POLICY BRIEF
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Rebuilding collective cultures for better public financial management in healthcare

Is centralised financial control necessary to achieve UHC?

The global call for universal health coverage (UHC) has prompted progressive reforms as countries work to improve access to healthcare. However, due to slow or no economic growth, many lower- and middle-income countries (LMICs), and even upper-middle-income countries (UMICs) – like South Africa (SA) – have been lagging with UHC goals.

To weather reduced budgets and systemic issues hampering performance, many South African provincial health departments decided to centralise financial management and decision-making – despite a growing consensus that effective service delivery requires giving those working at the coalface of healthcare more spending control.

The Provincial Department of Health (PDoH) this study focused on centralised financial management with the aim to prevent budget overruns, curtail the mismanagement of funds, and protect financial managers working in a punitive regulatory environment. However, the centralisation slowed down service delivery, strained relations between financial and clinical managers, and reduced the

Conclusions and policy recommendations

In South Africa, the move from a command-and-control culture to a participatory environment can be difficult. To transform these relationships and build a more functional organisation, the following measures can help to navigate positive reforms in PFM, foster trust, and prepare for decentralisation and National Health Insurance (NHI):

- Bring diverse managers together more often and in different settings.
- Achieve a greater understanding of challenges on the ground by rotating provincial finance managers through health offices (DHOs) and hospitals.

The following recommendations are also applicable internationally:

- Spend time in facilities and DHOs to give finance managers a better understanding of the realities on the ground.
- Support relational accountability between clinical and finance managers to improve organisational culture and functioning.

willingness of managers to work together for the greater good.

The findings presented in this brief and accompanying research paper call for public financial management (PFM) reforms that are designed collaboratively and are implemented in ways that support effective service delivery.

Study methods

Study design Our findings were based on interviews with stakeholders in one South African PDoH, on their experiences of centralisation reform. We used ethnographic research methods and a case study approach to analyse how the reform affected the department's work culture, challenges, and dynamics.

Study setting The province had a long history of financial mismanagement and is also one of the poorest performers in terms of service delivery in the country. Austerity measures and PFM centralisation had been in place since 2015.

Participants Participant observation techniques were used for 60 individuals in 10 meetings (including financial management meetings and meetings with hospital CEOs), and 30 semi-structured interviews were conducted.

Data collection and analysis Data were collected from July 2017 to June 2018. Most observations and interviews took place at the public hospital, and the questions prompted participants to share their experiences in their own words. An interactive workshop, to which all stakeholders were invited, allowed participants and other provincial stakeholders to provide insight and feedback on our findings.

Service delivery in an austerity climate

While staff differed about the health department's overarching goal, finance and clinical managers all agreed that the healthcare budget was insufficient for the province's needs. The expectations created in service delivery plans were also far removed from actual funding – which set those responsible for service delivery up for failure and amplified tensions between various levels in the system.

Our research yielded results in three distinct areas affecting participants: their perceptions about the conditions that gave rise to the status quo; how centralisation has impacted them as individuals – and collectively; and what the centralisation of financial management bodes for the future.

Financial management in context

A history of financial mismanagement and poor audit outcomes plagued the province, and this resulted in a cycle of centralisation and decentralisation of financial management, with provincial treasury more supportive of a centralised approach. Financial control would be revoked completely from all lower levels, not just offending individuals, when transgressions took place.

Many felt this was inefficient, and unfair to those who didn't infringe.

On the other hand, finance managers experienced the PFM regulatory environment as highly punitive, making the perceived risk of decentralisation unpalatable for them.

How centralisation played out

To improve audit outcomes, a centralisation committee was established to review expenditure and payment requests for the whole province. No representatives from the district or hospital level were included in the committee, so decisions were driven by the head office. It caused tension between the head office and lower levels of the PDoH and clinical managers often deemed decisions by the committee opaque or incorrect. The committee also frequently took too long to make (and communicate) decisions, delaying service delivery implementation. As a result, clinical and district managers were even less supportive of the centralisation reform.

More specifically, senior managers adopted an authoritarian management style to ensure compliance with the financial management reform, which further reduced support for centralisation. This aggravated power imbalances between finance and clinical managers, and ultimately, delivery suffered.

Because the management style allowed for little or no participation, organisational functioning was negatively affected. With no participatory culture in place, people worked in silos and negated their colleagues' needs. Additionally, clinical managers perceived that their opinions weren't considered in financial spaces. When opportunities did arise, they then often refused to participate in decision-making because of their previous experiences, which in turn decreased departmental performance.

The absence of a shared vision of the PDoH's main goal – to safeguard public funds or to deliver healthcare – drove the tension between finance clinical managers and led to a competitive organisational culture. This further weakened the system's ability to render quality service delivery.

The consequence

The strained relationship between finance and clinical managers mainly emanated from the lack of understanding about their respective individual and team roles. To remedy the situation, head office's financial management team promised that the reform was only temporary – and would only last until audits improved, or when it was possible to assess a manager's financial competency, including financial delegation. Due to fears of negative financial outcomes, this has not yet happened. However, there was a widespread desire among many managers (across disciplines) for a more collective culture – including more interaction and collaboration, and a better understanding of others' roles.

Where to from here?

The importance of giving spending control and flexibility to those responsible for healthcare – including facility managers and district health offices – is emphasised worldwide by entities like the World Health Organization (WHO) and The World Bank. Yet, while the aim is to use funding more efficiently, poor accountability mechanisms and a lack of capacity at the lower levels of the system prevent this shift in control in countries like South Africa.

The new findings discussed in this brief highlight the need for finance and clinical managers to find common ground in policy reforms.

One way would be through multidisciplinary committees that identify and harness opportunities to work together toward shared departmental goals. Another is to foster relational accountability by working more closely together and providing opportunities to view and support each other's work. Relational accountability supports realistic compromises, as supervisors gain a better sense of the challenges their supervisees are facing.

Relational accountability
a participatory management style emphasising positive supervisory relationships that exist alongside accountability measures

VS.

Authoritarian accountability
bureaucratic and punitive accountability mechanisms that aim to enforce adherence to policies

Wrapping up

The centralisation reforms rolled out by the PDoH in this study significantly changed the organisational culture in the districts and facilities that formed part of our research. It reduced opportunities for stakeholders to be part of effective decision-making processes, and also polarised finance and clinical managers – driving a deeper wedge between them instead of creating alignment around pressing healthcare needs and financial constraints.

These tensions and rifts hindered the implementation of positive reforms and affected the overall functioning of the health system. Looking forward, public healthcare systems will face even more financial constraints, while bearing the responsibility of shaping new systems to support UHC. It is therefore critical to develop and sustain PFM processes that optimise service delivery and mitigate the challenges presented by austerity, changing burdens of disease, and more.

Source: Wishnia, J and Goudge, J. (2020) 'Impact of financial management centralisation in a health system under austerity: a qualitative study from South Africa.' BMJ Global Health 5(10): 1-9. (https://gh.bmj.com/content/5/10/e003524.info)

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