

The data collection strategy can be described as an iterative process, encompassing five data collection techniques: document review, in-depth interviewing, observations, questionnaire, and focus group discussions. The figure below depicts the iterative nature of the data collection process, highlighting the multidirectional and follow up processes.

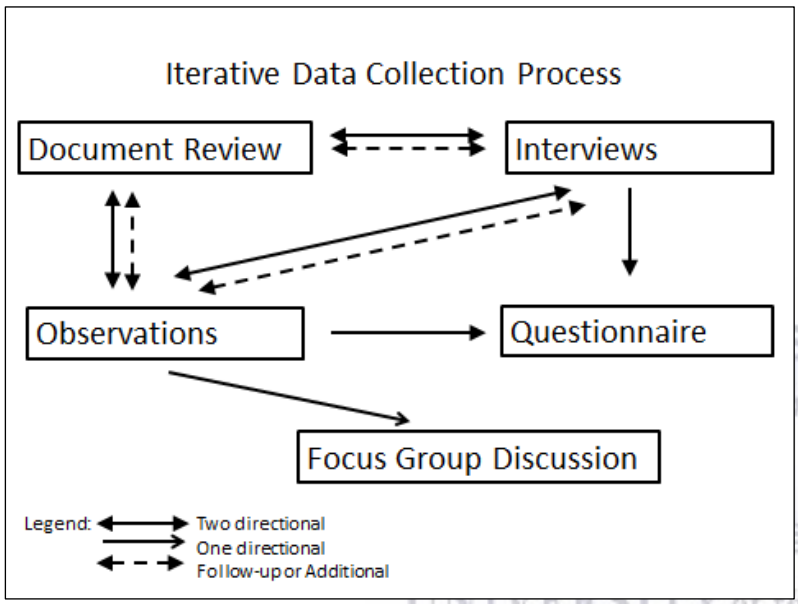


Figure 3.2. Iterative Data Collection Process

The data collection started with a document review. The list of documents reviewed and the purpose of the review for each document is outlined in Table 3.2 below. They included policies, reports, monitoring tools and communications. Altogether, the document review had three main objectives: (1) to describe and analyse the prescribed and actual HRM functions and practices; (2) to elicit the communication network between the different role players in HRM; (3) to describe and understand the context of district HRM.

Table 3.2. List of Documents Used in Document Review

Type of Document	Document Description	Purpose of Review
Policies	HRMs Acts	To identify the type of guidance, role and responsibilities, identify expectations, identify role players
	HRM Policies	To identify the type of guidance, description of processes and procedures
Reports	District Annual Reports	To identify strategic objectives, HR objectives, challenges, and plans
	HRM Reports	To identify decision making processes, roles of role players, use of information for decision making and planning
	Substructure Reports	To identify strategic objectives, HR objectives, challenges, and plans
	Presentation IFMS	To determine the use and role of information
Monitoring Tools	Quarterly Monitoring and Evaluation Tool	To determine the monitoring activities and tools used to monitor performance
	Monthly managerial checklist	To determine monitoring objectives and processes, and who is responsible and accountable
	Quarterly Audit Action Plan	To identify strategic objectives, HR objectives, challenges, and plans
Communications	Minutes of HR and operational management meetings	To identify processes and procedures, and challenges, to elicit the communication network between the different role players in HRM
	Agenda and Minutes of HR Forum Meeting	To elicit the communication network between the different role players in HRM
	Adverts for ASD and DD - HR	To establish requirements for HR managers
	E-mails and memos	To identify communication patterns, to elicit the communication network between the different role players in HRM

The document review provided information on the HRM functions and practices, the communication network, the context of district HRM, and finally the use of information for HRM.

After obtaining sufficient background information and a good understanding of the HR Programme, and how HRM was being performed in each of the districts, in-depth interviews with HR managers were scheduled and planned observations were identified. The interviews with the HR managers and observations took place simultaneously. The targeted study

population were HR managers on the salary grades 8 – 12, with the varied job titles referred to earlier. This group of HR managers have discretionary autonomy and authority in HRM and perform similar HRM functions.

Interviews were conducted face to face using a semi-structured interview guide **Error! Reference source not found.** to gain a deeper understanding of the context, functions, challenges and hindrances, and monitoring requirements for HRM. In addition, follow-up interviews were conducted with HR managers to clarify and confirm details provided during the interviews, and add new insights that may not have been mentioned before.

The direct observations were aimed at obtaining insights into the functions, relationships, communications and interactions within the HR Programme. The observations were conducted by the researcher at bi-monthly or quarterly HR meetings over a period of six months, as well as at bi-weekly HR operational meetings per district. At these meetings, the performance of HRM functions, such as the monitoring of the staff establishment, the process of addressing emerging HR issues, and the delegation of responsibilities amongst the HR staff were observed. In addition, observations were gathered on how communication takes place between employees and Line Managers, how HR issues are planned and implemented, and finally how the HR staff in the District HR Office interact with one another and for what purposes. The observations were recorded as field notes with support documents such as the minutes of the meetings.

During the process, the questionnaires **Error! Reference source not found.** were distributed to the HR Managers in each district. The purpose of the questionnaire was to collect descriptive data on the demographics, qualifications and training, roles and functions, communication and reporting lines of the human resource managers and practitioners. In one district, one set of observation results was used to distribute and complete the questionnaires because the majority of the HR managers targeted were present at that time. In the other district, a more formal process of distribution was used to each district office HR Manager from the target study, using the internal mailing system.

The interviews with Line Managers were also conducted concurrently with the interviews with the HR managers. The majority of the interviews were conducted face-to-face using a semi structured interview guide , with one conducted telephonically on account of the

distance and availability of the participants. A semi-structured interview guide was development for the Line Managers and used during the interviews. Upon reflection, after my first interview with a Line Manager, I adapted the interview guide to add specific explorations around the embedded cases, appointments, compliance and leave application. It was at this point when I decided on the HRM functions that would be used as the embedded cases for the unit of analysis. This decision making is illustrated with the extract below from the reflexive journal I was keeping during the process.

This led to my decision to use the following HR components for the embedded cases for which follow up interviews will have to be conducted: leave, appointments and compliance. In preparation for the interviews with the Facility Managers, these are the three components I will ask specifically about. For the embedded case, Leave, I have developed a scenario (Figure 4.8. Leave management scenario) to use as a departure point for discussion. For the embedded case of Compliance, I am also going to the use the Compliance Management Instrument which has to be completed and signed off every month by the Line Manager and the specific issues to be raised are:	
Compliance Management Instrument (Checklist)	**Questions**
Line Managers have been instructed to properly plan annual leave within the annual leave cycle (January/ February).	What is the instruction?
The timeous submission of leave forms to HR has been discussed and confirmed by all the Line Managers at monthly management meetings.	What is the expectation? Is it feasible? Do you have monthly meetings?
HR/Line Manager confirm that leave has been verified against attendance registers.	How is this done exactly? Who takes ultimate responsibility for this action point?
HR Manager has confirmed that all leave forms from current financial year are submitted and have been captured on Persal before 31 March each year.	
The HR Manager has confirmed that reports of employees with negative capped leave credits have been drawn and addressed accordingly.	Do you get a copy?
Line Managers have confirmed that all Procedure on Incapacity Leave and Ill-health Retirement (PILIR) applications have been processed and submitted to HR within the relevant time frames.	Do you keep your own records? In which format? How do you keep track of applications?
Management of sick leave has been discussed and analysed at monthly management meetings. HR has drawn quarterly reports and distributed them to Line Managers.	What are examples of discussions? How often? How is sick leave analysed monthly?
Line Managers have confirmed that sick leave is monitored and managed on a regular basis.	Describe the process. How monitored? How managed? Do you consult the HR practitioner at any point? What are your experiences?
Line Managers have confirmed that all sick leave application forms have been submitted to HR within the time frames.	
Line Managers have confirmed that all long periods of sick	How are long periods being monitored?

leave have been discussed with the HR Manager to ensure that the PILIR application is not delayed.	
The HR Manager has confirmed that sick leave has been captured and updated on Persal.	How?
Problem cases where extended absences have occurred have been identified and discussed at management meetings and a way forward is being addressed.	Is this not linked to previous action point of monitoring long periods of absences?
The HR Manager has confirmed that all PILIR applications have been processed and forwarded to the Health Risk Manager within the relevant timeframes.	
The HR Manager has confirmed that finalised PILIR cases have been captured on Persal and the declined incapacity leave has been captured as annual or unpaid leave.	
For the embedded case Appointments, I am going to use as a departure point the workflow diagram Appendix 3 **Error! Not a valid result for table.**and HR Compliance Monitoring Instrument Appendix 4**Error! Reference source not found.**: Line Managers and HR Managers have confirmed that the proper recruitment and selection process has been followed before any appointment, including contract appointment, is made. The other points are straight forward and not shared with Line Managers. Adding the senior levels in terms of how decisions and motivations are being made, competing interests and actors, process of deciding whether or not an appointment can be made or not.	

Box 3.1. Reflection on data collection for embedded cases

The extract above demonstrates the iterative and flexible data collection process adopted to gain deeper insights into how HRM functions are performed. Follow up interviews were conducted with Line Managers mainly to clarify processes within their accounts of the embedded cases.

The data collection process concluded with focus group discussions in each of the districts. The focus group discussions were scheduled after the first phase of data analysis, which was prepared for presentations for each of the districts. The purpose of the focus group discussions was to verify the findings of the situational analysis, to identify challenges in HRM, to gain updates on new developments or significant changes from initial data collection, as more than a year has passed, and finally to identify and explore potential interventions to address the human resource challenges.

Table 3.3 summarises the data collection techniques utilised in this research: a document review, sixteen interviews with six follow up interviews, observations, and two focus group discussions.

Table 3.3. Data Collection Techniques

Data Collection Technique	District 1		District 2	
	HR Managers	Line Managers	HR Managers	Line Managers
Interviews	4	4	4	4
Follow-up Interviews	2	1	2	1
Questionnaire	15		11	
Focus Group Discussion	1		1	
Formal Observations	4		5	

3.3. **Data Analysis**

The data analysis was conducted in two phases: an exploratory and descriptive phase in the form of a situational analysis of the HRM of the public health workforce in each district; and a more explanatory phase assessing the vertical and strategic alignment of HRM in each district.

In the situational analysis, the data analysis was centered on mapping the HRM functions, the role players, processes, relationships and context. The findings of the situational analysis phase are structured in a description of the context of HRM (Sub-chapter 4.1.); the case studies of each district (Sub-chapters 4.2. and 4.3.), and a comparative case analysis (Sub-chapter 4.4.) exploring the literal replication of the two cases.

The second phase of data analysis assessed the vertical and strategic alignment of the two HRM systems in the district case studies. This phase was conducted by applying the measurement tools proposed by Becker et al. (2001: 137) to assess the internal and external alignment of the HRM system in a district health system. Internal alignment is assessed through assigning the degree of internal alignment. External alignment is assessed through perspective and scale, where perspective refers to individual viewpoints and the findings of the case studies which justify these perspectives converted into statements; and scale refers to a Likert scale indicating agreement or disagreement with the perspectives or statements (Becker et al., 2001). The assessment of the vertical and strategic alignment of HRM is discussed in Sub-chapter 4.4 Results: Comparative Case Analysis.

The next process in this multi-strategy iterative data analysis was to combine the case study reports and comparative case analyses. The multi-strategy data collection approach yielded two types of data: qualitative and quantitative data. The qualitative data was analysed using Atlas.ti and the data collected from the questionnaire was captured and analysed in Microsoft Excel.

Of the range of three analytical approaches used for the qualitative data (Robson, 2011), I chose thematic coding analysis over quasi-statistical approaches, and the grounded theory approach. The selected approach is a constructionist method and serves "to examine the ways in which events, realities, meanings and experiences are the effects of a range of discourses operating within society" (Robson, 2011: 474). Coding is central to the analytical approach and because the process involves comparing new data with previous codes, to label similar data with the same code, it is often referred to as constant comparative analysis; this is followed by grouping the codes into a number of themes (Robson, 2011).

The thematic coding approach is described by Robson as progressing through the following phases:

1. *Familiarizing yourself with the data. Transcribing data, reading and re-reading data, noting down initial ideas.*
2. *Generating initial codes. This could be done by first devising a framework or template, or inductively by interaction with the data. Extracts from data are given codes in a systematic fashion across the entire data set, with similar extracts being given the same code.*
3. *Identifying themes. Collating codes into potential themes, gathering all data relevant to each theme. Checking if the themes work in relation to the coded extracts and the entire data set. Revising the initial code and/or themes if necessary.*
4. *Constructing thematic networks. Developing a thematic map of the analysis.*
5. *Integrating and interpretation. Making comparisons between aspects of the data using display techniques such as tables and networks. Exploring, describing and interpreting the patterns. Demonstrating the quality of the analysis* (Robson, 2011: 476).

The analysis of the transcripts of the interviews and focus group discussions occurred in four steps: data management; coding; developing themes; and developing case study summary

sheets. The first step was to develop a data management system. I downloaded each recorded interview from the tape recorder, labelled each recording and placed recordings in case folders representing the two case studies and two groups of interviewees. The labelled recordings were sent for transcription and I checked for accuracy of verbatim transcriptions from recordings. A backup of all the recordings and transcription files were copied to an external hard drive. I then created a master file to identify the case study, individual, and date of interview to match the labelled transcript. I proceeded to remove all personal identifiers from each transcript and then uploaded the transcripts according to their case studies to Atlas.ti.

The second step in the analysis was the coding of the transcripts. The coding and recoding process involved allocating codes to different sections in the transcripts, recoding by pairing similar codes together and finally defining each code. I started the coding process by reading the transcripts. The initial coding was done on paper per segment, where sticky notes were used to code the paragraphs in the transcripts. This process resulted in an initial coding list which was then imported into the qualitative analysis programme, Atlas.ti.

Step 1: The coding process in Atlas.ti started with one group of respondents in one case; a code list was created. The code list was then imported for the second case where codes were selected from the existing list and new codes were added to code the same group of respondents in the second case. The coding process ended with a new code list. This process was repeated with the second group of respondents and concluded with the codes amalgamated into 512 codes for both groups of respondents for both case studies.

Step 2: I printed the list of codes for each case study and each group in the case study to check if it adheres to the definition, and to be sure that the quotes selected were relevant to the codes. I embarked on reorganising the coding where new codes were added, resulting in a new list of codes. I categorised the codes, separating examples, and created descriptions that reflect their conditions and associated interactions, referred to as dimensionalising (Strauss & Corbin, 1990).

Step 3: The third step involved categorising the codes into themes. Finally, five (5) broad themes were developed made up of 344 codes.

Step 4: The final step was the development of a case study thematic summary sheet. The development of a thematic map did not appear to work in this investigation and I thus moved to developing a case study description using the themes.

For the quantitative data, the questionnaires of the HR managers were captured and analysed in Microsoft Excel. A codebook was created to describe the procedure for coding variables and their location in Microsoft Excel. The questionnaires were then captured per case study in separate Microsoft Excel files. Descriptive univariate statistics which describes numerical data was used to describe the patterns in the data. The data from the questionnaires was presented in tables, using raw count frequency distribution. The data was analysed using the following variables: demographics, job titles, qualification and training, roles and job functions, perceptions and attitudes towards information management. A summary sheet with the descriptive statistics for each case study was compiled with interpretations, or highlighting the main finding of each table.

The case study report was compiled using the case study description as a starting point and then adding tables from the descriptive statistics summary sheet to provide more detail on the HR managers. Thus, the themes emerging from the qualitative data and the tables from the quantitative data formulated the case study report on each district. The case study reports and the information extracted from the document review were then used to develop chapters on each of the district case studies.

The analytical technique used to develop the case study reports is the cross-case synthesis described by Yin (2014) as one of five analytic techniques in case study research. Cross-case synthesis describes the process of comparing cases to each other for similarities (Yin, 2014). The cross-case synthesis was first used to analyse the embedded units of analysis in the two case studies. Literal replication was undertaken, which aims to “predict similar results” through a careful selection of a few cases (2-3) to illustrate the similarities (Yin, 2014: 57); this was conducted through a systematic cross-case comparison and cross-case conclusions were developed. The embedded cases were examined by matching the similarities and patterns between the cases, to make cross-case conclusions.

In this case study research, the main case study is about a larger case than the embedded units of analysis. The findings and conclusions thus draw on a larger case or unit of analysis in

addition to the cross case data from the multiple embedded cases. Thus, the case study report draws on the data from both the cross-case synthesis of the embedded cases (HRM functions) and the larger unit of analysis – the case (HRM system).

The final process of analysis is the comparative case analysis, where the two cases (district case studies) are compared to each other using literal replication to develop a cross case conclusion. The purpose of the comparative case analysis is twofold, first to draw cross case conclusions and secondly to determine the extent of internal and strategic alignment based on the cross case conclusion. The findings of the comparative case analysis are presented in Sub-chapter 4.4, the next chapter.

3.4. **Rigour**

I employed different techniques to ensure rigour in the research which will now be explained each in turn.

To ensure credibility, the research applied the three principles in relation to case study research described by Yin (2014): using multiple sources of evidence, creating a case study database, and maintaining a chain of evidence. Using multiple sources of evidence ensures credibility and construct validity; construct validity is when construct, which in this case is HRM, is being measured or investigated adequately. The use of document review, interviews, observations, and focus group discussions for data collection created construct validity in terms of content, evidence and criteria used leading to a convergence of the evidence for a research. A clear and accurate account of the process of data collection and analysis was kept in detailed field notes and case study notes, which formed part of the case study database. Finally, to increase trustworthiness, I would demonstrate my meaning through the chain of evidence developed, documented and maintained, enabling an external observer to trace the steps in either direction from questions to conclusions through preservation of all original evidence.

Liamputtong and Ezzy (2005) describe several techniques for ensuring rigour in qualitative research: theoretical rigour, methodological or procedural rigour, interpretative rigour, triangulation, evaluative rigour, and finally rigorous reflexivity. The authors explain that theoretical and conceptual rigour refers to sound reasoning and argument, with appropriate

selection of methods to research a problem. I have constructed the arguments and drawn my conclusions based on, and clearly supported by evidence from this research and literature (Liamputtong & Ezzy, 2005).

In relation to methodological or procedural rigour, I have provided an explicit account of the research and an analysis of the data documenting decisions made and how conclusions were arrived at, providing an audit trail of decisions. To achieve interpretative rigour, several quotes were included in the case study reports and a comparative case analysis was provided to give a clear sense of the cross case conclusion drawn from the case study reports.

Triangulation was used in this research to enable a rich and detailed description of a complex phenomenon, which might not have been possible with using a single method approach (Liamputtong & Ezzy, 2005). Four types of triangulation have been identified: data source triangulation involving the use of multiple information sources; methods triangulation referring to using multiple research methodologies; researcher triangulation which requires the inclusion of a variety of researchers in the research process; and finally theory triangulation where multiple theoretical perspectives are used to provide new insights (Liamputtong & Ezzy, 2005).

Three types of triangulation were applied in this research: data source, methods and theoretical triangulation. Data source triangulation was used, with the multi strategy iterative data collection technique that was adopted in the study. The data collection techniques included a document review, observations, semi structured interviews, a questionnaire, and focus group discussions.

Methods triangulation is evident in the use of both qualitative and quantitative data in this research. The use of theoretical triangulation is illustrated in the Literature Review where different theoretical and conceptual perspectives are being used to develop new insights into understanding how HRM is being performed by the two role players, and determining the internal and strategic alignment of HRM.

In addition, a comprehensive member check was undertaken, not only to confirm factual and interpretative accuracy but also to provide evidence of credibility; this was done in both district case studies (Lincoln & Guba, 1985). Member checking involved the preparation of a

case study report for each case and presenting it to both role player groups, HR managers and Line Managers. Unfortunately, it was extremely challenging to have all the Line Managers in the district in one place, and opportunities to present the cases at existing meetings were explored, but insufficient time allocations made it difficult to conduct a member check with the Line Managers. Using the existing monthly or quarterly meeting of HR managers, the presentation of the case study was put on the agenda and member checking was conducted. This was achieved through a focus group discussion at which the presentation of the district case study was made. To start with, consent forms were signed by all the participants in the meeting, after which clarification questions were entertained, following which a discussion on the findings was held. Though the presentation was made almost two years after the data was collected, the participants unanimously agreed with the factual findings of the district case study. A majority consensus was reached on the interpretative findings and then the discussion continued by exploring mechanisms to address the challenges identified. The focus group discussion ended with an agreement on recommendations that could be made based on the findings, as well as discussion of new inputs and developments within the districts, which had to be incorporated into the analysis and interpretation of the findings.

Evaluative rigour is evident in my reflections on processes and interactions being observed and interviews conducted where I was trying to make sense of things (Box 3.2: Reflection for evaluative rigour). For example, the fact that I had a good rapport and long term relationship with most of my interviewees improved the quality of their responses as they were comfortable to have an in-depth conversation with me about the research topic. In places where I detected hesitance or reluctance to share I could explain it by environmental factors such as tension between role players or in some cases it ended with a conversation off the record. However, in the cases where I detected hesitance I have found it not be important as I considered it not to have any impact on the findings of the study.

The interview was set up for late in the afternoon and was scheduled for after another meeting. I prepared myself that the interview might not happen and I will have to reschedule. The interview started after 4.30 though it was scheduled for 3.00. This is was the first line manager interview and I felt unprepared as I was not as familiar with the roles and responsibilities of the line manager as I was with the human resource manager. The interviewee was open and descriptive with caution. It seems that she was holding something back and displayed caution not to divulge too much information but rather state her opinion and general state of affairs in the substructure.

Upon reflection, the hesitancy to share information was around her relationship with the ASD: HR as it appears that there might be some tension between the two role players. She kept on reaffirming

that things should get better now with the appointment of a Deputy-Director HR with whom she has a much better relationship.

This interview concurs with the literature suggested that HRM should move away from HR administration to added value to improve performance. All of concepts or issues raised are stated in the literature on what would be needed to shift. The research has a focus on roles and functions though it has become important that the HR managers' competencies to perform current roles and possible added value roles should still be explored. The question is how this can be done in the frame of this research?

Box 3.2: Reflection for evaluative rigour

Finally, the researcher reflected on how she and the research process had shaped the data and interpretation, taking into account her prior experience, biases and personal characteristics that may have influenced the inquiry (Mays & Pope, 2011). Reflexivity is considered

> … *a hallmark of excellent qualitative research as it entails the ability and willingness of researchers to acknowledge and take account of the many ways they themselves influence research findings and thus what comes to be accepted as knowledge. Reflexivity implies the ability to reflect inward toward oneself as an inquirer; outward to the cultural, historical, linguistic, political, and other forces that shape everything about inquiry; and, in between researcher and participant to the social interaction they share* (Sandelowski & Barroso, 2002: 216).

Liamputtong and Ezzy (2005) add to this by describing the researcher as part and parcel of the setting, context and culture she is trying to understand and analyse, and as such s/he has to constantly take stock of his/her actions and role in the research process, and subject these to the same scrutiny as the rest of the data. My prior experience in developing and training in the area potentially biases the study, but this experience also led to development of the critical research question of the study. Thus, being part of the setting, context and culture motivated my continuous introspection and reflection, achieved by keeping a journal to record my thoughts, actions and reactions, and changes in perceptions and understandings.

I wish to declare that this research has been influenced by my extensive past experience in developing human resource information systems for the past decade in the public health sector. I was previously part of the national implementation of a District Health Information System, working with stakeholders at different levels in the public health system. The conception of the research question was derived from my work in building the capacity of

HR managers to monitor the human resources for health in a district health system, to improve health service delivery and health outcomes. In that process, I became aware that the interventions and development areas neglected a key role player for improving HRM, that of the Line Manager.

Over the years, I have worked extensively with the different role players on different projects, but more recently I have been involved in the capacity development of HR managers in the two case study sites and in developing a monitoring system for them. Through this I have become very well acquainted with the HRM programme, its structure, policies and procedures, which provided me with the advantage of understanding the context in which HRM is being performed. In addition, I have been part of developing solutions to challenges faced within districts, through this long standing relationship and rapport I have built with participants in the district health system.

I am very aware of my preconceived ideas, understandings and perceptions, and through journaling, I have kept track of my thoughts and changes of understanding in the research process. I have therefore developed a process whereby I would write a summary and a reflection on what I was thinking and what should be the next steps, after each interview I conducted. This helped me to separate what the participants were saying and what I knew or believed, and then to determine where to go from there with the data collection process.

Below is an extract of my reflection after conducting three interviews in one day; this was a point when I changed my interviewing approach for the follow-up interviews, making sure that as an inquirer, I was responding to what the participants stated and not responding to my biases and understanding of the situation.

> The interviewees were draining and probably not a good idea to conduct three after each other. Interestingly, there were no points that I noted to carry from the one interview to the next. This could reflect the distinct difference in the job profiles or my inability to pick on the points as all of them characterised their relationships with the Line Managers as clear and not challenging. One of the interviewees referred to the appointments workflow diagram illustrating clear responsibilities. But [from my perspective] it does not. What is reflected is process and time frames and who is the person responsible for process item but not what should be done or which activities are joint activities or dependent on other processes or activities. Thus the workflow diagram illustrated an

overview of process, but was not clear on what has to be done by whom, thus providing a guideline and an opportunity for creating alignment.

Box 3.3. Reflection on interview approach

In my reflections, I also kept track of my decision-making trail, of who was chosen for follow-up interviews, reminding myself of what I was thinking at that point and what influenced the choices I was making. The reflections were extremely useful as they guided my thoughts and understanding, but also the data collection process in terms of what was needed, what was missing, and what could be improved upon in the process.

3.5. **Ethics**

Liamputtong and Ezzy (2005) posit that ethical and political aspects of qualitative research, referred to as evaluative rigour, have two dimensions: addressing procedural requirements and considering the political and social consequences of the research for the participants. In relation to completing the tasks required by procedural ethics in obtaining ethical approval from organisational bodies, the research project received ethical approval from the University of the Western Cape Research and Ethics Committee, as well as the Western Cape Research Committee. In addition, permission to enter the research sites was obtained both verbally and in written form from the District Management Team in each district.

Permission to engage with the participants was procedurally acquired through written informed consent, where the participants were given a Participant Information Sheet explaining the purpose of the study, assuring them of anonymity of their contribution, their right to refuse participation, that their participation is voluntary and where and how the researcher can be contacted. The participants were verbally informed that the research is for the purpose of a PhD study and consequent publications and that they had the right to refuse participation and to withdraw at any time during the research, without penalty or any loss of benefits. The verbal conversation continued with an explanation of the data collection process and the different data collection methods, whilst addressing and responding to questions and offering clarification when questions arose from the conversations. After being provided with the Participant Information Sheet and a verbal explanation of the research, the participants were asked to sign the Informed Consent Form. Confidentiality was assured to the extent that the names of people would be removed, but because of the nature of the research, the research district is identifiable. The individuals interviewed will not, however,

be identifiable because different pieces of information will be synthesised in the analysis and presentation of the findings of the study.

When considering the political and social consequences of the research for the participants, the potential risk factor that could influence the participants was identified as fear of exposure. It was recognised that exposure could manifest itself in three different ways. The first consequence to consider is the fear of exposing incorrect HR practices performed by participants. The second is the demonstration of the inability of individual role players to perform HRM practices and functions. The last consequence is revealing the mismatch between the policy and their practice, demonstrating poor performance. In addressing these concerns, I explained to all participants the purpose of the study, which is to identify mismatches, but not at an individual level but at a group and programme level. The long standing relationship and good rapport with the participants enabled me to address these concerns when reassuring the participants of the purpose and the potential benefits of the research. In respect of these concerns, I intend to return to each research site and the Provincial Department of Health to provide feedback on the final outcomes of the research. Furthermore, by way of the ethic of knowledge-sharing, I aim to also share my findings with academic colleagues through publication and conference presentations.

In summary, this research has made use of a case study approach, with an embedded multiple-case study design, employing five data collection techniques in an iterative data collection process. The chapter described data collection techniques utilised, as well as the data analysis phases in the research. The chapter concluded by describing the rigorous process undergone to ensure the validity and trustworthiness of the research and the ethical considerations that were addressed in the process of conducting the study.

The next chapter presents the results of the research and consists of four (4) sub-chapters:
Sub-chapter 4.1. Results: Contextualising Human Resource Management;
Sub-chapter 4.2. Results: Case Study 1 - Cape Metro District;
Sub-chapter 4.3. Results: Case Study 2 - West Coast District;
Sub-chapter 4.4. Results: Comparative Case Analysis.

The first sub-chapter aims to provide an overview of the context of the two case study districts, highlighting the policy environment in which both case studies have to perform

HRM. The two case studies provide a detailed description of each district, followed by a comparative case analysis highlighting the similarities and differences between the two districts, as well as assessing vertical and horizontal alignment.

4. RESULTS

There are four sub-chapters to Chapter 4. They focus on the context of this research (Sub-chapter 4.1), the Cape Town Metro District Case Study (Sub-chapter 4.2), the West Coast District Case Study (Sub-chapter 4.3), and Sub-chapter 4.4 – a Comparative Case Analysis.

4.1 RESULTS: THE CONTEXT OF THE RESEARCH STUDY

This sub-chapter aims to contextualise two district case studies by describing health sector reforms in South Africa, specifically the restructuring of the public health sector into a decentralised system taking the form of a district health system (DHS); this also entails the devolution of human resource management functions to districts and to Line Managers in the public health sector involved in health services and human resource management functions. In turn, the HR Manager is tasked with supporting Line Managers in providing human resource management. In describing the decentralization of human resource management functions, the absence of human resource information emerges as a constraint for Line Managers in performing their human resource management role.

Sub-chapter 4.1 concludes with an overview of the decentralization processes within two district case studies, and a short description of the two health districts, namely the West Coast District and Cape Town Metro District, as an introduction to the two district case study chapters that follow.

4.1.1 Restructuring the public health sector

To contextualise this restructuring, the background to the establishment of the district health system will be described, followed by an overview of the implementation thereof. This section focusses on the decentralization of health services and human resource management functions. Focussing on the decentralization process highlights the variances between provinces and districts in the country, whilst framing the process in its legislative and regulatory environment. This section concludes by highlighting the importance of the role of the line manager, and human resource information, in decentralising human resource management functions from a provincial to a district level.

Establishment of district health system in South Africa

Primary health care (PHC) has been recognized internationally as the preferred basis for health care for the past 30 years. In 1978, at the International Conference on Primary Health Care held in Alma Ata, the Declaration of Alma Ata was signed. The Declaration formed the basis for the development of the World Health Organisation's (WHO's) *"Health for All by 2000"* campaign, which promoted the DHS as the vehicle for delivery of PHC. Unfortunately the objectives stated were not met, but the principles of PHC remained the same and were affirmed by The World Health Report 2008, *"Primary Health Care: Now more than Ever"*. Further endorsement was received by the Sixty-second World Health Assembly on 22 May 2009, which reflects the Assembly "strongly reaffirming the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multi-sectoral action, decentralization and community participation as the basis for strengthening health systems" (WHO, 2009: 2).

By 1994 and the first democratic South African dispensation, health policies were in place which embraced PHC as the basis for health services and the DHS for delivery of these services. This is evident in the African National Congress Health Plan of 1994, which states that everyone has a right to achieve optimal health and that health services be restructured through the PHC approach, with full community participation and inter-sectoral collaboration. The plan pronounced that services were to be decentralised to the lowest level possible, that they should be people-centred and delivered through a DHS.

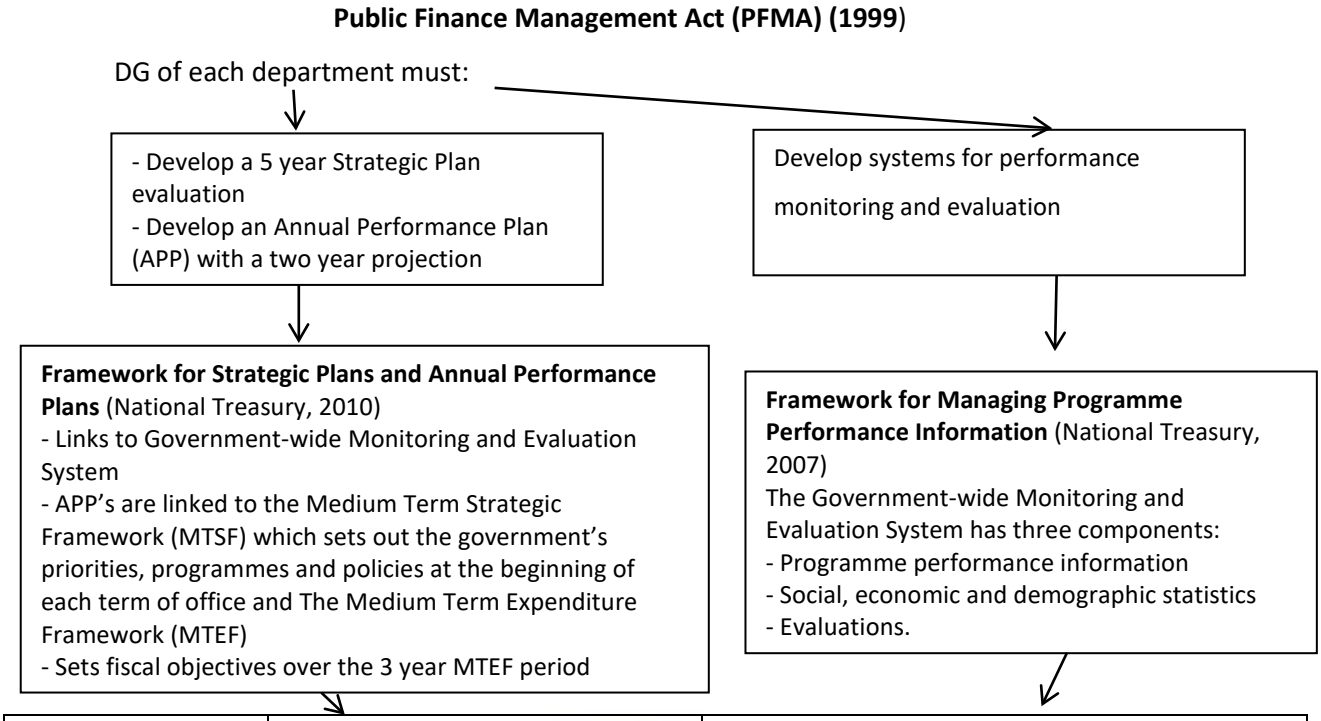
The Constitution of the Republic of South Africa 1996 assigns health services to national and provincial government, ambulance services to provincial government, and municipal health services to local government, without defining health services and municipal health services. The 1997 White Paper for Transformation of Health System embraces the vision of a decentralised system which is municipality-based, emphasises that PHC through a DHS will be the focus of the national health system, and that health care services be decentralised to municipal level.

The role of the DHS, according to the White Paper for Transformation of Health System 1997, states that

> *this level of the health care system should be responsible for the overall management and control of its health budget, and the provision and/or*

> *purchase of a full range of comprehensive primary health care services within its area of jurisdiction. Effective referral networks and systems will be ensured through co-operation with the other health districts. All services will be rendered in collaboration with other governmental, non-governmental and private structures* (National Department of Health, 1997: 30).

In response to this transformation, and to decentralising the overall management and control of the health budget to the DHS, public sector managers were empowered with enhanced control over public expenditure through the implementation of the Public Finance Management Act (PFMA) (1999), the Municipal Finance Management Act (MFMA) (2003) and the Public Service Act (1994 as amended).



Accountability cycle	Accountability documents	Performance information
National and provincial departments and public entities		
Policy development	• Policy documents • Explanatory memoranda accompanying bills	• Identify baseline information informing policy • Set out desired effect of policy
Strategic planning	• Strategic plans • Corporate plans	• Indicate outputs to be produced • Specify performance indicators
Operational planning and budgeting	• Operational plans • Budgets • Performance agreements	• Set performance targets • Indicate available resources • Allocate responsibilities
Implementation and in-year reporting	• Monthly budget reports • Quarterly performance reports	• Report progress with implementation of plans and budgets
End-year reporting	• Annual reports	• Report on performance against plans and budgets
Municipalities and municipal entities		
Policy development	• Policy documents • Explanatory memoranda accompanying bills	• Identify baseline information informing policy • Set out desired effect of policy
Strategic planning	• Integrated development plans	• Indicate outputs to be produced • Specify performance indicators
Operational planning and budgeting	• Municipal budgets • Service delivery and budget implementation plan • Performance agreements	• Set performance targets • Indicate available resources • Allocate responsibilities
Implementation and in-year reporting	• Monthly budget statements • Mid-year budget and performance assessments	• Report progress with implementation of plans and budgets
End-year reporting	• Annual reports	• Report on performance against plans and budgets

Accountability reports for the three spheres in government

Figure 4.1. Accountability reports of the three spheres of government (Source: Framework for Managing Programme Performance Information, National Treasury, 2007)

The figure above highlights two important aspects relevant to this research: responsibility for implementation and monitoring and evaluation. First, The Public Finance Management Act emphasise that "Line Managers remain responsible for establishing and running performance information systems within their sections, and for using performance information to make decisions" (National Treasury, 2007: 14). There are two things extracted from this quotation: the important role of Line Managers and the significance of information in their decision making. Secondly, the figure above highlights the focus on information, specifically performance information, in relation to the performance targets set at national, provincial, and local spheres, in line with the framework for managing programme performance information. The researcher posits that there is an absence of information in the local sphere for both informed decision making and for monitoring and managing the public health workforce.

Implementation of the district health system

The Constitution and the policy documents described above formed the basis for the development of health services in the provinces in the early years of democracy, but in the absence of legislation to support these policies, provinces developed different structures and systems for service delivery. At the time, the National Health Act was in draft form and interim measures had to be put in place since the transformation of local government and the health system (in terms of structure and functions) was running concurrently. The White Paper for the Transformation of the Health System 1997 put PHC at the centre of the transformation of the South African National Health System. Thus PHC was delivered through a DHS, with the following three possible governance structures, to allow for district variations across the country:

1. The provincial option, i.e. the province would be responsible for all district health services through the district health manager. (This option could be exercised where there was insufficient independent capacity and infrastructure at the local level).
2. The statutory district health authority option, i.e. the province, through legislation, would create a district health authority for each health district. (This option could be exercised in instances where no single local authority had the capacity to render comprehensive services).
3. The local government option, i.e. a local authority would be responsible for all district health services. (This option could be exercised if a local authority, whose boundaries were

the same as that of a health district, had the capacity to render comprehensive services) (National Department of Health, 1997).

Provinces followed different routes in developing a DHS: the Free State Province published the Free State Provincial Health Act spelling out the functions and responsibilities of the District Health Authority (which was then still to be created) that would be the governing body of the health district; the Western Cape Province produced a detailed document setting out the way forward to transferring PHC services by the province to local government; the process is described in Box 4.1. Western Cape experience provincialising PHC services (Source: Versteeg, Hall, May, Maredi, & de Visser, 2009: 29-30)

below. Ultimately, all the provinces in South Africa adopted the provincial option as the governance structure to provide PHC services.

The success of the process in the Western Cape is attributable in part to a bi-ministerial task team (BMTT) which was established and operated between 1997 and 2000. The task of this BMTT was to assess where primary health care services should best be placed for equitable service delivery. In 2000, the BMTT recommended that all primary health care services be delegated to the City of Cape Town and all category B municipalities in the province. This recommendation was confirmed by a provincial cabinet resolution in 2001. Various capacity and staff audits of all district municipalities were conducted by this task team and contracted consultants.

In July 2002, the Health MinMEC made the decision to narrowly define municipal health services as environmental health services in the draft Health Act. Based on this narrow definition and the shift in the national position in relation to the delegation of primary health care to local government, the provincial leadership took the decision to pro-actively implement the narrow definition of municipal health services.

The National Health Act of 2003 was enacted in 2005, confirming the approach adopted by the provincial leadership. Pursuant to this enactment, in February 2005, the Western Cape MEC, Pierre Uys together with the executive of South African Local Government Association (SALGA) concluded a framework agreement in Cape Town, governing the transfer of personal primary health care services previously provided by non-metropolitan municipalities to the Western Cape government. A phased approach to this transfer was adopted.

Various task teams were established to consult on the key issues involved in the transfer process. A provincial technical team undertook an audit of all staff members impacted by the transfer. Asset audits were undertaken as a priority. A finance task team was set up to ensure compliance with the

Public and Municipal Finance Management Act. All of the role players comprising these task teams met on a regular basis to work through the issues at stake in the provincialization process, in a very detailed and comprehensive manner. All of these various processes culminated in the full transfer of personal primary health to the province. From 1 April 2005, the province fully funded personal primary health care services. On 1 March 2006, the province took operational control of these services in the non-metropolitan areas, as stipulated in the framework agreement.

The consolidation of the district health system in the Western Cape has furthermore been strengthened by the adoption of the service delivery plan known as Health Care 2010. Health Care 2010 is a detailed plan that aims to shape and direct service delivery in the Western Cape with a view to strengthening the DHS, improving access to services by communities and ensuring that the DHS is integrally linked to Regional and Tertiary Hospitals. This would ensure a continuum of care and services that is easily accessible to communities.

The City of Cape Town is the only municipality that continues to deliver PHC in the Western Cape. This is done in terms of a service level agreement concluded with the province. They also have a co-funding arrangement with the province. While there are good intergovernmental relations in the Western Cape that contribute to the synergy between the province and the metro, the current service level agreement and co-funding arrangement is not based on an assignment or delegation of the function to the metro. It is therefore vulnerable to change if political leadership changes or the approach to provincialization in the province changes.

The current position in the Western Cape is:

- *All non- metro municipalities completed the transfer of both assets and personnel to the province before the deadline of 31 July 2007;*
- *Numerically, 23 municipalities have transferred the function with 542 individual staff members transferring to the provincial department of health;*
- *The metro continues to provide the service on the basis of a co-funding agreement with the province;*
- *The metro currently fulfils primary health care services in 98 clinics. The focus of these clinics is mainly promotive and preventative and certain curative aspects of health care for children under 13 years of age.*
- *The metro also runs four comprehensive Community Health Centres.*

Box 4.1. Western Cape experience provincialising PHC services
(Source: Versteeg, Hall, May, Maredi, & de Visser, 2009: 29-30)

The establishment of the DHS was brought about with the promulgation of the National Health Act (NHA) of 2004, providing the legal basis and formalising the minimalist definition of municipal health services and the responsibility for PHC to be with the provincial government. However, the Act makes provision for the assignment of PHC to municipalities if the municipality has the capacity to deliver, and willingness to deliver the

full range of services in line with the Constitution. This is indeed the case for one of the districts in this research (described later in sub-chapter 0).

Decentralization of health services to a district health system

The current status on the decentralization of health services to a DHS is described through the decision space allocated, (defined as the range of effective choice that is allowed by the central authorities to be utilized by the local authorities) (Bossert, 1998), and the constraints and challenges experienced by the District Health Management Teams in South Africa. The decision space of a decentralised DHS can be determined in South Africa by looking at the delegation of authority on two levels - financial and HR delegation. There is only one province listed as having complete HR delegation authority in South Africa, and that is the Western Cape Province, the research site for this investigation (Byleveld et al., 2008).

Organization/structure

- Western Cape's Service Transformation Plan (STP), known as Healthcare 2010, has been developed to guide health services improvement in the province.
- Western Cape previously operated with four regional structures but is restructuring into a district-based system comprising the Metro and five "rural" districts.
- The Metro Health District is divided into eight sub-districts, paired under four sub- structure offices.
- District Hospitals (or Regional Hospitals where there are no District Hospitals) supply HRM support for PHC facilities (clinics and CHCs).
- A new provincial Directorate: Nursing has been created.

Implementation

- Metro district currently has a Chief Director: Metro District Health Services and a Chief Director: Regional Hospitals, Associated Psychiatric Hospitals (APH) and Emergency Medical Services.
- Each "rural" district has a District Manager (Level 13) responsible for PHC and District Hospital Services.
- "Rural" districts have Sub-directorates for Comprehensive Health Services, Pharmaceutical Services, Professional Support, HR, Finance and Admin Support and Technical Support – the first five led by Deputy Directors.

Effectiveness

- Changes are expected in the Metro District due to the pending provincialization of the municipality's PHC services.
- There is no "rural" District equivalent of the provincial Directorate: Nursing, leading to communication anomalies and challenges for district management.

Financial delegations

- DMs can approve payments up to R500 000.
- Procurement of equipment done in district through district bid committee.
- DMs delegate certain responsibilities to DMT members. Formal letters of delegation exist.

HR Delegations

- All HR issues are handled at district level – very few things have to be sent to Province.

Provincial Support

- Provincial support to districts improved over last few years and districts experience that provincial staff always willing to support when needed.
- After strengthening of provincial office sectors provincial staff (e.g. finance and HR) visit districts on a regular basis to provide support.
- Districts feel a need to provide similar support within districts but are limited by insufficient staff.

Box 4.2. Summary of Western Cape Province District Management Assessment
(Source: Byleveld et al., 2008)

Box 4.2 provides a summary of the district management assessment in the Western Cape Province. It highlights the structure of one metro district and five rural districts where the metro district is divided into four substructures. More importantly, it highlights that District Hospitals provide human resource management to PHC facilities for all the districts in the province.

More recently (2013), the status of decentralization in South Africa and the constraints and challenges experienced by South African District Health Management Teams (DMT) in urban and rural districts was investigated (Wolvaardt et al., 2014). The resulting assessment was sobering, stating there are "inadequate delegation of authority, defective budgeting processes, staffing issues, lack of managerial skills, vacancies in key managerial positions, and ineffective use or absence of quality management information systems to support decision-making" (Wolvaardt et al., 2014: 81).

Specifically, the authors identified the institutional blockages as follows: District Management has no influence over policy directives, strategy is defined at national/provincial level; District Management has limited influence over allocated budget, District Management do not control workforce planning and appointment of staff, and finally there is no clear system whereby lessons learnt at district level is used to influence policy or strategy (Wolvaardt et al., 2014). In addition, the authors found a lack of delegation of most HR related authority to District Management Team, lack of reliable up to date HR information, limited attention to retention issues, and a lack of HR skills amongst Line Managers (Wolvaardt, 2013). However, in specific relation to information, the lack of data driven decision making as well as an inadequate data ownership and accountability for quality by Line Managers were found as major challenges (Wolvaardt, 2013).

The research described above highlights from the list of institutional blockages two pertinent issues to this research the capacity of Line Managers to perform human resource management and the lack of reliable up to date HR Information. These two issues are further explored later in this chapter.

Decentralization of human resource management functions

Human resource management in a DHS has to function within the legislative framework of the public sector, specifically the Public Service Act of 1994 which states the functions of the organization and staff stipulating how the public sector and staff will be organised and structured, how services may be obtained in the employment in public service, how services may be terminated, and states the obligations, rights and privileges of employees (Republic of South Africa, 1994).

The Public Service Regulations provide the regulatory framework to implement the Public Service Act as it sets regulations for conduct, financial disclosure, anti-corruption and ethics management. It also provides regulations on planning, organizational arrangements, and service delivery specifically on developing a strategic plan, human resource plan, information and technology plan, and annual reports; appointment and employment matters; leave; and working environment. The Public Service Regulations stipulates the regulations to which human resource management in the public health sector is framed in.

Two important management issues are drawn from the Public Service Regulations pertaining specifically to this research: the operations management framework and the management responsibility and accountability. The first management issue draws on regulation 36 which states that:

> *An executive authority shall establish and maintain an operations management framework which shall include:*
> *(a) an approved service delivery model;*
> *(b) a list of all core mandated services provided by the department;*
> *(c) mapped business processes for all services;*
> *(d) standard operating procedures for all services;*
> *(e) service standards for all services;*
> *(f) a service delivery charter referred to in regulation 37; and*

(g) a service delivery improvement plan referred to in regulation 38. (Republic of South Africa, 2016: 55)

This operations management framework described above refers to a District Health Management Team in the public health sector signifying the recognition of decentralization and standardization as important.

The second management issue draws on regulations 39 and 48 which places the management responsibility and accountability of specific human resource management functions relevant to this research on Line Managers. In the case of regulation 39 which is on establishing job description the responsibility is placed on the District Health Management Team whereas in the case of regulation 48 regarding the management of leave the responsibility is placed on the Head of Department (Republic of South Africa, 2016). These two regulations are of particular importance in this research as the human resource management functions referred to in the regulations causes role confusion and between the two key role players HR Managers and Line Managers which will be demonstrated in the two district case studies to follow.

Thus far, the regulatory framework has been discussed now we are moving to the policy frameworks in which human resource management in the public health sector is performed. The White Paper on the Transformation of the Public Service (WPTPS) 1995 (Department of Public Service and Administration, 1995), sets out eight transformation priorities, amongst others the restructuring and rationalising of the public sector and transforming service delivery. The White Paper for the Transformation of Service Delivery 1997 introduces the notion that the people comes first prescribing eight principals referred to as the Batho Pele (people first) principles. This white paper provides a policy framework and a practical implementation strategy for the transformation of public service delivery focussing on how public services are provided, and specifically about improving the efficiency and effectiveness of the way in which services are delivered (Department of Public Service and Administration, 1997b).

The development of the human resources for health has been identified as a national priority in several national documents appearing in the 10 Point Plan, Strategic Priorities for the National Health System 2004-2009 (National Department of Health, 2004) and in the

National Department of Health Strategic Plans from 2010 to the latest 2015-2020 and finally with development of the National HR Plan 2006 (National Department of Health South Africa, 2006) and the HRH Strategy for the Health Sector (Department of Health South Africa, 2011).

There are two key policy documents that frame the decentralization of human resource management in public health sector: The White Paper on Human Resource Management in the Public Service 1997 and the Human Resources for Health in South Africa HRH Strategy for the Health Sector: 2012/13-2016/17.

The purpose of the White Paper on Human Resource Management in the Public Service (WPHRM) is to "provide a policy framework that will facilitate the development of human resource management practices which support an effective and efficient public service, geared for economic and social transformation" (Department of Public Service and Administration, 1997: 7). The WPHRM proposes two things: HRM responsibilities to be decentralised and aligned with the line function; and a shift from administration to management, which underlies the entire Public Service transformation programme. The first, decentralization, underlies the public service transformation in the following two forms:

> *Devolution: The shift of final responsibility and accountability from the centre to the periphery, namely from the centre to the executing authority.*
> *Delegation: Assigning functions, powers and authority to a lower level* (Department of Public Service and Administration, 1997: 12).

The second is the shift of responsibility of human resource management to Line Managers. The shift requires human resource practitioners to provide Line Managers with professional advice and guidance whilst ensuring that human resource systems and procedures are focused on the organization's strategic objectives. The HRH Strategy for the Health Sector 2012/13-2016/17 identifies the role of the HR department as supportive and advisory to the Line Manager:

> *This is because, increasingly, in global Best Practice organizations, the central role in the management of the organization's HR has to be played by Line Managers. The role of the HR department is to act as a professional, internal consultant and to support management in their HR responsibilities* (Department of Health South Africa, 2011: 112).

More specifically, the WPHRM proposes that human resource practitioners develop

> *a more professional role, providing advice and guidance to management on such matters as employment legislation, Public Service-wide policies and norms, labour market trends, and employee development issues. They will also continue to administer many of the day-to-day personnel management activities, such as organising recruitment competitions, and administering entry and termination of services.* (Department of Public Service and Administration, 1997: 13).

In addition, the day-to-day personnel management activities that the human resource practitioners have to administer have to be agreed with, and be in line with the Line Manager's needs. The implication of this is a close relationship between human resource practitioners and Line Managers, as they are both expected to perform administrative day-to-day personnel management activities. The policy clearly identifies a shift in HR functions from the HR practitioner to the Line Manager, but what the policy omits are specifying the HR functions that should be shifted.

Another implication of the responsibility shift identified in the WPHRM is that "organizational structures will need to be far more closely aligned to the strategic service delivery goals of the organization, and will have to be flexible enough to adjust, as these goals change in line with the changing needs and priorities of the public and of government policy" (Department of Public Service and Administration, 1997: 12). This suggests the importance of internal and external alignment for successful devolution.

Operationally, the decentralization of human resource management functions, in conjunction with the objective of achieving clean audits, prioritized two mechanisms to be put in place in the form of tools to foster accountability and monitor implementation of HR policies and procedures in the HRM Programme. The tools are described as follows:

- *The Quarterly HR Audit Action Plan is utilised as a reporting tool by all HRM offices at institutional level, district/regional offices and head office.*
    - *The Quarterly HR Audit Action Plan consists of all matters raised by the Auditor-General over the past years and is updated if necessary on an annual basis.*

- *The HR Compliance Management Instrument (CMI) is utilised as a reporting tool by the Line Manager to the Hospital Chief Executive Officer (CEO) to ensure that Line Managers at institutions comply with HR responsibilities.*
    - *The HR CMI in conjunction with Persal reports are utilised by the Component HRM Advisory Services to prioritise institutions for investigations. Information obtained from the aforementioned interventions is used to provide assistance and training in order to enhance compliance* (Western Cape Government: Health, 2014: 292).

The second key policy document, the HRH Strategy for the Health Sector (under Objective 6.3 *Clarify roles and responsibilities of HRM function and Line Managers*) continues with the decentralization process, and states that more HRM functions have to decentralised from the district to the facility level. This is mainly because the facility level is the periphery level as well as the local sphere in government, which makes it logical for human resource management to be performed at this level. However, the district case studies reveal the actual implementation of this policy, and what is happening in reality in different districts.

The HRH Strategy for the Health Sector: 2012/13 – 2016/17 pronounces two strategies to improve the human resource management of the public health workforce in South Africa: professionalizing HR and devolving HRM responsibilities to the Line Manager.

The first strategy, *Professionalizing HR* is aimed at improving the human resource practices in the public health sector, as suggested by the HRH Strategy for the Health Sector: 2012/13 – 2016/17. It stipulates that the professional HR Managers in the public services should:

- *possess formal general management qualifications, including training in best practice human resource (HR) management;*
- *undergo training in specific government policies and procedures relating to HR, recruitment, induction, procurement and finance;*
- *have competencies in soft leadership skills fostered through mentorship and training;*
- *be managed against performance targets that include key performance indicators in HR* (Department of Health South Africa, 2011: 61).

The second strategy is proposed by the White Paper on Human Resource Management in the Public Sector, which aims to decentralise and align HRM responsibilities with line function in service delivery (Department of Public Service and Administration, 1997a). In PHC, the implication of the devolvement of HRM responsibilities to Line Managers is that the Line Managers will acquire formal HR responsibilities, which were previously performed by the HR managers in the district or provincial offices (Chabikuli et al., 2005). The WPHRM makes specific reference to Line Managers having greater responsibility for the performance management, conduct and career development of staff.

In addition, the Public Service Commission is mandated by Section 196(4) (b) of the Constitution, read in conjunction with section 9 and 10 of the Public Service Act, to investigate, monitor, and evaluate the organization of administration and personnel practice in the Public Service. The Commission recognizes HRM as one of the key functions in ensuring that a department meets its objectives and that without sound and proper HRM, a department would not be able to promote service delivery (The Public Service Commission, 2010).

Over and above considering the legislative, regulative and policy environment described above, there are two situational environments that are important to take into consideration when framing the context of human resource management in the public health sector: the shortage of human resources for health in performing health service delivery, and the challenges in recruiting and retaining human resources for health in South Africa. On the first, the shortage of human resources for health, a needs and gaps analysis of human resources for health in South Africa in 2009 examined the current shortages, the maldistribution of HRH, the production and growth of health professional categories, factors related to the attrition of HRH, policies and responses proposed and/or implemented to overcome the HRH crisis, and particular areas with HRH needs essential for achieving HIV prevention targets (George, Quinlan, & Reardon, 2009). The review highlighted that South Africa has a density ratio of medical practitioners and professional nurses that is higher than the minimum level proposed by the World Health Organisation (WHO), but that there is a significant difference in the density ratios of HRH between the public and private health sector (George et al., 2009). The review concluded that there is in fact a shortage of 80 000 HRH in the public health sector, demonstrating the severe constraints of health service delivery.

The second situational issue to take into consideration is the recruitment and ability to retain staff. In 2010, the Public Service Commission (PSC) conducted an assessment on the state of human resource management in the public service of South Africa. The assessment utilized a desktop review of reports published by the Public Service Commission and other organizations. The PSC used the five key areas of HRM, as identified by the Department of Public Service and Administration (DPSA) Circular on "Interventions to Improve the Human Resource Management Function in the Public Service", as the framework for the assessment. This includes:

1. Human Resource and Organizational Strategy and Planning
2. Human Resource Practice
3. Human Resource Utilization and Development
4. Employee Health and Wellness
5. Employee Relations.

The assessment developed indicators for each of the five human resource management areas to determine the extent to which HRM policy implementation has been met, and to identify the challenges experienced. The report acknowledges that procedural omissions undermine the credibility of some of the HRM processes. For example, in the selection process: "disregard of elementary processes such as compiling job descriptions, conducting job evaluations and obtaining approval of job adverts prior to their placement in the media" (The Public Service Commission, 2010: vii).

In this report, the challenge in administering HRM processes and practices as well as the lack of availability of human resource management information was highlighted. Administering HRM processes and practices is one of the focus areas of this research: this will serve to provide more insight into what human resource management functions are being performed by whom and what challenges are experienced with performing these functions. The challenges experienced with human resource management information is further supported by the paucity of information available for the review of HRH in South Africa; this points to the unavailability of human resource information for the monitoring and evaluation of the public health workforce. All in all, the two reviews conducted in South Africa highlight the unavailability, but need for human resource information, to monitor, manage and evaluate human resources for health. The identification of the role and importance of information in

the monitoring and management of the public health workforce led to exploring the next topic. This section aims to provide a backdrop to the human resource management information system in South Africa, with the objective of exploring information management further, as experienced by the role players in the district case studies.

The role of information in human resource management

In the South African Department of Health there is general agreement that the information for the planning and management of the public health workforce is not available (Department of Health, Republic of South Africa, 2006; Department of Health South Africa, 2011). This lack of accurate information on the health workforce in South Africa is reiterated by HRH SA 2030 – Draft HR Strategy for the Health Sector: 2012/13 – 2016/17, which highlights the need for HRM information to address the problems experienced in the health sector: "Information for planning and managing the health workforce is very problematic. The use of public service information system, Persal, is not accurate and various professional categories for example medical specialists by category are not captured. A reason for the significant health workforce problems identified in this HR Strategy Development process is that trends in the workforce are not monitored, evaluated and acted upon" (Department of Health South Africa, 2011).

The human resource information system for the South African Public Sector is Personnel Salaries (Persal). The Persal database is the human resource information system used by all public services in South Africa, which is linked to a shared mainframe computer system to manage personnel and financial data. Persal is a human resource information system hosting data in the following categories: Individual Member Data, Job Information, Organizational Structure and Salary Information.

Persal has been criticized for not being up to date and not collecting the information required for evidence-based decision-making, planning, and management. However, the main weakness of Persal as an information system is that its primary function is to manage salary payments, which dominate the use of the system to the detriment of the accuracy of the non-salary information in the system (Herbst et al., 2002). The system is developed to contain both financial and human resource information but it is only used for financial information; thus information pertaining to the race, gender, qualifications, movements of staff etc. could not be collected for this study from the system because it is either missing or inconsistently

collected. Owing to the high rates of missing and inconsistent non-financial data on human resources in this human resource information system, it is considered an unreliable data source for human resource information. In addition, two critical challenges have been identified: there is no routine aggregation of data, limiting the analysis and use of information for monitoring the public health workforce; and there is no district based monitoring system for managing the public health workforce (Mathews, 2005).

The unavailability of up to date reliable human resource information hinders the monitoring of the public health workforce, influences the effectiveness of the management of the workforce, and finally, affects the monitoring and evaluation of health systems performance as outlined in Figure 4.1. Accountability reports of the three spheres of government (Source: Framework for Managing Programme Performance Information, National Treasury, 2007)

Specifically, the unavailability of up to date reliable human resource information influences the implementation of human resource management functions and practices of Line Managers.

4.1.2 **Description of the districts in the research study**

This research study is located in the Western Cape Province where the Western Cape Department of Health comprises of six districts, five rural districts and one metropolitan district (Cape Town Metropole). The PHC services in the province consists of 479 PHC service facilities, 34 District Hospitals, Eight Regional Hospitals, Six Tuberculosis Hospitals, Four Psychiatric Hospitals, One Rehabilitation Centre, and Three Tertiary Hospitals.

The decentralization of provincial to districts functions, as outlined above, transpired differently in the rural and the metropolitan districts. In the case of the rural districts, the decentralization process took on the form outlined by the Comprehensive Service Plan for the Implementation of Healthcare 2010 (Western Cape Province Department of Health, 2007). Previously, there were three rural regions with West Coast/ Winelands, Boland/Overberg, and Southern Cape/ Karoo regional offices that formed the management structures. The demarcation of health districts and the various health reforms called for structural change. In 2000, the three rural regions were then divided into five rural health districts (Central Karoo,

Eden, Cape Winelands, Overberg, and West Coast) and 24 sub-districts. By July 2005, the rural local authority clinics and management structures were transferred to the Western Cape Department of Health (Figure 4.2. Rural Health District Management Structure).

The approach outlined in the Comprehensive Service Plan (Western Cape Province Department of Health, 2007) for rural districts is that PHC management and support is linked to District Hospitals at the sub-district level. Each rural district was divided into sub-districts rendering an integrated health service where each clinic is linked to a community health centre (CHC's) and CHC's linked to a District Hospital where health services are provided on a referral basis.

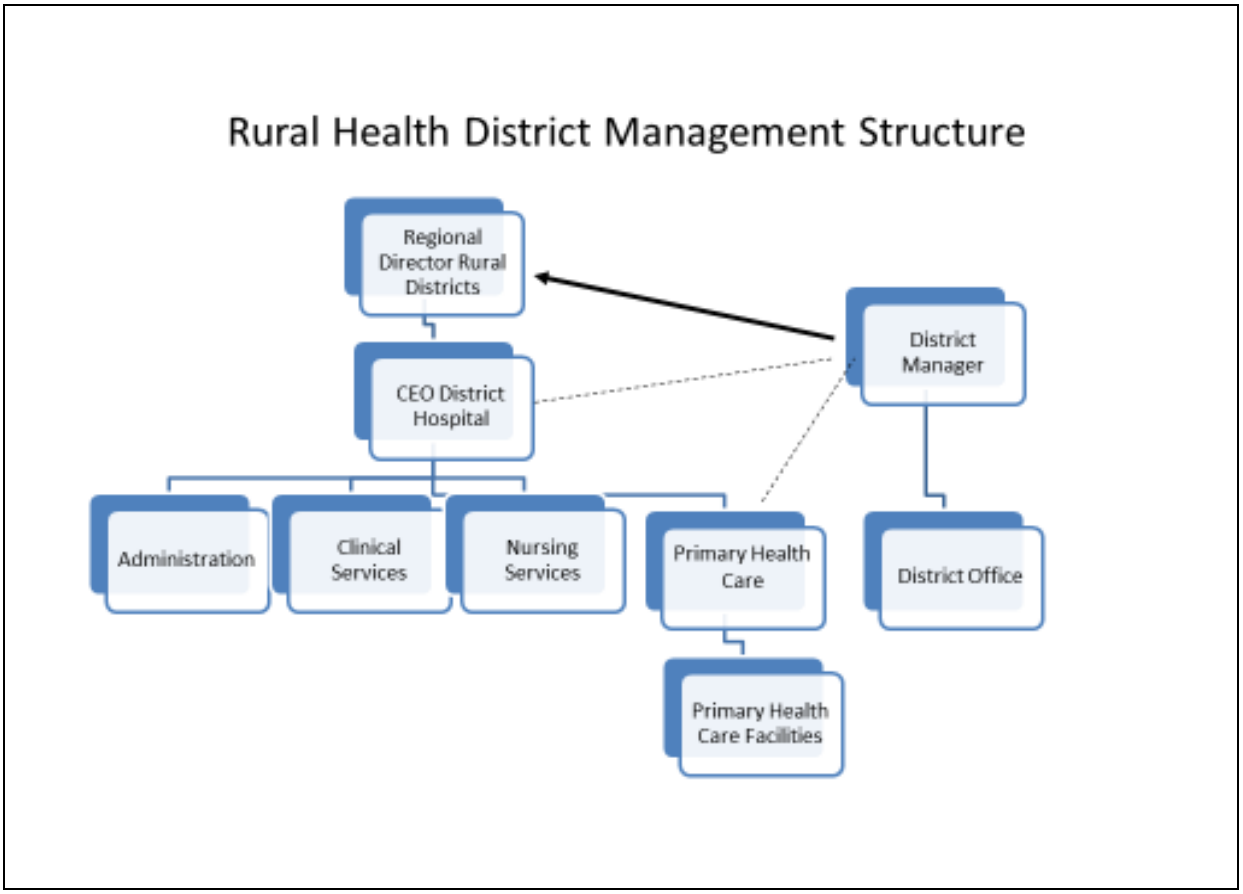


Figure 4.2. Rural Health District Management Structure

The densely populated Cape Town Metro District was first sub-divided into eight sub-districts and then into four substructures (where one substructures is a combination of two sub-districts), to provide the required management capacity. Furthermore, in a substructure,

PHC facilities were organised per sub-district and a PHC Manager was responsible for PHC services in a sub-district.
In addition, in the metropolitan district, PHC services are provided by different spheres of government in the Western Cape Province: local government serves the City of Cape Town (CoCT), and provincial government (the Western Cape Health Department) serves the Metro District Health Services (MDHS). The two organizations differ significantly in relation to their HR policies, functions, structure and processes. For this reason, this research focussed on the MDHS organization administered by the provincial government in the district, because the two organizations operate in completely different financial, legal, structural, fiscal and human resource management contexts in the DHS. For this research's purpose, the focus of investigation will be the MDHS, which will henceforth be referred to as the Cape Town Metro District (the provincially governed sphere) as proposed in the Comprehensive Service Plan 2007, excluding the City of Cape Town (the local municipality governed sphere).

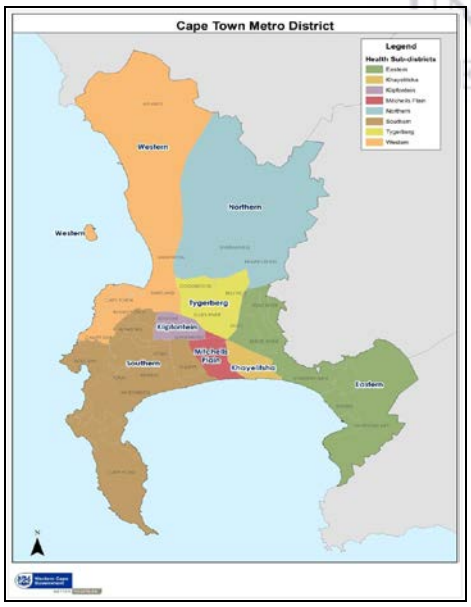
In relation to decentralization, the processes described above provide insight into different pathways to establishing a DHS within the same province. There are two distinctive differences described in the decentralization process for the metropolitan and rural districts. The first is transfer of local authority clinics to the provincial government, which happened in rural districts but not in the metropolitan district. The second is a chosen management entity or structure for PHC services. In the rural districts, PHC management is linked to District Hospitals at sub-district level, where the District Hospital provides support to the PHC services in sub-districts. This is different in the metropolitan district, where PHC management and support lies in the substructure office and not the District Hospital.

Thus, the two health districts selected for this research are the rural West Coast District and the urban Cape Town Metro District. These two districts were selected because they are representative of the two main types of districts in South Africa which are implementing decentralization, and because they demonstrate the different decentralization pathways undertaken, providing insight into other low- and middle-income countries implementing decentralization as a health sector reform.

Cape Town Metro District

In the past, three separate departments - Community Health Services Organization (CHSO), District, Specialised Hospitals, and Metropole Health Programme rendered health services to the same population but came together to be now known as the Metro District Health Services (Western Cape Department of Health, 2004). The MDHS came into existence in June 2003 following the restructuring of the Provincial Health Senior Management structure, in line with the Healthcare 2010 policy direction (Western Cape Department of Health, 2004). At this time, the MDHS was located in two separate locations, functioning independently from one another. In 2007, the structure became formalised with the appointments of four sub-structure directors responsible for Comprehensive Health Services, Pharmaceutical Services, Human Resources, and Finance and Support Services, in line with a DHS model. Setting up fully functional sub-structure offices at sub-structure level took place over time but presently all sub-structure offices are functional and operational at sub-structure level, with the district level functioning in Cape Town with other public service departments. This process is described in more detail and displayed diagrammatically in sub-chapter 4.2.

The figure below provides an overview of the location of the substructures and the population of each substructure in the Cape Town Metro District.



Sub structure	Sub- districts	Population (2011)	Area (km²)	Density (inhabitants /km²)
Khayelitsha/ Eastern	Khayelitsha	391748	43.7	8964.48
	Eastern	508689	429.65	1183.96
	Total	**900437**	**473.35**	**1902.26**
Klipfontein/ Mitchell's Plain	Klipfontein	384189	42.75	9000.9
	Mitchell's Plain	507237	50	10144.7
	Total	**891426**	**92.75**	**9611.06**
Western/ Southern	Western	470541	663.5	707.18
	Southern	516594	486.6	1061.6
	Total	**987135**	**1150**	**858.37**
Northern/ Tygerberg	Northern	363292	631.8	575
	Tygerberg	597732	119.85	4887.3
	Total	**961024**	**751.65**	**1278.55**
Total		**3740022**	**246775**	**1516**

Figure 4.3. Map and Population of Cape Town Metro District

West Coast District

The rural health district in this research, the West Coast Health District, consists of five sub-districts: Matzikama, Cederberg, Bergrivier, Saldanha Bay, and Swartland (Figure 4.4). The district borders to the north and northeast on the Namakwa District Municipality in the Northern Cape province, to the southeast on the Cape Winelands District Municipality, and to the south on the City of Cape Town.

Name of Sub districts	Population (2011)	Area (km^2)	Density (inhabitants/ km^2)
Swartland	113,762	3,707	30.7
Saldanha Bay]	99,193	2,015	49.2
Matzikama	67,147	12,981	5.2
Cederberg	49,768	8,007	6.3
Bergrivier	61,897	4,407	14.0
	391767	**31117**	**12.6**

Figure 4.4.Map and Population of West Coast District (Source: West Coast Municipality, n.d.)

In the West Coast District, the local authority clinics were transferred to the provincial government and PHC management was placed with the District Hospital. The District Hospital management structure was strengthened with a PHC manager and other support personnel responsible for PHC services per sub-district (Western Cape Province Department of Health, 2007). The management authority of West Coast District is the District Management Team, which is headed by both the District Manager and the CEO's of the District Hospitals.

In comparison, the West Coast District has a much smaller district population than the Cape Town Metro District, and the population density is significantly different with 12.6 and 1516 respectively. In addition, the West Coast District's PHC services are managed by District Hospitals, whereas in the Cape Town Metro District they are managed by Substructure Managers.

In conclusion, this chapter provided a description of the public health system of South Africa, placing it in the legislative framework and policy environment of the public sector and the public health sector; it presented key changes in the history of health sector reform since 1994. The chapter focussed specifically on the restructuring of public health sector, the establishment of the DHS, and the devolution of human resource management functions to line management, using these processes to frame the context in which human resource management is taking place in a health district. Monitoring and evaluation was highlighted by all reports as key to the successful implementation and management of any type of policy, strategy or reform. The chapter concludes by setting the scene with a description of the two districts for the two district case studies that follows this chapter.

4.2. CASE STUDY 1 – THE CAPE TOWN DISTRICT

Human resource management in the Cape Town Metro District (Metro) is the first of two case studies through which the results of this study are presented. This sub-chapter starts by describing the context of HRM in the Metro, in terms of ongoing decentralization of health service and human resource management functions. It continues with a description of the key actors in human resource management, grouped as HR Manager and Line Manager. The changing HR practices performed at this level are then inventoried, and the roles and responsibilities of each group of actors in relation to these functions described. Using embedded cases of specific human resource management functions, the case study concludes with a description of the factors influencing HRM and the emerging challenges and enablers in managing the public health workforce in the Metro District.

4.2.1 **Context**

Since 2003, the Cape Town Metro District has undergone a series of restructuring activities as part of the decentralization process and the establishment of the district health system (DHS) in the Western Cape Province. In the Metro, the implementation of the DHS involved the establishment of the substructure level with the characteristics of a district in terms of geographical area, population size, and management structure.

Figure 4.5 below summarise the restructuring process that occurred over a ten year period, from 2003 to 2012, towards decentralised substructures, including the management structures operational at the different time points, and specifically, the changing HR programme structures. In this period, the HRM Programme transitioned from a fragmented and centralised programme to a decentralised and integrated HRM Programme at substructure level. Initially, the District HR Office was a central place where all the HR functions were performed: "… *this (district) office was the main hub*" (UHR P 4: Interview MDHS AD-DD3.doc - 4:65), but the restructuring from district to substructure level led to the devolution of HR functions to substructure level, where the staff establishment was monitored and managed: "…*the substructure took full responsibility of the staff establishment*" (UHR P 4: Interview MDHS AD-DD3.doc - 4:91).

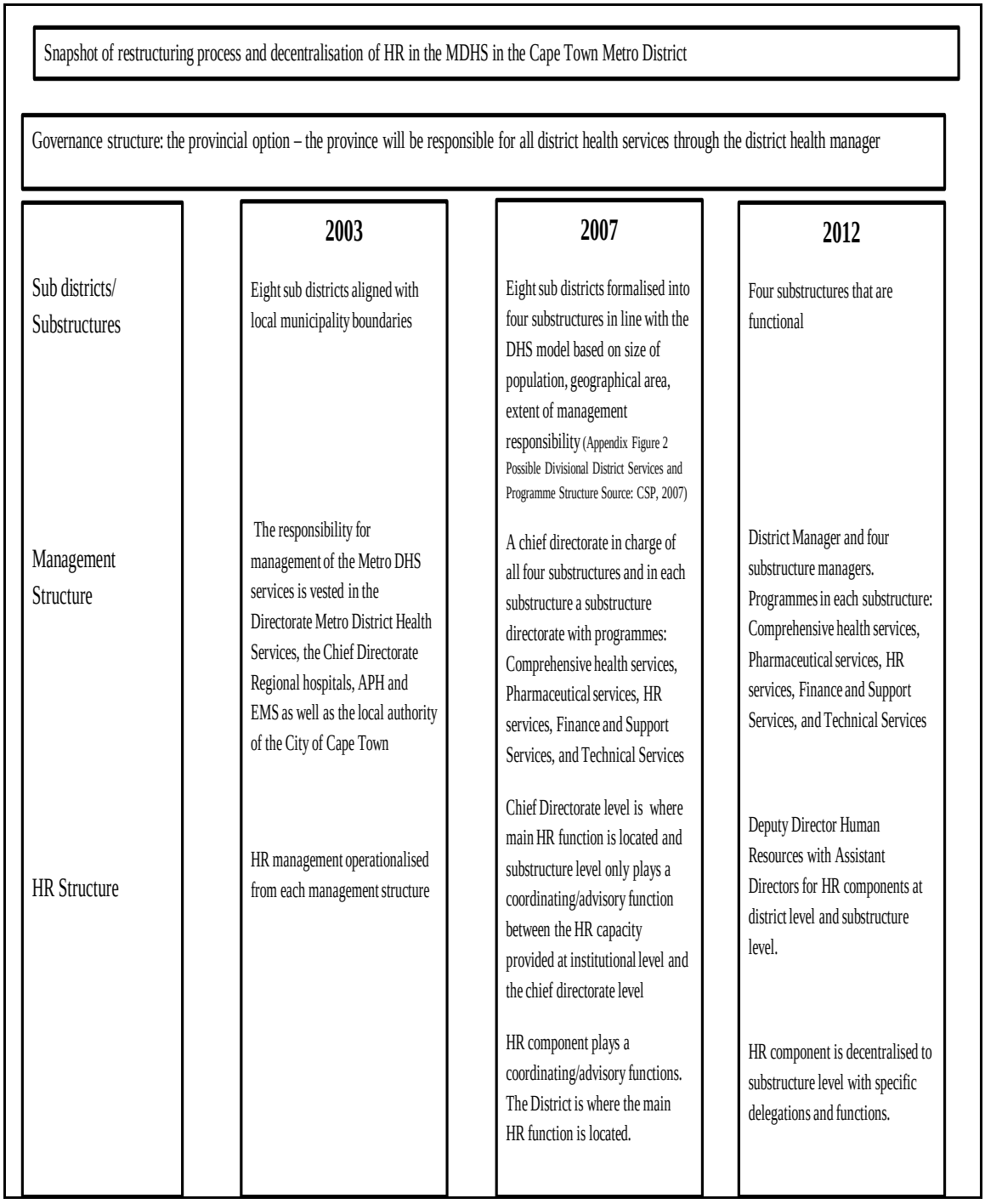


Figure 4.5. Snapshot of decentralization restructuring process of HR of MDHS in the Cape Town Metro District

In 2003, HRM in the then Directorate Metro District Health Services was divided in two sections: Human Resource Management and Planning; and Human Resource Development (HRD). All HR functions were decentralised to the district. The two sections functioned completely independently from one another and were physically placed in two different district hospitals, with different reporting lines within the DHS.

In 2007, with the formalization of the four substructures in the Cape Town Metro District, the HRM and Planning section (excluding the HRD Programme) was restructured and some functions decentralised to the substructures. The main HRM functions (for example appointments), however, remained at the district level. During the period 2007 and 2012, the HRM Programme was thus still centralised at district level with the substructure level performing an intermediary role, with an Assistant Director: in other words, HR in each substructure performed certain HR functions.

In 2012, all the HRM functions including HRD were decentralised to the substructures with primary health facilities (District Hospitals and Community Health Centres) allocated to the four substructures. District HR staff were reassigned to substructures; the District HRD section was disbanded and the purpose and delegations held at the residual District HR Office were changed. In this arrangement, the District HR Office would perform the same human resource management functions as those performed at substructures, but only for the (small) remaining staff establishment at the Cape Town Metro District Office. In addition, the District HR Office's purpose shifted to a focus on HR Planning and Compliance, monitoring adherence to policy, practice audits and maintaining norms and standards of practice.

As a result of the decentralization from district to substructure level, a new HR Programme structure was defined, consisting of five HR function categories: 1) Employment Policy and Practices, 2) Employee Sourcing, 3) Employee Benefit Administration, 4) Labour Relations, and 5) Human Resource Development. The specific components and functions of each category are listed in Table 4.1. HR categories, components and functions at Metro substructure level below.

Table 4.1. HR categories, components and functions at Metro substructure level

HR Category	HR Component	HR Functions
Employment Policy and Practices	HR Planning	Develop and Implement HR Plan Job Analysis Job Descriptions Employment Equity Monitoring and Evaluation HRM Information Control
	Human Resource Policy, Practices and Audits	Monitoring Policy Implementation Policy Training Policy Document Maintenance Conducting HR Audits
	Performance Management	Performance Agreements Grievance with SPMS Developing Transversal Norms and Standards Training on Performance Management System
Employee Sourcing	Recruitment and Selection	Motivations for Appointments Applications Screening Short listing Interviewing
	Establishment Administration	Establishment Monitoring Creating new Posts Abolition of Posts Advertising Posts Filling of Posts
Employee Benefit Administration	Personnel Administration	Service Exits Leave Management Conditions of Service Service Benefits.
Labour Relations	Labour Relations	Collective Bargaining Support and Maintenance Function Labour Relation Forums Statistics and Case Management System Database Training and Development in Labour Relations
Human Resource Development	Human Resource Development	Skills Audit Workplace Skills Plan Coordinating Training and Development Administration of Workplace Skills Fund

(Source: MDHS HR New Structure, 2013)

To give effect to this decentralised HR Programme structure, a new HR post establishment was defined, and the HRM Programme became part of the substructure management organogram. A new post at substructure level, Deputy Director (DD) HR, was established, with four different (specialist) Assistant Directors HR, reporting to the DDR, in contrast to the previous one Assistant Director HR post per substructure. The revised HR post structure established in 2012 at district and substructure levels is shown in Figure 4.6.

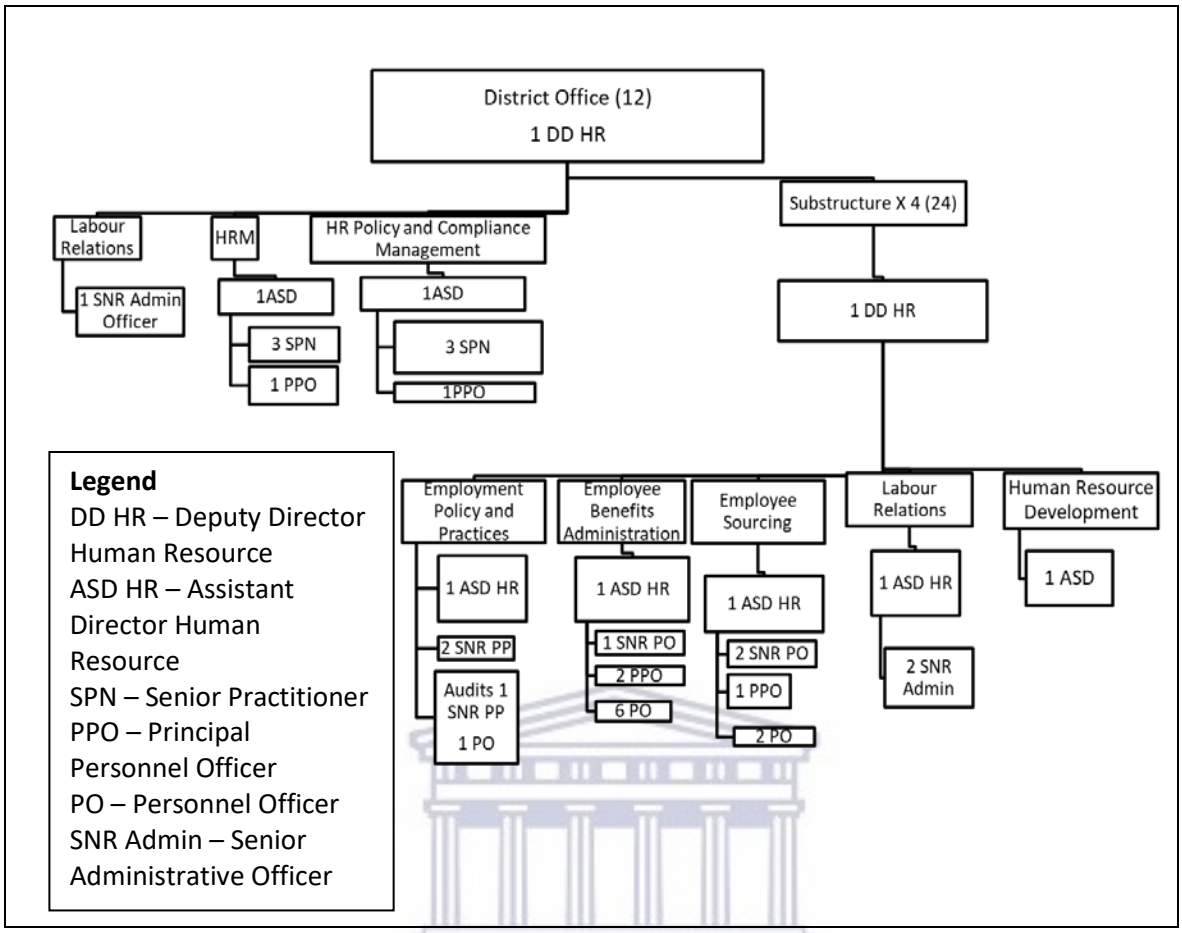


Figure 4.6. Revised HR post structure 2012

This revised post structure signified an important shift in the Department's HR management systems, moving from HR generalists to HR specialists. Previously, one ASD HR Manager was responsible for all the HR functions at the substructure level (albeit with limited authority). The shift from generalist to specialist functions required a shift in focus, from being able to cover the breadth of the functions to in-depth knowledge of specific functions.

Implications of the decentralization of the HRM Programme

The decentralization of the HRM Programme, accompanied by a revised HR structure and HR post structure had a number of intended and unintended consequences, specifically prompted by the move towards working with HR specialists.

One of the unintended consequences was a negative impact on staff morale. The decentralization of the HRM Programme involved the introduction of a new post in the substructure, Deputy Director HRM. This new position is in line with the HRH Strategy for

the Health Sector (2012/13 – 2016/17) that promotes professionalization of human resource managers requiring them to:

- possess formal general management qualifications, including training in best practice human resource (HR) management;
- undergo training in specific government policies and procedures relating to HR, recruitment, induction, procurement and finance;
- have competencies in soft leadership skills fostered through mentorship and training, and assessed through upward feedback mechanisms.

Aligning the new senior positions with the requirement of a formal HR qualification excluded the majority of existing HR staff. In the Metro, only one of the existing ASD HR managers qualified and was recruited to one of the new Deputy Director positions. The other managers expressed disappointment and frustration, as during discussions on the restructuring process, an expectation had been created that they would indeed be considered eligible for these positions: *"He told the four of us that they were going to look into our job descriptions and our workload and there would be a possibility that they will upgrade the post that we are currently in as DDs. We waited and we waited until we heard the end of last year that they will advertise the post of DDs, there is no more of upgrading the post."* (UHR P6: Interview MDHS ASD 2.doc - 6:65). Another expressed that *"… we were more disappointed to see that they had advertised the post with a qualification that we don't have"* (UHR P 6: Interview MDHS ASD 2.doc - 6:66).

The experienced existing ASD HR managers complained that they had not been recognized for their contribution to the development and operation of the HRM Programme and noted the absence of promotion and incentive opportunities. Finally, the promotion of one ASD to the new DD HRM post created resentment as he was not perceived as being more competent that the other remaining ASDs: *"I want him to show me that he is better than me. If he doesn't show that, I can either make myself more miserable or I can go with the flow. I am not intending to make myself miserable, I will hibernate and stay in my cocoon until the year is finished"* (UHR P 5: Interview MDHS ASD 1.doc - 5:96).

The restructuring of HRM thus created considerable tension and anxiety, compounded by uncertainty about how the situation would unfold and how the environment would change. Hence, the following quote concurs with the finding of low morale of the ASD HRMs: *"I am very de-motivated at the moment"* (UHR P 6: Interview MDHS ASD 2.doc - 6:64).

The shift from HR generalist to HR specialist has both advantages and disadvantages, impacting on the responsibilities of the ASD HR managers, and overall functioning of the HRM Programme. One of the concerns raised was the capacity of the ASD HR managers to perform specialist functions, potentially threatening the operation and proficiency of human resource management functions. A different view on the issue of capacity is that shifting from generalist to specialist, would, with time, create more proficiency in the specialist area in HR: *"… previously you oversaw, you will respond to all the functions, now you are going to be responsible for a specific function"* (UHR P 4: Interview MDHS AD-DD3.doc - 4:166).

The main perceived disadvantage of the shift was losing an overview and knowledge of developments in the different HR areas. Interestingly, in response to the shift in HR approach, the majority of the existing ASD HR Managers chose Employment, Policy and Practices HR Category as their preferred component. One of the main reasons for this was to stay abreast of policies and changes, as all policies across all HR categories would pass through the Employment, Policy and Practices HR Category: *"... as long as I'm abreast with the policies and what's happening within the department I will not lose sight of the operations, although I am not involved in the operations"* (UHR P 5: Interview MDHS ASD 1.doc - 5:63).

The new HR post structure, which added new posts in each substructure, required the allocation of additional funding to HRM. Unfortunately, the new post structure was not accompanied by a revised substructure budget. As in the case of one substructures: *"My feeling was if they had this thinking they would have thought about the funds. Where the funds would come from. Should the people* [devolved from District] *not want to be in (Substructure A). They need to tell (Substructure A) 'we giving you 2 posts but we giving you money. So we were disadvantaged in that"* (UHR P 6: Interview MDHS ASD 2.doc - 6:16).

Though some substructures were able to finance the additional posts within their current budgeting framework, others were unable to secure the funding required to fill the additional posts required to perform the specialist approach, prescribed in the new HR structure. As a result, a reallocation of tasks and responsibilities had to be put in place to perform the required human resource management functions. In particular, the Deputy Director of HRM has to perform operational tasks, which should be performed by ASDs, neglecting the management and oversight role for which the post was created: "*... operationally, I am too involved at the moment, I should just have a managerial and a long term strategic planning perspective, I am more operational and that shouldn't be the case*." (UHR P10: Interview MDHS DD Part 2.doc - 10:40). In addition, in the case of one of the substructures, the restructuring process took place in the absence of a physical office for the HR team in the substructure, causing dispersal of HR staff in the available spaces and coordination challenges: "*The only challenge is the fact that my one team is sitting upstairs, in the hospital, and I am sitting down here with the rest of the team*" (UHR P10: Interview MDHS DD Part 2.doc - 10:53).

The restructuring of the HRM Programme and its associated challenges impacted on the operation and performance of HR practices. Interviewees reported time delays in HR processes and expressed dissatisfaction with HR processes; this is discussed in more detail later in this chapter. An argument could be made that the issues mentioned above could be considered the inevitable teething problems in restructuring and change. However, in a follow up session more than two years after initial data collection (and after two budgeting cycles), the situation remained the same. This suggests a more fundamental problem in the functioning of HRM at district level.

4.2.2 **Institutional actors**

As indicated earlier, HR functions in any large organization are performed by two clusters of institutional actors: dedicated HR Managers and Line Managers who manage/supervise staff in the service delivery function. It is anticipated that the role players in these clusters should be working synergistically, to create a seamless and productive people management and service delivery system. In reality these alignments are often complex and fractured, particularly during processes of change and decentralization.

As also indicated in an earlier chapter, the dedicated Human Resource Managers (salary levels 8 -12) in the substructure comprise a range of staff with different job titles: Senior Personnel Officer, HR Practitioner, HR Manager, Assistant Director: HR, and Deputy Director: HR. The roles and responsibilities of HR Managers are to oversee a specific component or set of components, ensuring implementation of policy, prescripts and compliance, approving and authorizing HR processes in the specific HR component. With the 2012 restructuring, the HR Managers' reporting line is retained within the substructure health services and there is no direct or indirect reporting line to the District HR Office.

Staff performing HR line management functions (i.e. supervise other staff) including the Facility Managers, Operational Managers (managing a unit within a facility), PHC Managers (supervising Facility Managers), Substructure Managers, and District Managers. This case study focused on two of these: Facility Manager and PHC Manager.

This section examines in depth, the profile, capacity and roles of the two clusters of HR Managers in the case study district. This is followed by a consideration of their respective HR roles and the alignment of these through an examination of specific HR functions (the embedded cases).

Dedicated HR Managers

In this thesis, HR Managers are regarded as those on salary levels 8-12. At the time of the study (coinciding with the 2012 decentralization process), there were thirty-seven HR Managers employed in the Cape Town Metro District, with a wide variety job titles (see Table 4.2 for list). Seven of these were located at the District Office, and thirty in the four substructures.

Although the new the post structure was accepted and approved, posts were either not filled or in the process of being filled. According to the revised HR Post Structure (Figure 4.6) there should have been five ASD-HR posts for each substructure and two at district level, totalling 22 ASD HR posts in Cape Metro District. At the time of the study, there were only three designated ASD HR Managers, although six others were on the same salary scales (Table 4.2). The majority of HR Managers were not on the revised post structure, with HR Managers such as Director: Personnel Management Assistant apparently playing an equivalent role to that of the ASD: HR. In addition, none of the Deputy Directors HRM for

the substructures (and one at District level) had been appointed when the data were collected (2013). Thus, HR Managers at salary levels 8-9 were having to perform and oversee the new delegated human resource management functions for the substructure. There was also no clear distinction between responsibilities of an HR Manager on level 8 and a HR Manager on level 9, and each substructure team was responding as best as possible to the needs of the substructure using the available capacity.

Table 4.2. Cape Town Metro District HR Managers (2013)

		Salary Level			
Sub-Structure	**Job Title**	8	9	12	Grand Total
Metro Sub-Structure 1: Northern/Tygerberg	Administrative Officer: HR	1			1
	Senior Administrative Officer: HR	2			2
	Senior Administrative Officer: Labour Relations	1			1
	Director Personnel Management Assistant		2		2
	Chief Personnel Officer	1			1
Metro Sub-Structure 1: Northern/Tygerberg Total		**5**	**2**		**7**
Metro Sub-Structure 2: Western/Southern	Senior Administrative Officer: HR	2			2
	Senior Administrative Officer: HRD	1			1
	Senior Administrative Officer: Labour Relations	1			1
	Assistant Director: HR Administration		1		1
	Director Personnel Management Assistant		1		1
	Chief Personnel Officer	1			1
	Senior Personnel Practitioner	1			1
	Personnel Practitioner	1			1
Metro Sub-Structure 2: Western/Southern Total		**7**	**2**		**9**
Metro Sub-Structure 3: Klipfontein/M Plain	Senior Administrative Officer: HR	2			2
	Assistant Director: Labour Relations		1		1
	Senior Personnel Practitioner	1			1
	Chief Personnel Officer	1			1
Metro Sub-Structure 3: Klipfontein/M Plain Total		**4**	**1**		**5**
Metro Sub-Structure 4: Khayelitsha/Eastern	Senior Administrative Officer: HR	3			3
	Senior Administrative Officer: HRD	1			1
	Senior Administrative Officer: Labour Relations	1			1
	Assistant Director: HRM		1		1
	Director Personnel Management Assistant		2		2
	Chief Personnel Officer	1			1
Metro Sub-Structure 4: Khayelitsha/Eastern Total		**6**	**3**		**9**
Office of Chief Director: MDHS	Director Personnel Management Assistant		1		1
	Deputy Director: HRM			1	1
	Senior Personnel Practitioner	2			2
	Chief Personnel Officer	1			1

	Senior Personnel Practitioner	2			2
Office of Chief Director: MDHS Total		**5**	**1**	**1**	**7**
Grand Total		**27**	**9**	**1**	**37**

Questionnaires were distributed to all thirty-seven HR Managers with the objective, amongst others, of establishing their qualification profiles and experience. Fifteen out of thirty-seven (41%) HR Managers returned completed questionnaires. Table 4.3. Metro HR Manager Job Titles and Qualifications (n=15) depicts the qualifications of the HR Managers according to collective job titles. The majority of the HR Managers highest qualification was a Grade 12 with only three HR Managers with a tertiary education.

Table 4.3. Metro HR Manager Job Titles and Qualifications (n=15)

Cape Town Metro District				
Job title	**Grade 12**	**Diploma**	**Degree**	**Total**
No Response	2			2
Senior Administrative Officer	3			3
Personnel Officer	1			1
Chief Personnel Officer	2	1		3
HR Practitioner		1		1
Assistant Director: HR	3		1	4
Admin Manager	1			1
Total	12	2	1	15

Based on the years of experience, the HRM Programme appears to be a stable programme. All the staff were over the age of 30 years and the majority had been working for more than five years in the programme (Table 4.4. Metro HR Manager years of service per age group (n=15)). This could compensate for the lack of formal qualifications.

Table 4.4. Metro HR Manager years of service per age group (n=15)

Cape Town Metro District				
	0-5yrs	**5-10yrs**	**10-15yrs**	**20+yrs**
18-29yrs	0	0	0	0
30-35yrs	4	2	0	0
36-39yrs	0	0	0	0
40+yrs	2	2	2	3
Total	6	4	2	3

Line Managers

There are five levels of Line Managers in the hierarchy of Primary Health Care Services in the Cape Town Metro District (Figure 4.7).

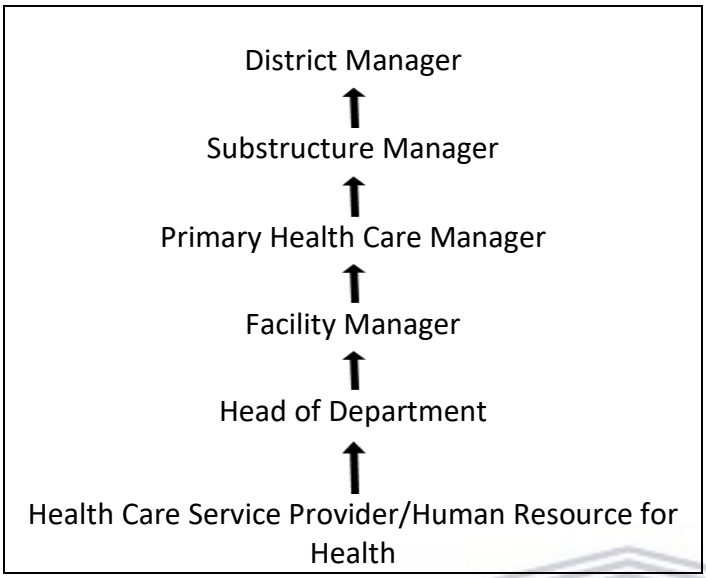


Figure 4.7. Simplified list of Line Managers in Cape Town Metro District

The Head of Department or operational manager is responsible for the personnel working in a department or unit within a primary health care facility, such as the pharmacy or X-Ray department. While the department heads are expected to manage the personnel working in the relevant department, this was reportedly not happening, with responsibility falling on the Facility Manager. The Facility Manager is located in the PHC facility and the PHC Manager is located in the substructure office and responsible for all the PHC facilities in the substructure.

The Facility Manager's job description stipulates that s/he is primarily responsible for the effective management of PHC services; Human Resources; Finances; and Supply Chain and Logistics, to ensure that holistic care is provided to patients and their families (Appendix 5 Job description of the facility managers in MDHS). The job description specifies the recommended allocation of time for administrative functions. In the job description of a Facility Manager, Human Resource Management receives a time allocation of 30% compared to 15% for Financial Management and 25% for Supply Chain Management and Logistics. Thus, human resource management forms a significant part of the Facility Managers' roles and responsibilities in the Cape Town Metro District.

District Health Services Development	5%
Human Resource Management	30%
Financial Management	15%
Supply Chain Management and Logistics	25%
Health Information Quality of Care TB HIV/AIDS Chronic Disease Management Women's and Child Health Mental Health Services	No time allocations

Box 4.3. Cape Town Metro Districts' Facility Managers' job description scope and time allocation (Source: MDHS Facility Manager Job Description)

The PHC Manager's job description is outlined in Table 4.5. Job Purpose of substructure PHC Manager in Cape Town Metro District. The incumbent has to provide technical public health expertise and general managerial support to the Facility Managers and other personnel in the sub-district. In addition, the PHC Manager provides effective liaison and co-ordination to all stakeholders in the sub-district (NGO, academia, private sector, communities, etc.). The time allocated to the various responsibilities is not stipulated but a description of the scope of responsibilities is outlined in the job description (Table 4.5).

Table 4.5. Job Purpose of substructure PHC Manager in Cape Town Metro District

Key Responsibility Area	**Output**
Planning, Monitoring and Evaluation	Develop annual and medium term strategic and operational plans for the PHC Services and Service platform for the sub-district with the guidance of substructure manager
	Periodical Monitoring and Performance Indicators
Line Management and Operational Management	Define and review on continuous basis the purpose (vision/mission), the objectives and priorities of the sub - district
	Review and adjustment of operational and strategic plans and prompt implementation with regard to health
	Co-ordination of PHC Services in the sub-district
	Provide professional, technical and administrative guidance and advice to CHC and clinic management, clients and sub-ordinates

	Co-ordinate the various services and sub-components
Resource Management	Human resource planning, recruitment, development and performance management
	Sound financial management and adherence to PFMA and other treasury regulations
	Revenue generation
	Stop or reduce losses and wastage
	Physical facility maintenance and improvement
Liaison	Joint services planning and monitoring and evaluation with City Health
	Teaching and research platform with universities
	Community participation including NGO

(Source: MDHS PHC Manager Job Description)

4.2.3 **HR practices**

HR practices are the formal activities, functions and deliverables as outlined in job descriptions for the two key role players - HR and Line Managers[2]. This research sought to identify the HR practices as prescribed by the job descriptions as well as what the role players considered to be their main human resource management functions. It is important to acknowledge that the description below is not a representation of a comprehensive list of the different HR practices performed by these two key role players, but rather what they considered to be the main human resource management functions occupying their time. The HR practices for each role player are outlined, followed by a comparison between the two, to identify congruence between actors, and between job descriptions and stated practices.

HR practices are best understood by examining the job descriptions of the two types of recognised HR Managers: Deputy Director HRM (DD HRM) and Assistant Director HRM (ASD HRM). These two were selected as they work directly with PHC service providers and with the Line Managers in the substructure. The two job descriptions were compared for similarities and differences, and to identify potential overlaps that could lead to role confusion (Appendix 6 Comparison of the DD HRM VS ASD HRM Responsibilities in Human Resource Management).

The job description of the DD HRM is that of an HR generalist, while the job description of the ASD HRM is that of an HR specialist. This differentiation is depicted in the detail

[2] The informal HR practices are undocumented activities and processes in managing people which are used to put HR Policies in place. These were not investigated because of time and scope of study limitations.

provided in the activities; the DD HRM activities are broad and vague, such as to manage recruitment and selection procedures and ensure that appointments are made. The ASD HRM's activities are more specific and detailed, for example, to approve interview panels and screen employment equity profiles. The oversight role lies clearly with the DD HRM, based on the action verbs used to describe the majority of the HR activities: to manage, to ensure, and to monitor. In the job description of the DD HRM, activities included: input into HRM policies, monitoring compliance to HRM policies, assisting Line Managers in restructuring, determining staffing requirements and strategies to implement the HR Plan, and finally to interpret and make decisions on complex HRM policies.

The ASD HRM job description included HRM information control, monitoring leave and addressing absenteeism. Despite its potential in strengthening relationships between key players, explicit mention of HR information management was not part of the DD HRM job descriptions, and only part of one of the five specialist ASD's HRM job descriptions. This appears to suggest an absence of recognition of the importance of information in the management of HRH.

Although data capturing is not one of the responsibilities in the job description of the ASD HR, this operational task was often performed by them: "*I'm not supposed to process or physically capture data on Persal*" (UHR P 5: Interview MDHS ASD 1.doc - 5:39). One of the situations raised where capturing of data is required, is with authorizing leave applications, where the ASD HR is required to capture the data first before the leave can be authorized "*I have to capture the leave I'm authorising*" (UHR P 5: Interview MDHS ASD 1.doc - 5:34).

The HR practices of Facility and PHC Managers as outlined in their job descriptions are detailed in Table 4.6.

Table 4.6. Line Managers' HR activities and deliverables

Line Manager	HR activities	HR deliverables
Facility Manager	• Recruitment and selection processes • Skills Plan developed and implemented • Codes of labour relations management adhered to • Application of Disciplinary Code and Procedure • Individual Performance and Development Plan (IPDPs) for all staff members signed off • At least 2 Quarterly Reviews completed. • Annual appraisal completed • Register with leave tracking system • Establishment checked monthly	• Fully staffed Community Health Centres with all funded posts filled at all times as per FPMI • Staff training needs are met against Skills Development Plan • Harmonious and good Labour Relations Management with all disciplinary and grievance matters resolved • Strategic Performance Management System (SPMS) in place, functioning and completed • Absenteeism reduced • Verified establishment
PHC Manager	Human Resource planning, recruitment, development and performance management	Absenteeism at 5% or less All vacant and funded post filled at 100% FPMI code of conduct protocol implemented HR Plan in place SPMS conducted

(Sources: MDHS Facility Manager Job Description, MDHS PHC Manager Job Description)

Drawing on the DOH's list of HR functions (Table 4.1. HR categories, components and functions at Metro substructure level) finalised in 2012 as a framework, the roles and responsibilities of the HR Manager were compared to those of the Facility and PHC Managers outlined above (Appendix 7 CTMD Comparison of HR Manager and Line Manager's roles and responsibilities in HRM). The human resource management functions of these Line Managers touch on all areas of the framework, leading to the conclusion that effective HRM depends fundamentally on the relationship between Line and HR Managers.

Once the HR practices were established from the job description, the two groups of Line Managers were asked to describe their main HR activities. The list and descriptions provided were closely linked to their job descriptions. Interviewees also highlighted the details in delivery and implementation of these functions, specifically the challenges experienced.

The descriptions of the main HR practices of both role players, HR and Line Managers, focused on three key activities: filling of posts, managing staff, and finally interpreting and

compliance to policies. In addition, the management of the HR information system, Persal, was a key function of HR Managers. These activities are described in more detail below.

Filling of posts

The process of filling vacant posts starts with the financial manager based at the provincial level, who determines the approved post structure for each district, commonly referred to as the Approved Post Listing (APL). The APL reflects the staff establishment for each district as funded posts that can be filled if vacant. Thus, each month an approved post list per district is provided from which the district manager can manage their staff establishment by making appointments into these vacant funded posts.

At the district level, the staff establishment is being monitored specifically on whether a post that was vacant has been filled: "*... monitoring staff establishment, monitoring vacancies within this office as well making sure that the post is not going to lay vacant. We initiate communication with that relevant Line Manager so from HR we initiate that thing*" (UHR P 4: Interview MDHS AD-DD3.doc - 4:183). In the case of the Cape Town Metro district, each substructure receives an approved post list.

The determination of vacant posts on the APL and filling those vacant posts requires a very important role player in each substructure, the financial manager. At a substructure level, the financial manager's role is to specifically monitor the filling of posts, and matching the filling of post with the approved posts. Thus, the finance manager plays a vital role in both decision making and planning, as all decisions are made in collaboration with them or their approval obtained before the appointment: "*I sit with my DD finance and then we also have the out of adjustment report*" (UHR P 6: Interview MDHS ASD 2.doc - 6:42).

In the substructure, the HR manager highlighted the responsibility of alerting the relevant Line Manager that the post is vacant by monitoring the staff establishment, starting the process for recruitment and selection to fill the vacant posts, and ensuring that all documents are properly signed off: "*the staff establishment goes to the managers. If they have a staff complement of 15 when they supposed to have a staff complement of 18, the budget and funding is there to fill 3 more posts*" (UHR P 5: Interview MDHS ASD 1.doc - 5:73). The HR Manager describes the process from when they receive the approved post structure on a Microsoft Excel Spreadsheet to when they send them out to the Line Managers to take the

process further: "*... they send us a spread sheet, we look at it, we send it to out and we alert the managers. We say hey, listen here, we have notice 4 or 5 posts. When are you going to fill the post? Give us time limit or tell us the process of that post"* (UHR P 5: Interview MDHS ASD 1.doc - 5:71). A Facility Manager expressed her role in relation to this as being alerted by the HR Manager: "*My role is to make sure that I have total staff complement for the facility"* (UHR P 2: Interview MDHS Line Manager 2 FAC MX.doc - 2:10).

Managing staff

Managing staff is considered a transversal human resource practice between the HR Managers and the two types of Line Managers. In the case of the HR Manager, "*HR is managing any unhappiness*" (UHR P 4: Interview MDHS AD-DD3.doc - 4:132). A Facility Manager described her role in managing staff as ensuring that the staff members receive the necessary information on the human resource issue in question: " *I need to make sure they get the necessary information regarding HRM, the leave profile, the information regarding the leave, housing subsidy*" (UHR P 2: Interview MDHS Line Manager 2 FAC MX.doc - 2:10).

Another Facility Manager found that the human resource management functions can be immense because of the extensive list and nature of these functions. One of Facility Managers reflected on her experience with human resource management responsibilities, finding them to be very overwhelming, because it consists of a large amount of functions which require working with HR staff and having certain information at your disposal: "… *finding the HR component of my work a bit overwhelming because there is so many thing. It's recruitment, it's your leave management, it's absenteeism management. I am trying to get to know all the people so that I know who to request the information I need from*" (UHR P 3: Interview MDHS Line Manager 3 OP MX.doc - 3:2).

Leave management posed particular challenges for both HR and Facility Managers. The leave management process is described in more detail later under Monitoring, as a misalignment between policy and practice, illuminating role confusion amongst the role players.

Policy interpretation and compliance

Finally, another HR practice is that of interpreting and complying with HR policies. Interpreting the policies requires a process where all HR Managers have a similar

understanding of the implementation of the policy. In addition, in order to comply with the policies, the HR Manager and Line Manager have to share a common understanding of a policy for implementation. It has been established that it is the HR Managers' responsibility to interpret policies, share the policies with Line Managers, and finally to ensure compliance with the HR policies: "…*when your policy comes out, make sure that the interpretation is correct and that it is shared with Line Managers. Basically make sure that at the end of the day, there is compliance*" (UHR P 4: Interview MDHS AD-DD3.doc - 4:16).

The description of the HR practices of both role players highlight two important points; first there is a clear overlap between what is performed by the HR Manager and the Line Manager; the second is the importance of these two role players working together to perform effective human resource management of the public health workforce.

4.2.4 **Factors influencing HRM in a district health system**

In this section of the case study, the factors influencing human resource management in a DHS, emerging from the data collected, are described. The first factor is the role of information in managing and monitoring the human resources for health, using leave management to illuminate the implications of unreliable information. The second is decision making, and specifically the decision space of different role players in filling a post in a health facility. The third factor emerging from the study is the difference in priority between the two key role players in managing the human resources for health, leading to implications for strategic alignment. The nature of the communication and reporting structure is the fourth key factor influencing HRM in the DHS, and role confusion is the fifth factor, where the implementation of the new HR structure and the responsibility shifts associated with it, causes confusion; this also highlights the capacity requirements. Finally, this section concludes on a positive note, describing substructure level leadership as an enabling factor for the decentralization of the HRM programme from district to substructure level.

Monitoring the Human Resources for Health

The researcher posits that the shared HRM functions of the two role players, the monitoring of the human resources for health, is a critical factor. It traverses the human resource functions and role players, thus providing an opportunity to strengthen both internal and

external alignment. In describing their human resource management function, the Facility Managers repeated the observation that it was key to their roles to have access to information so that they could make decisions based on information.

As mentioned before, Persal is the primary human resource information system used in the public health sector; however the table below reflects information sources not provided by Persal and used by substructure and district management structures to manage the human resources in a DHS.

Table 4.7. Sources of information for monitoring the public health workforce

Name of Information Source (Tool)	Purpose of the Information Source	Frequency of Compilation	Role players involved
Leave Planner	A yearly calendar to be completed by all staff members in a PHC facility to indicate the intended time and period of taking annual leave	Annually	Facility Manager
Leave calculator	A Microsoft Excel Worksheet with a formula to calculate absenteeism for individual public health employees	Monthly	Facility Manager
HR Audit Action Plan	The HR Audit Action Plan is based on previous findings of the Auditor General: compensation of employees. The report is compiled per institution, and completed by the institution and substructure. The actions required are stipulated per item in the Action Plan. This tool is monitoring where the action to rectify the audit item has been completed.	Quarterly	Responsible people for item in HR, institution, and substructure
Tracking Sheet for filling posts	This is a district tool used to track the filling of posts per substructure.	Monthly	District management
Compliance Management Instrument (CMI)	A managerial checklist in respect of HR matters. The checklist to be completed by the Superintendent General/Deputy Director General/Chief Director/Director on a monthly basis in consultation with Line Managers. In practice it has been completed by the HR Managers. The checklist is also referred to as the Compliance Management Instrument (CMI) as it monitors compliance to selected HR practices. The checklist covers an array of HR practices. Checklists are required to be signed by the Director of the Cape Town Metro District and submitted to the Director: HRM at provincial level	Monthly	HR Managers, Line Managers, directors of substructure and district
Executive summary of exit interviews	It provides a summary of types of terminations and staff categories that have exited the substructure or district, in addition to a labour turnover analysis that collects the length of employment, reasons for exiting and recommendations for preventing exits. This is to be completed electronically by the HR Manager	Quarterly	HR managers

Monitoring and Evaluation Report, HR	It is a Microsoft Excel Sheet with monitoring and evaluation HR Indicators compiled for each district per quarter. The information is discussed in terms of performance and variance at a quarterly provincial monitoring and evaluation meeting.	Quarterly	District management

The absence of reliable information for the managing and monitoring of the public health workforce can be deduced based on the different types of data collection tools developed to respond to this absence of information. The list described in the table above is not an extensive list, but it provides insight into the type of information required to monitor and manage, and identify the different role players involved at the different levels in the DHS.

In the questionnaires, the HR Managers were asked to indicate the frequency with which they performed HR functions related to information management. The results are presented in Table 4.8 below.

Table 4.8. Metro District HR Manager information management functions (n=15)

	Never	Rarely	Sometimes	Often	On a regular basis	No Response
I capture data on Persal	1	2	8	2	2	0
I ensure that the data is accurate on Persal	0	1	1	4	9	0
I share information with the colleagues in my human resource component	0	0	0	1	14	0
I share and discuss information with the colleagues in other human resource components	0	1	3	0	11	0
I liaise with the Facility Managers regarding the staff establishment information	1	3	3	2	6	0
I prepare and write staff establishment reports for Facility Managers	6	3	3	2	1	0
I prepare and write staff establishment reports for programme and sub-district managers	7	2	3	1	2	0
I interpret information on the staff establishment	4	1	3	2	4	1
I determine training needs	2	1	6	2	4	0
I give advice on human resource planning to the Line Managers (facility, programme, sub-district, district)	1	4	3	5	2	0

I give advice on human resource management issues to the Line Manager (facility, programme, sub-district, district)	1	1	1	8	4	0
I coordinate the information management in my component	1	3	1	3	6	1

Information management functions were common, but mostly those internal to the HR administrative structures, sharing and discussing information within a specific component as well as with other HR components. The researcher posits that information management and more specifically the monitoring of the HRH is essential for both HR Managers and Line Managers, but also provides a platform to strengthen the relationship between the two role players in sharing the responsibility of HRM in a substructure.

During the interviews with the HR Managers, the role of monitoring was accounted for as the process of sending the Microsoft Excel Sheet containing the staff establishment of a PHC facility to the relevant Facility Manager, alerting them to changes in the filled and vacant posts on their staff establishment through highlighting in the document or informing them of issues through an e-mail message.

As part of the questionnaire we wanted to establish the frequency of different ways of monitoring the staff establishment in order to expand this role. The results in the tables presented below are derived from the 15 out of 37 questionnaires completed by HR Managers, with different job titles and on different salary levels. However, the responses in the tables represent such variation that it is difficult to establish any consistent patterns.

It is important, however, to acknowledge that HR Managers do not have to prepare staff establishment reports as they receive these official reports from the provincial office. The one conclusion that can be drawn from the table below (Table 4.9) is that the HR Manager's role in the monitoring of the staff establishment is important, as they fill the gap between the health worker and Facility Manager; they are therefore in a better position to provide advice to the Facility Manager on human resource management than human resource planning.

The specific data collection topics on information management explored HR Managers' attitudes towards data quality, analysing information, producing reports, and presenting information. The findings revealed that the concept of information management and having

to perform this function was not a comfortable concept to a large proportion of the HR Managers. In the data (Table 4.9), a sense of undecidedness is identified in relation to whether or not HR Managers *should be* undertaking information management. The majority of the HR Managers expressed their uncertainty in performing the analysis and information presentation function, but this could be attributed to their uncertainty in relation to performing these specific information management functions.

Table 4.9. Cape Town Metro District attitudes towards Information Management

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	No Response
Information Management should be part of my job description	2	0	4	3	6	0
Producing information reports should be part of my job description	1	0	4	4	6	0
Ensuring the information is accurate is not my responsibility	4	5	3	1	2	0
Analysing and presenting information should not be part of my main duties and responsibilities	5	2	4	3	1	0
Information should be used for decision making and planning	0	0	1	6	8	0

Contrary to the attitudes represented above in Table 4.9, the HR Managers express strong confidence in their information management abilities Table 4.10, especially in monitoring, planning and interpreting staff establishment reports; this is with the exception of writing establishment reports.

Table 4.10. Cape Town Metro District's perceptions of Information Management abilities

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	No Response
I am able to perform accuracy checks on the data in Persal	0	0	1	5	8	1
I am able to write establishment reports	3	3	3	5	1	0
I am able to monitor the trends in the staff establishment	2	2	2	8	1	0
I am able to plan the staff establishment according to the approved staff establishment	2	2	1	7	2	1
I am able to interpret the human resource reports and use the information in the reports	1	2	0	7	5	0
I am able to determine the information needs of the Facility Managers	2	0	2	9	2	0

Remaining on the topic of information management but moving away from the role, perceptions and attitudes of the HR Manager, a mismatch was revealed between policy and practice, created by the absence of reliable information. The mismatch referred to is the leave application process, where the HR process as stipulated by policy, is undermined by the lack of availability of up-to-date reliable information.

Embedded Case 1: Leave Management

Leave management has been identified as one of the key challenges in the Cape Town Metro District. An increase in the utilization of normal sick leave was found, with the highest sick leave utilised by supervisory levels in the previous leave cycle of three years (Metro District Health Services Human Resource Plan Draft, 2012/2013). In addition, the poor management of sick leave was raised by the Auditor General in 2011, and subsequently circulars that made reference to the effective management of sick leave were sent to all Managers; in addition, the training of managers in the management of sick leave is part of the People Management Strategy, an initiative of the Corporate Services Centre for all Line Managers in the Province (Metro District Health Services Human Resource Plan Draft, 2012/2013). However, the specific impediments within the leave management system has not yet been investigated or documented, to inform planned training and interventions.

The leave management system in the public health system is clearly outlined in Chapter Four of the *People Management Toolkit: A guideline for Line Managers specifying the application and approval process* (Western Cape Province Department of Health, 2014). At the primary health care facility level, the information sources used to monitor and manage leave are a leave application form, annual leave planner, MDHS Leave Indicator Sheet, and a communication book.

The drawbacks in the leave application process has become evident through this study and is directly related to the leave management system outlined in the *People Management Toolkit*. The misalignment of the leave application process with the leave management system is described in Box 4.4 below, highlighting the role of information management in the process.

The staff member has to complete a leave application form which has to be signed and approved by their direct reporting Line Manager (the Head of Department) and then the Facility Manager.

The process is followed with the Facility Manager forwarding the signed documents to the HR Manager for capturing and authorising on Persal (electronic payroll system).
A quarterly leave report extracted from Persal is sent to all Facility Managers by the HR Manager to indicate the leave taken and remaining leave days of each staff member.

A leave application process is straightforward as illustrated in Figure 4.15. Leave application process However, the leave application process has a vulnerable area and that is the assumptions that the staff member applying for leave has leave days available. The vulnerability lies in the fact that the decision on whether or not to approve leave is dependent on the quarterly report extracted from Persal, reflecting a previous time frame which does not include the latest number of leave days taken by the staff member.

In addition, the situation is worsened when there is a delay in form submission or form capturing, resulting in the staff member already taking the leave before it has been processed. The situation could be further complicated if the staff member does not have annual leave days available.

Box 4.4. Drawbacks in the leave application process

This vulnerability, dependent on out of date leave information, causes a misalignment between policy and practice, and could lead to the scenario described in the figure below.

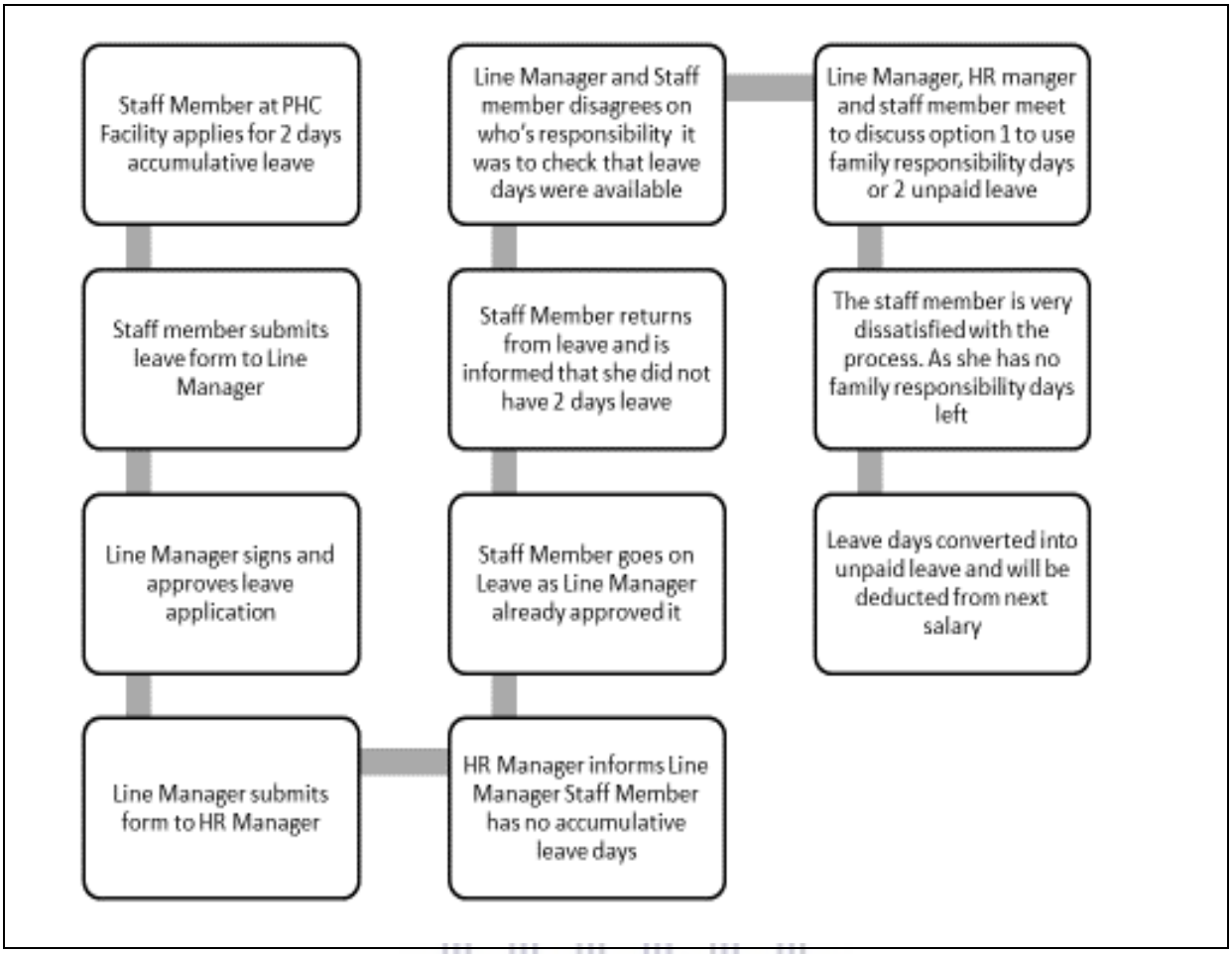


Figure 4.8. Leave management scenario

This leave application misalignment has been identified as a breakdown in communication:

> … *we see that the leave form, the Z1 and everything was completed correctly. If not we send it back immediately. In terms of the leave policy, the leave is supposed to be signed within 24 hours. The HR person responsible for the community health centre sometimes has to go and fetch the leave form at the facility. Sometimes the leave form is older than 3 or 4 days. Then we ask why it has been kept so long at the facility because leave is captured on a daily basis* (UHR P 5: Interview MDHS ASD 1.doc - 5:47).

In addition, leave reports are done on quarterly basis, and sometimes problems with leave applications are only addressed at that point, when the new quarterly reports are received: "*The person responsible for the facility gives us an update when it comes to quarterly reports*" (UHR P 5: Interview MDHS ASD 1.doc - 5:47).

However, the Facility Manager provides another perspective to this breakdown in communication, where the source of the breakdown is ascribed to the absence of up to date and quality information on remaining accumulative leave days. The absence of up to date and quality information was ascribed to two main sources of leave information, which were both considered inaccurate. The first source of leave information is the Payslip which is the only source of leave information for a staff member on their remaining leave days: "*The staff never goes according to what their pay slip say. I tell them to come to the office I have records to check how many leave days they have left*" (ULM P 3: Interview MDHS Line Manager 3 OP MX.doc - 3:14). This Facility Manager highlighted the incorrectness of the number of leave days on the payslip and thus classified it as an unreliable source of information, referring to alternative sources of information for leave days which are not provided by the HR Manager but kept by the Facility Manager.

The second source, the Leave Report is also considered unreliable and inaccurate as it does not provide an up-to-date reflection because of the frequency of production of the report: "*... we've discovered that often the leave days on the report don't correspond with the information we have. That is why we develop our own system so that we can be on top of the number of leave days the people in our facility have*" (ULM P 2: Interview MDHS Line Manager 2 FAC MX.doc - 2:28). That leave data is not up to date and unreliable is also borne out by an information audit conducted in the district, which found that most of the data is either not up to date or is not a true reflection of the human resource situation in the district (CDC/PEPFAR Report, 2013).

In response to and in order to prevent this misalignment, several Facility Managers developed their own monitoring system to manage leave at an institutional level, thus creating independence from the two source of leave information mentioned above; more importantly, this enabled them to collect more accurate information to provide them with the insight to make informed decisions regarding approving leave: "*We keep track of all the leave days taken in our facility. Because people take bits of leave in the year. Then they take 2 weeks, then 3 weeks or a bit here and there. Then leave from comes back from HR to say this person doesn't have any leave left and that person have to sign for unpaid leave. It's important for us to manage the leave properly*" (ULM P2: Interview MDHS Line Manager 2 FAC MX.doc - 2:27).

However, an institutional leave monitoring system in itself creates misalignment when it does not correspond with what the HR System reflects as the number of remaining leave days: *"I think dealing with leave management the system works for me, even though it doesn't always correspond with what HR has"* (ULM P 3: Interview MDHS Line Manager 3 OP MX.doc - 3:24).

This misalignment in the leave application process has resulted in several dissatisfied staff members, as the resolution of information conflicts has commonly been to the detriment of the staff member, as depicted in Figure 4.8. Leave management scenario.

This embedded case on leave management has illustrated the use of information for decision making on leave approval, where it is not the absence of information but the use of out of date information that is leading to serious consequences and dissatisfied staff members.

Coming to the next factor influencing the human resource management of the public health workforce and this the decision space of Line Managers to manage and plan their staff establishment.

Decision making

In the context of decentralization, the decision making space for a decentralised HRM Programme influences the operation and effectiveness of HRM in the Cape Town Metro District. The implications of some of the decision space afforded to two key role players are described in this section. To investigate the decision space, the appointment process is used as an embedded case to describe the roles and decision spaces of the different role players in this process.

Embedded Case 2: Appointments

The process described in the box below illuminates the roles of the different players and how time delays in the process impede the appointment process.

The appointment process starts with a document called the Approved Post List produced by the Finance Manager at Provincial Level on a monthly basis, and is sent to the Assistant Director Employee Sourcing.

This is followed by a discussion on the vacant posts with the relevant Line Managers, who will then resolve to proceed with filling the post and thus have to compile an advertisement to send to the HR Manager: "*I am talking about the Facility Manager. They give the go ahead, to process what is it in terms of the operations that you require, do want to fill the post, do you need the post, is there a need, what is the need at your facility. They can motivate and that will come to the HR as well as via the PHC manager who will come to HR and they will make a decision"* (UHR P 5: Interview MDHS ASD 1. doc - 5:52).

The post is advertised.

When the applications have been received, the PHC Manager constitutes a panel to conduct the interviews, of which HR is one of the panellists.

The interviews are conducted and a shortlist is compiled from which a selection is made based on the scores of the interviewees.

The successful candidate is then offered the post and accepts or does not accept the post; if not, the post is offered to the candidate second on the scoring list.

The HR Manager then requires the necessary documents to complete the appointment process. "*While this process is playing itself out, another substructure gives the job offer to your successful candidate*" (ULM P 1: Interview MDHS Line Manager 1 PHC MX.doc - 1:17).

As a result, there are time delays in appointing new staff once interviews have been completed and the candidate has been selected; because the HR process takes too long, the candidate may accept another job offer in a neighbouring substructure and the process has to be commence from the beginning: "*Province takes too long, the process is takes too long and then now the person get another job and then she has to start the process all over again*" (ULM P 2: Interview MDHS Line Manager 2 FAC MX.doc - 2:20).

Box 4.5. Embedded Case 2: Appointments

For Facility Managers, in terms of decision space in the appointment process, there is an agreement that the decision to make appointments to a vacant position is not at the PHC facility level but at the substructure level, sometimes at district or provincial level. The decision space is described as being able to motivate for the appointment of a particular person but not to make the decision: *"I think with recruitment and selection I think, its motivating probably for posts because usually at the end of the day you motivate but the decision doesn't lie with you to say Okay; it's Finance, it's your Director"* (ULM P 3: Interview MDHS Line Manager 3 OP MX.doc - 3:6).

Furthermore, the decision space of a Facility Manager in the appointment process is undermined when a motivation has been successful and the appointment has been successful but the appointee is not working in their facility: *"I mean I assume it's taking place on a higher level because from what I have experienced is that people is on my establishment but they are not physically here. I actually have discussed this with HR because I am seeing all these people on my establishment and at the end of the day if you look at the facility it looks like you do have all the staff but you don't"* (ULM P 3: Interview MDHS Line Manager 3 OP MX.doc - 3:20). The Facility Manager is then under the impression that the decision to appoint in the facility was overwritten by either clinical or strategic demands managed at a district or provincial level.

However, a PHC Programme Manager described decision making as an inclusive process involving the relevant role players like HR and Finance and found that the decentralization to substructure level facilitates finalization of processes which improves decision making: *"I make decision on HR with my Line Manager, who is the director and often also with the DD Finance, because a lot of the decisions around HR has a finance implication. So those are mostly the people that I concur with when I have to make a decision"* (ULM P 1: Interview MDHS Line Manager 1 PHC MX.doc - 1:1).

In the case of the HR Manager, the newly appointed DD: HRM works closely with PHC Manager on the staff establishment. The PHC Manager also has to work closely with the ASD: HRM in the appointment process. The approved post listing is decided at provincial level for each district and then at a district level. Decisions are made by the district executive committee, this includes the District DD: HRM within the scope of what is sent from the provincial level. The district then sends the approved post list for each substructure and the PHC Manager has decision space entailing whether or not to appoint in that approved post, and for which facility, whereas the Facility Manager's decision space is limited to making a motivation for a post or not. In other words, the Facility Manager can make a motivation for a post to be filled in their facility but the PHC Manager can decide to place the person appointed in another facility or give the post to another facility. The decision making power is determined based on the ability to implement or not.

Table 4.11 depicts an example of the decision making space in relation to the appointment powers for different levels and structures in the Cape Town Metro District.

Table 4.11. HRM decision making space on appointments at different levels in the health system

Levels	Structures/Positions	Ascribed Role in human resource management practices	HRM Practices in the Appointment Process	Decision Making Power (High/ Low)
Province	Provincial HR Cluster	development	policies, prescripts, amendments	High
	Provincial Management Team	development, implementation, monitor, management	budget, post structure,	High
District	District HRM Office	monitoring, advising, supporting, oversight	policies, prescripts, amendments	Low
	District Management Team	management, monitoring, advising, supporting, oversight	allocation of budget, setting priorities, deviations in post structure, manoeuvrability in post structure	High
	HR Forum	discussion forum	clarification of policies and prescripts, hr issues	Low
Sub structure	Substructure Management Team (Director Substructure, PHC Manager, Financial Manager, DD HRM)	management, decision making, monitoring, advising, supporting, oversight	allocation of budget, setting priorities, manoeuvrability in post structure	High
	HR Meetings (PHC Manager, Finance Manager, DD HRM)	decision making management	motivations, appointments, post structure amendments	High
	HR Management/ Operational Meeting (HR Staff)	implement, advise, guide, information control	operationalising hr functions, (processes, clarification and implementation)	Low
Institutional/ Facility	Facility/ Operational Manager, Head of Departments	management, monitoring, oversight	motivations	Low

Priority Differences: Service delivery needs vs HR policy and prescripts

The two role players experience different priorities, where the HR Manager prioritizes compliance with HR policy and prescripts and the Line Managers prioritize health service delivery. The HR Managers expressed their concern about the non-compliance to HR policies and prescripts: *"the managers sometimes want to do things to satisfy the service delivery needs, and not always according to the book, as it should be done"* (UHR P 9: Interview MDHS DD Part 1.doc - 9:14). In fact, one of the HR Managers expressed that: *"They don't wanna bend the rules, they wanna break it completely"* (UHR P 9: Interview MDHS DD Part 1.doc - 9:10) to attain their objective of responding to service delivery needs.

The difference in priorities is expressed explicitly by one of the Facility Managers: "*I think the compliance to me is not the main issue but filling of my post to make sure that I have enough people on the floor*" (ULM P 2: Interview MDHS Line Manager 2 FAC MX.doc - 2:35). This constitutes a conflict of interest between the HR Manager and Line Manager, where the HR Manager prioritizes HR compliance and the Line Manager is more concerned with filling of vacant posts.

These conflicting priorities impact on the ability for the two key role players to align with one another to achieve the strategic objectives: *"... those are basically where we go head to head with the CEO's, or with other HR Officers, to say: but this is not how it should be done"* (UHR P 9: Interview MDHS DD Part 1.doc - 9:15).

Communication and reporting structure

The decentralization process and devolution of HR functions from district to substructure level created complex communication patterns, experienced differently in each substructure. In addition, the HR staff at district level had to choose to which substructure they wanted to move to[3], with the consequence that some substructures are more resourced than others. As the staff moved from district to substructure, the human resource management functions were devolved, depending on whether or not there were staff to perform these functions. Thus, the decentralization process accompanied by the devolvement of human resource management functions from district to substructure determined the capacity of each substructure to perform human resource management. The communication patterns became complex, as they differed between substructures, mainly because it depended on the capacity in both numbers and abilities of the HR staff to perform human resource management functions.

However, change and challenges in communication patterns were expected, specifically in relation to the District Office, as most communication was required to be sent straight to the established substructure office, with or without capacity, on account of decentralization. However, for human resource management, the devolution of functions to the substructure had the most impact on communication patterns, as HR matters went straight to substructure

[3] As part of the HR restructuring process, all district level HR staff were given choice letters to decentralise to a sub structure. The choice letter gave them an opportunity to choose the sub structure they would prefer to move to.

and not to the District HR Office: *"the communication between the substructure offices and the district office has changed now with the devolvement of the staff coming down. Now everything is not coming to the district office anymore"* (UHR P 6: Interview MDHS ASD 2.doc - 6:34).

Thus the complexity of the communication patterns lies in the capacity of the substructure specifically, whether or not the human resource management function has been devolved to the substructure office or remains with the District HR Office. The communication pattern is further complicated by the type of issue, and identifying the person to whom this responsibility has been delegated: *"... it depends what type of issue it is and who's got the delegation to deal with it. Then we approach it via that line of communication"* (UHR P10: Interview MDHS DD Part 2.doc - 10:67). For example, labour relations issues depend on whether or not the substructure has an ASD Labour Relations or someone capable of handling these issues, and if not, then all labour relations issues have to be addressed by the District HR Office. In one of the substructures, the DD HRM was delegated the responsibility of addressing labour relations issues, as there was not anyone else qualified to undertake labour relations. These complex communication patterns are mostly experienced by the health care service providers in finding the right person to address the HR issue of concern.

In addition, communication patterns are not being used consistently. For example, when you want to communicate with the HR Manager in the head office, it should be via the District Office; but head office can communicate directly with substructure/sub-districts and not go via the District Office: *"… interaction with head office itself umm… through our offices then to the substructure"* (UHR P4: Interview MDHS AD-DD3.doc - 4:18). In one of the HR Forum meetings, the issue was raised of the District HR Office being left out of the feedback loop on HR issues, because the provincial office contacted the substructure HR Office directly; here an agreement was reached on how to address the type of appointment but the information was not shared with the rest of the district; several other similar cases were on hold, awaiting feedback on how to proceed. In a counter argument, it was raised that "… *any request as far as staff establishment is concerned is dealt directly from the substructure through to the provincial head office; its only specific request that comes through this district office that is our role and responsibility*" (UHR P 4: Interview MDHS AD-DD3.doc - 4:94). This unclear line of communication regarding when HR issues must go through District HR Office, and when it is not necessary, adds to the complexity of the communication pattern for

the substructure HR Offices.

The communication between the Facility Manager and HR Manager is further influenced by the diversity of people when providing guidance on performing human resource management. In a multicultural and multilingual district like Cape Town Metro District, diversity needs to be acknowledged and considered when developing communication patterns and structures. South Africa's multicultural nature may have eleven official languages, but the Cape Town Metro District employees predominantly speak only three of the eleven languages; this adds to the complexity in performing human resource management. Though there is an awareness and appreciation of the different languages spoken in the Cape Town Metro District, one interviewee commented: *"The (verbal instructional) communication is bit of a challenge due to language barriers at times but I try and do things as practical as possible"* (UHR P10: Interview MDHS DD Part 2.doc - 10:55).

In addition, the language barrier is compounded by the diverse cultures of all the role players performing human resource management, with the expectation of working together to achieve the same objectives: *"We've got different cultures and diverse groups, sometimes you come into a situation and you don't know how to handle it and then you first have to think before you give an answer"* (UHR P 6: Interview MDHS ASD 2.doc - 6:9).

This is especially the case when there are distinct differences in the age of the team members with whom personnel work and to whom they delegate responsibilities. Interestingly, this is experienced in both younger and older teams. In the case of a younger aged team, it is experienced that they complete their studies and then they leave the HR structure for better job opportunities: *"They are young and thus you need to develop them. But once they do some advance course or going into a specialized field they are going to apply for the post outside. You are going to have vacancies and often it's difficult to replace the ones who have left"* (ULM P 3: Interview MDHS Line Manager 3 OP MX.doc - 3:22).

On the other hand, in an older team, sensitivity to change becomes the main barrier to communication: *"I'm also sensitive to the idea that these are the people that are 56 and 57 and are almost 60."* (ULM P2: Interview MDHS Line Manager 2 FAC MX.doc - 2:22). The implication is that Line Managers have to be sensitive in managing both the younger and older staff establishment as different approaches and strategies will be required to address their respective needs.

As a result, effective communication becomes vital to ensure good relationships and maintain effective human resource management. Findings on the communication patterns identified several challenges and some barriers to effective communication. The main challenge is the complexity of the communication pattern, as different variables influence how it is determined and implemented; this makes it difficult to control. The biggest impact of complex communication is difficulty sharing information specifically in relation to standardising HR practices and solutions to address HR issues raised. However, a reporting line provides the means to fill this gap in creating standardization, creating common understandings and shared solutions in addressing issues raised in human resource management.

In terms of the reporting structure, a clear and contextual reporting line is required in establishing structure, as it delineates the powers and influences over implementation practices and accountability. The reporting line impacts on the ability of the Deputy Director HRM to standardise and manage the implementation of HR protocols. The reporting line of the Substructure DD: HRM is to the director in the substructure office and not to the director of HRM in the District Office: "*... the technical arm is with the district office and the reporting line is with the director*" (UHR P 5: Interview MDHS ASD 1.doc - 5:58). Thus, there is no accountability for non-compliance to policies and procedures as there is no reporting line to the DD: HRM District Office.

Furthermore, the Hospital DD: HRM reports to the Hospital Director and not to the Substructure DD: HRM. The extent of the impact of reporting is illustrated by the following description of a situation that needed addressing within a substructure: *"The District DD: HRM had to intervene and tell the Hospital DD: HRM that they had to work via substructure office and he had to explain to them what the role of the substructure office is"* (UHR P 6: Interview MDHS ASD 2.doc - 6:51).

A complex reporting situation is created when there are three reporting structures (District, Substructure, Hospitals) in a District HRM Programme undergoing a decentralization process as depicted in Figure 4.10. Communication and reporting line. The root cause of this aspect of the reporting problem is that the District Management Structure according to the Comprehensive Service Plan 2010 places hospitals and other health institutions under the substructure management structure, but in reality, the reporting line of a Deputy Director

HRM placed at a hospital remains with the Head of that hospital and not with the Substructure Management Structure.

The next diagram aims to demonstrate the HRM Programme Management Structure in the Eastern-Khayelitsha Substructure. The diagram illuminates the complexity of the HRM management structure in two forms: the first form is within the hospital structure where HR staff report to the CEO of the hospital and not the DD: HR at the substructure office; the second is the unofficial reporting line between the DD: HR at substructure level and the DD: HR at District Office HR. The reporting line of the Substructure DD: HR is with the Substructure Director, who is overall in charge of the substructure.

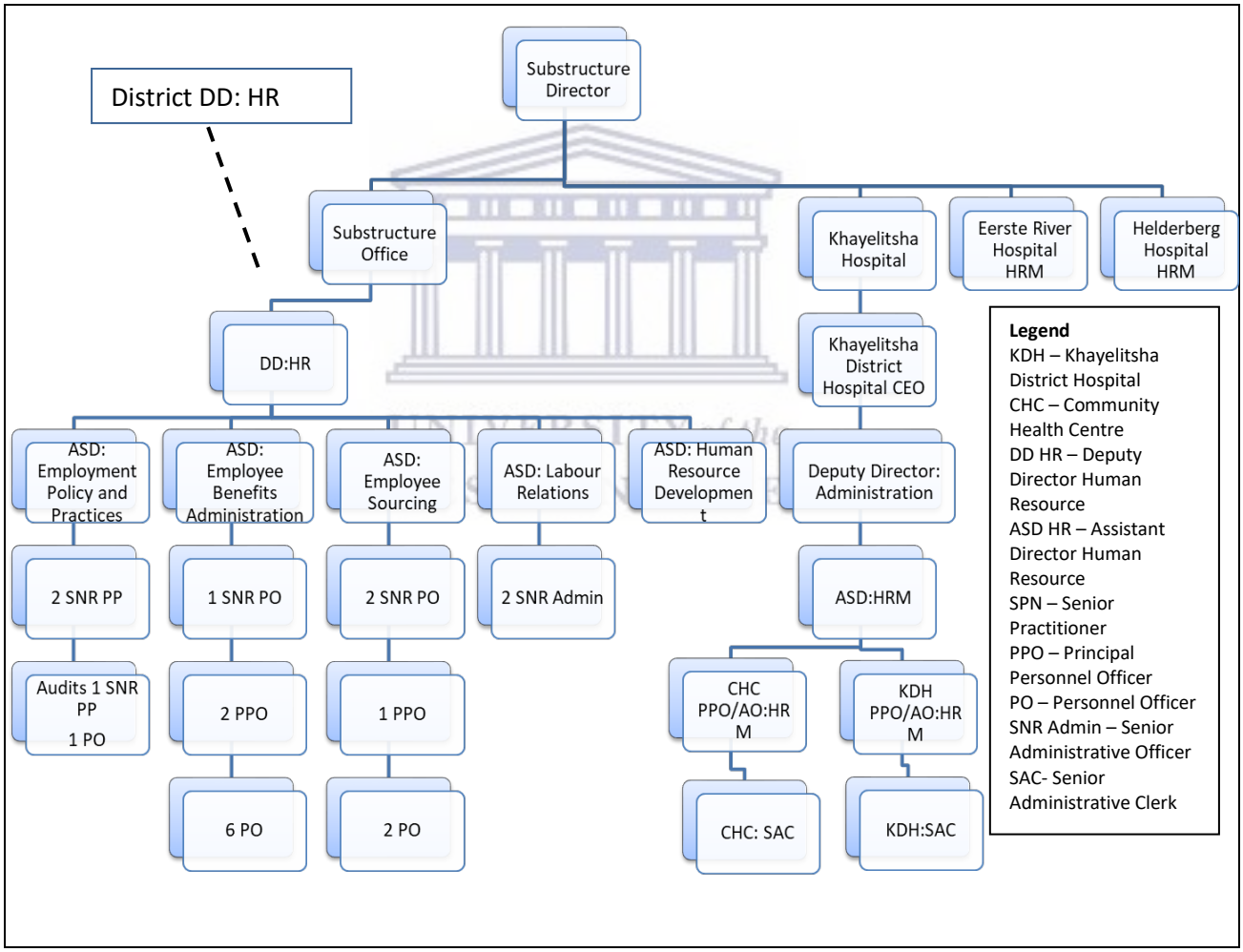


Figure 4.9. Eastern/Khayelitsha HR management structure

The first complex configuration is between Hospital HRM and Substructure HRM and the second between substructure and district level HRM. The complex configuration can be seen in this diagram, with the dotted line implying some accountability for compliance and

implementation of HR policies and procedures.

This specific configuration of the reporting line impedes the performance of human resource management functions, as it allows for the two Deputy Directors: HRM and Hospital to approve different HRM decisions, and to provide different directions for HRM in the substructure.

The diagram below, Figure 4.10. Communication and reporting line illustrates the complexity of communication patterns between the different levels and people in the human resource management structure in the Cape Town Metro District. It is expected that a reporting line runs parallel with communication patterns to receive instructions, communicate and for accountability. The communication patterns are depicted between the different levels and people, highlighting the reporting structure of the HRM programme where the HR Manager does not report to the HR Manager on the next level, but to the Health Manager on their own level in the district health system structure. The diagram presents a snapshot of the complexity of communication patterns and reporting structure of a HRM Programme.

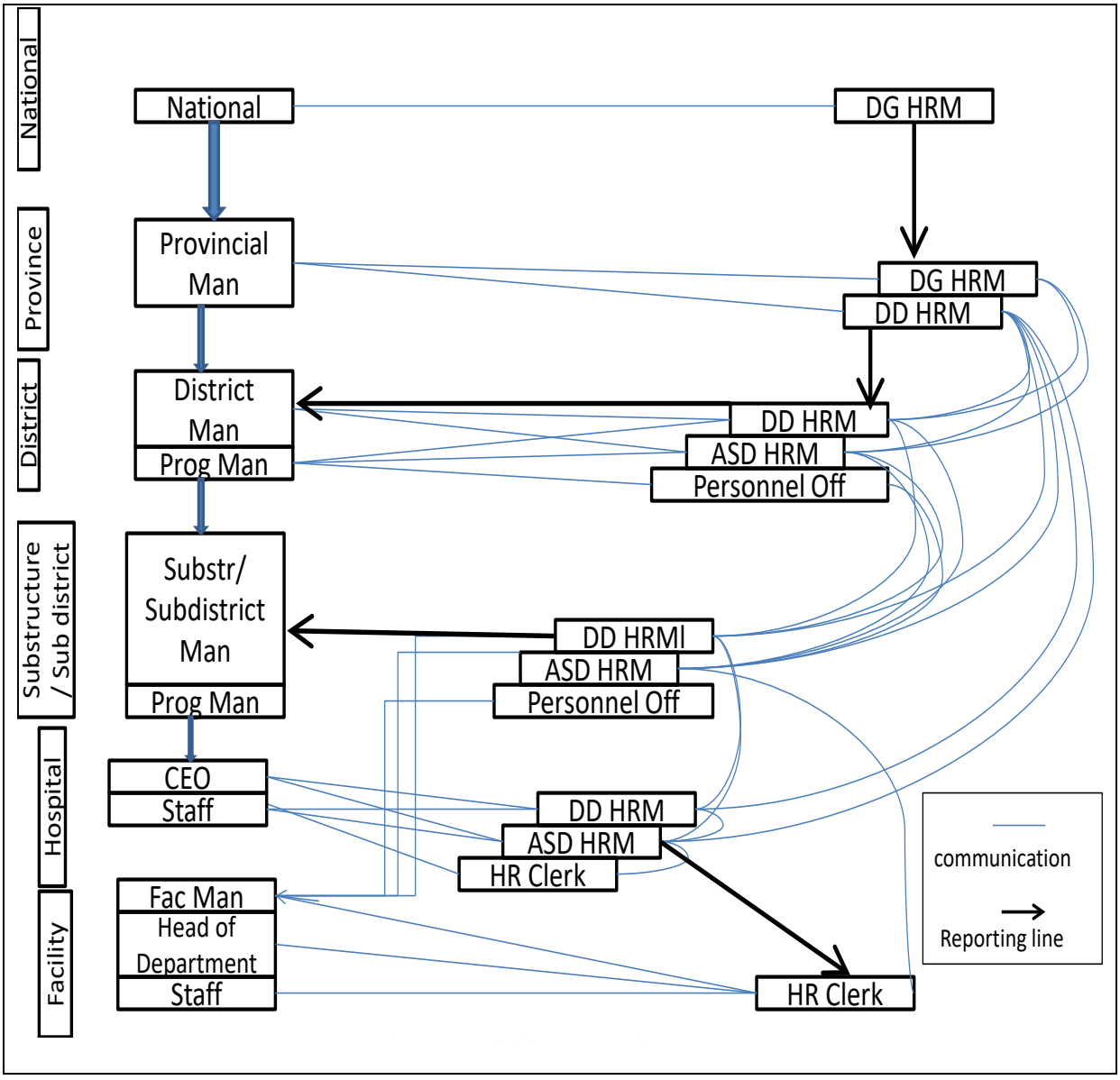


Figure 4.10. Communication and reporting line

Role confusion

Role confusion has manifested in this case study in two ways: the implementation of HR practices and responsibility shifts.

Initially role confusion manifested during the devolution process, where the decentralization of the HRM Programme from the District Office to substructure office led to the implementation of the new HR structure, with several implications. The implication with the greatest impact is the lack of capacity of existing HR staff to perform the specialised roles and tasks delegated to them within the substructure. The District HR Office responded to this

lack of capacity by devolving human resource management functions over time, instead of all at once, depending on the abilities of the HR staff at the substructure office, playing a: *"... supporting role to let the substructure run smoothly. Slowly but surely we will give those type of functions over and they can run with in"* (UHR P 4: Interview MDHS AD-DD3.doc - 4:198). The handover process is still ongoing, the process was initiated less than two (2) years ago, as substructures are still in the process of developing their capacity to take on all the HR delegations still performed by the District HR Office.

Another response from the District HR Office was to build the capacity of the substructure staff through a transfer of knowledge and experience in operationalising HRM functions that were previously undertaken by the District HR Office. For example, the bursary application process highlighted the complications of the devolution process and the need for capacity building in performing a specialist approach in HR: *"The biggest challenge, last year I think, was with regards to the bursary application process because bursary application process was, basically fell in our laps. As this handover was taking place, so then there was major chaos but we have now already put something in place for this year so this year it should go a lot better than it did last year"* (UHR P10: Interview MDHS DD Part 2.doc - 10:35). A dedicated person was identified to take on the bursary application process and training was received from the one of the ASD's at the District HR Office to prepare this person to perform this function.

Once the functions and people were devolved, role confusion was identified between the HR Manager and Facility Manager even though job descriptions for each role player were developed. The HR Managers expressed their confusion as being unclear on the new roles and delegations, and waiting for further instructions to clarify roles and responsibilities: *"The HR delegations were not clear, specifically on what to delegate to who and whose delegation lies where with regards to signing off of documents. I don't know what my role really is"* (UHR P 6: Interview MDHS ASD 2.doc - 6:60). It was also identified by one of the Facility Managers who stated that *"I think there is a lot of overlapping at the moment there is a lot of things that I think I'm doing and that the HR is supposed to be doing"* (ULM P2: Interview MDHS Line Manager 2 FAC MX.doc - 2:39).

At the time of the study, the devolution process was being initiated and structures and delegations were being put in place, which raises the question, to what extent these

implications are merely start up challenges as opposed to fundamental flaws in decentralising the HRM Programme. The restructuring process introduced a new HR structure but the HR practices have not changed, besides taking on a specialist approach. The embedded case described earlier in this chapter (*Embedded Case 1: Leave application*) describes role confusion inherited from the previous structure and still in place. For example there is role confusion on who approves leave, if the Facility Manager has to contact the HR Manager to confirm the number of leave days available. The lack of capacity is still ongoing, and thus not a teething problem, as two budgeting cycles have passed and no change in capacity has occurred. The HR delegation remains unclear as it is dependent on the capacity of the substructure: thus as long as the substructure does not have the full staff complement according to the revised HR structure, the full range of HR delegations cannot be devolved to substructure level.

The impact is upon effective operation of human resource management functions which in turn impact on health service delivery; for example, if time delays are being experienced as a result of procedural issues, this not only impacts the morale of the employees but also the ability to perform the health service.

The second way in which role confusion is manifested in this case study is through the responsibility shifts occurring in three different ways, mainly as a result of the decentralization of the HRM Programme from district to substructure. The first responsibility shift is the devolution of the HRM functions from the District Office to the Substructure Office, where some HR delegations have been handed over but some have been retained in the District Office as a result of capacity constraints.

The second responsibility shift is the transfer of responsibilities between the HR Manager and the Line Manager. An example of the transfer of responsibilities between the HR Manager and the Line Manager is the exit interview. The exit interview which was previously the responsibility of the Line Manager, for example, will now form part of the responsibilities of the HR Manager: *"There is going to be a new policy on the exit interview. Obviously the old didn't work; the Line Manager didn't take responsibility, not all Line Managers. I don't think it's a question that they didn't assume responsibility I think that they couldn't see what value was added"* (UHR P 4: Interview MDHS AD-DD3.doc - 4:128). Another example is a proposed shift of responsibility, the compilation of the job description, which is currently the

responsibility of the HR Manager: *"HR must assist with job description; it's also a responsibility of each Line Manager as this is an agreement between you and that specific individual"* (UHR P 4: Interview MDHS AD-DD3.doc - 4:118).

The implementation of the new HR structure brings about opportunities for other fundamental changes when looking at human resource management being performed by two role players, and where which responsibility should lie. The argument around this is that the Line Manager is the person the employee reports to, and thus should take on specific human resource management functions that previously were the responsibility of the HR Manager: *"anything around the employer itself they try to sort of shift instead of managing. The person actually report to you direct so you in a position to address certain things otherwise get the information and feed it back to the employee"* (UHR P 4: Interview MDHS AD-DD3.doc - 4:133).

The responsibility for actual and proposed shifts are compounded by the shift in responsibility of the compilation of the Compliance Managerial Instrument (CMI) which was the responsibility of the HR Manager to compile. However, this managerial checklist which has been in place for several years, has been recently revitalized and the responsibility and accountability has now been placed on the Line Manager to complete it. *"…the game has changed a bit, Line Managers must now actually give their inputs, because it is their checklists, not HR's checklist"* (UHR P 9: Interview MDHS DD Part 1.doc - 9:4). Though this process has been put in place, it has not yet become the Line Managers' responsibility thus causing role confusion and misalignment within HR components. The Facility Managers noted during the interviews that they have never seen it before but the PHC Managers acknowledged their awareness of the checklist although they have not taken responsibility for it yet.

The final responsibility shift is in relation to the HRM approach which has shifted from a generalist to a specialist approach. This responsibility shift was previously discussed under the subheading Context highlighting the change of focus in the HRM approach.

Moreover, role confusion can also be ascribed to past experiences of how human resource management functions were performed previously, because things are being done the same way it was done in the past. A mind shift is therefore required: "*The managers also still need*

to get accustomed to the human resource management practices, we have always been doing it with the District HR Office. Now it's just that changeover that has to take place, that mind shift" (UHR P10: Interview MDHS DD Part 2.doc - 10:19).

Role confusion has manifested itself through the implementation of the new HR Structure and the various responsibility shifts occurring as part of the decentralization of the HRM Programme and the implementation new HR Programme. Consideration has been given to whether or not these problems are associated with any restructuring process and thus will be overcome, but the data suggests that these are in fact not teething problems. The challenges appear to be brought across from the previous HRM Programme and thus, if not intentionally identified and addressed, could lead to an ineffective HRM system and poor health outcomes.

Up until now, the factors described posed challenges or hindrances to effective human resource management in a DHS. The next factor is an enabling factor as it was identified as key in health sector reform, specifically in change management and strategy implementation.

Leadership as an enabling factor

This case study has revealed the areas that could be improved upon and focussed on identifying the areas of misalignment; however, the case study has identified a positive aspect as an enabling factor. Leadership is considered an enabling factor for any health sector reform. Leadership is the key to successful health sector reform; the findings of this case study concur with this assertion, inasmuch as it emerged that leadership is in fact considered by the interviewees as an enabling factor to the successful implementation of the HRM Programme restructuring process. Leadership with a specific emphasis on being able to delegate and support were identified as key enablers; in some instances, it is the differences between the substructures which are recognized and better functioning is ascribed to the leadership qualities of substructure management: "*certain substructure they have more support more knowledge but also leadership*" (UHR P 4: Interview MDHS AD-DD3.doc - 4:110).

The leadership approach that showed to lead to success included being strategic, participatory, a good communicator and giving feedback: "*... it's strategic, we do planning and how we can assist one another. We look at how to take this team forward not for the individual, not for that component but taking the substructure forward. The Director of the*

Substructure is giving us regular feedback at all the meetings, I don't know if other directors do that" (UHR P 5: Interview MDHS ASD 1.doc - 5:103).

Furthermore, this type of leadership was elaborated to include taking ownership and responsibility, which were identified as key determinants for successful implementation of the new HR structure: "*it was also a question of being responsible and taking ownership. You make sure that things run smoothly so parties were not left to their devices and they have to work together"* (UHR P 4: Interview MDHS AD-DD3.doc - 4:171).

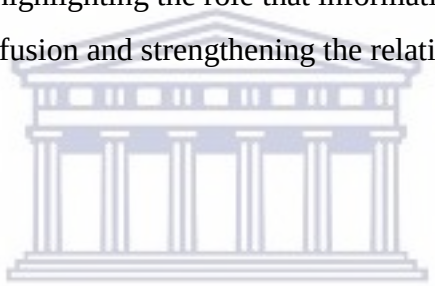
However, it is important to take cognisance of the fact that where leadership was identified as an enabling factor, the substructures concerned did not experience the same budget constraints as some of the other substructures, which created a more enabling environment for successful implementation of the new HR structure. Though leadership is considered key to the successful implementation of health sector reform, there are not withstanding, other requirements for success. Next, the West Coast District Case Study will be presented.

4.3. RESULTS: CASE STUDY 2 – THE WEST COAST DISTRICT

The West Coast District case study is the second of the two case studies developed for this study, and presented as part of the Results. This case study follows a similar structure and layout to the Cape Town Metro District case study presented in Chapter 4.2. There are two important differences, however, in the restructuring approach of the West Coast District: their HRM Programme remained centralised at district level; and primary health care (PHC) facilities continue to be managed by District Hospitals and not sub-districts.

After describing the restructuring process, the roles of key HR and Line Managers and their respective roles and functions in human resource management are analysed. Though very similar to the Cape Town Metro District in terms of HR practices, there are important differences which impact HR practices. The district case study concludes with the factors influencing the HRM system, highlighting the role that information management could perform in addressing role confusion and strengthening the relationship between the HR Manager and Line Manager.

4.3.1 **Context**



At the time of the study, the West Coast District had a population of 314 926; to serve this population it had 27 fixed Primary Health Care (PHC) facilities, 42 non-fixed PHC facilities and seven District Hospitals supported by a total public health workforce of 1 210.

The Comprehensive Service Plan (2010) states that mobile and satellite clinics, clinics and CHCs would be allocated to the envisaged infrastructure in each sub-district of the rural health district. However, as described in Chapter 4.1, in the West Coast, primary health service delivery is managed by the District Hospitals and not a sub-district structure, with a PHC Manager in charge of all the Community Health Centres allocated to the District Hospital (Figure 4.2. Rural Health District Management Structure).

The HRM Programme is located at district level and is responsible for authorizing and approving all Human Resource (HR) matters. Figure 4.11. West Coast District HRM Programme below illustrates how the HRM Programme operates in the West Coast. The seven District Hospitals are each staffed with a HR Manager on salary level 8-9 with HR staff

on salary levels 5-7 to provide HR Management functions to both hospitals and Community Health Centres.

It has to be acknowledged that the West Coast District experienced a major staff turnover with more than 60% of their experienced HR staff leaving the District Office to the hospital level or leaving the district completely. This is important because opportunities had to be created to fill these critical vacated posts through internal promotions, as well as employing new staff members to the staff complement. The District HR Office has been successful in acquiring a full HR staff complement, with the exception of one post at the time of the study, as indicated in the figure below. Thus, the West Coast District HRM Programme is not experiencing the same challenge of HRM staff shortage as the Cape Town Metro District.

Noteworthy, is that in the West Coast District, the HR Clerk (level 5) placed in the public health facility frequently performs multiple roles, which could be as an administrative and/or financial clerk and/or human resource management role, depending on the needs of the facility. This is important because it signifies the absence of a dedicated HR person at a PHC facility level to respond to and address HR issues and concerns, thus placing all responsibilities on the Hospital HR Manager. All public health workers would have to contact the HR Manager at the hospital level to address HR matters, queries and concerns. One implication of this is that if the HR Manager is not on duty or absent for a period of time, there would be considerable time delay in addressing HR processes and procedures, as there is no other person appointed to perform these processes.

The HR structure at hospital level is similar to that of the Cape Town Metro District, the difference being the decentralised point. The West Coast District does not have decentralised HRM, but has increased HR delegations to the hospital level. However, the majority of HRM functions performed at the hospital level must still be authorised at the district level, as it remains a centralised system. The figure below aims to provide a snapshot of how the HRM Programme in the West Coast District is structured, illustrating not only the two reporting lines but two HR functioning lines.

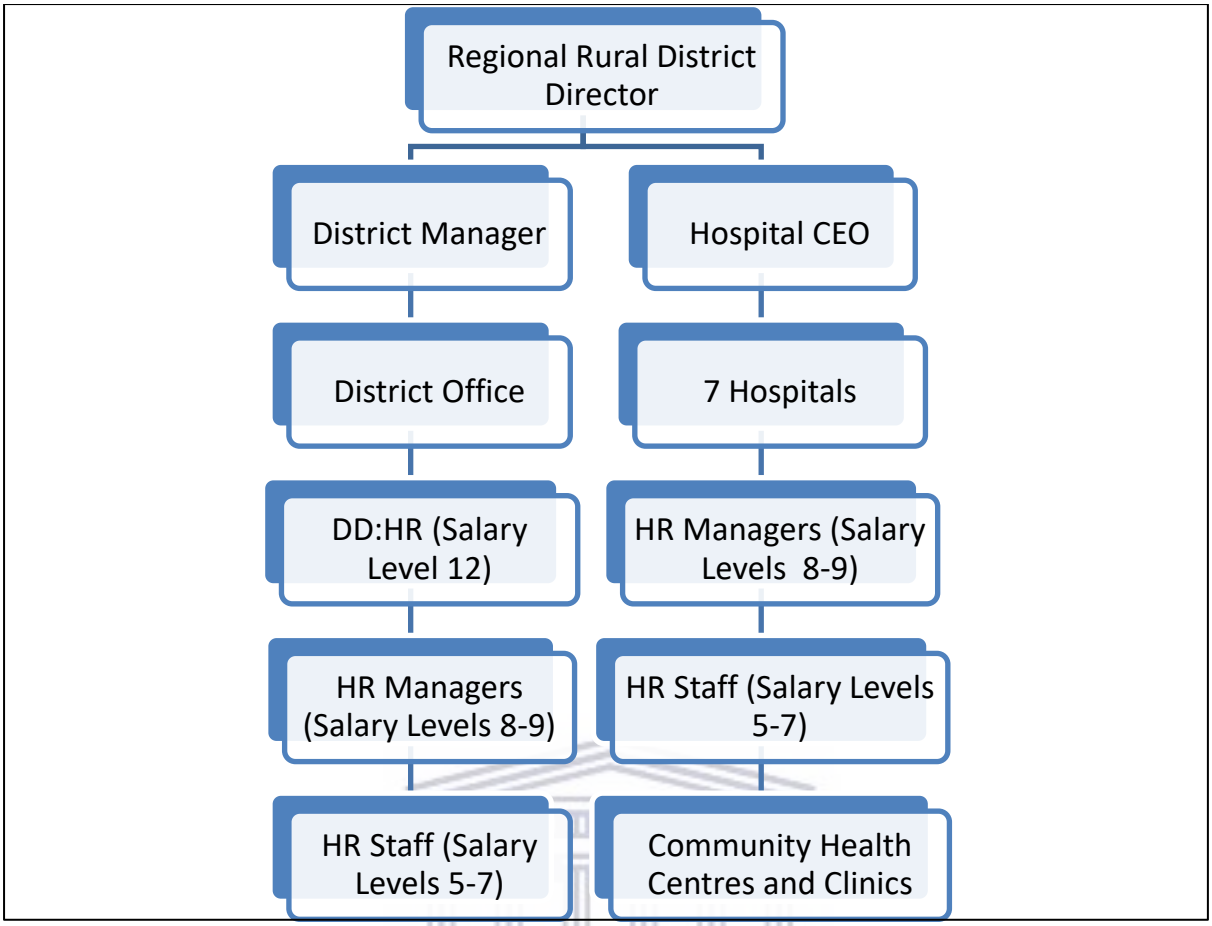


Figure 4.11. West Coast District HRM Programme

The District HR Office is staffed by a Deputy Director (DD) Human Resource Management (responsible for the entire district) and four Assistant Directors, Human Resources (ASD: HR), accompanied by supporting personnel illustrated in Figure 4.12: West Coast District Office HRM Programme Organogram

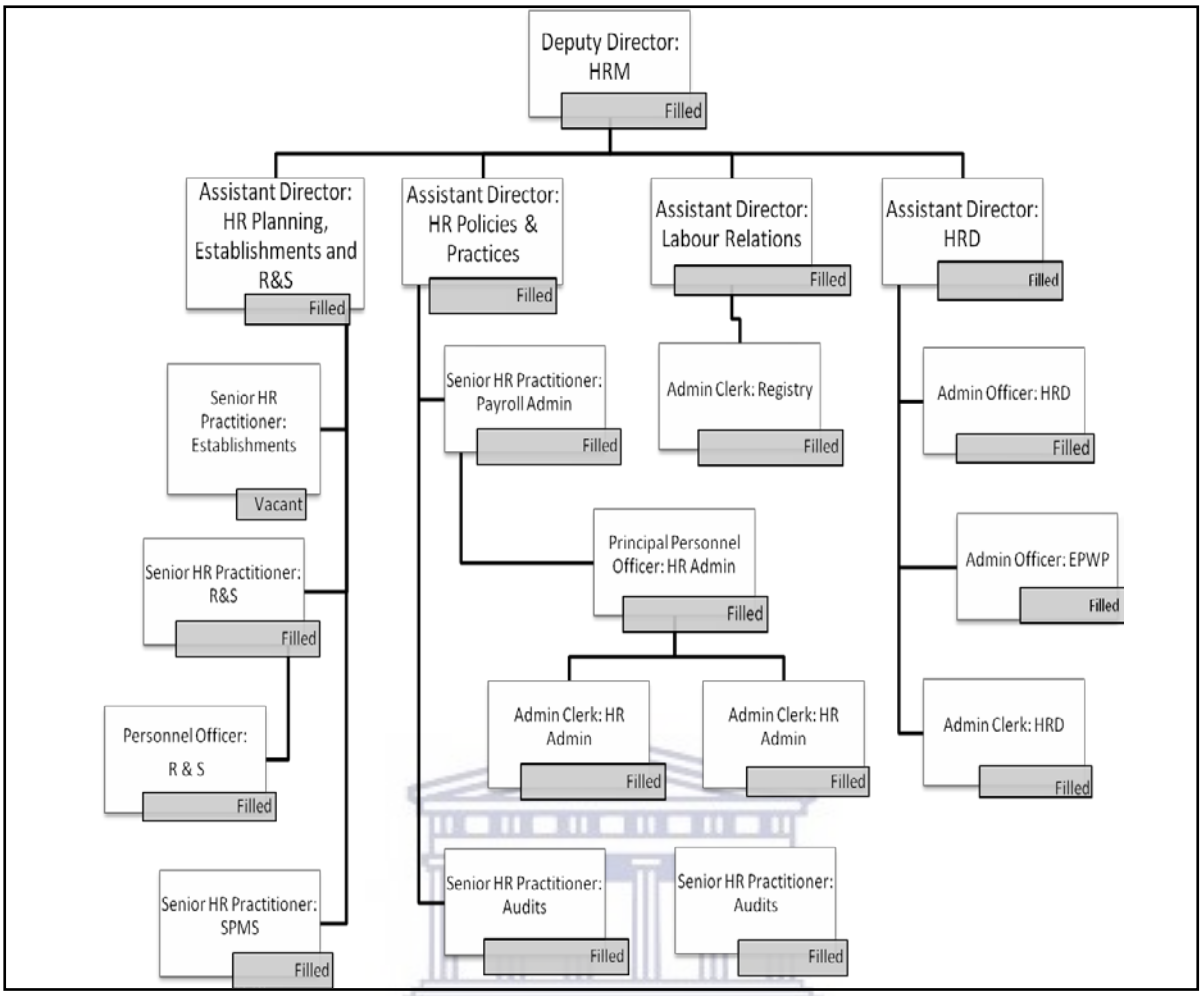


Figure 4.12: West Coast District Office HRM Programme Organogram[4]

The District HR Office functions as the central hub for the majority HR formal practices. In other words, all HR transactions need authorization and approval from the District HR Office. The Deputy Director claims that even though "*the bulk of the functions are still centralized* [at District level]*"* (P 7: WC DD HRM Manager1.doc - 7:43), there have been movements towards decentralization with *"very strong outreach support and control depending on the level of autonomy and capacity of that specific sub-district"* (P 7: WC DD HRM Manager1.doc - 7:54).

The main argument for centralising the HR System is to create standardization in the West Coast District: "*everything that they* [District Hospital HR Managers] *do must be approved or not approved by me or must be recommended or not recommended by me so that we are*

[4] Explanation of abbreviations: R&S – Recruitment and Selection; SPMS – Service Performance Management System; EPWP –Expanded Public Works Programme.

working in a standardized way across the district" (P 7: WC DD HRM Manager1.doc - 7:142).

When the West Coast District restructured the HRM Programme, the focus was not on the devolution of HR functions to the hospital level, but on compliance to HR policies and procedures. The district decided to remain centralised, thus retaining its District HR Office, and to delegate more HR functions to hospital level but not dissolve the District Office and its centralised function. The district prioritized compliance as a focus of restructuring, illustrated by the creation of the two new funded posts focussing on audits. This decision appears to be in response to the findings of the unqualified HR audits[5] for the previous two years, experienced by the district. This led to the creation of two new posts adding to the existing post structure: two Senior HR Practitioners: Audits (commonly referred to as HR Compliance Officers). These new posts are reflected in the post structure in the diagram Figure 4.12: West Coast District Office HRM Programme Organogram depicted in the HR Compliance, Policy and Audit Component. The main mandate of these newly created posts is to ensure compliance to HR policies and prescripts, to ensure clean audits.

The drive to achieve clean audits is further supported with a renewed emphasis on the implementation of existing tools to monitor compliance of HR policies and procedures: these are the HR Compliance Monitoring Instrument (CMI) (**Error! Reference source not found.**) and Quarterly HR Audit Action Plan. These mechanisms are considered to be effective tools to improve compliance to the HR regulatory framework, as well as to ensure compliance with HR practices by HR practitioners, HR Managers and Line Managers (Western Cape Health Government, 2013). The tools are, however, dependent on information to update the progress on the action plan and the indicators prioritised in the CMI.

In the West Coast District, both these tools are compiled and monitored by the HR Managers at the hospital and the District Office. This is similar to the Cape Town Metro District, though both districts indicated a shift of the CMI tool from the HR Manager to the Line Manager, and both districts are still in the process of implementing the shift.

[5] Unqualified HR audits are conducted annually on compliance on HR practices by HR Managers and Line Managers.

4.3.2 **Institutional actors**

In this district, the HRM of the public health sector is performed by two main role players: Human Resource Managers and Line Managers. The HR Managers will be described first, followed by the Line Managers. The term Human Resource Managers is used to describe HR staff on a Level 8 -12 salary level: they may however have different job titles (Senior Personnel Officer, HR Practitioner, HR Manager, Assistant Director: HR, Deputy Director: HR).

The profile and roles of HR Managers

In the West Coast District, the majority of the HR Managers have qualifications at tertiary level, with only a few having not more than a Grade 12 (school leaving) qualification. Their qualifications are summarised in Table 4.12 below. However, it is important to note that not all the tertiary qualifications listed are in human resource management.

In addition, upon further investigating whether a HR Diploma is considered a requirement for a HR Manager, a Manager replied: *"no a diploma in HR gives you an edge"* (P 1: WC HR Manager 2.doc - 1:114); another noted: *"They have changed it now, yes, previously it wasn't but they want to professionalize HR now"* (P 1: WC HR Manager 2.doc - 1:115).

Table 4.12. West Coast District HR Managers' job titles and qualifications

Job Title	Grade 12	Diploma	Degree	Total
Hospital Secretary	1			1
Senior Administrative Officer	1			1
Chief Personnel Officer			1	1
HR Practitioner		1	1	2
Senior Personnel Practitioner	1	1		2
Assistant Director: HR	1	2		3
DD: HRM			1	1

In Table 4.13 below, only two of 11 HR Managers have more than 5 years' experience because the HR Programme experienced substantial staff turnover in the year preceding the research. It is noted that limited years of experience could influence the capacity of the HR Managers to perform the human resource management functions. Historically, the

effectiveness of the HRM Programme depends on the experience of the HR staff in the programme, and not qualifications in the field, and it is only that a qualification is required for this position.

Table 4.13. West Coast District HR Managers' age and years of experience

Age	Years of experience		Total
	0-5yrs	5-10yrs	
25yrs	0	0	0
25-30yrs	3	1	4
30-35yrs	3	0	3
35-40yrs	0	0	0
40yrs	3	1	4
Grand Total	9	2	11

In the West Coast District, HR Managers work on two levels: the District Office and the District Hospital (as illustrated in Figure 4.12 above and Figure 4.13 below). The implication of the two levels is that it creates two different reporting lines, where one HR Manager reports to the District Office and another HR Manager reports to the CEO of the hospital. The challenges facing these two different reporting lines will be further described under factors influencing HRM.

Figure 4.11 and Figure 4.12 above highlight the different placements and levels in the public health system in which a HR Manager on the same salary could be functioning. The significance of this is the roles and responsibilities ascribed to the HR Manager in the two organograms. At a district level, the HR Manager has more HR responsibilities and authorization of HR functions, whereas at the hospital level the HR Manager has HR delegations, and no HR functions; HR Managers at hospital level can also not authorize HR functions thus only perform HR processes.

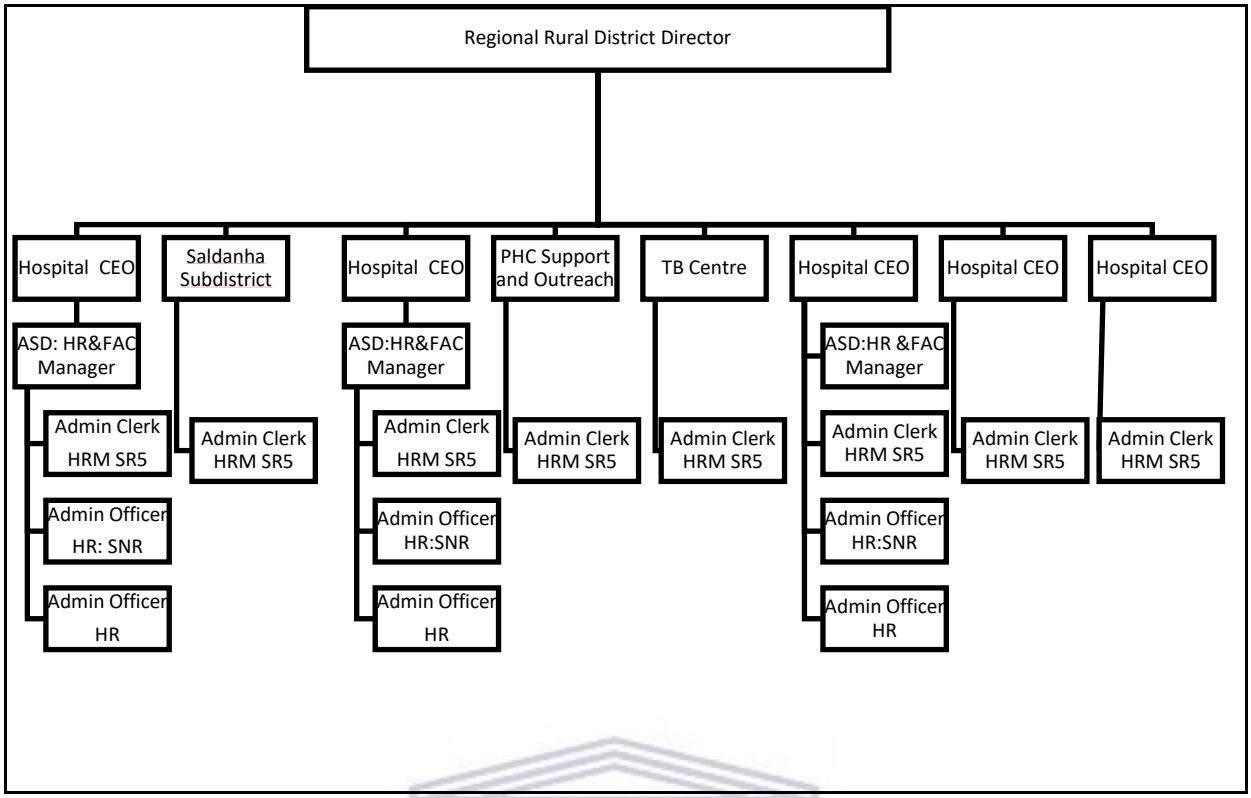


Figure 4.13. West Coast District Hospital HR staff organogram

Furthermore, the West Coast District's HR Managers occupy an array of different job titles, qualifications and human resource management experience. As in the case of the Cape Town Metro District, HR Managers on salary level 8 were also found to perform similar HR responsibilities to those on salary level 9. In the West Coast District, in contrast to what was found in the Cape Town Metro District, job titles are not directly associated with salary levels. For example, a Senior Personnel Practitioner can be on the same salary level as an Assistant Director HR. The HR Managers on salary levels 8 and 9 in different job titles work together, and have to perform similar HRM functions. In both districts, it was very difficult to find a complete distinction between HR Managers on salary level 8 and HR Managers on salary level 9, which brought the researcher to the conclusion to group the job titles on the two salary levels together and refer to the group as irrespective of their individual job titles.

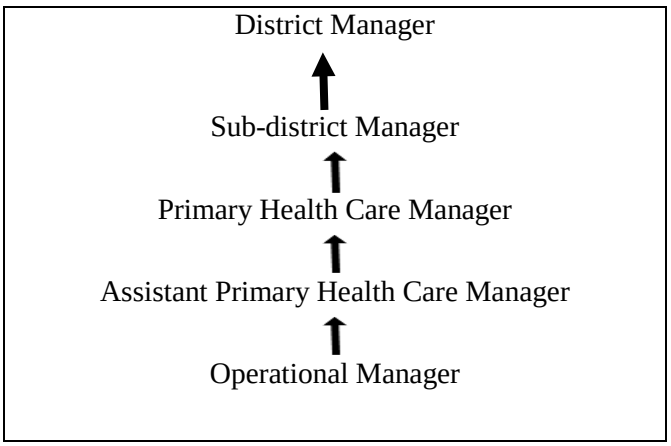
Comparing the job descriptions of an Assistant Director HR (ASD HR) and a Senior Personnel Practitioner in the same HR component (**Error! Reference source not found.**), it was found that a Grade 12 and not a tertiary qualification in HRM was the stipulated qualification requirement for both job descriptions. The comparison further revealed different functions performed by these two HR staff in the same HR component, reflecting no

duplication and no clear overlap of HRM functions; instead it reflects how the one job description feeds into the next job description in specific relation to having to conduct the activity, and having to oversee the activity. The Senior Personnel Practitioner, in this case, deals with the information on Persal in terms of processing, approving and authorising HRM functions, for example leave and overtime pay. The ASD HR on the other hand has an oversight role and receives the reports of the entire district with the role of monitoring and evaluation. The implication for this is that the health worker has to work with both these HR Managers depending on the type of HR matter, concern or query.

HR roles of Line Managers

The Line Managers in the HRM System have been identified, alongside HR Managers, as the other key role player in HRM. The Line Managers in the West Coast District are Operational Managers, Assistant PHC Managers, and PHC Managers. The Line Managers referred to are mainly female nurses with extensive experience, working in the frontline of the public health system. The list of Line Managers presented below is not exhaustive and only represents the range of Line Managers considered for this district case study in relation to their HRM functions.

The box below depicts five levels of Line Managers in the hierarchy of Primary Health Care Services in the West Coast District[6].



Box 4.6. Simplified list of Line Managers in the West Coast District

[6] It is important to note that the reporting hierarchy varies from facility to facility, depending on the size of the facility. The diagram is therefore a simplification of a more complex pattern.

Table 4.14. Job purpose of Line Managers

Type of Line Manager	Job Purpose
Operational Manager	To manage and render a Comprehensive PHC Service in a PHC Facility and to make use of a holistic approach.
Assistant PHC Manager	Effective implementation, coordination and support of programmes in an integrated PHC service in the sub-district.
PHC Manager	To manage and co-ordinate the Personal Primary Health Care Services within the district health system in the two sub-districts.

(Source: Operational Manager Job Description, Assistant PHC Manager Job Description, PHC Manager Job Description of the West Coast District)

Using the above structure, this research selected the Operational Manager, PHC Manager, and Assistant PHC Managers as the Line Managers in human resource management because they are considered the frontline for the managing of the public health workforce. This section continues by elaborating in turn each Line Manager's role and responsibilities in HRM listed in Table 4.14 above.

According to the job description of the Operational Manager in the West Coast District, 80% of their time is allocated to clinical duties, and more specifically patient care, and 20% to the effective and efficient management of the PHC facility, mobiles and satellites[7].

This 20% of the Operational Managers' time has to be spent on effective people management, information management, infrastructure management, and liaison with relevant stakeholders.

However, in reality, even less time is spent in management: *"but most of the time I do patient care. I want to actually say so about 1% I can yield to admin"* (P1: WC Line Manager 1 OP MX.doc - 1:6).

The main reason for this difference between what is prescribed in the job description of the Operational Managers to perform their administrative and HRM functions, and what is

[7] PHC mobiles are when public health services are being provided from a vehicle and PHC satellites are temporary facilities using a property on certain days or for a certain amount of hours per day to provide public health services.

performed in reality, is their capacity to perform these duties. This capacity comes into question as they have limited expertise and experience in HRM. In fact, the PHC Manager said that Operational Managers have not been trained or delegated these HRM responsibilities: *"They are not equipped to be Managers. I think they've been working in the clinics as Clinical Nurse Practitioners and then came in the Occupational Specific Dispensation (OSD) and they were put in those positions, without being equipped"* (P 3: WC Line Manager 3 PHC MX.doc - 3:22). Because Operational Managers in the West Coast District are mainly doing clinical work, the extent of human resource management functions is limited to planning leave; however they are not delegated to approve leave, due to their limited decision making powers, and have to refer health workers to the relevant people on HR issues, as they do not address these.

Thus, the HRM expectations of the Operational Manager are mismatched, there is a difference in prescribed expectations in their job description, and what they actually perform in practice. The main implication for this is that the administrative duties and specifically the HRM responsibilities are therefore transferred to the Assistant PHC Manager and PHC Manager.

The following table provides a snapshot of the Assistant PHC Managers' job description, where only 10% of their time is allocated to HRM, and this time has to be shared with the management of other resources as well.

Table 4.15. Summary Job Description of Assistant PHC Manager West Coast District

Key Area	**Time allocation**
Monitoring and Evaluating PHC Services	40%
Operational Management and implementation of PHC services in sub-district	25%
Effective management of resources	10%
Quality Assurance	15%
Liaison in micro and macro environment	10%

(Source: Assistant PHC Manager Job Description)

The 10% allocated to "effective management of resources" includes the following:

- Overseeing of Non-Profit Organizations; expenditure and claims
- Effective management of assets

- Effective people management including:
    - Leave planning
    - Recruitment and selection
    - Performance management
    - Labour relations
    - Employee Assistance Programme
    - Induction and orientation of all new appointees

In summary, the responsibility for performing HRM functions in the West Coast District lies with the Assistant PHC Manager or PHC Manager: "… *for HRs all of the clinics report to me* [Assistant PHC Manager] *when they have staff shortages they report to me, then I will try to sort something out. I also do leave, the leave comes from the facility to me, then I authorize, then give it to the Primary Health Care Manager who authorizes it. The Operational Manager must give the year planner so I look at that. All of the nurses, we must renew our licenses every year so I check that. Contracts maybe come via us so if we have contracts we have to report them. I do interviews. I do motivation*" (P4: WC Line Manager 4 Assistant PHC MX.docx - 4:5).

In comparison, the PHC Manager's job description (Table 4.16) includes financial management and strategic management, which are not specified in the Assistant PHC Manager's job description.

Table 4.16. Summary job description of PHC Manager in West Coast District

Key Area	**Time Allocation**
Financial management (monitoring and evaluating expenditure)	20%
Operational and strategic management	20%
Management of all Health Programmes and implementation of health policies (monitoring and evaluating of new and current policies)	10%
Liaison and interaction with specific and general environment (public speaking, district and facility board meetings, media)	10%
Clinical and support services for all the public health facilities within the sub-district	20%
Human Resource Management	20%

The job description of the PHC Manager stipulates the following HR activities and HR deliverables represented in the table below.

Table 4.17. HR Activities and HR deliverables of PHC Manager, West Coast District

HR Activities	**HR Deliverables**
Participate in all HRM meetings in the district	Appointment of HR within budget constraints and CSP (Comprehensive Service Plan)
Direct all HRM sub-district meetings	Ensure appropriate HR, LR and disciplinary procedures and practices
Direct meetings	Plan, co-ordinate and motivate skills development of staff according to Personal Development and service needs
Keep abreast with HR developments	Determine HR needs according to annual SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis of sub-district
Manage leave of personnel	Direct, implement and monitor SPMS (Service Performance Management System) in sub-district
Discipline staff	
Responsible for SPMS of personnel directly under supervision	
Ensure implementation of SPMS (Service Performance Management System) in sub-district	
Ensure Skills Development Plan in place	
Direct HR (Training meetings – selection of study applications)	
Ensure orientation and induction of new Appointments	
Compile an annual HR SWOT analysis of sub-District	

The Assistant PHC Manager and PHC Manager are unable to complete all their human resource management functions because of limited time allocation for all the functions and competing service delivery demands. An example of competing service delivery demands is demonstrated when a PHC Manager's role to support and mentor an Operational Manager is undermined, because of clinical demands for service delivery on account of the staff shortage:

> *I walked into a clinic, and here's a Sister standing in the office saying; 'people, I'm the only sister on duty today. You'll have to wait, you'll have to be patient'. How can I still take that lady and take her to her office and do whatever? What I then do is say:*

'Sister, what can I do to help you? Can I do the pharmacy? Can I see the babies?' That, is what's wrong in the sub-district (P 3: WC Line Manager 3 PHC MX.doc - 3:25).

4.3.3 **HR Practices**

The HR practices that are described in this research are the formal procedures and functions used to put HR policies in place, and to manage staff. In the West Coast District Case Study, HR Practices were extracted from documents, such as job profiles and job descriptions.

The HR practices depicted in Table 4.18 compares the formal HR functions of a HR Manager with the list of HR functions extracted from the PHC Manager's and Assistant PHC Manager's job descriptions in the West Coast District.

Table 4.18. Comparison of HR functions of the HR Manager and Assistant PHC and PHC Manager

HR Category	**HR Component**	**HR Manager HR Functions**	**Assistant PHC and PHC Managers' HR responsibilities**
General management			Participate in all HRM Meetings – District; Direct all HRM sub-district meetings; Direct meetings; Direct HR (Training meetings – selection of study applications).
Payroll, policy and practices	Human resource policy, practices and audits	Monitoring policy implementation, policy training, policy document maintenance, conducting HR audits.	Ensure appropriate HR, labour relations and disciplinary procedures and practices; Keep abreast with HR developments.
	Service conditions and benefits	Service exits; Leave management; Conditions of service; Service benefits.	Manage leave of personnel; Verification of benefits
HR Planning and establishment administration	Recruitment and selection	Motivations for appointments; Applications screening; Short listing; Interviewing.	Interviewing
	Establishment	Establishment	Motivation of posts;

	administration	monitoring; Creating new posts; Abolition of posts; Advertising posts; Filling of posts.	Appointment of HR within budget constraints and CSP; Ensure orientation and induction of new appointments.
	HR	Develop and implement HR; Plan; Job analysis; Job descriptions; Employment equity; Monitoring and evaluation; HRM information control	Compile an annual HR SWOT analysis of sub-district; Determine HR needs according to annual SWOT analysis of sub-district.
	Performance management	Performance agreements; Grievance procedures with SPMS; Developing transversal norms and standards; Training on performance management system.	Plan, co-ordinate and motivate skills; Development of staff according to personnel development and service needs; Direct, implement and monitor SPMS in sub-district; Responsible for SPMS of personnel directly under supervision; Ensure implementation of SPMS in sub-district.
Labour relations	Labour relations	Collective bargaining; Support and maintenance function; Labour Relation Forums; Statistics and case management system; Database training and development in labour relations.	Discipline staff
Human resource development	Human resource development	Skills audit; Workplace Skills Plan; Coordinating training and development; Administration of Workplace Skills Fund.	Ensure Skills Development plan in place

In essence the HR functions of the HR Manager in the West Coast District is the same as in the Cape Town Metro District, but is operational at different levels in the district health

system, (i.e. in the Metro these functions are performed in devolved sub-structures). One example of an HR function only performed at district level is labour relations: "*I think as far as labour relations are concerned, there is a fairly centralized decision making at the District HR Office. Grievances are dealt with by the institutions and my office here* [District HR Office]. *We literally have a weekly or two weekly meeting to look at any grievances, are there any grievances because we must deal with them in 30 days and we have to make a decision with the Director*" (P 7 WC DD HRM Manager1.doc - 7:67).

One of the other reasons why labour relations in the West Coast District is centralised is because there is a lack of capacity to perform the Labour Relations HR function: "*very few managers are unfortunately trained in labour relations and have the opportunity to preside over a disciplinary hearing. In fact, we are not being able to really conduct the disciplinary proceedings where they have to issue a written warning"* (P 7: WC DD HRM Manager1.doc - 7:97).

This is similar to what is experienced in one of the sub-structures in the Cape Town Metro District where there is a shortage of staff: because of lack of capacity to deliver HR functions, other HR staff have to either take on additional roles or those in strategic roles have to move to a more operational role, which is the case for both districts in this research.

The notion of managers having to be more operational than strategic was supported in the West Coast District, when the DD HRM at the District HR Office said: "*we* [District HR Office] *are only supposed to monitor, look at the beautiful report of what's going on out there, then make some recommendations, and give direction. But the District Office team go to the institutions and do things on a day to day basis and they are supposed to do more strategic stuff*" (P 7: WC DD HRM Manager1.doc - 7:57).

The next set of formal HR practices to be discussed is those of the Line Manager, extracted from the job description of the Assistant PHC Manager and the PHC Manager. According to their job descriptions, their time allocation to HRM is 10% and 20% respectively. However, closer scrutiny of the list of expected HRM functions of these two PHC Managers reveals that they are performing similar activities, and that the functions require more time than has been allocated in the job description.

Table 4.19. Comparison of human resource management functions Assistant PHC Manager and PHC Manager

	Assistant PHC Manager	**PHC Manager**
Same HR activities	• Leave planning	• Manage leave of personnel
	• Labour relations	• Discipline staff
	• Performance management	• Responsible for SPMS of personnel directly under supervision; • Ensure implementation of SPMS in sub-district.
	• Induction and orientation of all newly appointees	• Ensure orientation and induction of new appointments.
Different HR activities	• Recruitment and selection • Employee assistance programme	• Participate in all HRM meetings – District; • Direct all HRM sub-district meetings; • Direct meetings; • Keep abreast with HR developments; • Ensure skills development plan in place • Direct HR (Training meetings – selection of study applications); • Compile an annual HR SWOT analysis of sub-district.

(Source: PHC Manager Job Description and Assistant PHC Manager Job Description)

The table above details the HRM activities of the Assistant PHC Manager and the PHC Manager, highlighting the shared (which could also be considered duplicated activities) and the HRM functions not shared. The shared HRM functions are leave management, labour relations, performance management, and induction of staff. The HRM functions not shared are human resource development performed by the PHC Manager and recruitment and selection, performed by the Assistant PHC Manager. From this comparison the conclusion can be drawn that both Assistant PHC Manager and PHC Management are involved in the direct management of the public health workforce, indicating a shared responsibility for performing HRM function over and above sharing this responsibility with the HR Manager.

In conclusion, the responsibility of human resource management is shared between the PHC Manager and Assistant PHC Manager. In addition, the time allocated to perform human resource management functions is an underestimation of the time required to perform human resource management especially with the devolvement of HRM to the Line Manager.

4.3.4 **Factors influencing the HRM system**

The factors with considerable influence on the HRM of the public health workforce which emerge from this case study are: the communication and reporting structure, responsibility shifts, role confusion and decision space.

Communication and reporting structure

There is a need for a good communication structure within the HRM Programme and between HR Managers and Line Managers to maintain a good partnership. A good communication structure helps the implementation and sustainability of alignment within the HRM Programme and with objectives of the organization, for improved service delivery and health systems functioning. It also strengthens the very important relationship of the HR Manager and Line Manager in providing human resource management to the public health workforce.

These three role players: staff members, HR Manager, and Line Manager form an HR triad that depends on a clear and effective communication system to address and respond to HR issues. However, according to HR Managers, communication channels between Line Managers and staff members appear strained for two reasons: firstly, employees do not contact their Line Manager for clarifying or approving HR related issues and prefer to contact the HR Managers directly: "… *someone will call HR straight and ask you something then they have not cleared it with their manager. Now the problem with that is that at the end you* [HR] *are the one that gets the flack because you have said so, but I have called him and he said so"*(P 1: WC HR Manager 2.doc - 1:73).

Secondly, some employees question the capacity of the Line Manager to address HR related issues and will instead contact the HR Manager: "*They sometimes tell me they fear their supervisors, their supervisors cannot explain the stuff properly, they feel maybe more comfortable or I have a more informal way of dealing with the things" (*P 3: WC HRM Sen Practitioner 3.doc - 3:25).

As a result, the breakdown in the communication perceived by the HR Manager between the Line Manager and the employee influences the relationship between the Line Manager and

HR Manager, and leads to questioning the expected roles to be performed by each role player in managing the public health workforce.

The HR processes are further hampered by poor communication in the form of omitting to devolve information to the different levels in the health system structure: *"It's usually, I believe on that platform (management committee) where either the problem is not addressed or it's not filtered down. So yes, it could be communication that has not been filtered down to the supervisors. Or it could be that it has never been taken to the management meetings"* (P 1: WC HR Manager 2.doc - 1:88).

In the West Coast District, the absence of communication infrastructure within the district impedes effective communication channels. For example, one of the key resource shortages identified within the communication structure is the absence of a document storage hub: *"in the department we don't have that intranet kind of central hub of documents and protocols"* (P 7: WC DD HRM Manager1.doc - 7:157). The absence of a central hub or storage facility impedes the ability to share information, and access to the necessary information to manage people.

Another structural issue impeding communication channels is the process involved in making decisions regarding an HR issue. Infrequent meetings and circuitous decision processes lead to substantial time lags in resolving HR issues. Processes are initiated at the quarterly HR Forum where an HR issue being experienced is raised. Subsequently "*we refer from the forum to head office and then we come back to the next forum and we indicate on* how [the issue] *should be dealt with"* (P 7: WC DD HRM Manager1.doc - 7:111).

Finally, the reading of HR policies is one of the key communication channels for operationalising effective HRM. However, the challenge experienced is that staff members often simply do not read relevant circulars and other documents. One of the Operational Managers suggested the implementation of a reading recording system to ensure the communication of HR matters: *"I am now going to implement a book where you must sign to indicate that you have read it, then come share with us, and then you go through what you have read with your circular and your policies"* (P 2: WC Line Manager 2 OP MX.doc - 2:11). The approach suggested is a response to staff members not being aware of changes in HR policies or new policies being implemented; thus a reading record not only seeks

confirmation of having read policy documents, but is also a mechanism to ensure that staff members are aware of HR changes that affect them.

The challenges facing the communication structure in the West Coast District create a misalignment through either not receiving the necessary relevant HR information or not understanding the HR policies and procedures when they are shared.

Moving from the communication to the reporting structure, in the West Coast District case study, the reporting structure causes misalignment between the different levels in the district health system, in this case between the District HR Office, hospitals and sub-district office. Figure 4.14. West Coast District Reporting Structure illustrates the reporting structure of the West Coast Health District highlighting that HRM is placed under hospitals and the District Manager, which creates two reporting lines within this district health system. The straight lines demonstrated the reporting line based on structure and accountability, whereas the dotted line represents an informal understanding of communication and relationship.

To illustrate the point, the Deputy Director HRM at the District Office does not report to District Manager, but to a CEO of a Tertiary Hospital: *"I don't report to her, I report to the CEO at Groote Schuur Hospital"* (P 7: WC DD HRM Manager1.doc - 7:143). In addition, the District Office HR has no authority over the Assistant Directors HRM outside of the District Office. Figure 4.14. West Coast District Reporting Structure shows the reporting line of the Assistant Director HRM is to the Hospital CEO, located in the HRM component of the hospital, whereas an Assistant Director HRM placed at the District Office reports to the DD: HRM at the District Office.

The District Office HRM has to use informal communication channels to guide policy implementation in the absence of a formal reporting line: "*I have a lot of e-mail communication type of instructing them in a way what to do. But it's on policy implementation. It is merely saying what they should be doing for certain rules or regulation. But I can't really tell them what to do"* (P 7: WC DD HRM Manager1.doc - 7:135).

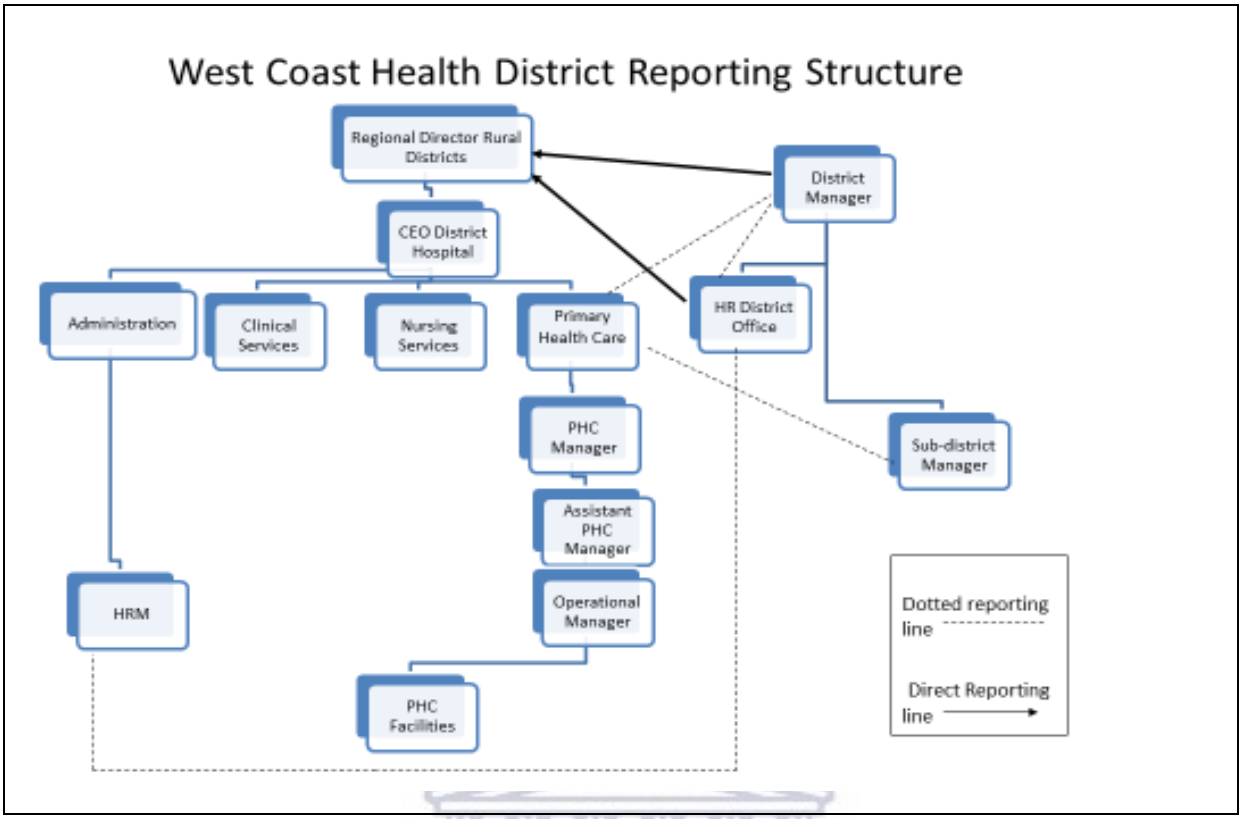


Figure 4.14. West Coast District Reporting Structure

In conclusion, the reporting structure of the HRM Programme in the West Coast District shows evidence of several mismatches in the district health system. The first is the lack of accountability of the Hospital ASD HR staff to the Deputy Director HR at the district level, whose purpose is to coordinate and manage the HRM functions in the district health system. The reporting structure provides limited scope of authority for the Deputy Director HR at the District Office, and combined with a centralised HRM Programme perpetuates complexity within the HRM Programme, specifically in performing HRM functions. The misalignment in the reporting structure impacts on the operationalising, standardising and ensuring of compliant human resources management in the HRM Programme to achieve HR outcomes and organizational strategic objectives.

Responsibility shifts

Responsibility shifts in accountability for the functions stipulated on the Compliance Monitoring Instrument (CMI) (**Error! Reference source not found.**) have been experienced. The Compliance Monitoring Instrument has been revised, and was previously the responsibility of the HR Manager and is now being shifted to the Line Manager, and moving from a generalist to a specialist HR Manager. This instrument had been operational for more

than five years prior to the time of this research, but appeared to have either not been implemented, or been implemented only by the HR Manager.

The revised Compliance Monitoring Instrument checklist reassigns responsibility and, more importantly, accountability for the instrument from the HR Manager to the Line Manager, as illustrated by the following quote: *"The HR Manager was responsible for the completion of the CMI before. There is a post that is going to have to be advertised by Line Management but HR cannot post that advertisement because they are waiting on Line Management to bring them an advertisement before he can post an advertisement. So now, Line Management must tick off post advertised on that checklist"* (P11: WC HR Manager 4.doc - 11:46).

At the time of the study, a workshop was planned to reintroduce the revised CMI to Line Managers, but had not yet been implemented: *"We would have had the workshop last week but because a lot of information was still coming through from MDHS District, they said it must wait so long. We sat last year with the CEO's, the PHC Manager, the HR Managers and the whole HR. We also had a workshop on the CMI. We are going to have a workshop again where we are going to invite all the Line Managers, so that they can know what is their responsibilities and how to interpret it"* (P11: WC HR Manager 4.doc - 11:49).

A perception is held by HR Managers that Line Managers are not knowledgeable in HR policies: *"We expect the Line Manager to know the basics of the policy. They shouldn't create an expectation with the person. For example, when the Line Manager did not make it clear when they have their performance appraisal discussion remember you don't qualify although you've got only 80%. Then when it comes to performance bonuses and letters the person would not get bonuses and would be highly upset"* (P7: WC DD HRM Manager1.doc - 7:81).

Unsurprisingly, Line Managers felt that they did know what to do in their jobs and that if they did not, they would ask their Line Manager first. Line Managers also indicated that they had limited contact with HR Managers.

"I know what I must do but (the HR Manager) don't always know what he must do" (P 3: WC Line Manager 3 PHC MX.doc - 5:15).

"Yes so now and again but I don't actually have a lot of contact with them because it is not actually necessary. Its just like I say the Leave, if there is something that I don't know how to fill in" (P 1: WC Line Manager 1 OP MX.doc - 26:12).

As with the case of the Cape Town Metro District, the West Coast District's HR Managers functions have been shifted from a generalist to a specialist approach. What complicates the situation further is that the majority of the West Coast District HR Managers have less than 5 years' experience in human resource management. Some of the HR Managers might therefore not have been long enough in the public health service to be able to adapt to changes as they do not have the institutional knowledge on how things can be done. In this case, in the absence of training and with the limited years of experience of the HR staff, the HR Manager has to do more in one area of human resource management compared to a little in all areas.

The shift from generalist to specialist impacts on the ability to perform the specialist human resource management functions that they are now required to: *"… their lack of capacity in a specific area then causes them to be uncertain and insecure with things"* (P 7: WC DD HRM Manager1.doc - 7:122). As a result: *"Now they not experts, remember they used to be general experts acting in all the little pieces in all hospital administrations. Now all of a sudden you take that post away and you tell them to only focus on that specific area. Their knowledge will have to increase significantly"* (P7: WC DD HRM Manager1.doc - 7:48). This leads to the question of whether HR Managers have the ability to perform the human resource management functions required by a specialist approach.

The responsibility shifts raise an implication of the impact on operationalising HR in the absence of formal HRM training as well as resource constraint environment when the two key role players question each other's ability to perform HRM.

Role confusion

Role confusion is experienced by both Line Managers and HR Managers in performing human resource management functions and processes. The Assistant Director HR and the PHC Manager seem to agree that there is no clarity on their roles and responsibilities in human resource management: *"There is no clarity. They must get Standard Operating Procedures and staff to say this is your responsibility, this is our responsibility. I can't*

address it and then the person must still phone HR" (P 4: WC Line Manager 4 Assistant PHC MX.docx - 4:35).

To demonstrate the experiences of role confusion, the "*Embedded Case 1: The Leave Application Process*", below, is used to highlight the situations where role confusion takes place and the implications thereof.

Embedded Case 1: Leave Application Process

The application of leave is one of the simple HR processes that has been clearly outlined with prescribed documents and requirements. The employee fills in a form, the supervisor approves the leave by signing the form, and the employee takes the requested leave. Figure 4.15. Leave application process below depicts the straightforward nature of the leave application process in human resource management.

Figure 4.15. Leave application process

However, this simple process is flawed by two things:

1. The availability of up to date information on leave days for the supervisor to make an informed decision in responding to the leave request.
2. The role of the HR Manager in approving leave by proxy, because of having the up-to-date information on available leave days.

There are implications when the leave days information is incorrect when approval of leave is granted; as well as in the role of the HR Manager in approving leave, if the supervisor has to contact the HR Manager to confirm the number of leave days available before approving the requested leave.

As a way of unpacking the leave application process, two different scenarios based on the data will be presented and followed by a diagrammatic illustration of the possible outcomes of the two scenarios.

Scenario 1

The first scenario is based on the three-monthly leave reports received by Operational Managers from the HR Managers. The leave report provides information on the remaining leave days for every staff member at the primary health care facility. A problem arises when the leave report used by the Operational Manager to decide on awarding employees leave contains contradictory information to the leave report used by the HR Manager to approve leave decisions. In the presented scenario, the Operational Manager made a decision based on a leave report from HR Manager that indicated sufficient leave days for the member of staff, but when the approved form was sent to the HR it was returned stating that the staff member did not have sufficient leave days to cover the number of days requested. Thus, the Operational Manager approves the leave based on the 3 month leave report and the HR Manager declines the leave because recent leave days taken are not reflected in the 3 month leave report: *"I send in a leave application form. I (Operational Manager) cannot plan the Leave if I don't know, but I send it in. Then HR will let me know or from the personnel office "Sister, but this sister only have 5 days over. This is what they always feedback if it cannot happen (when the leave is not approved by HR)"* (P 1: WC Line Manager 1 OP MX.doc - 1:23).

In summary, the Operational Manager has to make a decision to approve or decline the leave application with an outdated leave report. Following the proper process, the supervisor would approve the leave by signing the application form, only for it to be declined at a later stage by the HR Manager due to insufficient available leave days.

Scenario 2

In this scenario, the employee's leave application is declined by the supervisor for operational reasons, rather than because of insufficient available leave days; however, because the HR Manager informed the employee that leave days were available, the employee questions the supervisor's authority to decline the leave application: *"The employee phones you (HR Manager) to inquire about available leave days. Then they go back to their supervisor and they say but (HR Manager) said I had so many leave days. But the manager is not approving*

the leave for other reasons maybe there isn't anybody to replace operational wise. But the employee would insist but (HR Manager) said I have got leave days so I can take my leave" (P 1: WC HR Manager 2.doc - 1:75).

The diagram below (Figure 4.16) illustrates the two scenarios as two leave application processes with their potential outcomes in order to highlight the implications of role confusion.

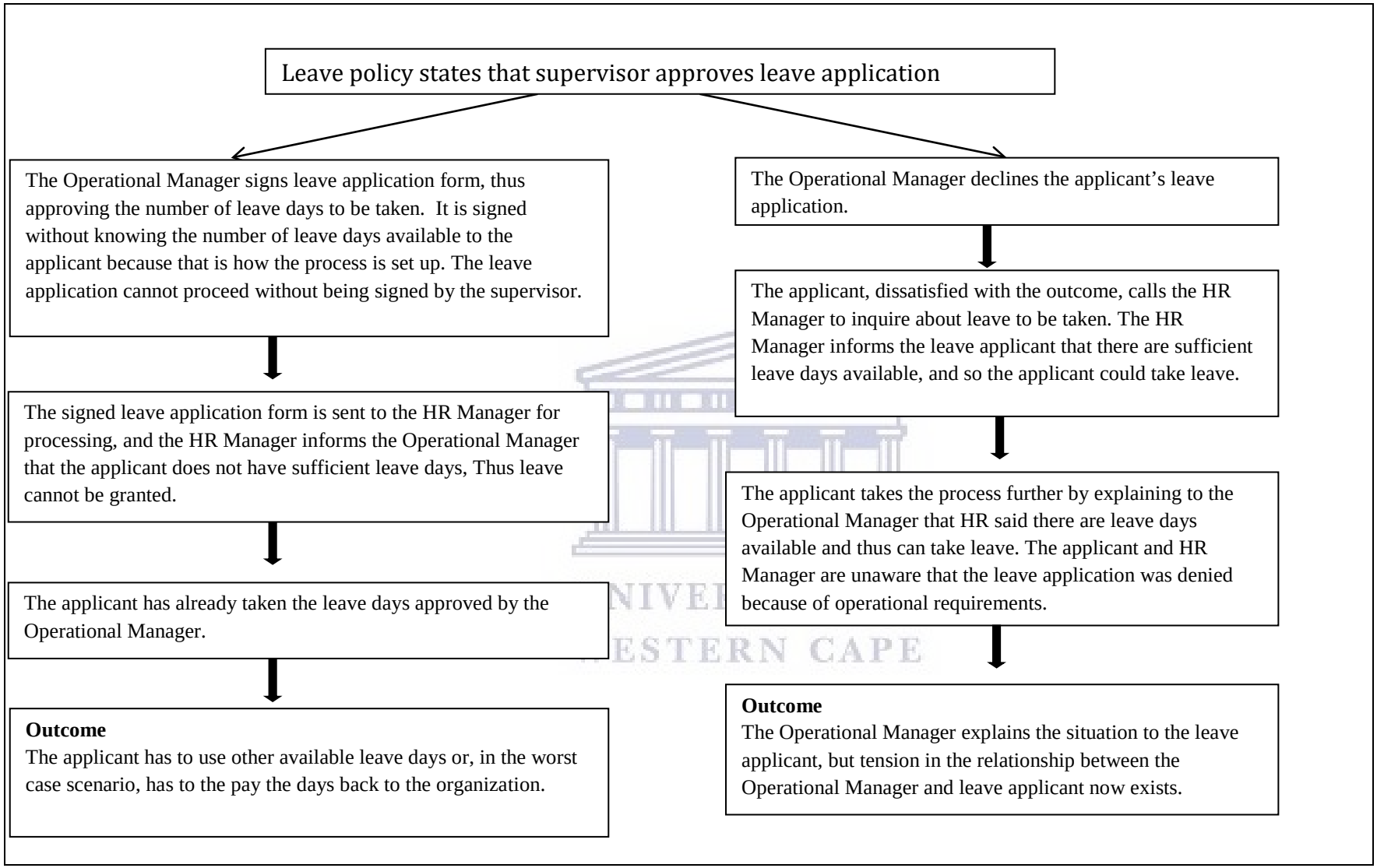


Figure 4.16. Leave application process scenarios

The diagram above depicts two different scenarios in one HR process where, in the first scenario, the need for reliable up-to-date information is highlighted, and also demonstrating the role of the HR Manager in the actual leave application process though it is not stipulated in the policy; and in the second, the HR Manager's role in deciding whether an employee can take leave or not can lead to the decision making authority of the frontline manager being questioned.

This research identified the importance of adequate, accessible and up-to-date information for the management and monitoring of the public health workforce. The sources of information in the West Coast District are the same as the sources of information in the Cape Town Metro District (Table 4.7. Sources of information for monitoring the public health workforce). The researcher posits that in both district case studies, information management is crucial in the ability to manage the public health workforce for both the HR Manager and the Line Manager, and provides a mechanism to strengthen not only human resource management, but also the relationship between these two key role players.

In exploring information management, it was discovered that the ranking of the most important information management functions, specifically the most important and the two least important functions, by the HR Managers in the West Coast District was the same as the Cape Town District's ranking.

1. Sharing HR Information in HRM Programme Component
2. Advise on HRM Issues
3. Determine training needs
4. Liaise with Facility Manager on Staff Establishment reports
5. Ensuring Data Accuracy on Persal
6. Coordinating information management in the HR Component
7. Advise on HR Planning
8. Interpret information in Staff Establishment reports
9. Capture data on Persal
10. Prepare Staff Establishment reports for Facility Managers

Furthermore, the majority of HR Managers perceive information management to be part of their job description but do not, however, consider data analysis and presentation as part of their job descriptions, although they expressed confidence in their ability to perform information management. Data capturing, considered an operational function and time consuming, scored low in the ranking. The ranking suggests that the HR Manager's information management approach is more strategic than operational.

The section has provided examples of the role confusion experienced, and demonstrated the challenges that exist with the mechanisms in place to address the role confusion, and the resulting impact on the relationship between the two key role players. The section also highlighted two important implications for human resource management. First, is the misalignment between the HR practices of the HR Manager and those of the Line Manager, with challenges highlighted about where the HR Manager starts the HR process and where the Line Manager takes over from the HR Manager, and about the roles performed between the two role players. The second implication is with regards to the role that information management could play in alleviating parts of the role confusion scenarios, and the benefits it could have in strengthening the relationship between the two key role players.

As part of the endeavour to decrease the delays in the appointment process and as a result of role confusion being identified as an obstacle, an appointment process workflow chart was developed in the province and put in place to address the issue. The workflow chart for the appointment process mapped and sequenced the HR processes and functions, outlining the requirements for the different HR activities in the appointment process.

Embedded Case 2: The Appointment Process

Role confusion was identified in the appointment process and, in response, a role clarification process was put in place:

> *"There was always this discrepancy when we have done our (HR Manager) part by providing the motivation for the appointment. Then the Line Manager had to contact the candidate to inform them they got the job. This was always a discrepancy because the Line Manager thought it was an HR responsibility. We had a role clarification meeting to say who's responsible for what and when and where*" (P1: WC HR Manager 2.doc - 1:25).

The new appointment process was developed in a consultative process involving HR Managers and Line Managers: "*… now we have 70 days to fill the post and we sat down and broke down who's responsible for what*" (P 1: WC HR Manager 2.doc - 1:26). The outcome of this process is the workflow chart for the appointment process () highlighting the various phases in the process, with the accompanying timeframe attached to each phase.

However, closer inspection of the workflow chart reveals that the details within each phase are not clearly outlined, and there is no clear indication as to who is responsible for which part in the chart. For example: "*… the Line Manager is supposed to supply us with the job description and the advert and then we take it further from there*" (P1: WC HR Manager 2.doc - 1:20). This demonstrates that it is not clear who is responsible for what, with the implication of role confusion and time delays in completing required HR activity.

Moreover, the workflow chart has not addressed the role confusion as time delays are still experienced, and unfortunately the underlying causes of the time delays have not yet been identified. The Assistant PHC Manager identified the cause as a verification process that took very long and often lead to the undesirable result of failing to fill the post: "*Like we do the interviews, we do motivation, send it the day after the interviews, the verification of the candidates takes very long. In the mean time they(candidates) go for another interview, after the interviews the people let them know so they take that post and then they decline our post"* (P 4: WC Line Manager 4 Assistant PHC MX.docx - 4:33).

The appointment process described above epitomises the unclear roles and responsibilities and, specifically, the human resource management functions shared between the HR Manager and the PHC Manager in the West Coast District.

In response, a further call for role clarification was made because of the delay in the filling of vacant posts in the West Coast District being ascribed to this role confusion: "… *you have to go through each and every single HR function and see what is the line management role, what is the HR role so that we don't end up with this problem driving vacant post*" (P 7: WC DD HRM Manager1.doc - 7:84).

In addition, the appointment process illuminates the competing priorities of the HR Manager and the PHC Manager. This is demonstrated in such a scenario as when the PHC Manager fills a post with a contract position to ensure the priority of service delivery, with the result that this impedes the permanent filling of a post, which conflicts with the priorities of the HR Manager: "*Yes but the problem is that when a post becomes available we give them a contract person to fill the position. They don't usually care about the permanent post being filled because there is a person there. Maybe if we take that (contract person) away from them then there would be more compliance to the seventy days because there will be no person working there"* (P1: WC HR Manager 2.doc - 1:96).

Decision space

Both the HR and Line Manager experience limited decision making space. For the HR Manager, the limited decision space is delineated by the role they perform in the HR process, which is to highlight and communicate information for the purpose of creating awareness and being part of the decision making process. In the leave application process, their role is to inform the Line Manager of the number of leave days available, and in the appointment process, it is to: *"… highlight the vacant post in the staff establishment report and then I write it down in the email"* (P 1: WC HR Manager 2.doc - 1:81). In both these scenarios the HR Manager provides the information and the Line Manager has to make the decision with no strategic input from the HR Manager: "… *that is where my hands are cut off because I can only report a vacant post to the line manager. Then he decides what is going to happen"* (P 1: WC HR Manager 2.doc - 1:83).

However, the Deputy Director: HRM at district level has more decision space with regards to appointments, as he can decide whether or not to make a motivation/ proposal for an appointment[8]: *"We then make a motivation/ proposal to the district director, the district management committee, which is your district office managers, and they can say yes or no. In the district management committee a proposal for an appointment could come from a line management within a sub-district, but if intra-sub-district then it comes through us, and we (HR) initiate it ourselves"* (P 7: WC DD HRM Manager1.doc - 7:70).

The decision space of the Line Managers in the West Coast District is varied, and sometimes ill-defined. For instance, the Operational Manager has no decision-making power in the appointment process. In support of this, one of the Operational Managers described how her powerlessness is exemplified by the absence of even communication regarding available posts in the district: *"That is out of my hands. I also have nothing to do with advertisements. All that we see is, we know that there is a vacant post, then we just watch the newspapers and then we will know there is a post at that clinic or there's a post at that clinic"* (P 1: WC Line Manager 1 OP MX.doc - 1:11).

Furthermore, the involvement of the Operational Managers in the appointment process is restricted to participating in interviews for Operational Manager positions, which involves them in the interviewing process but not in the rest of the appointment process: *"But we get turns to sit in interviews for Operational Managers, to ask questions, but as I say we don't do the appointments*" (P 1: WC Line Manager 1 OP MX.doc - 1:10).

The decision spaces of the PHC Manager and Assistant PHC Manager are not clearly delineated and there is variance between sub-districts. For example, in one case the Assistant PHC Manager is included in the appointment process, but the function of motivating for a post is ascribed to the PHC Manager: "*She makes the decision. I will say there is a post. The two of us will talk about it but she will write the motivation*" (P 4: WC Line Manager 4 Assistant PHC MX.docx - 4:27). In another sub-district, the Assistant PHC Manager writes the motivation and bypasses the PHC Manager: *"If we are doing the interviews, then I will do the motivation, then I don't even send the motivation to the Primary Health Care Manager*.

[8] A motivation/proposal for appointment refers to letter written to the committee where a request is made to fill a post that has become available with a specific recommendation on a staff cadre and a specific staff establishment.

Then it goes to HR and the sub-district HR they will make sure that everything is there. They will send to the district HR office" (P 4: WC Line Manager 4 Assistant PHC MX.docx - 4:26).

Ultimately, decisions on whether or not to fill the post, or to move a post to another facility, and the final appointment, lie at the district level and completely out of the scope of the decision space of all the three Line Managers: *"… the decision of whether a post should be filled or not lies with the director or the district office to make that decision"* (P 7: WC DD HRM Manager1.doc - 7:59).

Thus far in the Results Chapter, the context of the District Human Resource Management System has been presented with two case studies, one urban and one rural. To conclude this chapter a comparative analysis between the urban and rural case studies will be presented.

4.4. RESULTS: COMPARATIVE CASE ANALYSIS

The comparative case analysis illuminates how the decentralisation of Human Resource Management was implemented in the two districts, one urban, one rural, highlighting the similarities and differences. It is important to emphasize that the comparative case analysis is situated in the early stages of a national health sector reform of the decentralization of the District Health System, and even more so of the HRM Programme, for which the onset of this process began less than two years before the study was conducted. In this thesis, the decentralization of HRM refers specifically to the allocation of tasks to a lower level in relation to its being centralized at a higher level; whereas devolution is used in reference to devolving human resource management tasks previously undertaken by the HR managers, to the Line Managers.

Taking this into consideration, the researcher takes cognisance of the fact that some of the findings presented might reflect only teething problems, and not fundamental challenges to a decentralised system; the researcher nevertheless considers these findings as lessons and insights from which one can learn. As a reminder, the two district case studies being compared are situated in one province, and thus share the same policy structures and provincial management structures; they are however, very different entities in terms of size, management structure and, especially, implementation of policies and strategies.

The comparative case analysis provides the key points for the Discussion chapter that follows, by highlighting the similarities and differences, and drawing conclusions on the nature of the HRM system in a district health system. It describes the factors influencing HRM in a district health system, starting with the nature and functioning of the HRM, by comparing the roles and responsibilities, HRM functions, structures and procedures in the two district case studies. This is followed by examining the impact of national policies and context, limited decision space, and the absence of reliable information. The comparative case analysis concludes with an assessment of the internal and external alignment of HRM in a district health system, responding to the research questions regarding the extent of the alignment of the HRM Programme.

4.4.1. **Factors influencing HRM in district health system**

The factors identified are the following: the nature and functioning of HRM; the impact of national policy and context; limited decision making space in HRM; and absence of reliable information.

Nature and functioning of HRM

As a reminder of the population in the cases included in this research, the Cape Town Metro District serves almost 4 million more people than the West Coast District, creating a significant difference in the dependent population for public health services . It is also important to restate that the Cape Town Metro District does not necessarily conform to the WHO recommended size and composition of a district. In point of fact, the substructures within this district are more in line with what is usually considered a district.

Table 4.20 summarises the key similarities and differences in HRM in the two districts studied. In relation to the HR staff to public health workforce staff ratio, the Cape Town Metro District's ratio is significantly higher than that of the West Coast District.

Table 4.20. Summary comparison of two district case studies

Variable	**CTM District**	**WC District**
Public health workforce	6095	1210
HR Managers	37	17
Ratio	1:165	1:71
Generalist/Specialist Approach	Specialist Approach	Specialist Approach
Human Resource Management Approach	Traditional Approach	Traditional Approach
Line Managers responsible for HRM and the time allocated to this function	In PHC facility: Facility Manager (95% Administrative duties, including HRM) At substructure level: PHC Manager (20% HRM)	In PHC facility: Operational Manager (20% Administrative duties, HRM not part of main administrative duties) At subdistrict level: Assistant PHC Manager (10% HRM) PHC Manager (20% HRM)

The restructuring of the HRM Programme brought about a change in the HR approach in both districts, from a generalist to a specialist approach. The HR generalist has a broad scope, having expertise in more than one area of HR, whereas a HR specialist specializes in one area of HR; for example, compensation, training, or payroll. The shift in approach was evident when looking at the post structure, and the outline of the HR component, as well as the structure of the HRM Programme in each district.

In the Cape Town Metro District, this change was illustrated in the restructuring of the HRM Programme into five HR Components, Table 4.1. HR categories, components and functions at Metro substructure level, with an Assistant Director HR responsible for each component, as opposed to all HR functions being assigned to one person. In the West Coast District, a revised District HRM Programme Organogram, Figure 4.12, depicts four HR components centralized at the district level. In view of the low overall qualifications of the HR staff establishment and lack of experience in specialist fields of HRM, this change was questionable and perceived as problematic.

The HRM functions, extracted from the HR Managers' job descriptions and other documentary sources, were similar in the two districts. The profile of HRM functions laid out in these documents followed a traditional approach to HRM; to recruit, train, retain and motivate staff. This is contrary to the intended paradigm shift, towards a Strategic HRM approach that aligns HRM as a strategic partner to the public health organisation. These documents, in fact, provided a comprehensive overview of the HRM functions in the public health sector.

The key Line Managers responsible for Human Resource Management in the two district case studies were identified as: Facility Manager (frontline manager) and PHC Manager (supervisory) in the Cape Town Metro District; and Operational Managers (clinical supervision), Assistant PHC Manager and PHC Manager (both frontline managers) in the West Coast District.

Table 4.21. Comparison of Line Managers' Clinical and Administrative Responsibilities

	Cape Metro District		**West Coast District**		
	Facility Manager	PHC Manager	Operational Manager	PHC Manager	Assistant PHC Manager
Clinical	Clinical duties 0%	Clinical duties 0%	Clinical duties 80%	Clinical and support services for all the PHC facilities in the district 20%	Clinical duties 0%
Administration	Human Resource Management 30%	Resource Management	Administration 20%	Human Resource Management 20%	Effective management of resources 10%
	Financial Management 15%			Financial Management (monitoring and evaluating expenditure) 20%	
	Health Information Quality of Care TB HIV/Aids Chronic Care Management 5%	Planning Monitoring and Evaluation		Management of all Health Programmes and implementation of Health Policies 10%	Monitoring and Evaluating PHC Services 40%
	District Health Service Development 5%	Line and Operational Management		Operational and Strategic Management 20%	Operational Management and implementation of PHC services in sub district 25%
	Supply Chain Management and Logistics 25%				Quality Assurance 15%
		Liaison		Liaison and interaction with specific and general environment (public speaking, district and facility board meetings, media) 10%	Liaison in macro and micro environments 10%

A fundamental difference between the two case studies is that in the Cape Town Metro District, HRM is central in the day to day running of a primary health care facility, while this is not the case for the West Coast District, where HRM is performed by the Assistant PHC Manager, the first supervisory layer, who is not present at the public health facility on a regular basis. Thus, West Coast PHC Managers have much less time allocated to HRM compared to Cape Metro's Facility Managers.

Table 4.21 highlights the time allocated to HRM and the competing demands of patient care and general management influencing the capacity of the Line Managers to perform HRM in the two districts. In the West Coast District, responsibility for providing clinical care to patients and the capacity to perform HRM limits the ability of Operational Manager to perform HRM functions. In the Cape Town Metro District, the PHC Managers and Facility Managers expressed being overwhelmed by all the administrative and general management responsibilities allocated to them.

Furthermore, the Line Managers' capacity was influenced by their lack of expertise in the field of HRM in the public health sector. Line Managers in both case studies were clinically trained, and mostly nursing professionals. Although some of them had some training in general management, they had received no training, induction or preparation for performing the HRM functions allocated to them.

In conclusion, the Line Managers' roles and responsibilities are influenced by their lack of capacity to perform HRM. The Line Managers' lack of capacity can be ascribed to their lack of expertise in the HRM field, the time allocated to HRM activities, and, finally, the competing demand of being a health service delivery manager in a resource constrained public health service.

Partnership between HR Manager and Line Manager

The effective management of the public health workforce in the district health system is dependent on the partnership between HR Managers and Line Managers and on how they collaboratively perform HRM functions.

The nature of this partnership is influenced by the backgrounds of these two sets of players, and where they are situated within the district health system. The HR and Line Manager have different backgrounds and qualifications and hold different perspectives and priorities. In addition, these two role players are situated in different components (referred to as programmes) of the district health system, with HR Managers in a supportive administrative programme and Line Managers in the health service delivery programme, functioning under different management structures and directives.

HR Managers' priorities lie with the adherence and compliance to HR policies, and the Line Managers' priorities are focussed on health service delivery. For example, in the Cape Town Metro District Case study, the Line Manager was willing to "bend the rules" for the benefit of service delivery, whereas the HR Manager was resistant to this, as it would be non-compliant to certain HR policies. In the case of the West Coast District, competing priorities were demonstrated when the Line Manager was satisfied with a temporary appointment in a vacant position, to address the health service delivery needs, whilst the HR Manager sought a more permanent appointment that would take longer, and thus impact on health service delivery. The divergence between the HR Manager and Line Manager on the implementation of, and compliance to, HR policies embodies their competing priorities, and the inherent tensions in the partnership between the two role players in managing the public health workforce.

The partnership is further influenced by the competing demands and capacity constraints facing each set of managers described in the previous section. The partnership is also influenced by the complex reporting and communication structures found in the two district case studies. For example, HR Managers in the hospitals were placed in the Health Service Delivery Programme, and reported to the CEOs of the hospitals and not to the Substructure HR Office (Metro) or the District HR Office (West Coast), thus bypassing the HRM Programme reporting line. Neither the Substructure Deputy Director HR, nor the District Deputy Director HR had formal authority over the Hospital HR staff. Furthermore, Substructure HR managers in the Metro District did not report to the District HR, but to the Substructure Management. All in all, there was no direct reporting line to the District HR Office in either district, and all reporting lines led to the health service delivery line management structure.

An implication of the absence of reporting is that standardization and oversight of the implementation of HR Policies and Procedures across the district health system face challenges. In both districts, because the District Deputy Director HR was not in the direct reporting line, he/she had no authority in the implementation of HR policies and procedures in substructures, and hospitals and had to put mechanisms in place to exert influence for standardization and compliance. The mechanism used in both district case studies was the HR Forums held monthly in the Cape Town Metro District, and quarterly in the West Coast District. Thus, although not outlined in the structures, in both district case studies, the District HR Deputy Directors referred to a perceived "dotted" reporting line from the substructure HR Office and Hospital HR to the District HR Office.

In both districts, the exercise of influence through HR Forums was observed by the researcher and further corroborated in interviews, including that with the District Deputy Director HR in the West Coast District, who highlighted the importance of a good relationship between himself and the Hospital HR Staff, in order to be able to influence the implementation of the HR policies, procedures and processes. The key differences between relationships of authority and those of influence, and the limitations of a "dotted" and not a "solid" reporting line are reflected in Table 4.22 below.

Table 4.22. Difference between authority and influence

Authority	**Influence**
Static, structural aspect of power	Dynamic, tactical element
Formal aspect of power	Informal aspect of power
Formally sanctioned, right to make final decision	Not sanctioned, not a matter of organisational rights
Involuntary submission by subordinates	Voluntary submission
Flows downwards, unidirectional	Multidirectional, upward, downward, horizontal
Sole structural	Source may be personal characteristics
Circumscribed; domain scope and legitimacy of power are specifically delineated	Uncircumscribed; domain, scope, and legitimacy of power ambiguous

(Source: Bush, 2011:108-109)

Exercise of influence rather than authority requires voluntary submission, and is thus dependent on the relationship; but more importantly, the legitimacy of HR Managers is ambiguous. The issue of the legitimacy of the HRM Programme emerged as a significant underlying theme in the research, and is further explored in the Discussion chapter. The lack of authority is demonstrated by the West Coast District Deputy Director HR, who attested to how he could "ask for something" but could not "tell" the ASD: HR at the hospital what to do. The effects of the dotted reporting line between substructure and hospital and district on standardization are evident on the HR processes and practices in a District HRM Programme. This was also exemplified in the Cape Town Metro District when mediation was required to resolve differences between the SubStructure and Hospital HR on the implementation of HR Policies and Practices.

Moreover, the communication patterns are rendered more complex because individual HR issues follow different routes in search of resolution. The communication patterns were found to be complex in different ways in the Cape Town Metro District and the West Coast District. For instance, in the West Coast District, several HR issues have to be sent to the Provincial HR Office to be resolved, causing time delays in performing HRM functions. In the case of the Cape Town Metro District, the complexity of the communication patterns is depicted in the diagram in the Cape Town Metro District study (Figure 4.10. Communication and reporting line). The evidence suggests that it is the nature of HR issues, the expertise levels of the role players, and the extent of decentralization that creates the complexity of the communication patterns influencing the efficiency of HRM functions.

Impact of national policies and context

Professionalising HR

The policy directing the change in the restructuring of the HRM Programme is part of the HRH Strategy for the Health Sector to professionalise HR (Department of Health South Africa, 2011), which requires all HR Managers to possess a formal general management qualification, including training on the best practices in HRM. This research found that, although some HR Managers possessed a tertiary qualification, very few of them held a qualification in HRM. Moreover, the level of education required for certain specialist HR Managers was a Grade 12, and not a tertiary qualification, as stipulated by the HR Strategy.

The strategic objective of professionalising HR followed different pathways in the two district case studies. Both district case studies created new posts in revising and restructuring their HRM Programmes but did not completely align themselves with the strategy. Instead, they adapted the strategy to respond to the contextual needs of their respective districts. In the case of the Cape Town Metro District, as the HRM Programme was decentralized from district level to the sub-structure, a new post of Deputy Director HRM, with a requirement of a relevant tertiary qualification in HRM, was established. Noteworthy is that this post is positioned at the same level at substructure and district level, thus indicating no hierarchical structure between the position of a Substructure Deputy Director HRM and a District Deputy Director HRM.

Conversely, the West Coast District in their restructuring process added two new cadres to their post structure, to provide support to the Assistant Directors HRM at hospital level: Compliance Officers and Senior Administrative Assistants. The appointment of Compliance Officers was in line with a directive from the provincial office to address the compliance issues raised in audits, while the Senior Administrative Assistants were brought on board specifically to increase capacity to enable devolution of more HRM functions to hospital level. The response to the new cadres was positive as it was seen to fill a gap in HR functions and improve the performance of both the District HR Office and the Hospital HR Office.

In both district case studies, the implementation of the policy was adapted to suit their contextual and, specifically, workload related needs. Filling the staffing gap in the HRM Programme was prioritized. In the Cape Town Metro District more HR Managers at Deputy Director Level were required, to alleviate the workload of the District Deputy Director; in the West Coast District, an HR specialist gap was prioritized to implement compliance across the district.

The implementation of the revised post structure in the Cape Town Metro District, however, did not have an accompanying budget, and thus created a shortage in the staff structure of the HRM Programme. This affected performance, in particular, the reorganisation and reprioritization of roles and tasks to be performed. In the case of the Cape Town Metro District, the staff shortage in the HRM Programme led to the neglect of the strategic and managerial roles, with the newly appointed Deputy Director HR at sub-structure level having to perform operational tasks in direct contrast to the core mandate of this job position.

Similarly, HR Managers in the West Coast District claimed that their strategic input was constrained by the need to assist Line Managers in basic personnel tasks. There was thus a clear neglect of the strategic role of HR Managers in the two districts, which was further evidenced by the number of HR Managers involved in the basic task of data capturing, contrary to their job descriptions.

This scenario had a parallel with the experience of the PHC Managers in the West Coast District, where their core purpose of oversight was diverted to responding to health service delivery needs, specifically clinical duties. All in all, the strategic roles of both HR Manager and Line Manager are challenged by the context in which they are expected to perform these roles.

In summary, the Cape Town Metro and West Coast Districts both introduced new cadres of staff as a strategy to implement the strategic objective of Professionalizing HR, but each district employed different strengthening strategies that responded to their respective needs based on their individual contexts. In the process of implementation, however, the intended shift towards greater strategic HRM roles was not fully realised and different pathways were undertaken to respond to contextual needs.

Decentralisation of HRM and devolution of HRM functions

The decentralization and restructuring of the HRM Programme took place in a resource constrained environment, as a result of which the Cape Town Metro District was not able to fill the posts required, to perform the decentralized functions at Substructure level. At the time of the study, there were several vacant positions in the restructured decentralized HR Department, limited funding available for overtime, and challenges in moving from temporary to permanent positions, culminating in serious capacity challenges in the delivery of effective human resource management. While the West Coast District did not experience the same challenges, as all of their posts were filled, they had capacity challenges in terms of the limited experience of HR staff.

As mentioned in the sub chapter RESULTS: THE CONTEXT OF THE RESEARCH STUDY two key policy documents frame the decentralization of HRM in the public health sector: The White Paper on Human Resource Management in the Public Service 1997 and the Human Resources for Health in South Africa HRH Strategy for the Health Sector: 2012/13-

2016/17. The policies highlight the professionalizing of HR (described above), the alignment of HRM with the line functions and, linked to this, the decentralization from centre to periphery, with delegation of functions, powers and authorities to a lower level.

Decentralization within the district occurred in the Cape Town Metro District but not in the West Coast District. In the case of the West Coast District, the District HR Office still functioned as the central hub of final responsibility and accountability for HRM functions. In contrast, the Cape Town Metro District's HRM functions shifted from the central District Office to the sub-structure HR Offices, with the final responsibility and accountability lying at this level.

In both the West Coast District Case Study and the Cape Town Metro District Case Study responsibility for HRM functions shifted from the HR Manager to the Line Manager. The compilation of job descriptions, in the case of the Cape Town Metro District, and the verification of commuted overtime in the West Coast District, were used to illustrate specific types of responsibility shifts. Most significant in both districts was the delegation of the completion of the HR Compliance Management Instrument monitoring tool from HR Manager to Line Manager, in line with the guidance of the White Paper on Human Resource Management in the Public Service.

In this process of delegation, both the HR Manager and Line Manager agreed that there were no clearly defined roles and responsibilities between them for performing HRM functions. This viewpoint, that there is no clarity on the boundaries regarding HR responsibilities for the HR Manager and Line Manager, echoes what has been found in other studies (L. Harris, 2007). In addition, the actual uptake of the devolved HRM responsibilities of Line Managers varied in the two case studies, subject to the capacity and willingness to perform the devolved tasks.

Role confusion in the two districts was evident in both the appointments process and leave management system. In the case of appointments, both HR Manager and Line Manager were involved in appointing a new staff member in the public health sector. While the appointments process was clearly depicted in a workflow chart providing a visual representation detailing the tasks and processes required, it did not, unfortunately, identify who was responsible for each of the tasks in the process. The appointments process is

complex, as it involves several HRM functions, moving between several HR components, and a number of HR Managers expected to perform different tasks at specific intervals. In both districts, the main misunderstanding lay in what was to be done by whom, at what point the task was to be handed over to the next person, and who was responsible for what. The process illuminated the unclear expectations for each task, timeframes per task and person, and how each role player fit into this complex process.

Similarly, it was unclear who was responsible for authorizing leave because what happened in practice did not correspond with what was stipulated by the leave application process; considerable unhappiness arose amongst public health workers on the outcome of leave applications.

Analysis of their job descriptions showed that the HR Manager and the Line Manager performed the same HRM functions, but there was no document or guidance on how the two role players were to perform the same HRM functions together. During the course of the research, as a response to the unclear roles and responsibilities, the Western Cape Department of Health developed a Human Resource Management People Management Toolkit. The toolkit was identified during the Focus Group Discussions that were conducted during Phase 2 of data collection. At the time, it had not yet been implemented and training was being planned for the roll out to Sub-Districts and Substructures in the two districts.

The People Management Toolkit sets out the responsibilities of the Line Manager and is a guideline to be read in conjunction with HR resolutions, policy documents, circulars, directives and delegations. The toolkit aims to create clarity on what is expected of the Line Manager, inform them of the administrative processes, enabling them to empower those reporting to them on administrative procedures and HR policy issues, and, finally, encouraging close partnership with their HR Component, to ensure that they receive training and are kept informed of developments regarding HR policy issues (Western Cape Province Department of Health, 2014).

Furthermore, the toolkit describes processes and procedures attached to the different HRM functions, whilst identifying the applicable policy or circular to each process or procedure. It is thus a guide through the forest of HR policies and regulations. For example, the toolkit

outlines the process of filling of posts in a flow diagram, and it ascribes the development of a job description as a line management function.

However, although it describes the roles and responsibilities of the Line Manager within the process, the description of the responsibility remains broad and not specifically related to the processes described. In addition, in many cases the description does not clearly outline the responsibilities of the Line Manager and HR Manager within a particular process. The toolkit focusses on equipping Line Manager with the expertise in performing HRM and does not acknowledge the important role of the HR Manager in the various processes.

Another response to role confusion was the revitalisation of the HR Compliance Monitoring Instrument (CMI), a managerial checklist which had been in place for many years but not used in the districts. The CMI managerial checklist is used as both a monitoring and an accountability tool on prioritized HR processes and issues. Previously, HR Managers completed the CMI managerial checklist, but this was shifted to Line Managers to increase their accountability for HRM.

At the time of the study, the Cape Town Metro District Facility Managers had not seen or heard of the CMI, or that they would be held responsible for completing the tool. Although the tool had been in existence for several years, the District Deputy Director HR acknowledged that Line Managers still had to be inducted and trained on completing the CMI. In the West Coast District, the HR Managers were completing the CMI, and although PHC Managers agreed that it should be their responsibility, there was no stated intention to devolve this responsibility.

Limited decision space in human resource management

Decentralisation involves a shift of authority and responsibilities from the centre to lower levels in the District Health System. Bossert and Beauvais (2002) describe different levels of "decision space" for the various HR practices in low- and middle income countries. They argue that the fourfold typology on decentralization (deconcentration, devolution, delegation, privatization) does not address the issue of decision making and, specifically, the range of choices that is granted to the decision makers at the decentralized level. Similarly, Green (2005) describes key features for administrative decentralization which include that: the functions are clearly defined; staff can be allocated across functions as needed; they are able

to attract and retain qualified individuals; and lastly, flexibility in managing financial resources. These key features require a degree of autonomy, influence and power in decision making. The concept of "decision space" was introduced by Bossert (1998) to describe the range of effective choices that is allowed in decentralized systems.

The decision space of actors in the two districts was mapped on a continuum of low to high, illustrated with the example of creating a new post in a staff establishment. The different degrees of decision space are outlined in the Box 4.7 below.

Low decision space is when you are consulted or informed of the process.

Medium decision space is when you are able to motivate for a post for due consideration within an existing staff establishment.

Medium-high decision space is when you can move posts around in an existing staff establishment, either changing the post or locating the position in a different health facility.

High decision space is when you can motivate for a new post outside of the existing staff establishment.

Box 4.7. Categories of Decision Space
Adapted from Bossert and Beauvais (2002)

Using this categorisation, Table 4.23 below compares the decision space of the various actors in the two districts. Interestingly, despite different degrees of decentralisation within the district, HR Managers in both the Cape Town Metro District and the West Coast District had limited decision space in the appointment of staff.

Table 4.23. Comparison of role players' decision space in creating a new post on a staff establishment

	Cases	Low	Medium	Medium -High	High
Deputy Director: HRM District Level	Cape Town Metro District			X	
	West Coast District			X	
Deputy Director: HRM Sub district Level	Cape Town Metro District		X		
	West Coast District				
HR Managers Salary Level 8-10	Cape Town Metro District	X			
	West Coast District	X			
Assistant Director: HRM	Cape Town Metro District				
	West Coast District		X		
PHC Manager	Cape Town Metro District			X	
	West Coast District		X		

Assistant PHC Manager	Cape Town Metro District			X	
	West Coast District		X		
Facility Manager	Cape Town Metro District		X		
	West Coast District	X			

Line Managers, specifically PHC Managers in the Cape Town Metro District, appeared to have medium to high decision space in human resource management decisions, as they discussed and determined HR issues with the Financial Manager, Sub-structure Manager, and District Manager in the District Management meetings. The PHC Managers' decision space in the West Coast District appeared to be more limited in comparison.

Absence of reliable information on the public health workforce

The need for reliable information on the public health workforce is exemplified in the Embedded Case of leave management in both district case studies, as outlined in the previous chapter. The absence of up to date and correct information on remaining, "accumulative" leave days, created challenges for both the Cape Town Metro District and the West Coast District. Implementing policy on the process and requirements for leave application relies on up-to-date information on available leave days of the employees. Unfortunately, in both districts, Line Managers did not have up-to-date information on available leave days, thus having to make decisions on approving leave based on incorrect and outdated information. Two scenarios were presented in the case studies, both ending with aggrieved and dissatisfied staff, because leave days taken were converted to unpaid leave days, and thus deducted from the employee's salary.

As a result of the unreliability of the sources of leave information, a Facility Manager in the Cape Town Metro District had developed a separate leave monitoring system to be better able to make informed decisions in approving leave requests.

The study found limited use of technology to enhance information use HRM. There was reliance on the outdated Persal information system, which did not respond to the information needs of the Line Manager. Facility Managers developed their own parallel information systems to respond to their information needs. All in all, the absence of reliable information

was identified as a hindrance to achieving both operational and strategic objectives, as well as for the monitoring and managing of the public health workforce.

4.4.2 **Alignment**

A key objective of the research was to determine the extent of the alignment of the HRM components within the HR Department and the strategic alignment of the HR Department with the organisational strategic objectives. In order to determine the extent of alignment, the measurement tools developed by Becker, Huselid, and Ulrich in 2001, used mostly in the corporate sector, were utilised and adapted to fit the public health sector.

Assessing the internal alignment of the HRM Programme

HRM functions are integrated with one another (Becker et al., 2001). To illustrate this phenomenon, the HRM functions are categorized into components, each of which is associated with an ASD: HR, and have been listed in Table 4.24. Here the relationships between HR Components/Managers in a selected HRM process, namely the appointments process, is further illustrated. This was selected because it provides the most connection points between HR Components.

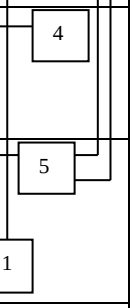
The appointment process can be simplified into a five step process as follows:

1. The creation of a post
2. Advertising of the post
3. Interviewing and shortlisting of candidates
4. Motivating for an appointment
5. Filling the post.

The appointments process highlights the cross-cutting nature of HRM functions requiring coordination and management across components.

Table 4.24. Internal Alignment Illustration: the Appointments Process

HR Category	HR Component	HR Functions
Employment Policy and Practices	HR Planning	Develop and implement HR Plan Job analysis Job descriptions Employment Equity Monitoring and Evaluation HRM information control
	Human Resource Policy, Practices and Audits	Monitoring policy implementation Policy training Policy document maintenance Conducting HR Audits
	Performance Management	Performance Agreements Grievance with SPMS Developing Transversal Norms and Standards Training on Performance Management System
Employee Sourcing	Recruitment and Selection	Motivations for appointments Applications screening Short listing Interviewing
	Establishment Administration	Filling posts Advertising posts Creating new posts Abolition of posts Establishment monitoring
Employee Benefit Administration	Personnel Administration	Service exits Leave management Conditions of service Service benefits
Labour Relations	Labour Relations	Collective bargaining support and maintenance function Labour relation forums Statistics and case management system database Training and development in labour relations
Human Resource Development	Human Resource Development	Skills audit Workplace Skills Plan Coordinating training and development administration of Workplace Skills Fund



The assessment of internal alignment of the HR Components is taken further in Table 4.25 below, where each HR Component is linked to the most relevant other HR Components. The analysis suggested little alignment between the HR Components.

Table 4.25. Internal Alignment of HR Components

HR Component	Linked Aligned HR Components	Analysis of alignment
HR Planning		This is a neglected component in the programme as it has little implementation at district level.
HR Policy, Practices and Audits	HR Planning, Human Resource Policy, Practices and Audits, Performance Management, Recruitment and Selection, Establishment Administration, Personnel Administration, Labour Relations, Human Resource Development	Plays a very important role in providing policy and procedures on all HR matters and is thus aligned with all the other HR components in terms of providing the documentation for implementation. It is also pivotal for compliance, and receives dedicated posts to achieve compliance, but no information sharing across components.
Performance Management	Human Resource Policy, Practices and Audits	This component functions completely independently from the others, though informed by HR Policy. It is also considered a very sensitive HR function as it is related to financial compensation of employees.
Recruitment and Selection	HR Planning, Human Resource Policy, Practices and Audits, Recruitment and Selection, Establishment Administration, Personnel Administration,	Recruitment and Selection and Establishment Administration should be the closest aligned because they are in one HR Category and the functions performed in each are interrelated to perform the appointment of a person (illustrated in table above). However, this was found to not be the case where in fact, different people are responsible for the two components within one category, functioning completely independently from one another.
Establishment Administration	HR Planning, Human Resource Policy, Practices and Audits, Performance Management, Recruitment and Selection, Personnel Administration	This component is considered more important compared to the others due to the appointment process being embedded in this component. As illustrated in the table above, there are several linkages between this component and the other components, creating a greater internal alignment.
Personnel Administration	HR Planning, Performance Management, Recruitment and Selection, Establishment Administration	This component is considered a labour intensive component as it is administratively intensive. Interestingly, even though the component has to be up to date with HR policies, there is no direct relationship or shared functions with HR Policy and practices.
Labour Relations		This component functions completely independently, and in the West Coast District does not have a dedicated person allocated to it. In the Cape Town Metro District, representatives from this component do not attend HR Forum meetings with other HR representatives, and instead have established their independent Labour Relations Forum.
HRD		The HRD component recently joined the HRM Programme, where it previously functioned completely independently and is still in the process of being integrated into the HRM Programme.

In both districts, Labour Relations and Human Resource Development functioned completely independently from the rest of the components. Interestingly, training of the health workforce formed part of the processes performed by both these components and yet they had no partnership or collaboration with one another on this particular function.

The Human Resource Policy, Practice and Audits component exhibited the strongest relationship with other components, mainly because of its role in guiding HR policies in the other components. HR Planning is the most neglected component according to the analysis, either receiving limited attention or not being implemented either because of a lack of capacity or as a result of its being performed at a higher level. Interestingly, the issue of (lack of) fit between HR Planning and Human Resource Policy, Practice and Audits was inconsequential, because the components were managed by the same HR Manager.

In conclusion, the degree of internal fit between HR components in a District HRM Programme is limited. In fact, most of the HR processes and functions are performed independently from one another, and thus do not reinforce one another, but lead to opportunities of misalignment.

Assessing the external alignment between the HRM Programme and the organisation

As indicated previously, external alignment is the extent to which the HRM system is aligned with the objectives of the organisation. To assess the external alignment, two things have to be taken into consideration: what to assess (perspective and domains) and how to assess (the measurement scale for) external alignment. Drawing on the overall strategic perspective and factors (contingency factors and organisational context) influencing HRM alignment identified in this study's Literature Review chapter and conceptual framework (Figure 2.7), a list of external alignment "statements" is presented in Table 4.26 below.

Each of these statements was assessed by the researcher on a 5-point Likert scale. This assessment, translating thick qualitative descriptions into a summary, in the form of a semi-quantified set of variables, provided the investigator with a tool to present concluding perspectives from this comparative case analysis.

Table 4.26. Assessment of external alignment

Statement	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
The HRM Programme has been decentralized to the District Health System					X
The budget is aligned with the decentralization of the HRM Programme	X				
The strategic objectives of the HR Manager and Line Manager are aligned		X			
The operational objectives of the HR Manager and Line Manager are aligned				X	
The Line Manager has the capacity to perform the required HRM functions		X			
The professionalising of HR Strategy has been successfully implemented		X			
The HR Manager has the capacity to perform the required HRM functions				X	
The role of a HR Manager has shifted from being administrative to being more strategic	X				
Technology is used to enhance information management and HR Processes	X				

4.4.3 **Conclusion**

In summary, the district case studies described the HRM processes, practices and implementation strategies experienced in two districts of one province, highlighting the complexity of establishing a district health system in varying contexts.

The decentralisation of the HRM in the two districts led to the adoption of different HRM structures, degrees of sub-district delegation and distribution of HRM roles. In both districts the decentralization of the HRM Programme was not accompanied by a budget or a financial allocation for the revised post structures, and thus was faced with the normal procedures of acquiring additional posts in a resource constrained environment.

In the public health sector, HRM is performed by two key role players ostensibly in partnership. The comparative case analysis also found that the operational objectives of the HR Manager and Line Manager were aligned in their job descriptions, and that mechanisms had been put in place to guide the two role players in achieving these operational objectives. Examples of mechanisms were the Workflow Chart and People Management Toolkit, and the CMI tool. However, competing priorities experienced by the two role players created a misalignment between the strategic objectives of the HR Manager and Line Manager in performing HRM.

The study identified several challenges with regard to the devolution of HRM functions to the Line Managers, as intended by policy. These included the lack of competence in Line Managers, who had received limited training or induction in HRM functions; role confusion and limited decision space. In addition to capacity constraints, they experienced challenges with the inadequate time allocated to HRM functions and competing service delivery priorities.

The districts followed different pathways in their implementation of the national Professionalising HR Strategy. Each prioritized their respective needs, based on their context, when they implemented the policy. There was no indication of future plans to upgrade the training of the existing HR Managers to comply with this strategy, and the focus appeared to be on identifying suitable new recruits only. The study also found that the HR Managers were not trained or equipped to be HR specialists and that there was a neglect of the strategic role of the HR Manager. This contrasted with the core objective of the Professionalising HR Strategy of developing specialist HR Managers able to perform strategic roles within the organization.

Though the majority of the HR Managers in this research did not have any formal training in HRM, they seemed to have the capacity to perform the required human resource functions as stipulated by their job descriptions. However, the HR Managers were not strategically oriented and competent as specialists in HR to implement the shift from the general to the specialist approach of the Professionalising HR Strategy. The role of the HR Manager remained administrative and had not encompassed the other roles of change agent, strategic partner, and employee champion, as postulated by Ulrich (1997).

This assessment of the internal and external alignment of HRM in District Health System highlights several misalignments. The misalignments impact both the HR outcomes and the health service delivery. These point to the key priorities and opportunities for strengthening the HRM Programme in the District Health System. These will be further discussed in the concluding sections of this thesis.

5. DISCUSSION

5.1 Introduction

This research set out to investigate how the different elements of a human resource management system in a decentralised and decentralising district health system interact with one another in the management of the public health workforce. The research objectives were to describe the district human resource management system, to assess alignment between components in this system and, finally, to identify system strengthening opportunities. To achieve these objectives, the researcher observed the unfolding processes of the decentralisation of human resource management and its varied impacts across two local contexts (one rural, one urban).

The thesis thus provides a detailed description and analysis of the reconfiguration of district human resource management systems, against the background of decentralisation processes in the public health system of a middle-income country. It highlights how the following interact with one another to influence the performance of a district health system: institutional and organisational context; type, roles and responsibilities of actors; the selection and implementation of HR practices, policies, and strategies; and finally, the alignment of HR functions and objectives.

It describes the factors influencing the implementation of policies to decentralise human resource management from provincial to district level, and the devolution of HR to the Line Manager, through the eyes of front line actors. Lastly, it highlights how policy intentions to professionalise HRM play out at district and sub-district levels in the context of these decentralisation and devolution processes.

Overall, the study found a commitment to a paradigm shift from the more traditional personnel management approach to strategic HRM within the policy environment, with increased emphasis on the devolvement of HRM to Line Managers. HRM is spearheaded by two policies: the White Paper on Human Resource Management in the Public Service 1997, and the Human Resources for Health in South Africa HRH Strategy for the Health Sector: 2012/13-2016/17.The study, however, concluded that this paradigm shift from personnel management to strategic HRM had not taken place. The difficulty in achieving such a

paradigm shift has been described for other low and middle-income countries (Mwita et al., 2009), and in Australia (Bartram, Stanton, Leggat, Casimir, & Fraser, 2007), where traditional philosophies of HRM prevail.

This chapter discusses the key challenges identified in this thesis in shifting towards strategic HRM, referring to the literature while doing so. These challenges lie in the following: the roles and competencies of the key actors – HR and Line Managers – and the relationship between them; incomplete decentralisation processes; and problems of alignment.

The chapter then discusses underlying themes driving developments in the HRM systems studied: role ambiguity and conflict; legitimacy of the HRM programme and the best fit versus best practice debates. Finally, the chapter proposes leverage points for strengthening a decentralised HRM system as relevant to the South African context.

5.2 Roles and competencies of HR and Line Managers

In the two district case studies, human resource management functions were distributed between HR and Line Managers. The roles and responsibilities of these actors are similar to those found in the United Kingdom's National Health Service (NHS) (Purcell & Hutchinson, 2007; Hutchinson & Purcell, 2008).

Ulrich (1997) proposed a framework of four roles (administrative expert, employee champion, change agent, strategic partner) and five competencies (personal credibility, HR delivery, business knowledge, HR technology, strategic contribution) required for strategic HRM. These were described in detail in the literature review chapter. Ulrich's framework was originally intended for the HR Manager, but has been applied to both HR and Line Managers in subsequent studies (Hassan, Mansor, Rahman, & Kelena, 2015), including in the health sector (Saidi, Naha, Mansor, Anvari, & Ayyub, 2014).

The same framework of roles and competencies is applied to HR and Line Managers in this research, to first describe their roles and competencies, and secondly, to assess their capacity for performing HRM.

The study found that the first role, administrative expert, was performed by the HR Manager, and noted that this was similar to that found in other settings (Rosman, Shah, Hussain, & Hussain 2013). Although there was not an expectation that a Line Manager would be an administrative expert, it was deemed necessary to be competent in terms of knowledge and implementation of HR policies, processes and procedures.

However, the personal credibility of the HR Manager as administrative expert was questioned as a result of the absence of a reporting line within the HRM Programme. For example, where HR Managers reported to the CEO's of the hospital or to the Sub-district manager, this influenced accountability and standardisation of practices and processes within the HRM Programme. HR Managers on the different levels were connected informally through hardly visible dotted lines, representing the absence of authority and a dependence on relationships, to ensure conformity to standardised practices and sustain internal alignment. There is also dearth of literature on the structural arrangements within HRM Programmes and their relationship with the service delivery component of public health care organisations.

The importance of reliable and accurate information in the public health workforce has been established (Dal Poz, Neeru, Quain, & Soucat, 2009;Schenck-Yglesias, 2004; Capacity Project, 2007), and human resource information systems have been identified as an enabler for Line Managers' involvement in HR processes. Moreover, HR professionals need to be able to leverage technology for HR practices and use e-HR/web-based channels to deliver value to their "customers" (Mukherjee, 2001 in (Long & Ismail, 2008); Parry, 2011). Administrative efficiency requires a comprehensive human resource information system for accurate and timely information for decision makers (Friedman, 2007).

HR technology was found to be very limited in the district case studies, and restricted to the use of HR Managers only. In both districts, the Line managers did not have up-to-date information on available leave days, thus leading to making decisions based on incorrect information. In the absence of reliable up-to-date information, Line Managers developed duplicate information systems to provide them with the information they needed to manage the public health workforce. The Irish health service had a similar experience when devolving HRM to middle managers: "*HR managers were devolving HR activities but were still retaining control of information systems and this was both slowing down middle management*

decision making and leading to the creation of new databases by the managers themselves" (Conway & Monks, 2010: 361).

The second role, employee champion, is best ascribed to the Line Manager, who is best placed to understand the needs of the employees, attempt to meet those needs and to increase employee commitment (Ulrich, Losey, & Wiley, 1997). This is in line with the roles and responsibilities of frontline managers for delivering effective people management described with reference to the NHS, where what was considered to be a good Line Manager included *"to be a good role model, have excellent leadership skills, operate fairly, have the ability to motivate and delegate, be approachable, develop people and be able to deal with poor performers"* (Hutchinson & Purcell, 2008). However, this research observed that this role was also located with the HR Manager. The deliverable for the employee champion role, as stipulated by Friedman (2007), is to maximize the employee's contributions to the organisation and to advocate for employee rights. The employee champion role of the Line Manager is challenged by the breakdown in communication that was observed in the research. The unclear roles and responsibilities of HR and Line Managers not only led to role confusion (described further below), but also to communication challenges between Line Managers and health workers. The management environment created by outdated and unreliable human resource information complicated the Line Managers' ability to manage effectively, and undermined trust with health workers. Studies investigating the breakdown of trust between the Line Manager and the public health worker have identified the Line Managers' ability to be an employee champion as a key factor (Scott, Mathews, & Gilson, 2012; Gilson, Palmer, & Schneider, 2005; Willis-Shattuck et al., 2008).

HR delivery is the accompanying competency to the role of employee champion, and the Line Manager is challenged by balancing being an advocate and activist for employee rights, with the needs of the organisation (Ehrlich, 1997).

In relation to the third role, the change agent, the research found that the HR Managers did not possess sufficient business knowledge of the public health sector to be able to perform the role of the change agent. The HR Managers' understanding of the organisation's strategy, primary purposes, finance, operations and general management was limited, although this is the core mandate of the Line Managers. Friedman (2007) argues that HR Managers are expected to help Line Managers develop and communicate clear visions of the future, yet the

ability to perform change management remains questionable. This gap is not confined to public health systems, and has been described in the private manufacturing sector, where HR Managers were less competent than Line Managers in innovation and crisis management (Selmer & Chiu, 2004; Long & Ismail, 2008; Long, Ismail, & Amin, 2011).

The last of Ulrich's roles, the strategic role, is to create alignment between HRM practices and Line Management objectives. It requires that HR Managers be part of leadership teams with other organizational players (Brockbank & Ulrich, 2003). The study found that, in contrast to Line Managers, HR Managers did not perform a strategic role because they were "not seated" at the district level leadership "table", where organisational objectives were set. This is supported by Barney and Wright's (1997) finding, that many HR executives complained about not being invited to the strategic planning "table". In contrast, Wright et al. (1998) found that HR and Line Managers held different perceptions of the HR Managers' strategic role. Line Managers did not believe HR Managers added value in a strategic role (Mcdermott & Keating, 2011).

In conclusion, application of Ulrich's model identified key gaps in the roles and competencies of both Line and HR Managers. The capacities of each, and the relationships between them, are discussed further below.

5.3 Capacity and motivation of the Line Manager

This study highlighted the pivotal role of the Line Manager in performing effective human resource management. Line Managers expressed the willingness or desire to carry out HR functions, but their ability to perform these functions was limited by lack of training in human resource management. The study found that the Line Managers had not been adequately capacitated to perform the expected roles, functions and responsibilities in HRM. A similar situation is found in other low to middle income countries, where more than 70% of the managers reported that they required additional skills and knowledge to perform HRM functions (Mwita et al., 2009). Unfortunately, the belief that HRM is based on inherent and natural abilities is still common, and the development of Line Manager HR skills and socialisation in HR practices are neglected (HRM, 2004; Budhwar & Sparrow, 2002).

In recent years, the role of Line Managers has received more attention, with the Line Manager being placed centre stage and made a core element of a HR Approach. Thus, Line Managers have increasingly become a subject of research as a result of their pivotal role in HRM. To this end, this study's findings are in line with empirical literature on the challenges identified with devolving HRM to Line Management: the ability and willingness of Line Managers to carry out HR tasks properly, HR support from different structures, Line Managers' knowledge and competence in implementing HR policies (capacity) and, finally, the relationship between Line Managers and HRM specialists (Renwick, 2003; Nehles, van Riernsdijk, Kok, & Looise, 2006; Hutchinson & Purcell, 2008; Mcguire, Stoner, & Mylona, 2008; Elarabi & Johari, 2014; Op de Beeck, Wynen, & Hondeghem, 2016).

The majority of Line Managers are health professionals, and not trained in general management and, more specifically, in HRM. There is evidence that this is changing in the health systems of other African countries. For example, in Uganda, all health sub-district managers are now required to hold a Masters in Public Health (MPH), and in many cases, they obtain this qualification after their appointment (Egger & Ollier, 2007). A similar situation pertains in Togo, with District Medical Officers undertaking MPHs post-appointment (Egger & Ollier, 2007). It is a challenge that the devolution of operational HRM activities to Line Managers requires substantial investment and time away from the management position to capacitate the individual to perform the HR roles of the Line Manager (Farrel, 2015).

5.4 Professionalising HR

The attempt to shift from personnel management to strategic HRM is exemplified in the national Professionalising HR Strategy, which requires tertiary level education of HR Professionals in the public health sector. However, the research found that the strategy has not yet been successfully implemented; in both district case studies, only a few HR Managers possessed formal tertiary qualifications.

In South Africa, the South African Board for Personnel Practice was established in 1982 to direct and sustain a high level of professionalism and ethical conduct in personnel practice (Carrell et al., 1999). An HR Practitioner can register with this board as a specialist or generalist, or even both, where the specialist categories include: industrial relations,

psychology, employee assistance, education and research, personnel services, recruitment and selection, training and development, and employee assistance. The professional registration levels range from certificate (HR Technician) to degree (Chartered HR Practitioner) and masters or doctoral level qualifications (Master HR Practitioner) (Erasmus et al., 2005:77).

However, the implementation of professional registration of HR practitioners is not adhered to in the public health sector, with HR practitioners not required to be affiliated to a professional body. This raises questions on the degree of professionalism and ethical conduct in HRM in this sector.

The study contributes to the current debate about whether HR is a profession or not, documenting responses to the following two questions: *Is HR a profession?;* and *if not, why not?* In its definition in policy, HR is certainly positioned as a profession (Carrell et al., 1999; Erasmus et al., 2005) with one criterion missing in the policy, which belongs to a professional body aimed at regulating the profession (Armstrong, 2006).

In 2001, Bach asserted five realities that hinder HR from becoming a profession in the public sector. The study found that these realities remain applicable in 2017. The first is that the HR departments are not designed to provide behaviour modification through collaborative analysis, with a focus on creating a competitive advantage. Secondly, HR activities are not based on theory and research. The third reality is inadequate measurement, specifically the measurement of the impact of HR practices on performance/outcomes. Fourthly, and probably the most debated, is that HR professionals do not add value using their intellectual and business knowledge to how HRM is being performed in the public health sector. The fifth is that HR Managers have not transferred ownership of compliance to Line Managers.

The research found that these five realities still persisted in the two district case studies in the following ways: the HRM programme had not shifted to being strategic and providing a competitive advantage; HR Managers fell short in terms of being qualified in HRM; HR practices and outcomes measurement were limited at the decentralised level of implementation; HR Managers provided little added value as they neither had the capacity nor the opportunity; and finally, administrative compliance was prioritized by HR Managers but not Line Managers, who prioritised service delivery.

Focusing on the operation of one human resource management function, workplace discipline, Jones and Saundry (2012) argued that the relationship between the HR and Line Manager was crucial in shaping and influencing the outcome of HR processes and procedures. Key to this relationship is the support provided to Line Managers. The HR Manager, supervisor and co-workers are identified as key to providing the HR support needed by the Line Manager to perform the required role in HRM (Beeck, Wynen, & Hondeghem, 2016).

The study found that although HR support was available in the two districts, there were challenges arising from the different priorities of the HR Manager and Line Manager, and it thus did not meet the HR support requirements of the Line Manager.

5.5 Decentralisation of HRM

Decentralisation of HRM as outlined in policy, involves the simultaneous devolution of HR functions to the Line Manager and a shift from centre to periphery, assigning functions, powers and authorities to a lower level. Whilst observing the unfolding processes of decentralisation, the study identified several challenges facing effective HRM in a District Health System. The decentralisation of HRM is not widely found in South Africa (Byleveld et al., 2008) unless in large municipal districts, where a shift from centralised to decentralised strategic HRM has been observed (Phirinyane, 2009).

In this research, decentralisation involved a restructuring of the HRM Programme, and though guided by the HRH Strategy, the restructuring process revealed how the district case studies responded to their respective specific contextual needs and their gaps in their HRM Programmes. Thus, whilst the HRH Strategy focusses on qualifications and training, the district case studies illuminated the different pathways each district undertook to meet their needs. In one district case study, the HRM functions were decentralised to the periphery (the sub-district level) while in the other case study it remained centralised at the district level.

Adequate resourcing of the HRM function is a critical factor for success (Stanton et al., 2004). The study observed the lack of resources, where the district's budget was not aligned with the decentralisation of the HRM Programme. Bossert and Beauvais (2002) described a similar situation in the Philippines, where the financial allocations to local governments were

not in line with responsibilities, and ascribed this to an error in central design, rather than local choice. Adequate financing is essential for both public health service delivery and HR service delivery (Dussault & Dubois, 2003).

There are several elements that signify Line Managers' involvement in HRM, but the most relevant is that Line Managers provide a comprehensive approach to HRM and can expedite decision-making (Brewster & Larson, 2000). In terms of decision-making being expedited, the study observed several challenges with the delegation of functions, powers, and authority to the Line Managers. There was limited decision space for HRM even in the case where decentralisation had taken place. Line Managers had to perform HRM in a low decision making space. This was also documented by Cogin et al., (2016: 60) who found that "*there was no managerial discretion to fast track decisions"* for Line Managers. This is important because it is not just about the devolvement of functions to the periphery but also about the decision space allocated to the different role players, especially the key role players in performing HRM (Green, 2005).

Before the decentralisation process, District Managers were found to have limited control over their health staff, specifically in relation to human and financial resources; for example, in hiring staff (Egger & Ollier, 2007). This research found that, with decentralisation, while District Managers had more control over appointments, they still needed to submit their staffing needs to the provincial level where human and financial resources were allocated. The decision making space is thus located with one person, the District Manager, with limited decision making space at the periphery. This situation was also found in Ghana, where the transfer of authority for management decision making and planning to district level was rarely operational, as control over financial and personnel decisions remained centralised (Sakyi, 2008).

Research in other low to middle income countries concluded that choices in the decision space over the functions such as finance, human resources and innovation may have contributed to some of the successes and failures of decentralisation (Bossert & Beauvais, 2002). The authors documented a range of choices over financing issues and the allocation of hiring, firing and supervision authority, which influenced governance and real decision space at lower administrative levels (Bossert & Beauvais, 2002).

5.6 Alignment

The study identified the key strengths and weaknesses of the HRM system by analysing the internal and external alignment of the HRM Programme. The study observed that most of the HR processes and functions were performed independently of one another, and thus came to the conclusion that the HRM Programme was not internally aligned. The internal alignment of the HRM programme within a District Health System is critical because it enables the HRM Programme to add value to the organisation beyond providing administrative support (Stanton et al., 2004).

In addition, the study found that the HR Managers were not trained as HR specialists and that the strategic role of HR Manager was neglected; the paradigm shift to strategic HRM had thus not occurred. The study also observed that the objectives of the HRM Programme were not aligned with the objectives of the organisation, which could be interpreted as a lack of commitment to attaining organisational objectives. Liu, Martineau, Chen, Zhan and Tang (2006) found that when HRM was decentralised in China, the HRM actions were not in alignment with the health service objectives. They ascribed this to the complexity of decentralisation, which is similar to what was found in the district case studies. The interplay of the different elements in a HRM system and factors influencing the alignment described in the comparative case analysis, led to the conclusion that there was not a strategic alignment between the HRM Programme and the strategic objectives of the organisation. Furthermore, as indicated earlier, the decentralisation of the HRM Programme was not accompanied by a budget; Line Managers experienced challenges with the time allocated to HRM functions and the capacity to perform the HRM functions devolved to them; and, finally, the competing priorities of the two key role players created a misalignment between the strategic objectives of the HR Manager and Line Manager, and the organisational objectives. This interplay of the different elements is depicted in the framework presented in the literature (Figure 2.3. A Framework for Optimising Human Resources in Health Care).

Järvalt and Liiv (2010: 244) argue that: "*Vertical and horizontal integration of HRM assumes the presence of a public sector-wide HRM strategy (and a respective coordinating institution) as a framework for designing, steering and coordinating micro-level HRM strategies in individual public sector organisations and Line manager ownership of HRM*". Although

both an HRM Strategy and devolution of HRM to Line Management were present, vertical and strategic alignment was not observed in the districts.

5.7 Key underlying themes

The factors described above were influenced by a number of underlying themes. These included role ambiguity and conflict, the status and legitimacy of the HRM programme, and the design of HRM systems as "best practice" or "best fit".

Role ambiguity and role conflict

The different orientations, backgrounds, and priorities of Line and HR Managers caused role confusion in the shared role of HRM. The HR Manager is a non-clinically orientated person who does not necessarily hold a tertiary education qualification, compared to the Line Manager, who has a clinical orientation and has attained a tertiary qualification. In addition, the HR Manager is situated in a supportive administrative programme with compliance as the main HR deliverable, while the Line Manager is situated in the Primary Health Care Programme with the objective of service delivery. This divergence is a recognised feature in the literature on HRM in both the private and public sectors (WHO, 2004; Harris, Doughty, & Kirk, 2002; Morley, Gunnigle, O'Sullivan, & Collings, 2006).

In the research, both sets of role players identified the lack of clear roles and responsibilities in performing HRM as a key issue. Lack of clarity on the boundaries between the HR Manager and Line Manager with regards to HR responsibilities has been identified by others (McGovern et al., 1998 in Harris, Cortvriend, & Hyde, 2007).

Role theory provides insights into the experiences of HR Managers and Line Managers in performing HRM. Role ambiguity is described as the uncertainty in the minds of employees on their role, responsibilities and expectations with regard to their jobs, when the definition of the employees' job is vague or ill-defined (Handy, 1999). In the case of the Line Manager, role ambiguity occurs in the absence of clearly defined roles and responsibilities, when additional HRM responsibilities are placed on them in the devolution of HRM. Hutchinson and Purcell (2010) described role ambiguity and conflict amongst hospital ward managers whose work had been expanded to include an extensive portfolio of HR duties, requiring them to perform a multiplicity of the roles. In contrast, Gilbert, Winne and Sels (2011) argued

that it was not the increased number of HR tasks that created role stress, but the absence of appropriate HR support, advice and training of Line Managers in HR.

For the HR Manager, role ambiguity was created in the restructuring process of the HRM Programme with the establishment of new components on different levels of the health system, and with devolution of HRM to the Line Manager. These findings are in line with those of Morley, Gunnigle, O Sullivan and Collings (2006: 612), who described the role ambiguities facing HR professionals, as follows:

- *"Powerlessness or marginality in the managerial decision making process, particularly at a strategic level.*
- *Difficulty in defining and maintaining the boundaries of their specialist expertise from encroachment or control by managerial intervention.*
- *Lack of clarity or accountability in specifying the bottom Line contribution of the HR function; and finally.*
- *Tensions in sustaining an ethos of mutuality given the opposing interests of employees and managers."*

Thus, the researcher observed that the absence of clear roles and responsibilities in an uncertain and unfolding decentralised HRM environment creates unclear expectations as to what is expected from the respective role players.

The study found that role conflict was mainly experienced by the Line Manager in having to choose between what was the best for health service delivery compared to the needs of the individual public health employees. Role conflict was also experienced by Line Managers in hospitals in the United Kingdom in performing HRM when having to comply with training needs of health professionals against the background of an inadequate hospital resource system, and thus having to negotiate different priorities between the different sub systems within the health system (Cogin et al., 2016).

Role theory makes a start in explaining the complexities of performing HRM with the need to manage the tensions between the different priorities and expectations within the sub systems of a district health system.

Legitimacy of the HRM Programme

In both districts, the personal credibility and knowledge of HR Managers were frequently questioned by the players with whom they engaged – Line and Senior Managers, and employees. The HRM programme as a whole could be regarded as suffering from a problem of low legitimacy, where legitimacy implies that the programme's existence and actions are both valued and considered valid by its constituencies (Wilcox, 2009).

Legitimacy of a HRM Programme has regulative, normative and cognitive sources: *regulative* legitimacy is tied to the political and legal rules and sanctions; *cognitive* legitimacy relates to the degree to which a HR department's actions make sense; and *normative* legitimacy relates to the degree to which a function like HRM would be considered valuable and "right" in terms of wider social values and norms (Wilcox, 2009). In the case of both district case studies, regulatory legitimacy is established in the key policy documents such as the White Paper on Human Resource Management in the Public Service 1997 and the Human Resources for Health in South Africa HRH Strategy for the Health Sector: 2012/13-2016/17. However, in the cognitive and normative realms, the legitimacy of the HR Departments and Managers could be threatened. Cognitive legitimacy of the HR Department is established as part of organisational life, and thus assessed through the impact it has on the organisational performance, specifically its functions and practices in managing the employment relationship (Thompson, 2011). The research found negligible attempts at connecting the role of the HRM Department to achieving organisational performance in the two districts.

The size and capacity of the HR Department, relative to the size of the organisation, also provides an indication of its legitimacy (Schuler & Jackson, 1999). While the restructuring and decentralisation of the HRM Programme was accompanied by an increase in the proposed size of the HR staff establishment, there was no accompanying budget to realize this increase in HR staff.

Normative legitimacy would have resulted from the HR Department taking on not only administrative, but strategic functions. As already discussed, the HRM Programmes in the two districts were not strategically aligned with organisational objectives to improve performance. Normative legitimacy was further challenged by the competing priorities of the HR and Line Manager, manifesting in adherence and compliance to HR policy and prescripts versus service delivery.

To add value, HR Managers need to be part of decision making processes. However, as indicated, the HRM Department had limited input, being restricted to human resource issues and not having overall input into management and planning in district management teams, and so negating the purpose of adding value strategically. The role of the HR Manager was limited to monitoring progress on provincial HR indicators and targets. These findings are in line with empirical evidence elsewhere, that participation and decision making on planning and strategic issues lies with the Line Manager and not the HR Manager (Isosaari, 2011) and the perceived failure of HR to add value (Mcdermott & Keating, 2011).

Best fit versus best practice debate

Finally, the study observed how the decentralisation of HRM and implementation of the strategy to professionalise HR took different pathways in the two district case studies, with each district experiencing a different mix of factors influencing the HRM system. The two cases presented in this thesis have different contexts and the findings demonstrated how the district case studies responded to their respective context when implementing the strategy. This supports the notions of "context mattering" and the best fit, and not the best practice approach, which would seek to define and construct a single approach to HR practices and the HRM. This is somewhat contrary to that suggested by Trebble, Heyworth, Clarke, Powell and Hockey (2014), who argued for the need for best-practice approaches as the basis for effective HRM.

Leverage points for strengthening a decentralised HRM system

While there were important differences in the sizes of the districts, post sizes of the HR programme, management structure and implementation of the professionalizing HR strategy, the HRM programme in the two districts studied had the same design logic, and were governed by the same HR policies, processes and procedures. In terms of design, the HRM Programme in both districts was restructured towards a specialist approach. However, the HR Managers did not have the qualifications or in-depth knowledge, and were not trained or capacitated to perform their specialist functions. This represents the first leverage point for strengthening the HRM system in the two districts.

The implementation of HR policies, processes and procedures is influenced by various factors, but the study found two key factors: unclear roles and responsibilities and the availability of reliable, up-to-date human resource information. The restructuring of the HRM

programme and the devolution of HRM to the Line Manager contributed to the unclear roles and responsibilities found in the study. As both processes had recently been instituted, it is difficult to conclude whether the challenges found were fundamental problems, or teething problems. However, it nevertheless represents another potential leverage point. At the time of the research, interventions were being put in place to address these challenges, such as the People Management Toolkit and the Compliance Management Instrument. These interventions sought to, firstly, clarify roles and responsibilities, and secondly, devolve HRM through accountability for key HR performance areas. Despite these interventions, there is still much room for improvement in the partnership between the HR and Line Managers for effective HRM. Action in this regard is required at district level where the study found HR policies are adapted to suit local context, where HR Managers' report to Line Managers (and not to other HR Managers) and where there are challenges regarding control and accountability between players.

Although this study did not measure performance, it can be concluded that the absence of vertical and strategic alignment, the unclear roles and responsibilities, lack of adequate resources and low capacity of role players performing HRM, all are likely to have negative implications for the performance of the district health system. The finding that the decentralisation of the HRM Programme from the district office to the various sub-district offices was not accompanied by a budget to fund the additional posts and structural requirements, impacted negatively on sub-district, which could not mobilise financing from their existing budgets. Posts remained vacant within the new post structure for the HRM Programme, leading to the neglect of key roles and functions.

However, steps to foster partnership between the HR and Line Manager in planning, monitoring, and managing the public health workforce, are a potential leverage point to strengthen alignment in the HRM system. Such a partnership could be a mechanism by which to transfer knowledge and expertise in performing HRM functions. The roles and responsibilities of the two key role players could be developed and allocated to each, based on the roles and competency framework suggested by Ulrich. This partnership would be greatly strengthened by initiatives to build the abilities of the Line Manager in HRM, and the development of HR specialists.

Finally, investment in better HR information systems would also strengthen the partnership. The study found that the shared role of HRM was undermined by the absence of reliable up to date information, leading to Line Managers developing duplicate information systems to provide themselves with the information they needed to manage the public health workforce. HR Managers in the two district case studies demonstrated the capacity to perform information management (Mathews, 2012). With the potential use of e-human resource management (Parry, 2011), improved monitoring and evaluation of public health workforce can become an important mechanism that fosters the partnership between the HR and Line Managers. A monitoring and evaluation framework with clear performance objectives and indicators, accompanied by capacity building in monitoring and evaluation and human resource management, is thus also a potential leverage point.

5.8 Conclusion

This research took place in the context of health system decentralisation from the provincial to the district level. In the process, the investigation provided insights into the unfolding processes of the decentralisation of the public health system, specifically, the decentralisation of HRM to the district health system. The subject was investigated from the perspective of frontline actors in two districts, the Cape Town Metro District and the West Coast District, and in this thesis are described the various factors influencing these actors, and the interplay of different elements in a district-based HRM system. This thesis provided a framework for investigating the factors influencing HRM, by assessing vertical and strategic alignment. It applied Ulrich's role framework on strategic HRM to both the HR and Line Managers, as the roles are transversal for these two key actors in managing the public health workforce.

The research found that the paradigm shift to strategic HRM, as outlined in HRM policy, had not taken place yet. Though several responsibility shifts had occurred, such as HR Managers moving from a generalist to a specialist role, and the devolution of HRM to the Line Manager, the study found that both role players were challenged by a lack of capacity in HRM. The study demonstrated how vertical and strategic misalignment influenced the implementation of effective district based strategic HRM.

The study also found that the two district case studies, while similar in HRM system design and structure, followed different pathways in policy implementation, these pathways guided

by their specific local needs. The case studies highlighted similar challenges in the two districts, such as role confusion, lack of capacity to perform HRM, a misalignment amongst the internal components of the HRM Programme, as well as a strategic misalignment with the objectives of the organisation. In addition, the implementation of HR policies, processes and procedures was impeded by unclear roles and responsibilities, and the absence of up-to-date, reliable HRM information.

5.9 Recommendations

The decentralisation of HRM to the district health system underscores the need for the development of sound district-based HRM systems. Based on the findings of the research and the leverage points discussed in the Discussion chapter, a number of recommendations for strengthening district HRM systems are put forward.

The decentralisation of human resource management involved the restructuring of the HRM Programme, and thus the post structure of the programme; however, funding for the posts did not follow.

- It is recommended that the vacant posts within the revised post structure be filled by allocating an additional, dedicated budget, to enable each district and sub-district to have a full HR staff complement to perform effective HRM.

The restructured HRM Programme depicted a reporting line conflicting with the attainment of vertical alignment within the HRM Programme.

- It is therefore suggested that, in the absence of a direct reporting line from the sub-district or hospital level to the district level, an indirect reporting line be instituted to ensure coherence in the district based HRM system.

The decentralisation process also involved the devolution of power and authority, specifically for decision making in HRM.

- The decision making space of the Line Manager has to be expanded in order for the Line Manager to fully embrace the devolvement of, and accountability for, HRM.

A shared vision and shared objectives for HRM between the HR and Line Managers needs to be developed.

- The shared HR objectives have to be linked to the HR deliverables within the job descriptions relating to the key performance areas of the two key role players identified. The development of a shared HR vision, objectives and deliverables would then enable the measurement of HR performance. It would also contribute to creating strategic alignment between the HRM Programme and the organisation, through setting HR objectives and deliverables in line with the organisation's strategic and operational objectives.

More generally, to achieve strategic and effective HRM in the public health sector, it is vital to strengthen the partnership between the HR and Line Managers.

- This can be done through improved coordination within HR components, role clarification, capacity building, improving the human resource information system, and positioning an accountability framework for the partnership:
    - To improve vertical alignment, the coordination within and between HR components needs to structured and monitored. The HRM Programme has to institute a coordination role for the person responsible for the HR component (in this case the ASD: HR), which involves working across and between HR components to achieve operational objectives as well as strategic HR objectives and deliverables.
    - Role clarification of the HR and Line Managers will alleviate the role ambiguity experienced and provide clear roles and responsibilities for each role player. Role clarification should enhance accountability and thus influence the transition and devolution of HRM to the Line Manager. It is proposed that Ulrich's role framework of roles and responsibilities be used to allocate roles required to achieve strategic HRM, and at the same time illuminate the gaps and constraints in performing these roles. Resources such as the People Management Toolkit and workflow charts can then serve to clarify specific roles related to HR functions and processes. The workflow charts could be used to demonstrate the HR function in relation to the achievement of a given objective, outline the tasks required within the function, specify who the person responsible for the task is, and allocate a time period for the task to be completed.

- Capacity building is required for both role players. For the HR Manager, training is required on: information management – which involves basic principles, skills and techniques; specialist skills in HR functions; business knowledge (best approaches in managing public health organisations); and general management training in conflict resolution and negotiation skills. The biggest challenge for this is that the capacity building required is not neatly packaged in a programme or qualification. In other words, the combination of skills required is not part of one training programme or tertiary qualification. Thus, an in-service training approach is recommended where the various training needs are either provided for by different institutions, or a customised programme developed and implemented by the provincial government. For the Line Manager, capacity building on HRM policies and procedures, and information management are required. In the case study districts, capacity building was being planned in the form of induction programmes and workshops on HRM policies and procedures. This still leaves the gap of capacity building in information systems, specifically HRM information systems. Typically, the focus of training is in developing health information systems, with a neglect in information for the monitoring and managing of the public health workforce. Line Managers should be capacitated to produce, interpret and use HR information to plan, manage and monitor the public health workforce.
- Linked to this, opportunities to improve the technology for the HR information system should be explored. Opportunities could be in the form of additions to the existing system, providing platforms to streamline HR processes, or to link existing systems with new systems in order to address the most challenging HR issues.
- Finally, a "horizontal" accountability framework for the partnership, where the role players can hold one another accountable for jointly achieving the HR objectives and deliverables, would ideally frame the partnership. It is suggested that a monitoring and evaluation framework for a district-based HRM system be developed and used as an accountability framework. Monitoring can be used for routine day-to-day management of the programme through a management information system, to identify operational constraints in programme effectiveness; and evaluation can be used to determine whether

the desired effect or impact has been achieved by measuring whether the objectives have been met. The monitoring and evaluation framework should be based on the shared vision, and HR objectives and deliverables agreed upon by the role players in the district health system; a cyclic approach should be adopted requiring review and setting of new objectives; the framework should include performance measures in the form of standardised indicators; it should also be supported by a management information system in order to support the production of the indicators required to be able to measure HR performance; monitoring activities should be allocated; and, finally, a platform be created for human resource information to be discussed between the Line and HR Managers.

Further research is recommended on the structural arrangements within the HRM Programme, the relationship between the two programmes (PHC Service Delivery and HRM Programme), and finally on the association between HRM and the public health organisations' performance.

Comparative international research is needed on of HR approaches and strategies and their alignment to achieving the desired HR deliverables and objectives.

Finally, the international, Human Resource Information Reference Group's role should be expanded to provide more active support to low- and middle income countries. In particular, the Group could undertake the development of standardised human resource information data and indicators and provide support in improving the quality and distribution of existing human resource information systems.

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Appendix 1 Interview Guide

Interview Guide

What is your current job title? How long have you been working in this position?

How long have you been working in the public health sector?

What is your profession and work experience?

What is your current role in human resource management?

What are your current human resource management responsibilities?

How long have you held responsibility for human resource management?

Were you promoted, deployed or directly employed for this position?

What was your prior position?

How are human resources managers selected?

How would you describe your relationship with the human resource manager/line manager?

What are the challenges in communications between you and the human resource manager/line manager?

Specifically with respect to your role in human resource management, what main challenges do you face?

How did your pre-service professional training prepare you in human resource management skills to be effective in your current job?

What additional coursework or training have you received in human resource management?

Has this additional knowledge been useful in your work? If so, what helped or hindered your ability to apply this additional training in your work?

In addition to human resource kills training, what additional management and leadership training do you believe you need to enhance or advance your ability to perform your current role in human resource management better?

Appendix 2 Questionnaire Human Resource Managers

Questionnaire

Thank you for agreeing to participate in the research study. Please complete the attached questionnaire by making the appropriate selection for each question.

The questionnaire includes the 3 following sections:

Section 1	-	Demographic Details	16 questions
Section 2	-	Functions and Responsibilities	15 questions
Section 3	-	Perceptions and Attitudes	15 questions
Total number of questions:			**46 Questions**

QUESTIONNAIRE IDENTIFICATION NUMBER |CAPE___|_____|_____|

District Cape Metro

Section 1: Demographic Details

Complete the following section by selecting the correct response. Question 110 and 112 multiple responses could be selected.

No.	Questions and Filters	
101	Age	<25yrs ☐ 25-30yrs ☐ 30-35yrs ☐ 35-40yrs ☐ 40+years ☐ No Response ☐
102	Gender	Male ☐ Female ☐ No Response ☐
103	Marital Status	Married ☐ Divorced ☐ Single ☐ Widowed ☐ No Response ☐
104	Ethnicity	Black ☐ White ☐ Colored ☐ Indian ☐ Other: _____
105	Highest Qualification	Less than Grade 10 ☐ Grade 10 ☐ Grade 12 ☐ Diploma ☐ Degree ☐
106	Do you have qualifications in HRM?	Yes ☐ No ☐
107	If yes, what qualifications?	Short course ☐ Diploma ☐ Degree ☐ Other:_____
108	What is your job title?	
109	Number of years employed in current position?	0-5yrs ☐ 5-10yrs ☐ 10-15yrs ☐ 15-20yrs ☐ 20+ yrs ☐ No Response ☐

110	In which human resource component (s) are you currently working?	HR Planning	☐	Labor Relations	☐
		Establishment Administration	☐	Performance Management	☐
		Recruitment and Selection	☐	Personnel Administration	☐
		HR Policy, Practices and Audits	☐	Human Resource Development	☐
		Other	☐		
111	How long have you been working in this component (s)?	0-5yrs ☐	5-10yrs ☐	10-15yrs ☐	15-20yrs ☐	20+ yrs ☐	No Response ☐
112	In which human resource component (s) have you previously worked?	HR Planning	☐	Labor Relations	☐
		Establishment Administration	☐	Performance Management	☐
		Recruitment and Selection	☐	Personnel Administration	☐
		HR Policy, Practices and Audits	☐	Human Resource Development	☐
		Other	☐		
113	What are your main job functions according to your job description?				
114	Are your job	Yes		No	

	functions in your job description different from the functions you currently performing?	☐ ☐
115	Have you attended training on Human Resource Management in the last 3 years?	Yes ☐ No ☐
116	List the training in Human Resource Management you have attended in the last 3 years?	

Section 2: Functions and Responsibilities

Complete the following table by selecting the appropriate response to the statements.

No.		Never	Rarely	Sometimes	Often	On a regular basis
201	I capture data on PERSAL	**1**	**2**	**3**	**4**	**5**
202	I ensure that the data is accurate on PERSAL	**1**	**2**	**3**	**4**	**5**
203	I share information with the colleques in my human resource component	**1**	**2**	**3**	**4**	**5**
204	I share and discuss information with the colleques in other human resource components	**1**	**2**	**3**	**4**	**5**
205	I liaise with the facility managers regarding the staff establishment information	**1**	**2**	**3**	**4**	**5**
206	I prepare and write staff establishment reports for facility managers	**1**	**2**	**3**	**4**	**5**
207	I prepare and write staff establishment reports for programme and sub-district managers	**1**	**2**	**3**	**4**	**5**
208	I monitor the movements of the staff establishment	**1**	**2**	**3**	**4**	**5**
209	I interpret information on the staff establishment	**1**	**2**	**3**	**4**	**5**
210	I motivate for different or additional staff	**1**	**2**	**3**	**4**	**5**
211	I determine training needs	**1**	**2**	**3**	**4**	**5**
212	I coordinate the information management in my component	**1**	**2**	**3**	**4**	**5**
212	I give advice on human resource planning to the line managers (facility, programme, sub-district, district)	**1**	**2**	**3**	**4**	**5**

213	I give advice on human resource management issues to the line manager(facility, programme, sub-district, district)	**1**	**2**	**3**	**4**	**5**
214	I give feedback on human resource information to facility staff using reports and other communications	**1**	**2**	**3**	**4**	**5**
215	I provide feedback on human resource information to management through reports	**1**	**2**	**3**	**4**	**5**

Section 3: Perceptions and Attitudes

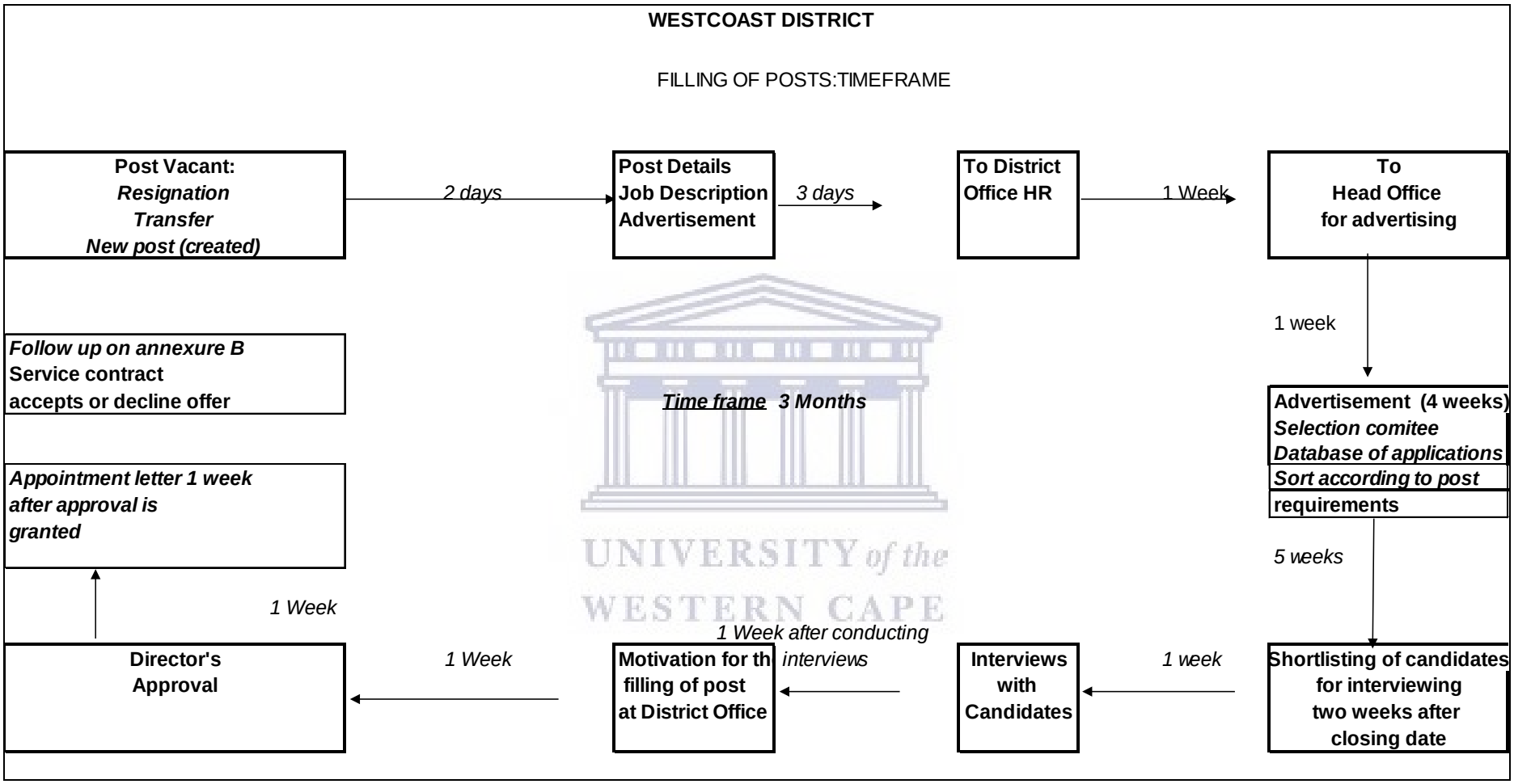
Complete the following table by reading the statements and circulating the most appropriate response.

No.		Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
301	I am able to perform accuracy checks on the data in PERSAL	**1**	**2**	**3**	**4**	**5**
302	I am able write establishment reports	**1**	**2**	**3**	**4**	**5**
303	I am able to monitor the trends in the staff establishment	**1**	**2**	**3**	**4**	**5**
304	I am able plan the staff establishment according to the approved staff establishment	**1**	**2**	**3**	**4**	**5**
305	I am able interpret the human resource reports and use the information in the reports	**1**	**2**	**3**	**4**	**5**
306	I am able determine the information needs of the facility managers	**1**	**2**	**3**	**4**	**5**
307	Information Management should be part of my job description	**1**	**2**	**3**	**4**	**5**
308	Producing information reports should be part of my job description	**1**	**2**	**3**	**4**	**5**
309	Ensuring the information is accurate	**1**	**2**	**3**	**4**	**5**

	is not my responsibility					
310	Analyzing and presenting information should not be part of my main duties & responsibilities	**1**	**2**	**3**	**4**	**5**
311	Information should be used for decision making and planning	**1**	**2**	**3**	**4**	**5**
312	Line Managers and Human Resource Managers are not working together in managing the staff establishment	**1**	**2**	**3**	**4**	**5**
313	Managers and Human Resource Managers should work together on managing the staff establishment	**1**	**2**	**3**	**4**	**5**
314	Human Resource Managers from different human resource components should work together in managing the staff establishment	**1**	**2**	**3**	**4**	**5**
315	Some human resource components are functioning completely separate from the other components	**1**	**2**	**3**	**4**	**5**

Thank you very much.

Appendix 3 Workflow Chart



Appendix 4 Compliance Management Instrument (CMI)

MANAGERIAL CHECKLIST IN RESPECT OF HR MATTERS: HEAD OFFICE

(to be completed by the Superintendent General/Deputy Director General/Chief Director/Director on a monthly basis in consultation with Line Managers)

DIRECTORATE/CHIEF DIRECTORATE:

MONTH:

SG/DDG/ Chief Director/Director: **Print Name**

		Yes	No	Comments
1. HR Audit Action Plan				
1.1.	The HR Audit Action Plan and compliance thereto is monitored and discussed with the HR Manager on a monthly basis and submitted on a quarterly basis.			
2. Vacancies				
2.1.	A list of all funded and vacant (APL) posts has been drawn for urgent filling.			
2.2.	The HR Manager has confirmed that the Recruitment and Selection template has been updated and is monitored on a monthly basis.			
2.3.	Line Managers have confirmed that advertisements have been compiled in respect of all vacant funded posts for placement.			
2.4	The HR Manager and Line Manager have confirmed the status of all advertised posts for filling within two (2) months after closing date.			

		Yes	No	Comments
3. Appointments				
3.1.	Line Managers and HR Managers have confirmed that the proper recruitment and selection process has been followed before any appointment, **including contract appointment,** is made.			
3.2.	The HR Manager has confirmed that verification checks in respect of all new appointments have been conducted in line with Circular H164/2010.			
3.3.	The HR Manager has confirmed that check lists for appointments are in place and that the required documentation is filed correctly and available for audit purposes.			
3.4.	Line Managers have confirmed that probation reports are submitted quarterly to HR.			
4. Sessional Appointments				
4.1.	Clinical Heads have confirmed that the current sessional employees are needed to continue the service for which they were appointed.			
4.2.	Sessional contracts are in place for all sessional employees and are revisited on an annual basis.			
4.3.	Control measures are in place to monitor hours worked.			
5. Commuted overtime (Not applicable with the exception of the Directorate: Forensic Pathology Services)				
5.1.	The Chief Director has approved cases exceeding 32 hours per week (20 hours commuted overtime plus 12 hours normal overtime) and reports are drawn in this regard.			
5.2.	The Clinical Heads of all components have submitted verification forms at the end of each month.			

5.3.	The Clinical Heads of all components have confirmed that duty rosters are in place and adhered to.			
5.4.	Commuted overtime contracts are in line with operational requirements and are in place for all participating employees.			
5.5	Commuted overtime contracts are reviewed and renewed in November / December of each year.			
		Yes	**No**	**Comments**
6. Normal Overtime (Circular H148/2010)				
6.1.	This institution is in compliance with the control measures with regards to overtime indicated in Circular H148/2010.			
6.2.	Authorization for overtime has been obtained before 1 April each year and based on a needs analysis; the projected expenditure has been calculated.			
6.3.	Line Managers have confirmed that overtime in excess of 30% is monitored.			
6.4.	Overtime in excess of 30% has been approved by the Chief Director.			
6.5.	Line Managers have confirmed that no overtime payment is authorized to staff while on leave.			
6.6.	Overtime attendance registers are in place and duly signed and authorized before any payment is processed.			
6.7.	HR Manager has confirmed that backdated cost of living adjustments for overtime payments effected under allowance code 0169 have been addressed where applicable.			
7. Membership with professional bodies				
7.1.	All Line Managers have been instructed to inform employees who require statutory membership with a professional body, to renew his / her registration on an annual basis.			

7.2.	Line Managers confirmed that all professional employees have submitted their annual proof of registration.			
8. Acting Allowance				
8.1.	HR Manager has confirmed that Persal report (#4.8.41) of all acting employees has been drawn monthly to monitor compliance to the Acting Allowance Policy.			
8.2.	The vacant funded posts have been advertised in order to prevent employees acting for excessive periods.			
8.3.	Approval from the HOD has been obtained where acting periods have exceeded twelve (12) months period. **(Acting in excess of the 12 month period has been addressed to DPSA and until such time as a response has been received no employee should be allowed to act for a period in excess of 12 months).**			**HRM TO RESPOND**
		Yes	**No**	**Comments**
9. Leave				
9.1. General Leave				
9.1.1.	Line Managers have been instructed to properly plan annual leave within the annual leave cycle (January/ February).			
9.1.2.	The timeous submission of leave forms to HR has been discussed and confirmed by all the Line Managers at monthly management meetings.			
9.1.3.	HR/ Line Manager confirm that leave has been verified against attendance registers.			
9.1.4	HR Manager has confirmed that all leave forms from current financial year are submitted and have been captured on Persal before 31 March each year.			
9.1.5.	The HR Manager has confirmed that reports of employees with negative capped leave credits have been drawn and addressed accordingly.			

9.2. Sick Leave				
9.2.1.	Management of sick leave has been discussed and analyzed at monthly management meetings. HR has drawn quarterly reports and distributed them to Line Managers.			**HRM TO RESPOND**
9.2.2.	Line Managers have confirmed that sick leave is monitored and managed on a regular basis.			
9.2.3.	Line Managers have confirmed that all sick leave application forms have been submitted to HR within the time frames.			
9.2.4.	Line Managers have confirmed that all long periods of sick leave have been discussed with the HR Manager to ensure that the PILIR application is not delayed.			
9.2.5.	The HR Manager has confirmed that sick leave has been captured and updated on Persal.			
9.3. PILIR				
9.3.1.	Line Managers have confirmed that all PILIR applications have been processed and submitted to HR within the relevant time frames.			
		Yes	**No**	**Comments**
9.3. PILIR (Cont)				
9.3.2.	Problem cases where extended absences have occurred have been identified and discussed at management meetings and a way forward is being addressed.			
9.3.3.	The HR Manager has confirmed that all PILIR applications have been processed and forwarded to the Health Risk Manager within the relevant timeframes.			
9.3.4.	The HR Manager has confirmed that finalized PILIR cases have been captured on Persal and the declined incapacity leave has been captured			

	as annual or unpaid leave.			
10. RWOPS				
10.1.	Line Managers have confirmed that all applications for employees performing RWOPS have been approved and forwarded to HR to place on file.			
10.2.	HR Managers have confirmed that registers for employees performing RWOPS are in place.			
10.3.	Nursing Managers have confirmed that nurses performing RWOPS via nursing agencies have rendered 3 times 12 hour overtime shifts per month before working RWOPS.			
11. Paysheets (Finance Instruction G13/2001)				
11.1.	The HR Manager has confirmed that a responsible official has been appointed in writing to request and distribute pay sheets on a monthly basis.			
11.2.	Line Managers have confirmed that paysheets have been signed and returned to the HR Office before pay date.			
11.3.	Compliance in respect of the afore-mentioned Finance Instruction and control of paysheets has been discussed at monthly management meetings.			
12. Service terminations and overpayment of salaries				
12.1	Line Managers have confirmed that HR has been timeously informed of all service terminations.			
12.2.	The HR Manager has confirmed that a list of terminations has been drawn and files have been thoroughly audited.			

		Yes	No	Comments
12. Service terminations and overpayment of salaries (cont.)				
12.3.	Outstanding debts are managed according to Finance Instruction G17/ 2009.			
12.4	The HR Manager has confirmed that all pension documents have been timeously completed and submitted to the Government Employees Pension Fund.			
12.5	HR Managers confirmed that all backdated cost of living adjustments in respect of salary, other allowances, leave gratuity and service bonuses have been effected and the amended Z102's have been finalized.			
		Yes	**No**	**Comments**
13. HR Administration (Filing of documentation)				
13.1	A proper filing system for HR files and documentation is in place and maintained.			

I am aware that I can be held accountable for ensuring compliance to the above:

_____ _____

Print name Signature Date

Checklists to be submitted on a monthly basis to the Director: HRM (Attention:)

The personal assistants to the respective Managers should co-ordinate the process

Appendix 5 Job description of the facility managers in MDHS

Departement van Gesondheid

Department of Health

JOB DESCRIPTION

A. JOB INFORMATION SUMMARY

Name and Surname	
Job title of post	Facility Manager
Minimum qualification required	Relevant Tertiary qualification. Appropriate experience in Management.
Motivation for minimum qualification required	Incumbent must be a specialist with regards to management that would require performing multi-skilled complex tasks on management level.
Current qualification of incumbent	
Job title of incumbent	
CORE	Nursing Management and support Personnel.
Salary level	11
Salary level of incumbent	
Date of appointment/promotion into post	
Date of promotion into current rank	
Institution	Metro District Health Services
Component	Community Health Centre
Reports to	PHC Manager: Sub Structure Office
Organogram	PHC Manager ↑ Facility Manager – 24 hour facility.

B. JOB PURP0SE

Describe in short the purpose of the job. No more than two sentences. The description of the purpose should include such key words as who, where, why, what and how
Incumbent is primarily responsible for the effective management of the component with regards to Primary Health Care; Human Resource Management; Financial Management; Supply Chain & logistics Management to ensure that holistic care is provided to patients and their families.

C. POST DIMENSIONS

• **Personnel expenses**	*Applicable to salary level 9 and higher. Minimum rand value in R10 000, R100 000 or R1 000 000*
Budget	n/a
Equipment	n/a
Buildings	n/a
• **Livestock**	n/a
Clients	n/a

- **D. DESCRIPTION OF JOB**

KRA	OUTPUT	ACTIVITIES	WEIGHT OF OUTPUT	STANDARD	EVIDENCE	COMPETENCY
The final product or main objective to of a job achieved against one or more outputs without which results cannot be achieved	*Describe the sub results in order to achieve the KRA. Limit the outputs to as few as possible*	*Describe the activities in order to achieve the output*	*Indicate the weight of each output. All outputs together should not weigh more than a total of 100%*	*Describe legislation, protocols, policy, directives, minimum requirements, set parameters and rules that govern or define the output. Describe the criteria according to which the output must conform*	*Describe how you would prove that the output has been achieved. What would exist because it has been achieved. The evidence must be tangible*	*Describe the knowledge, skill and behaviour necessary in order to achieve the output*
D.1 District Health Services Development	D.1.1 Fully functional Health committees at each CHC.	1. Regular meetings and minutes. Each CHC manager attends workshop to establish basic norms, codes, etc Number of CHCs Management teams informed regarding legislation and National Health Act Committee Members to attend training programs.	5%	Public Service Act,1994 (as amended) Public Service Regulations National Health Act & legislation. Departmental and internal Policies Circulars, agreements and instructions. Public Finance Management Act. BAS Financial Delegations / Instructions.	Minutes received and filed at each CHC Designated staff member represents CHC at all meetings Number of CHCs Management teams informed regarding legislation and National Health Act % committees trained in: proposal writing basic accounting	<u>Knowledge:</u> Responsible for the management of material and human resources within the financial framework of nursing units. Implementation of quality improvement programmes in nursing units. Planning & organizing (how to plan activities which may include projects, policy matters and compilation of management reports. Training- assist in developing & presenting formal training

					practice conduct of meetings, office bearers	courses to build capacity of public service. Occupational Health & Safety Act. <u>Skills:</u> Management Discipline Analytical Presentation Team building/ motivation Project management Research Behaviour: Professional Meticulous Organized Innovative
D.2 Human resource Management	D.2.1 1. Fully staffed CHC. All funded posts filled at all times as per FPMI 2. Staff training needs met against SDP 3. Harmonious LR. Good LR Management. All disciplinary and grievance matters resolved 4. SPMS in place, functioning and completed. 5. Absenteeism reduced 6. Verified establishment	1. Recruitment and selection processes 2. Skills Plan developed and implemented 3. Codes of labour relations management adhered to. Application of Disciplinary Code and Procedure. 4.1 IPDPs for all staff members signed off 4.2 At least 2 Quarterly Reviews completed 4.3 Annual	30%	Dept.of Health: Recruitment & Selection Policy, 2002 Public Service Regulations, 2001 Skills Development Act Labour Relations Act Individual SPMS Plan 2007/8. Dept.of Health	1. No vacant posts 2. Report on staff trained. 3. No outstanding disciplinary processes or grievances. Proportion of disciplinary concluded and grievances resolved. 4. SPMS cycle completed.	<u>Knowledge of:</u> HR Matters (HR Management practices, legal issues, negotiations, dealing with conflict. Assist in career planning and utilization of personnel.. Performance Appraisal <u>Skills:</u> Management Analytical Team building <u>Behaviour:</u> Professional Meticulous

		appraisal completed 5. Register with leave tracking system 6. Establishment checked monthly		Establishment, 2000	Leave Charts for all staff.	Organized Innovative
D.3 Financial Management	D.3.1 1. Balanced budget with expenditure controls in place 2. Revenue targets met 3. Compliance with financial prescripts 4. Financial Efficiency	1. Monthly expenditure reports evaluated and corrective action taken. Expenditure control systems implemented. Check stock and finances before ordering 2. Monitoring of fee collection 3. Corrective steps from Auditor General and financial inspections 4. Monitor monthly cost per visit	15%	Public Finance Management Act National Treasury Instructions BAS Financial Delegations / instructions.	1. Monthly expenditure reports and variance 2. Revenue reports 3. A-G and inspection reports 4. Cost per visit	<u>Knowledge of:</u> Finance (Financial regulations & instructions must be followed during the normal course of work.) How to execute overall control of budgets of projects and component to limit financial losses. <u>Skills:</u> Analytical Discipline Computer literate <u>Behaviour:</u> Meticulous
D.4. Supply Chain Management & Logistics	1. All essential supplies at all times 2. Asset management system in place 3. All essential equipment present and working 4. GG vehicles well managed	1. Storekeeping, stock taking, regular and frequent ordering 2. Asset register implemented and stock taking done 3. Audit of essential equipment list, procurement	25%	Public Finance Act National Treasury Regulations BAS Procurement Delegations	1. Stock reports of essential items 2. Asset register audited 3. Audit report	(same as above)

		and servicing of equipment 4.1 Log sheets properly completed and controlled 4.2 Trips properly authorized 4.3 Vehicles serviced regularly				
D.5 Health Information	D.5.1 1. Accurate and valid information 2. Timeous information 3. PHCIS managed and used optimally	1. Monthly RMR checked and signed off before submission 2. RMR submission on due date 3. Strict supervision of data entry into PHCIS. Reengineer reception and filing systems			1. Signed RMR reports 2. Reports from Health Information section on submission rates 3. PHCIS Duplication Rate educed from baseline	
D.6 Quality of care	D.6.1 Batho Pele Occupation Health and Safety. CHCs are clean and safe. Monthly M&M meetings	Training of staff OHS reps appointed and trained. Infection control in place. Monthly inspections. Meetings with Mortality and Morbidity reports.		Batho Pele Handbook Occupational Health & Safety Act no.181 of 1993	% of Staff trained % CHCs with monthly inspections % CHCs with reports on file	Knowledge of: Batho Pele Handbook OHS Act Skills: Team building / motivation Presentation Excellent verbal & written communication skills. Behaviour: Meticulous Organized.
D.7 TB	D.7.1 Increased rates of	TB Sputum Register implemented		Departmental and Internal Policy	Proportion of total headcount	Expert knowledge of Primary Health

	TB Case detection			TB control Programme-2003	tested. Sputum Positivity Rate. Sputum +ve patients started on treatment.	Care & tertiary qualification in Nursing Sciences. <u>Skills:</u> Providing & obtaining information requiring complex explanations. Conduct research Behaviour: Professional confidentiality
D.8 HIV / AIDS	D.8.1 Improved VCT Uptake STI partner treatment rate. Female condom distribution from primary distribution sites. Male condom distribution rate from public sector health facilities(per male 15 years and older) To improve access to ART	Supervise Lay counselors Commence ART Services		Departmental & Internal Policies Transversal Framework HIV /AIDS & STIs.	Counseling rate Cumulative number of clients on ART at Cross Roads, Nyanga, Heideveld and Browns Farm CHCs	(same as above)
D.9 Womens and Child Health	D.9.1 National cervical cancer screening policy implemented. Comprehensive Management of Rape Survivors IMCI Trained Nursing Staff	Cervical Cancer Screening Register Implemented, Staff trained, equipment available, client recruitment system in		Public Health Programme.	Monthly reports on targets reached and ECC component % Of sexual assault cases reporting to health facilities who	(same as above)

	Diarrhoel Disease controlled Improve School Health	place. Register in place Monthly report produced. IMCI Training ORT Corners at each CHC Manage and supervise School Health Teams			received a full course of PEP Proportion of nurses trained ORT corner in place Implement phase 1 of School Health Policy.	
D.10 Improved Chronic Disease Management	D.10.1 Chronic Care Team with Clinical audit in place Clubs/Therapeutic Groups/Support groups Improved management of CVS disorders Improved foot care and eye screening in diabetics Improved wound care An effective alternate dispensing system	Identification of team with at least one audit cycle completed for CVS disease and asthma Implementation of Clubs and groups. Ensure minimum norms & standards of chronic disease Management in place. (for Diabetes & Asthma) Implementation of Foot screening record. Implementation of retinol screening, by camera if possible. Training in foot screening and retinal examination. Training in		Public Health Programme.	Audit report and improved plan implemented. Patient support system in place % diabetics screened. Staff trained Wound Care Guidelines implemented, with structured records and audit care Number of prescriptions issued for chronic medication through Provincial CDU suppy	(same as above)

		guidelines Introduction of structured record Implement CDU System			system	
D.11 Improve Mental Health Services	D.11.1 To provide adequate number of MH nurses at facilities	Active recruitment and selection of MH Nurses		Departmental & Internal Policies	% of MH nurses appointed against CSP norms per sub-district	(same as above)

E. INHERENT REQUIREMENTS OF THE JOB

The inherent requirement of the job is derived from the essential functions of the job. The incumbent must be able to perform these essential functions. For example, the 24-hour service provided in a hospital environment will require that the individual work shifts in order to meet operational requirements. The inherent requirement of the job is therefore, that the incumbent is able to work shifts. Similar examples relate to: working hours, standby, willingness to travel and a drivers license. ***Other examples of inherent requirements could relate to the physical attributes of the incumbent. These can be linked to section 6(2) of the EEA, 1998, which states that the employer may fairly discriminate against the incumbent if such a physical attribute is regarded as an inherent requirement of the job. These include: race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV/AIDS status, conscience, belief, political opinion, culture, language and birth.***
Registration as a Professional Nurse with 10-15 years experience Course in Hospital / financial management advantageous. Good interpersonal & communication skills Conflict Management skills Effective administration of resources Leadership abilities and decision- making skills Good organizational skills

• F. MEDICAL TESTING

In cases where specific health or physical attributes are essential for the performance of the job, the Minister of Labour must be approached for the necessary exemption. If exemption is obtained, such requirements should clearly be stated in the job description and advertised as such. ***Health requirements should relate to the inherent requirement of the job. No pre employment testing (health questionnaire, medical testing, medical reports etc) should be undertaken should the inherent requirement of the job not require health/physical attributes.***
n/a

G. CAREER PATHING

Describe the necessary knowledge, skills and behaviour in order to progress with regard to career pathing (career advancement). This may be horizontal (lateral transfer) or vertical movement (promotion). This should include in service training as well as formal education. ***Promotion to the next higher post is subject to availability of a post, satisfactory work performance as well as conforming to the applicable recruitment and selection procedures.***
Promotion to next higher post is that of Deputy Director depending on the availability of funded vacant post. Knowledge and skills comparable to that normally obtained through formal studies towards obtaining an applicable degree / diploma. Incumbent should have extensive experience in management and perform multi skilled tasks and complex work on management level that require frequent interpretation of information in the absence of an established framework.

H. AGREEMENT

• **Agreement**	This job description has been consulted and agreed to between the relevant parties.	
• **Employee**	*Signature*	*Date*
Direct supervisor/manager	*Signature*	*Date*
Higher level supervisor	*Signature*	*Date*

Appendix 6 Comparison of the DD HRM VS ASD HRM Responsibilities in Human Resource Management

Deputy Director: HRM	Assistant Director: HRM
Activities	Activities
• Manage personnel administration on Persal system • To manage basic conditions of employment and service benefits • To ensure that HR audits are conducted on MDHS personnel administration and that audit reports are implemented • To manage recruitment and selection procedures and ensure that appointments are made • To manage the SPMS and PMDS system • To ensure the implementation of HRM policies, practices and procedures • To provide input to HRM policies, practices and procedures • To monitor compliance to HRM policies within central and substructures • Assist Line Managers in restructuring exercises • Determine staffing requirements and strategies to implement HR Plan • To manage the staff establishment • Give guidance and advice on complex HRM policies and practices • To interpret and make decisions on complex HRM policies • Manage collective bargaining structures in MDHS • Manage the disciplinary process • Manage the grievance process • Manage the dispute and conflict resolution process • Manage the implementation of Labour Relations functional training • Recording and collation of labour relations information in order to monitor and evaluate labour relations within MDHS • Workplace Skills Plan • Develop implementation plan for skills development interventions • Ensure implementation of in-service training intervention	1. Management of HR Planning • Co-ordinate micro-HR restructuring • Development and implement HR micro Plan • Co-ordinate OD intervention • Co-ordinate job evaluation processes • Conduct job analysis in terms of HR Plan • Develop and maintain job descriptions and conduct training • EE plan implementation and M&E • HRM information control 2. Management of establishment administration • Conduct establishment administration control • Administer creation/abolition of posts provided • Provide input to FPMI and apply FPMI with filling of posts • Co-ordinate HF2 process • Maintain database • Render a Recruitment &Selection function • Co-ordinate and manage the advertising of posts • Manage and co-ordinate the filling of posts • Screen application and acknowledge receipt • Maintain database of applications • Co-ordinate short listing process • Approve interview panels • Screen EE profile • Facilitate motivations for appointments • Investigate grievances and disputes • Do authorizations of appointments (Persal) • Co-ordinate verification checks on appointment and maintenance of a database • Conduct training 3. Effective supervision of staff • Review and discuss individual performance and development plan

• Ensure implementation of bursaries • Ensure implementation of learnerships • Annual training Report • Act as head of sub directorate • Handle all matters related to supervision of component • Managing capacity building of subordinates • Assume responsibility for all delegated powers • Ensure sound labour relations of sub directorate	• Draw up performance- and development plan • Conduct quarterly reviews and assessments and finalize annual reviews • Facilitate and monitor poor performances/unsatisfactory cases throughout cycle • Ensure that audi alteram partum rule was applied at all times where applicable • Submit to head of component/Pre-Mod Committee • Monitor leave and address absenteeism and enforces Code of Conduct • Investigate grievances and disputes

Appendix 7 CTMD Comparison of HR Manager and Line Manager's roles and responsibilities in HRM

HR Category	HR Component	HR Functions	Facility Manager	PHC Manager
Payroll, Policy and Practices	Human Resource Policy, Practices and Audits	Monitoring Policy Implementation Policy Training Policy Document Maintenance Conducting HR Audits	Monitor Policy implementation	Monitor Policy implementation
	Service Conditions and Benefits	Service Exits Leave Management Conditions of Service Service Benefits	Register with leave tracking system	Monitor Absenteeism
HR Planning and Establishment Administration	Recruitment and Selection	Motivations for Appointments Applications Screening Short listing Interviewing	Recruitment and selection processes	Recruitment
	Establishment Administration	Establishment Monitoring Creating new Posts Abolition of Posts Advertising Posts Filling of Posts	Establishment checked monthly	Fill vacant and funded posts
	HR Planning	Develop and Implement HR Plan Job Analysis Job Descriptions Employment Equity Monitoring and Evaluation HRM Information Control		Human Resource planning
	Performance Management	Performance Agreements Grievance with SPMS Developing Transversal Norms and Standards Training on Performance Management System	IPDPs for all staff members signed off. At least 2 Quarterly Reviews completed. Annual appraisal completed	Performance management
Labour Relations	Labour Relations	Collective Bargaining Support and Maintenance Function Labour Relation Forums Statistics and Case Management System Database Training and Development in Labour Relations	Codes of labour relations management adhered to. Application of Disciplinary Code and Procedure.	FPMI) code of conduct protocol
Human Resource Development	Human Resource Development	Skills Audit Workplace Skills Plan Coordinating Training and Development Administration of Workplace Skills Fund	Skills Plan developed and implemented	Human Resource Development

Appendix 8 Comparison of Job Descriptions of HR Managers

	ASD HR	Senior Personnel Practitioner
Service Termination		Resignations Death Ill-health Retirement Early Retirement Discharge / Dismissal Age Retirement Severance package
Personnel Administration	Delegate and control work flow Give guidance and advice to staff Utilise and manage staff optimally in terms of skills, knowledge, etc. Apply SPMS	Processing of documents pertaining the functional activities of the section. Handling of telephonic and personal enquiries Keeping record of acts ,regulations and instructions Attend meetings, courses and workshops Quarterly evaluations (Review & Appraisal) of SPMS of sub-ordinates
Persal Administration	Prepare and present Payroll statistics to district management and Institutional management.	Request of Persal reports and pay sheets Approve and authorise of leave, housing allowance, commuted overtime, public holidays, normal overtime etc. Approve and authorise of transactions on Persal
		Maintain the data integrity of the Persal Payroll system
Conditions of Service		Correct implementation of policy with regard to: State Guarantees All types of Leave Quarterly reports Occupational Injuries and deceases Housing and rental Allowance Uniform Allowance Overtime, Night Shift and standby allowance Pensions RWOPS Commuted Overtime etc.
Supervision	Provide regular feedback with regard to relevant HR matters Act in supervisory capacity when necessary Represent supervisor at meetings when necessary Adhere to the Public Service Code of Conduct	Support to supervisor Give guidance and advice to sub-ordinates and line functionaries Support and advisory services in terms of policies, prescripts and enquiries.
Labour Relations	Investigate grievances Promote sound labour relations	Give guidance, advice and support to sub-ordinates Supervised sub-ordinates Ensure good leave planning for section

		Manage Sick leave within section Taking Disciplinary action if necessary Assist with grievances and disputes within the section See that policies and prescripts are implementing correct
Support to institution		Strengthening of HRM at institutional level To render a relief function in the office and district Relief function to Sonstraal en Radie Kotze Hospital
Human Resource Development	Identify training needs Provide training programmes or info sessions to HR components at institutions on HRM policies and prescripts Evaluate effectiveness of training programmes	
Compliance/Auditing	Coordinate and manage audit investigations at district hospitals as well as follow up of audit investigations performed by H/O Keep tracking system of CMI's Prepare and report on audit findings to District and Institutional Management.	Audit of HR files
Monitoring and Evaluating	Keep abreast of existing and new legislation and policies Analyse, interpret, evaluate and provide solutions for complex HR problems experienced by district management and institutions Provide guidance and advice during meetings to ensure consistency and correct application of HR policies and prescripts Handle written and telephonic queries Provide advice on the implementation and application of HR policies and pre-scripts Monitor and evaluate the implementation and application of HR policies and prescripts at institutional level Write submissions/ recommendations to management regarding specific HR issues to ensure the correct application thereof	Implement, advice, conduct audits and provide induction training on Payroll policies, procedures and practices with respect to: Handling of ad hoc projects and ministerial enquiries from Head Office Reporting on statistics for Head Office Due dates and follow up of information