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Budget Reform

An evaluation of the implementation of performance budgeting in the Department of Health, Mpumalanga

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Abstract

Due to the resource constraints faced by most governments, there is increasing recognition globally of the need to improve the efficiency and effectiveness of public service delivery. The budgeting system is a critically important tool with which to do this. Budget reform consists not only of reforming the resource allocation process, but goes much further to include reform of financial planning and management systems and processes of monitoring and evaluation. Even more crucial is the implementation process of budget reform: no matter how good a budgetary system has been developed, the test of the system is not in the design but in the implementation.

This dissertation evaluates the implementation of budget reform within the Chief Directorate: Health in the Department of Health, Welfare and Gender Affairs of the Province of Mpumalanga. Chapter 1 sets out the rationale for the study. Chapter 2 reviews traditional budgeting and its limitations in terms of allocating resources for improved service delivery, and discusses the evolution and inadequacies of budgeting in South Africa. Chapter 3 is a theoretical review of the performance budgeting system, detailing its various components including strategic planning, financial planning, expenditure management, performance management and organisational design. Chapter 4 categorises issues concerning successful implementation of performance budgeting in terms of political, administrative/ bureaucratic and technical aspects.

Chapter 5 describes the goals, objectives and organisational structure of the Chief Directorate: Health of Mpumalanga. The limitations of the previous budget process and structure are reviewed, highlighting the need for reform. Chapter 6 evaluates the implementation process of performance budgeting in the Chief Directorate: Health, describing the three conceptual phases of the process and focusing on the obstacles faced. Chapter 7 recommends the following for the successful implementation of performance budgeting: a detailed situational analysis to improve the understanding of the current situation and provide a common reference point; development of an implementation plan; personal involvement of top management; effective management of the process of transformation; documentation of the process as it unfolds; and development of management capacity at all levels.

1. Introduction

In recent decades there has been a global surge towards budget reform. Increasingly, governments have recognised the need to improve the efficiency and effectiveness of their spending in order to enhance public service delivery. The budgeting system is one of the tools with which to do this. Current thinking holds that budget reform consists not only of reforming the resource allocation process, but goes much further to include reforming the financial planning and management systems and the processes of monitoring and evaluation.

In a society undergoing political and economic transformation such as South Africa, the imperative for public service delivery to redress past inequities is self-evident. Since the budget is a crucial instrument in allocating public funds, the ability to rectify past injustices in service delivery is critically interwoven with the budgeting system. In order to enhance the delivery process it is essential to have a budgeting system in place which encourages efficiency, accountability and transparency in the public sector.

One of the first attempts at reforming the budgeting system in South Africa has been the adoption of performance budgeting by the Chief Directorate: Health in the Department of Health, Welfare and Gender Affairs of the Province of Mpumalanga. This is the first time in South Africa that such a system has been initiated, and it thus affords a good opportunity for a case study to evaluate the implementation process. The formulation of new budgetary policy instruments is important, but even more crucial is the implementation process. No matter how good a budgetary system has been developed, the test of the system is not in the design but rather in the implementation. The international literature on budget reform has been mostly theoretical, with little discussion of implementation processes. Therefore, documentation of the implementation processes involved in specific budget reform case studies is extremely important, and has policy relevance for future studies. It must be noted, however, that although broad

principles regarding implementation exist, each individual case must be tailored to the specific prevailing institutional conditions.

Performance budgeting is a system of budgeting which integrates the processes of strategic planning, financial planning and financial management, with an emphasis on performance so as to improve allocative efficiency and delivery efficiency.[1] It is a budgeting technique which focuses on delivery-oriented resource allocation and financial planning. It is based on setting goals and objectives in the form of outputs and outcomes and defining the inputs necessary to achieve these goals. Broad objectives are defined by policy-makers, and then programmes and sub-programmes are developed to achieve these objectives. The inputs for the activities for each programme are determined, as well as how they translate into outputs. Performance measures can then be defined so as to measure the effectiveness of the activities in achieving the desired goals. Progress towards allocative and delivery efficiency can therefore be monitored more effectively. Performance budgeting advocates delegation of managerial authority to the point of service delivery, encouraging agency managers to take responsibility for financial control. For performance budgeting to be effective, political, administrative and technical transformation of the current system is required. It is argued here that performance budgeting, if implemented with institutional and managerial support, can vastly improve the efficiency and effectiveness of resource allocation, resulting in enhanced service delivery to the most needy.

The successful implementation of performance budgeting necessitates transformation in a holistic manner. This implies that change is required not only at a systemic level (such as the budgeting system and institutions) but also at a managerial level (management systems) and at a conceptual level. Therefore all role players should be involved in the process, from top management through to the point of service delivery, in order to avoid implementation taking place in a structural vacuum. The implementation strategy is also important: it may either follow a systemic approach in which the reforms are undertaken in all areas and agencies simultaneously, or it may follow the pilot approach in which the reforms

1. Allocative efficiency pertains to the allocation of resources in accordance with government priorities, whereas delivery efficiency pertains to the least-cost provision of public services.

are implemented in selected agencies and then spread horizontally. It is critical to take into account that delivery of services must continue during the process of reform, and therefore due care should be taken with the implementation process.

The Chief Directorate: Health in Mpumalanga had begun restructuring towards a more decentralised, district-based system, and recognised the need for improved service delivery at district level. It was therefore decided to implement performance budgeting at the district level. However, it was soon realised that budget reform went further than just the district health system: in fact, it had implications for the entire health services system of the province, and the logical decision was thus to extend performance budgeting to the entire Chief Directorate. In this case, the result of the reforms was a fundamental restructuring of the budgeting, financial planning and management systems of the Chief Directorate: Health. Systemic transformation is difficult and time consuming, as it involves considerable change not only in the structure of institutions, but also in the conceptual understanding of financial management systems and general administrative and management functions. Numerous challenges were thus encountered during the implementation process. These ranged from lack of acceptance and political support to technical problems such as inadequate information systems. Difficulties also arose in the administrative sector regarding issues such as the delegation of responsibilities, organisational structures and lines of accountability. It was also recognised that change does not happen instantaneously, but rather is a learning process which happens gradually over a period of time.

At the time of writing, the implementation of performance budgeting in the Chief Directorate: Health of Mpumalanga was incomplete. The aim of this dissertation is, therefore, not to evaluate the performance budgeting system itself, but rather to review and evaluate the implementation process to date. By way of introduction, the dissertation will review performance budgeting as an alternative to traditional budgeting, and discuss salient issues regarding the implementation process. It will then apply the theoretical framework using the Chief Directorate: Health of Mpumalanga as a case study. Material for the case study was obtained from open-ended interviews with members of the consulting team who developed the

performance budgeting system and facilitated its implementation, and members of the Chief Directorate: Health in the Department of Health, Welfare and Gender Affairs of Mpumalanga who are involved in the actual implementation.

Chapter 2 reviews traditional budgeting, which includes both incremental and zero-based budgeting. It looks at the limitations of these budgeting systems in terms of their inefficiency and ineffectiveness in allocating resources for improved service delivery. It also discusses the evolution of budgeting in South Africa and its associated inadequacies.

Chapter 3 is a theoretical review of the performance budgeting system. After briefly describing the differences between incremental budgeting and performance budgeting, it discusses in detail the various components of the performance budgeting system including strategic planning, financial planning, expenditure management, performance management and organisational design.

Chapter 4 deals with issues regarding successful implementation of performance budgeting, setting out the framework for the case study to follow. Implementation issues are categorised in terms of political aspects (policy formulation), administrative/bureaucratic aspects (financing and organisation) and technical aspects (operational). For each of these groupings, implementation issues will be discussed in terms of preconditions for success, possible areas of failure, suggested possible solutions, and experience from other countries. Specific elements will include *inter alia* political acceptability, quality of leadership, accountability, delegation of responsibility, programme structures, performance measures and information systems. The different types of implementation strategy are also discussed.

Chapter 5 describes the goals, objectives and organisational structure of the Chief Directorate: Health in Mpumalanga. The prior budget process and structure are reviewed, emphasising the limitations of the system and the consequent need for reform.

Chapter 6 is an evaluation of the implementation process of performance budgeting within the Chief Directorate: Health in Mpumalanga. It describes the

three conceptual phases of the implementation process, and focuses on the obstacles faced by the Chief Directorate in terms of the political, administrative and technical aspects described in Chapter 4. The discussion highlights the operational difficulties encountered with implementation and the risks involved with major systems change, and indicates issues still outstanding in the implementation process.

Chapter 7 concludes by highlighting the iterative nature of the process of implementing performance budgeting. It also suggests recommendations for the successful implementation of performance budgeting in the future.

2. The Need for Reform

Budgeting is seen as a process for systematically translating the expenditure of public funds into the achievement of policy objectives. Therefore, in the public sector, the budgeting system is a major vehicle for the delivery of public goods and services. Globally, in both developed and developing countries, it is being recognised that government funds have not been used optimally, in the sense that they do not achieve maximum impact. In turn, this recognition has prompted calls for major initiatives to reform the budgeting system. This chapter will discuss traditional budgeting methods and their shortcomings. It will then discuss the budgeting system in South Africa, and why reform is necessary.

2.1 Traditional budgeting

The focus of traditional budgeting systems is on expenditure control. It is believed that if all expenditures and revenues are accounted for, the budget process will essentially be effective in achieving its objectives. Traditional budgeting lists all expenditures by line-item. This means that the budget shows exactly how much is spent on each item of expenditure such as salaries and wages, transport, equipment, maintenance, etc. It does not, however, provide any information on the objectives of a particular government department, or any results which are to be achieved by that department. This format of the traditional budgeting system has become known as line-item budgeting. An example of a traditional line-item budget can be seen on page A1-2 of Appendix 1. In addition, traditional budgeting is usually conducted on a cash basis. This indicates that the accounting system recognises only cash inflows and outflows in the period that they occur. There is no record of assets or liabilities and therefore no balance sheets. Planning and management, in these traditional systems, play only minor roles. The links between planning, management and budgeting tend to be tenuous.

Traditional budgeting systems may include incremental budgeting as well as zero-based budgeting. Incremental budgeting is an annual budgeting system which

takes the current year's budgeted allowances as the starting point for preparing next year's budget. It presumes that the current year's budget is the most appropriate basis for estimating the following year's budget. It also presupposes that the existing budget is efficiently and optimally allocated, and is thus a sufficient basis for estimating the next year's budget. The projected estimates are generally obtained by adding a marginal amount (increment) to the previous year's amount in order to compensate for inflation. According to Green (1996), the crudest form of incremental budgeting is where any growth (or cut) in the budget is applied equally across departments or institutions. This approach ensures that the *status quo* is maintained, with no room for changing priorities. Green (1996) adds that a less stringent approach, which may allow for some change, is where the incremental growth in the budget is not distributed equally, but shared only among priority services. Essentially, however, incremental budgeting remains backward- rather than forward-looking. As Wildavsky (1997, p.328) points out, this is one of the major obstacles of incremental budgeting: "Comparing this year with last may not mean much if the past was a mistake and the future is likely to be a bigger one". Incremental budgeting appears to be most appropriate in circumstances where the resource envelope is steadily increasing. However, in times of fiscal austerity, with a shrinking budget constraint, the disadvantages become more manifest as reprioritisation is neglected.

Zero-based budgeting (ZBB), in contrast, is a system in which each item of expenditure is justified on an annual basis. Every year expenditures are projected from a zero base, as though being compiled for the first time. In contrast to incremental budgeting, there is no reliance on historical expenditure patterns to determine current resource allocation. The ZBB approach thus takes nothing for granted, as the budget is compiled each year from a zero starting point. This allows for the continuous reassessment of all expenditures in terms of efficiency and effectiveness. Priorities may be identified and activities which do not conform to the current priorities may be discarded. The ZBB approach implies that all government services and projects need to be reviewed regularly and systematically. The necessity of each existing government programme should be questioned as if being considered for the first time.

If the budget is to be a tool for allocating scarce resources so as to promote service delivery, then there are serious inherent shortcomings in using line-item traditional budgeting systems, be they incremental or zero-based. As Dean (1989) points out, line-item budgeting is concerned only with control of financial inputs and ignores completely what the inputs are designed to achieve. There is no mechanism in place which relates costs to expected achievement of government objectives (service delivery). This leaves the budget in "an analytical vacuum". Accountability for the delivery of goods and services remains obscure, since there is no link between expenditures and activities and responsible officials. Dean (1989) adds that because the budget is presented according to organisational votes, rather than in relation to programmes of expenditure, projects with related objectives might be financed under different votes. In this way there is no coherence in the budget, as similar projects are considered in isolation from one another.

In addition, traditional budgeting appears to be driven by technicians rather than by policy-makers. In other words, politicians play a role in setting the policy objectives of a department, but the actual allocation of resources is not linked to these decisions and is left to the financial staff. According to Green (1996), it is not uncommon to find responsibility for the budgeting process in the hands of the accounting department. Under these circumstances, changes in the budget are based on priorities determined by accountants. These priorities are more likely to concentrate on expenditure levels than on the necessary activities themselves. The Presidential Review Commission (1997) concurs that the incremental budgeting approach, in particular, leaves little room for policy changes; it presupposes that the existing objectives and activities are optimal, and therefore tends to maintain the *status quo*. New projects, which may be more important in relation to changing economic priorities, may be disregarded as funds are channelled into existing and inherited obligations.

Zero-based budgeting, on the other hand, could allow for the possibility of redirecting spending. In periods of fundamental change there is the potential to eliminate obsolete expenditures, but it is still often technically driven. It should also be noted, however, that there are transaction costs associated with ZBB that

render it highly impractical. A great deal of information is required for ZBB and it is costly to obtain, if it exists at all. There is often also a lack of the necessary capacity required, as well as time constraints. Wildavsky (1997, p.338) puts it aptly: "By foregoing the past agreements embodied in the base, zero-base budgeting generates more conflict and more calculation than it can manage".

With traditional budgeting there is also a distinct lack of integration between planning and budgeting. Each of these is conducted separately with scant regard for the constraints the other imposes. While financial information is essential to planning, planning information is equally important in informing resource allocation. There is also no component in the traditional budgeting system which encourages the monitoring and evaluation of service delivery in order to inform the planning process. When and if it does occur, it tends to remain divorced from the budgeting system. Moreover, the traditional budgeting system has an annual budget cycle. It has been recognised that to effectively integrate planning and budgeting, and to determine the full cost of programmes, there needs to be a move towards a multi-year framework. This will create certainty in the planning environment, by making explicit the intended future financial costs of programmes.

Under traditional budgeting, the control of inputs and the allocation of resources are highly centralised. There is generally a budget office or treasury which assumes total responsibility for allocating resources among the specific spending agencies, i.e. departments, parastatals and other government bodies. This tends to prompt the spending agencies to demand budgets that are excessive, as they expect their proposed budgets to be cut by the central office during the allocation process. Such a system does not promote managerial efficiency, as the role of managers in spending agencies tends to be reduced to the *administration* rather than the *management* of budgets.

This situation means that managers have procedural control of inputs, which entails ensuring that finances are being used for authorised purposes in compliance with procedures prescribed by the treasury - in effect, administrative control. They do not, however, have any managerial discretion regarding the

control of outputs in terms of ensuring value for money spent. Because of their reduced managerial authority, managers have no incentive to increase the efficiency of their agencies. This degree of centralisation of budget control also blurs the lines of accountability: agency managers will blame lack of service delivery on the central budget office which limits control over inputs, while the central budget office in turn will blame the agency managers.

There are very few positive aspects of traditional budgeting that warrant its continued use. These include the fact that incremental budgeting is a relatively simple process. Because it does not involve a comprehensive review of the activities to be funded, it is comparatively easy to perform the necessary supporting calculations. Many of the budget preparation processes required need to be performed on a yearly basis, and the incremental approach eases the administrative burden of these processes. With respect to this cyclical aspect of the budgeting process, the appeal of zero-based budgeting is that spending is re-examined on an annual basis to ensure that value for money is obtained. In practice, however, much of the spending on public services is ongoing, and there is little scope for radically changing expenditure patterns.

From the above discussion, it is clear that there are serious deficiencies in traditional line-item budgeting. These shortcomings have motivated policy-makers to explore alternative budgeting systems which address such faults and enable more efficient and effective resource allocation. One such system is performance budgeting, which will be discussed in detail in Chapter 3.

2.2 The evolution of budgeting in South Africa

Historically, South African government budgeting has been based on the traditional system, with all expenditures listed by line-item, incurring all the concomitant disadvantages discussed in Section 2.1. In the mid-1970s it was recognised that as government spending was continuously increasing as a proportion of gross domestic product,[2] it was crucial for it to become more

2. Government expenditure as a percentage of GDP rose from 17 per cent in 1961 to 25 per cent in 1976, and was 31 per cent in 1998.

efficient and effective. To this end, programme budgeting was introduced in 1976, and now budgeting at all levels of government is drawn up in a programme format.

Programme budgeting, as Abedian, Strachan and Ajam (1998) point out, departs from traditional budgeting in that it focuses on how much has been spent on each function of government (e.g. research on HIV and AIDS), rather than on how much has been spent on each type of input (e.g. salaries and wages). It begins with defining the objectives of an organisation, which are organised into programmes and may be further divided into sub-programmes. Activities which contribute to the attainment of the programme objectives are then determined, as well as the inputs necessary for these activities. Finally, the links between the inputs and the desired outputs (service delivery) are considered. By setting specific objectives for programmes, managers can be held responsible for achieving them. The efficiency of the activities in achieving the required goals can be gauged by looking at the outputs attained within the resource constraints given.

It should be noted, however, that in the South African situation, programme budgeting has not been implemented in a holistic manner. Although the budget is drawn up in programme format, it does not appear as if the programmes are set up to achieve any specific objectives. Spending on a particular objective is not grouped under one programme. In addition, no specific outputs are specified, which makes it difficult to consider the links between programme inputs and the achievement of desired objectives. As Abedian, Strachan and Ajam (1998) assert, the implementation of programme budgeting appears to have happened in form rather than in substance. "The programme budget outlay amounted to nothing more than a reclassification of expenditures, and therefore many of the real benefits of programme budgeting were not gained" (Abedian, Strachan and Ajam, 1998, p.59). The present system is therefore in actuality a hybrid of the old traditional budgeting system and programme budgeting.

An example of the present budgeting system is provided in Appendix 1, *viz.* the budget for the Department of Health of Free State Province. From this example it can be noted that budgeting is still based on inputs. Even though there is a

programme classification, there is insufficient information to even begin to try and link the budget inputs with outputs and outcomes (objectives). The aims of programmes and sub-programmes are listed, but there is no mention of how the inputs to these relate in any way to achieving the stated objectives, which are themselves ill-defined and unquantifiable. As an example (p.A1-4 of Appendix 1), the programme 'District Health Services' has the aim of rendering primary health care services. The programme is then divided into the following sub-programmes:

- district management;
- community health services;
- emergency medical services; and
- district hospitals.

Each of these sub-programmes has a description of what it is intended to achieve. When looking at the actual budget, however, there appears to be no relation between the amount budgeted and the achievement of sub-programme goals. It can be seen that R22.69 million is to be spent on district management, R369.9 million on community health services, R51.2 million on emergency medical services and R194.5 million on district hospitals. Detail on how these amounts should relate to achieving the desired outcomes is, however, completely lacking.

The importance of multi-year budgeting, which allows for a long-term perspective on resource allocation, has been recognised. Consequently, in the South African situation, there has been an attempt to move towards a medium-term expenditure framework (MTEF). The essence of the MTEF, which embodies multi-year budgeting, is that it may be used as a tool for budgeting and financial planning. However, in the current system (an example of which is provided on p.A1-3 of Appendix 1), the implementation of the MTEF is still based on input costs, with no detail of any relation to programme goals. It thus makes no attempt to integrate any output planning into the system. The result is that there is still no synthesis between budgeting and planning, and the budgeting system therefore remains largely ineffective.

Abedian, Strachan and Ajam (1998) identify two major areas of concern arising from the present budgeting system. The first relates to the lack of integration

between planning and budgeting. The focus of the current budget is on providing information that is organised around input costs. Objectives are only vaguely defined in terms of what they are to achieve, when, how or for whom, and are not linked to input costs. In effect, the budget becomes a technical allocation of resources, and hence a form of expenditure control, rather than a financial support to the planning process. There is also no integration between financial management, which is based on expenditure information, and financial reporting, which is based on the budget. Thus, financial management is reduced to an exercise in planning, the underlying objectives of which may not always be realisable. In addition, there is no mechanism to ensure that resource allocation reflects planning priorities, as the present system still seems to use the incremental approach based on historical patterns of expenditure. "The budgeting process still reflects incremental increases in existing expenditure, and budgeting decisions are still taken mainly on the basis of the size of the increments and not on the basis of the effectiveness of the project or the necessity of its continuation." (Erasmus and Visser, 1997, p.217).

The second area of concern is the lack of monitoring and evaluation processes. The goals and aims of the programmes and sub-programmes are not well defined. In addition, the links between sub-programme (and even sub-sub-programme) goals and the final programme goals are not apparent. There are also no performance measures built into the system to evaluate whether or not these goals have actually been achieved. Because of this, there is no feedback into the budgeting process regarding the effectiveness of programmes. Consequently, spending agencies have no incentive to manage funds more efficiently and more effectively. When budgets are cut, this tends to happen across-the-board, rather than looking at which programmes are achieving their goals or where priority areas lie. Furthermore, management of the budget process is still highly centralised in the current system. This is a crucial issue, because unless a manager has flexibility regarding programme inputs he or she cannot determine the timing and sequencing of service delivery. Programme managers, therefore, tend to act as administrators rather than managers, and this further undermines their motivation to act more effectively and efficiently.

Ideally, the budgeting system should be an integrated, iterative process where planning feeds into the budget process, and the resulting allocation of resources can be monitored and evaluated and fed back into the planning process. Programmes should be developed with definite goals which can in some way be measurable. There should be a multi-year framework which details not only the financial position, but also the projected delivery of goods and services. Programme managers should be given more flexibility to manage their programmes, and thereby be made more accountable for the outputs of their particular programmes. Clearly, because of these concerns and the need for improved service delivery in South Africa, it is essential to reform the current budgeting system to a system which is more transparent and accountable for results.

2.3 Summary

The need for reform of the traditional government budgeting system is evident in that it is not a rigorous enough tool for allocating public resources so as to obtain the best value for money in service delivery. In particular this is shown in the South African situation, where the current budgeting system is concerned mainly with controlling financial inputs, and has no clear and explicit relation to the desired outcomes these inputs are meant to achieve. Further, the planning and budgeting functions are largely separate, and there is no mechanism in place for monitoring and evaluating the efficiency and effectiveness of service delivery. Correction of these shortcomings in the traditional budgeting system is essential for the effective and efficient allocation of public resources.

3. Performance Budgeting

Performance budgeting is an alternative approach intended to remedy the shortcomings of traditional budgeting. It is a system which aims in particular at enhancing the efficiency and effectiveness of service delivery. This chapter will provide an overview of the performance budgeting system, and will then describe in detail the various components of the system, *viz.* strategic planning, financial planning, expenditure management, performance management, and organisational design.[3]

3.1 Overview

Performance budgeting is a *system* of budgeting which attempts to integrate the processes of strategic planning, financial planning and performance management. The emphasis here is on a *system* which focuses on outcomes rather than activities. In contrast, a *process* focuses on activities rather than outcomes, in the belief that if the process is working properly the outcome will follow. In the system of performance budgeting, outcomes are related to specific objectives which should be measurable. The primary emphasis in performance budgeting is therefore on the outcomes of budgeting, rather than on the process of budgeting itself, although the process is an important component (Quade, 1972).

Traditionally, the focus of budgeting was on the custody of funds. In contrast, performance budgeting focuses on how funds are actually used. By relating purpose to cost, it addresses issues of efficiency and effectiveness and provides a more distinct linkage between resources and results. It is based on setting goals and objectives in the form of outputs and outcomes, and defining the inputs necessary to achieve these goals within a given fiscal constraint. The procedure begins with policy-makers being required to set goals for an organisation, unit or public agency, and identifying broad objectives needed to achieve them. These are

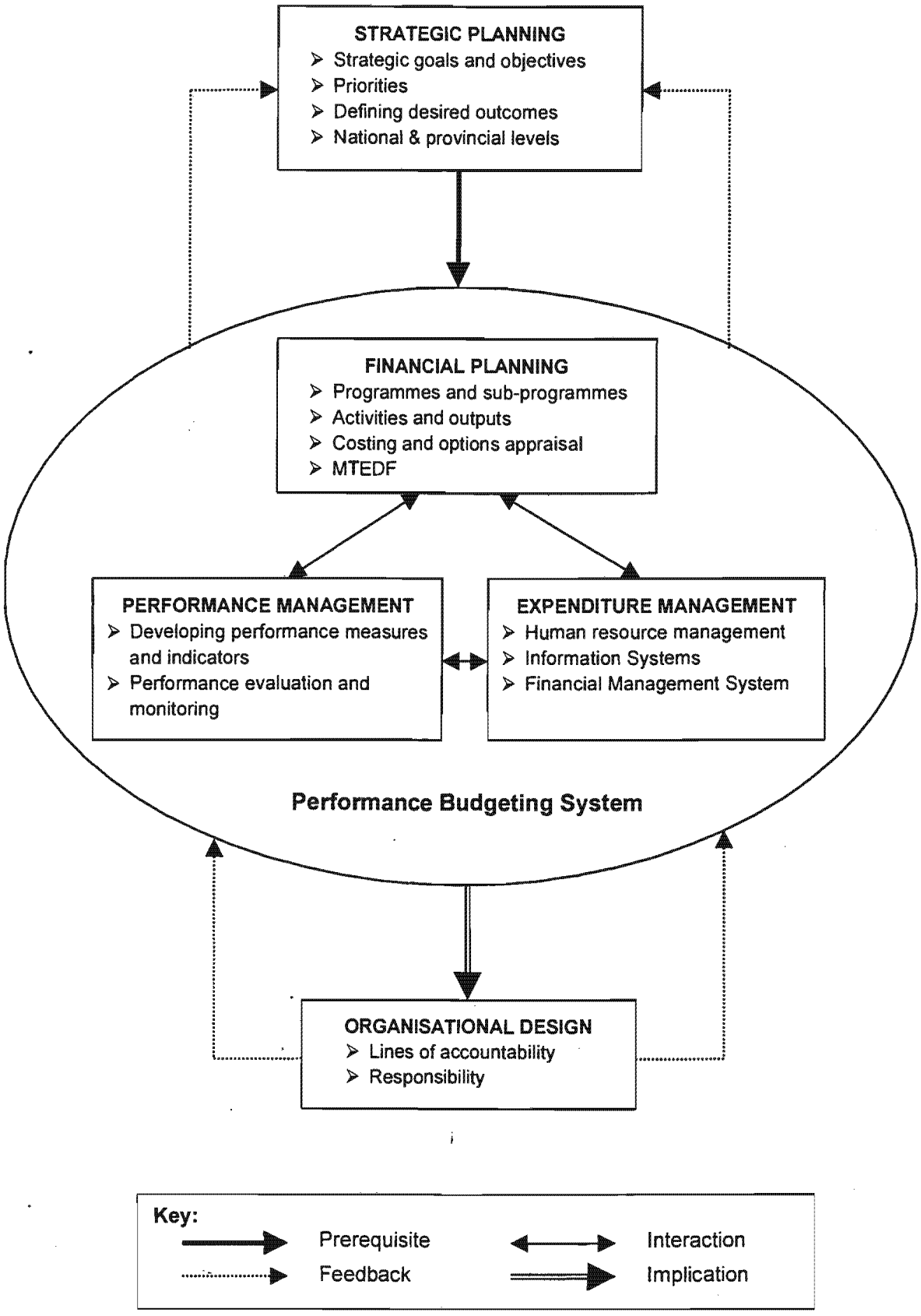
3. This chapter draws heavily from Abedian, Strachan and Ajam (1998) and Presidential Review Commission (1997).

then translated into programmes, which, in turn, are divided into sub-programmes. Activities for each sub-programme are then identified, with each activity having clearly defined inputs that will result in well-defined outputs. These outputs, in turn, link up with the desired outcomes which should satisfy the intended objectives originally set by the policy makers. This is discussed in more detail in Section 3.3.2. The focus, therefore, is on how much is spent on each type of function or programme of government, rather than on each type of input.

Performance budgeting encourages delegation to lower levels of management. It allows agency managers to take responsibility for the financial management of their budgets rather than just being able to administer them. Each programme manager is expected to set goals for their own particular budget, and can therefore be held accountable as to the effectiveness of achieving these goals. Performance measures which evaluate programme outputs are defined so as to measure the effectiveness of the activities in achieving the desired goals. In this way, allocative and delivery efficiency can be monitored more effectively, and service delivery becomes more transparent and accountable.

In order for performance budgeting to be effective the entire system of budgeting needs to be transformed. In systems analysis, the part is always viewed in relation to the whole. The integrated components which make up the system of performance budgeting include financial planning, expenditure management, and performance management. A necessary prerequisite for performance budgeting is a strategic planning component which informs the system of broad policy objectives. Furthermore, a vital implication of the budgeting system is an organisational design component. Each component is a unit on its own and together the units become a system (see Figure 3.1). For performance budgeting to function effectively, it is vital that each unit operates effectively, and that the articulation between units is sound. The different components will now be discussed in turn.

Figure 3.1 Performance budgeting system



3.2 Strategic planning

Budgeting is essentially a political process and the strategic planning component constitutes the political decision-making process which informs the budgeting system of policy objectives. It provides policy direction to the formulation of the budget by deciding on the longer-term objectives of the organisation. These objectives form an agreed set of priorities in the form of policy goals or outcomes which guide the process of resource allocation. Strategic planning is not just a top-down process, but is a co-ordinated effort including managers from all levels contributing to the process.

Strategic planning takes place at both the national and provincial levels. At each level, government is responsible for defining a set of strategic goals and objectives in order to achieve certain policy decisions. In this way, political office bearers can be held accountable for the attainment of these objectives. At the national level, planning is carried out by the Cabinet. Their main functions are the co-ordination of objectives, outcomes and outputs at a national level; ensuring integrated planning of delivery of services so as to maximise linkages and synergies; and political accountability for the policy mix and broad budget allocations. The decisions taken at the national level are then carried down to the provincial level. Once again, within the national framework, each province should then decide on their particular objectives and rank them in order of priority. The ranking process is necessary because both resources and the capacity to deliver are limited, and it is inevitable that not all objectives will be immediately attainable. In addition, the most appropriate set of outcomes should be defined to reflect the prioritised objectives. These decisions are specifically the domain of the politicians.

The next step is to identify the appropriate mix of outputs needed to achieve the desired outcomes. This step requires the joint effort of individual ministers together with heads of departments. The specified link between outputs and outcomes ensures that political structures can be held responsible for allocative efficiency, i.e. choosing the correct mix of outputs in order to effectively produce the outcomes. Strategic planning also provides a conceptual framework guiding the sequencing and timing of policy implementation, which is important in this phase. Continuous monitoring and evaluation (discussed in Section 3.5:

Performance Management) should inform the strategic planning process. Regular, reliable and strategically relevant information flows are essential in identifying blockages in service delivery and objectives that are not being achieved.

Strategic planning is an important prerequisite to the budgeting system, as it is where the entire procedure begins. It is also the stage where, given the budget constraint, priorities regarding service delivery need to be decided upon, and accordingly where trade-offs in resource allocation occur. Consequently, without this key component, the budget would be reduced to a financial numbers game, largely unrelated to service delivery. This was generally the case with the previous traditional budgeting process, where there was little or no co-ordination between strategic planning and the budgeting process.

3.3 Financial planning

After the strategic planning process has been completed, the financial planning component makes its contribution by outlining in detail the allocation of resources necessary to achieve the objectives decided upon. It is in this phase that attempts are made to link resources with results in accordance with programme goals and objectives. It is the responsibility of the head of the department concerned to ensure that outputs are delivered efficiently (best value for money) within the allocated budget. This component includes defining a detailed programme structure including programmes, sub-programmes, activities and outputs. It is also necessary to determine the feasibility and viability of each programme including available capacity, timing, etc. This entails the inclusion of a costing process to identify the resource implications of achieving outputs as well as a process of estimating future resource requirements.

3.3.1 Programmes and sub-programmes

The process begins by setting up the programme structure. The framework for the programme structure is defined by the core and supportive objectives identified in the strategic planning phase. Thus each programme that is identified should be aimed at a specific goal reflecting the mission of the organisation, and should take into account all the activities required to reach this goal. A programme may be a

single line function, such as Hospital Services, or an integrated set of actions, such as District Health Services (DHS). The optimal number of programmes needs to be developed, taking into account what is useful for strategic analysis and budgeting. Within each programme a number of sub-programmes are defined which are more specific and a part of the broader programme. Examples of sub-programmes for the DHS programme may include District Management, Clinics, and Emergency Medical Services. Each sub-programme is made up of activities that contribute to the achievement of its goals.

3.3.2 Activities, outputs and outcomes

Activities deal with the actual provision of goods and services. Examples of activities for the sub-programme Clinics (under the DHS programme) may include the more specific activity of immunisation of children, or on a much broader level, curative and diagnostic services. A number of activities are likely to contribute to one sub-programme, and similarly one activity may contribute to the objectives of a number of sub-programmes. Each of the listed activities for a particular sub-programme should capture the essence of the action required for delivering a particular service. Together, provision of these services should constitute the objective of that particular sub-programme. Essentially, activities take inputs and translate them through action into physical outputs, which in turn contribute towards achieving outcomes, which are the defined goals of the sub-programmes identified in the strategic planning phase. In other words, outputs are the goods and services produced by activities, while outcomes are the effects of those outputs on the community. Table 3.1 illustrates the relationship between activities, outputs and outcomes.

Table 3.1 Relationship between activities, outputs and outcomes

Activity	*Output*	*Outcome*
1. Treatment of patients	Treated patients	Reduced morbidity and improved access to primary health care
2. Immunisation of children	Immunised children	Reduced infant mortality for immunisable conditions

Outputs are generally tangible and measurable, and there is a well-defined relationship between inputs and outputs. In other words, it is possible to

determine the precise cost of the inputs which are required to attain a particular output. An example of an output for Activity 2 in Table 3.1 would be the number of children immunised, and determining the cost of the inputs required would include the cost of syringes, vaccine, staff, transport, etc. Outcomes, on the other hand, are qualitative and harder to measure. The outcome for the above example would be reduced infant mortality for immunisable conditions. This is more difficult to measure and might only be measurable after a period of time. As illustrated by the immunisation example, the relationship between inputs and outcomes is less definite. There may be numerous other factors which influence health service outcomes, such as improved sewage facilities in residential areas, over which the health services have little or no control.

3.3.3 Costing and options appraisal

As part of budget preparation it is necessary to determine the monetary value of the inputs needed to undertake the activities necessary for the provision of a particular service. This is known as costing. It is a significant area because if getting value for money is a priority of the budgeting process, then one must know what the cost of service delivery is. Costs are usually divided into operating costs (the ongoing costs of delivering a service) and capital costs (the acquisition of a durable asset). Closely linked to capital costs is maintenance expenditure. When assets are budgeted for there needs to be the appropriately linked maintenance budget to avoid asset deterioration and consequent financial loss. Maintenance budgeting is, therefore, an important element of asset management and financial planning. Another important link is that between capital expenditure and current expenditure on operations. For example, if a hospital is built, the cost of running the hospital must be taken into account.

There are a number of basic methods of costing, examples being resource-based costing, activity-based costing, process-based costing and target-based costing. Generally, it is recommended that activity-based costing is the most appropriate form of costing for performance budgeting, because it is better able to determine the exact cost of service delivery by linking input costs to activities. This approach focuses on the activity level by identifying the costs of each activity's inputs, as

well as apportioning the cost of common overheads according to some agreed upon criteria.

According to Abedian, Strachan and Ajam (1998) there are a number of necessary steps which should be followed for measuring the operating (recurrent) costs of service delivery. These are:

- deciding on types of services offered;
- establishing policy on standard and quality of services;
- determining the activities needed for specific packages of services;
- identifying inputs (resources) for each activity to be undertaken;
- obtaining information relevant to each input costing;
- allocating shared costs;
- adding a reserve for contingency; and
- estimating medium-term projections.

Estimating capital costs is equally important, and includes the following components:

- human capital - training, capacity building, efficient organisation design and use of human resources;
- physical capital - buildings, equipment and infrastructure;
- maintenance; and
- utilisation.

Due to limited resources, it is inevitable that choices will need to be made. This necessitates the use of option appraisal. This may take place at the project level, whereby costs and benefits are determined and the most cost-effective projects for achieving certain objectives are chosen. At a broader level, option appraisal may take place to determine the framework within which service delivery takes place. Such options would include state provision, sourcing, commercialisation, privatisation, contracting and financing.

3.3.4 Medium-term expenditure and delivery framework (MTEDF)

In an environment where effective service delivery is essential, to plan and budget for only one year is short-sighted. Thus, a move towards multi-year budgeting and

planning (known as a medium-term framework) is beneficial, because it extends budgeting over a number of years, creating more certainty regarding resource allocation and prioritisation. Since the performance budgeting system links budgeting to service delivery, it is also crucial that service delivery plans are included in the medium-term framework. Service delivery plans would detail the timing, sequencing and extent of service delivery (i.e. the mix and level of services) over the medium-term. They should also reflect policy priorities and allocate finances accordingly. The expanded framework, which includes service delivery plans, is known as a medium-term expenditure and delivery framework (MTEDF). The MTEDF allows planning and implementation to be linked in a dynamic way, while ensuring accountability for delivery over a number of years. Future costs and revenues are estimated and activities chosen to ensure effective delivery of goods and services. Because of the multi-year nature of the MTEDF it is possible to define a delivery timetable, identify the beneficiaries of delivery and monitor delivery performance.

3.4 Expenditure management

After the financial planning decisions of resource allocation have been made, the expenditure management phase begins. This phase connects the missions and goals of the agencies to their day-to-day operations. It focuses on the efficient and effective implementation of the decisions made regarding resource allocation and budgeting. It includes the areas of human resource management, information systems and financial management systems.

3.4.1 Human resource management

To ensure effective and efficient service delivery it is important to have the appropriate mix of skills and the necessary management thereof. Without human capacity, there is little chance of successful implementation. Employees will need to be trained and new personnel systems set up in accordance with the performance budgeting system. For example, in the past financial management was exclusively the responsibility of finance personnel. Now, in a devolved performance-based system, financial management becomes the responsibility of every programme, sub-programme and sub-sub-programme manager as well, and

each of these managers will need financial management training. Accountability and responsibility lines should be clearly defined for improved management efficiency. Each employee, from the point of service deliverer all the way through to top management, should have clearly defined job descriptions which include the activities they are responsible for and the measurable outputs related to these activities (see Section 3.6: Organisational Design).

3.4.2 Information systems

Information systems refer to the gathering, collection and analysis of data. The information produced is a critical input into managerial decision-making, which entails reporting on performance for both monitoring and evaluation purposes (discussed in more detail in Section 3.5: Performance Management.) It is essential for effective management and oversight that information is produced timeously and accurately. The information should also be consistent and comparable over time. Different levels of disaggregation are required for different purposes. For example, a clinic manager would require information on budgeted and actual expenditure, as well as performance measures for a particular activity such as Child Health, whereas a district manager would require information which would show comparisons of expenditure for all clinics in that particular district. The system should therefore be able to deal with these differing requirements.

3.4.3 Financial management system

The financial management system is ultimately responsible for the control and monitoring of the appropriation of resources, which may be done via accounting and auditing practices. Accounting is concerned mainly with the recording of financial transactions, whereas auditing is concerned more with effecting accountability and transparency.

There are many different types of accounting system, and there has been much debate over which is the most appropriate. Traditional budgeting, as described in Chapter 2, uses cash accounting, which recognises only cash inflows and outflows. This system is not completely accurate in presenting the financial affairs of an organisation, as it fails to take into consideration the time lags between incurring an obligation and actually paying for it. There is no registering of assets or

liabilities, and therefore no fixed asset values or stock adjustments. This makes it extremely difficult for managers to monitor asset utilisation and maintenance and to perform option appraisals or opportunity cost analyses. Increasingly, therefore, experience from the reform of budget systems has advocated the use of the accrual accounting system. This system recognises revenue and expenses as they are earned and incurred, and not when money is received or paid. It is therefore possible to keep track of exactly what costs are incurred for each type of service delivered. The major advantage of this system is that it encourages the efficient utilisation of public assets which is one of the aims of the performance budgeting system. Accrual accounting also necessitates the management of asset depreciation and replacement. Consequently, the actual cost of public services is reflected more accurately, and it is therefore possible to be more aware of the implications of the provision of specific services for resource allocation.

Auditing may be internal or external. As Abedian, Strachan and Ajam (1998) explain, internal auditing should be an unbiased analysis of the management and financial practices of an organisation. Its main objective is to focus on the internal control system, ensuring accountability within the organisation. In this regard the internal auditors should ensure that management policies and directives are adhered to; that assets are safeguarded; that records are accurate, complete and reliable; and that statutory requirements are followed. The internal auditors are always employees of the audited organisation.

External auditing, on the other hand, is concerned with the examination by an independent body of the financial statements and operations of an organisation, and is essential for ensuring accountability and transparency within that organisation. The main functions of an external audit, as stated in Abedian, Strachan and Ajam (1998), are to evaluate: the adequacy of the internal control system; compliance with statutory requirements; the economy, efficiency and effectiveness of the use of resources; and environmental practices. However, in order for the auditors to undertake such a comprehensive assessment, the budgetary system should lend itself to this. In other words, it is necessary that outputs and outcomes are clearly specified and reported on in order to allow for a meaningful evaluation of the efficiency and effectiveness of resource use.

3.5 Performance management

Performance management is concerned with measuring, monitoring and evaluating performance in relation to value for money, effectiveness and economy. It is a management tool which links directly to the strategic planning, financial planning and expenditure management components of the performance budgeting system. In traditional budgeting, there is no performance component and therefore no monitoring and evaluation process to link to the resource allocation process. Performance management has both quantitative and qualitative dimensions.

3.5.1 Developing performance measures and indicators

Performance measures and indicators may be a mixture of financial and non-financial measures, and relate directly to the achievement of programme objectives. Therefore objectives need to clearly reflect organisational priorities and be related to activities and resources.

Performance measures are used when trying to measure the productivity of resource use, which can be clearly quantified. In other words, performance measures gauge the efficiency of translating inputs to outputs. Generally, efficiency may be measured by the ratio of outputs to inputs. An example of a measure of efficiency for the output of number of treated patients may be cost per patient treated or cost per patient day. These measures are indicative of the efficiency with which inputs such as staff, beds, drugs, etc., are used to produce treated patients (output). The steps involved in developing these measures would be firstly to determine exactly what is to be measured, and secondly to choose which of the available measures are to be used. If outputs and activities have been clearly defined in the financial planning stage, defining the associated performance measures should be a relatively simple task.

Performance indicators are used when trying to measure how effectively outputs are translated into outcomes. The development of indicators is a more difficult task as it deals with less direct relationships which are often intangible. The different types of indicators include statistical indicators (morbidity and mortality

data), composite indicators (potential years of life lost), qualitative indicators (quality of life) and opinion surveys.

3.5.2 Performance evaluation and monitoring

Once performance measures and indicators are in place, they provide the tools for monitoring and evaluation. For example, performance measures may be used by programme managers for benchmarking analysis. This would entail tracking the unit cost trajectory over time, which would facilitate the assessment of productivity of resource use. Each unit or department should develop its own monitoring and evaluation framework according to their organisational objectives. This framework should include among others what is to be monitored, how often monitoring should take place, how often evaluation should take place, the level of detail required and who is responsible for collecting and disseminating information. Certain information such as the quality of service delivery might require monthly monitoring reports. An annual report, however, might be sufficient regarding information for strategic planning, as long as it contains all the relevant detail such as the organisational objectives, budgets and expenditure in relation to output, and evaluation of key performance areas. The design of information systems should take cognisance of performance monitoring systems so that reporting is easily facilitated. The effective use of the evaluation and monitoring processes provides management with a tool to focus on client needs, as well as improving the efficiency and effectiveness of the organisation.

3.6 Organisational design

The organisational design of an institution or department plays a critical role in financial planning and expenditure management. It should therefore be informed by the broader system in place, including the financial and budgeting systems. It is essentially concerned with dividing the work and responsibilities in a coherent manner, so as to obtain the best performance from individuals and the organisation as a whole. A rigid or hierarchical structure may lead to lengthy and bureaucratic decision-making processes. This in turn may lead to frustration among lower levels of management staff, which impedes efficient and effective service delivery. It also tends to blur the lines of accountability. Ideally, the

organisational design should be streamlined, with managerial powers and control over decision-making distributed and delegated according to programme structure. In this way specific individuals are made responsible for certain functions and activities and can be held accountable for these. Within the performance budgeting system each manager, given the necessary responsibilities, can be held accountable for achieving specific objectives in the form of outputs or outcomes, depending on the level of management.

Organisational design should also include an appropriate incentive structure which encourages efficiency and effectiveness. According to Scott, Ball and Dale (1997), it is essential that incentives regarding personal accountability are aligned with the system as a whole. In other words, it is no use expecting managerial behaviour to change if the appropriate structural changes have not been made. Scott, Ball and Dale (1997, p.376) point out that in New Zealand, departmental chief executives are motivated by holding them accountable for the performance of their organisations "... through limited term, performance-based employment contracts and annual performance agreements which specify the performance to be delivered and the *ex post* performance information to be provided". To assist the assessment of managerial behaviour, the development of appropriate performance measures (described in Section 3.5.1) and information systems with relevant reporting, is essential. Communication and co-ordination is also essential between different levels of management, within departments, between departments and central agencies, as well as among the legislature and the executive.

3.7 Summary

The components discussed in Sections 3.2-3.6 are interlinked to form the integrated performance budgeting system illustrated in Figure 3.1. The process begins with the prerequisite strategic planning phase defining the objectives and outcomes of the organisation. This feeds into the financial planning phase in which resources are allocated in order to achieve desired outcomes. Financial planning informs the organisational design required for the delegation of responsibility for resource allocation. It also informs the expenditure management phase, which deals with actual implementation. The implementation process will also inform

the organisational design in terms of the required structures and division of personnel. Both financial planning and expenditure management are linked with performance management, as the defining of performance criteria will depend on the relation between activities, outputs and outcomes. The evaluation and monitoring that takes place in performance management is a vital feedback to the strategic planning, financial planning and expenditure management phases.

4. Issues for Successful Implementation of Performance Budgeting

The successful implementation of performance budgeting requires change at both the political and managerial level, and ultimately depends on how the process is managed. Each of the components of the system, described in the previous chapter, should function satisfactorily and in a co-ordinated manner. There are, however, certain potentially problematic areas which need to be given special attention. This chapter will discuss these areas, which have been categorised into the following groups:

- political;
- administrative/bureaucratic;
- technical;
- linkages and co-ordination; and
- implementation strategy.

4.1 Political

Political obstacles may hinder even the most technically sound budgeting systems. The areas of potential difficulty begin with the necessity for a coherent, consistent policy framework with well-defined objectives. It is crucial that the system is acceptable to political structures, and that good quality leadership exists to market and implement the system and to follow through with issues that arise from the post-implementation phase.

4.1.1 Coherence and consistency

A coherent and consistent framework is essential for successful implementation. Having a clear conceptual model is valuable in ensuring that reforms are developed systemically to focus on the causes and not the symptoms of dysfunctionality. It also ensures that all aspects of the system are addressed in a consistent and integrated manner, even if the implementation process happens in

stages. Moreover, consistency aids in reducing fears that reform is simply an *ad hoc* government initiative not to be taken seriously. The framework should also be comprehensive, including all the components of the system from the planning phase through to implementation. If any one of the components is not in agreement with the suggested reforms, the entire system could fail (Scott, Ball and Dale, 1997). In addition, having a specified framework gives guidance to the sequencing and timing of implementing the reforms. As Bale and Dale (1998, p.115) state: "Basing reforms on an analytically rigorous conceptual framework appropriate for the jurisdiction concerned and having the framework apply to the entire public sector is likely to improve significantly the chances that the reform will be successful".

4.1.2 Defining and prioritising objectives

The task of defining objectives and priorities of agencies in the strategic planning phase may be rather difficult. Lewis and Jones (1990) state that objectives are often descriptions of what organisations do, and these descriptions need to be unpacked. Objectives should be defined in terms of quality of service, and quantity if it is at all measurable and meaningful. For example, instead of defining an objective as simply "to process applications", it could be defined as "to process all applications within five working days". Prioritisation may also prove to be a complex task. According to Joyce (1993), different role players may prioritise differently, with some arguing for efficiency as a primary objective, while others argue for extending provision of service with cost as a secondary concern. In addition, a programme may have several objectives, and there may be disagreement about their relative importance. Developing consensus on this issue is an essential step in determining performance measures. Boston and Pallot (1997) highlight the fact that in the New Zealand experience, politicians and bureaucrats were unwilling to set goals against which they might later be held accountable. There were also conflicting objectives both within and across agencies, as well as confusion between means and ends.

4.1.3 Political acceptability

In order for successful implementation to occur, there must be political acceptability of the system. This acceptability should come from the executive,

legislators and departments. If there is resistance to change from ministries or departments it will be difficult to have recommendations taken seriously. In order to facilitate this process it will be necessary to educate and familiarise politicians with the performance budgeting system. All stakeholders should be included in the process of change and be kept well-informed of prospective changes before they happen.

4.1.4 Quality of leadership

Successful implementation is reliant on strong and competent leadership. The effect of the New Zealand reforms, for example, has been varied and dependent on the quality of leadership and the levels of efficiency prior to the reforms (Bale and Dale, 1998). All stakeholders should be well-informed of prospective changes to the system.

4.2 Administrative/bureaucratic

The problematic areas in this category deal with financing and organisational issues. Potential areas of difficulty include accountability issues and the delegation of responsibility; the appropriate organisational design and accounting procedures; clear performance specifications; and the implication of implementation costs.

4.2.1 Delegation of responsibility

Successful implementation is specifically attributable to the extensive autonomy granted to departmental chief executives, allowing them to make decisions and implement them (Scott, Ball and Dale, 1997). This applies to the managerial level as well. If managers are allowed to manage, and are given the appropriate responsibilities which will allow them to do this, the emphasis moves from bureaucratic control to service delivery. In Britain and New Zealand, successful reforms were achieved by moving away from unitary civil service systems towards more flexible agency-based systems, and by devolving responsibility from the central civil service agency to departmental managers (Kettl, 1997). As Bale and Dale (1998) point out, chief executives of each department are free to run

their departments in the way they deem fit to meet the agreed-upon performance goals. They are responsible for making all decisions regarding the number of employees needed, the skill mix of personnel as well as appointments and terminations. It is important that managerial authority matches the department's expected responsibilities. However, Mascarenhas (1996) cautions that it may be difficult to enforce responsibility and accountability on a single department when public sector programmes cut across several departments. Furthermore, Laking (1998) points out that there is an added risk in developing countries that devolving management authority will lead to loss of control without the benefit of improved results, as there may be insufficient managerial capacity at lower levels.

4.2.2 Accountability

Associated with delegated responsibility is accountability. The New Zealand experience has shown that by making the chief executives personally accountable for the performance of their organisations, with the concomitant incentives, public sector performance has improved (Scott, Ball and Dale, 1997). Defining lines of accountability is equally important, i.e. the distinction between accountability for outputs and outcomes. Bale and Dale (1998) suggest that success hinges on the fact that a clear definition is made in this regard. Chief executives should be accountable for outputs (goods and services produced), while ministers should be accountable for outcomes (the effects of those outputs on the community). The relationship between elected officials, heads of departments and managers should therefore be clearly defined from the outset. The focus on performance should shift the emphasis of accountability downward towards customers and results, rather than upward towards elected officials. The area of service delivery must be kept in mind continuously, as it might be problematic if the agencies are run like businesses with an emphasis on costs and efficiency rather than on effectiveness and accountability to the public.

4.2.3 Organisational design

It is important that the organisational structure of departments should be changed so as to be more closely aligned with programme structures (Bellamy and Kluvers, 1995). In other words, it is beneficial to align organisations with areas of delivery and lines of accountability. It is also advantageous to involve staff in the

implementation process, as limited staff involvement and inadequate training may prevent the system from reaching its full potential.

4.2.4 Clear performance specifications

Accountability processes are much more effective if outputs and outcomes are clearly specified in advance. In addition, agency responsibility for specific outputs should be clarified in relation to the agreed-upon objectives. "Conventional wisdom suggests that specific goals and objectives should be stated clearly, explicitly (and preferably quantitatively), and that they should be assigned to individuals or organisational units along with quantitative performance measures to facilitate accountability and control" (Boston and Pallot, 1997, p.395). If there is disharmony between the objectives of the legislature and the executive, or between the agency and its 'clients' (service delivery recipients), agency performance may be undermined. If agencies receive different or conflicting objectives, this may result in confusion and blurred lines of accountability. It is important to define performance dimensions relative to responsibility for each output and the performance reporting to be provided to each stakeholder. "An imbalance between the performance required and the control over resources is likely to be dysfunctional" (Scott, Ball and Dale, 1997, p.377).

4.2.5 Accounting procedures

In order to successfully monitor departmental performance, information about the full resource cost of service delivery (including the depreciation of assets, the opportunity cost of capital, and the utilisation of assets and liabilities) is necessary. For this reason, a shift to accrual accounting for reporting financial performance is preferable for the implementation of the performance budgeting system. In New Zealand, for example, departments provide monthly financial statements using the accrual system, enabling government to simply sum all of the accounts and produce national financial statements (Bale and Dale, 1998).

4.2.6 Implementation costs

There are certain costs involved in the implementation of the system. A good deal of time and resources may be required to develop and implement the system, and

it is necessary to ascertain whether the benefits of implementing the system will outweigh the costs involved. These costs include hiring and training analysts, the costs of acquiring and synthesising new data, and the monetary and non-monetary costs of altering the roles and functions of the existing structure.

In addition, the cost of reform failure should be taken into consideration. The risk exists that in the process of implementing reform the entire public service could collapse if strong and reliable control mechanisms are not in place. This factor should be given serious attention as the consequences could be dire.

4.3 Technical

Technical issues are concerned with the practicalities of actually implementing the system. Areas which may prove problematic include defining performance measures and indicators, defining programme structures, acquiring the relevant resources such as skills and capacity, and setting up a well-functioning information system.

4.3.1 Defining performance measures and indicators

Whether measuring outputs or outcomes, defining performance measures and indicators can be extremely difficult. The process should include clarifying the desired objectives, identifying accurate indicators, and establishing the relationships between outputs and outcomes (Mascarenhas, 1996). Both Australia (in regard to measuring outcomes) and New Zealand (in regard to measuring outputs) have acknowledged that developing measures is a long-term project (Kettl, 1997).

Outcomes, in particular, are difficult to measure, as they may be due to agency efforts or external factors which are beyond the control of the department in question. It is extremely complex to formulate measures of the achievement of policy objectives, since these may be influenced by factors that are beyond the control of programme designers and agency managers. "To the extent that these factors that are external to public agencies can influence outcomes, the direct 'production' of the agency will misstate the effect of its policies" (Joyce, 1993, p.9).

In addition, outcomes may only actually be achieved after a number of years, therefore developing multi-year measures may be necessary.

In terms of output measures, one area of concern may be how the use of assets should be accounted for in unit costs. There may be a lack of cost information, especially for capital costs, which may retard the costing process. The measurement of quality of service may be another area of concern, and guidance should be given on the use of surveys and other measures of qualitative assessment. Validity and reliability issues are equally important. The chosen measures should be sufficiently valid and accurate so as to avoid being misleading. Standards for acceptable performance levels should be set explicitly in advance; they should take into account the specific demographic compositions of different target communities when used for comparative purposes.

4.3.2 Defining programme structures

Not only is it difficult to define performance measures and indicators, it is also complex to define the actual programme structures themselves. According to Seidman (1972), most programmes have multiple objectives and outputs which any structure will have difficulty taking into account. He cites the example of the activity of family planning which has two significant outcomes, reducing poverty and reducing infant mortality. Given these outcomes, it is a complex decision as to where in the structure to put this programme – does it fall under a programme for reducing poverty or under a programme for reducing infant mortality, or is it a programme or sub-programme in itself? The definition of programme structures will probably need to be an evolutionary process, generating more meaningful and appropriate structures over time.

4.3.3 Relevant resources

No matter how good a system is developed, it will not succeed if the necessary resources (human, technological and financial) are lacking. The performance budgeting system requires the transformation of the culture of public service organisations towards being more service delivery-oriented. This has implications for broader civil service and legislature reform. All participants and structures, from agency level through to legislators, will need to be included in the capacity-

building process. The United States General Accounting Office (1997) illustrates this by pointing out that at the agency level this would mean acquiring the necessary resources and skilled personnel, as well as developing the management leadership needed to sustain a performance-based organisation. Similarly, legislators will need to expand their capacity so that they can actively participate in strategic planning. They need to be able to communicate results-based expectations and manage the use of the performance information provided by the agencies.

Human resources are a major component in implementing the system, and therefore employee training and new personnel systems are necessary. Expertise is required in a number of areas and these should be considered in detail. As the Presidential Review Commission (1997) points out, achieving objectives requires managers who are competent and who are able to take the initiative. It also requires management systems which are flexible and accountable. Therefore, building both management and administrative capacity is crucial. The Australian model of budget reform, in particular, has focused strongly on civil service reform as the cornerstone of a broader movement towards public sector reform in general. "The Australians have concentrated on improving the skills of their managers through training and by reshaping the civil service system to encourage performance, compared with the fundamental changes in process driving the New Zealand and United Kingdom reforms" (Kettl, 1997, p.453). Nonetheless, both systemic changes and training are important in the budget reform process.

4.3.4 Information systems

One of the most crucial requirements for success is a proficient information system which can deliver regular, reliable and strategically relevant information. This will enable early identification of problematic areas, as well as provide a sound basis for strategic decision making and performance oversight. Within the performance budgeting system, informational requirements need to serve multiple ends such as public accountability, policy changes, management control and performance evaluation. It is therefore important that the type and quality of information generated is tailored to the needs of end users (Mascarenhas, 1996). In New Zealand, for example, reliable information on the quality, quantity and cost of

outputs has better enabled ministers to prioritise and make choices regarding outputs (Boston and Pallot, 1997). Care should also be taken to prevent information overload. If there is too much information dealing with minor detail, this may result in a lack of focus on key factors, and could hinder the proper appraisal of programmes in the evaluation stage.

4.4 Linkages and co-ordination

Successful implementation of reforms rests on a series of linkages and strategy co-ordination. A strong link between planning and budgeting is necessary to ensure that financial outlays are adequately linked to physical targets. The accounting and financial management systems should be in line with the performance management system to ensure meaningful monitoring and evaluation of programmes. Co-ordination between strategic planning, resource allocation and policy analysis is required to avoid any bottlenecks developing in the system. In New Zealand, for instance, co-ordinating committees were established, consisting of senior government officials, to ensure that policy options are developed in a co-ordinated way across government (Bale and Dale, 1998).

4.5 Implementation strategy

A decision on what type of implementation strategy to use should be made at the outset. The Presidential Review Commission (1997) suggests that there are two approaches in this regard. The first is the systemic approach, where reforms are undertaken in all areas and agencies simultaneously. The second is the pilot approach, where reforms are implemented in selected agencies and then spread horizontally. The essential difference between the approaches is not necessarily the timing of implementation, since the systemic approach may be unrolled gradually. The difference lies rather in the fact that with the systemic approach the fundamental principles are set out in a coherent framework before initiating transition, whereas with the pilot approach they may evolve from experience gained in small-scale pilot projects.

The advantages of the pilot approach are, firstly, that by emphasising learning by doing it is basically a more flexible approach, which has the potential to evolve as the system develops. Secondly, using a pilot strategy lowers the financial and political risks for government, although it does heighten the risk of not achieving improved service delivery. The disadvantages are that the reforms might never be taken seriously and therefore will not be absorbed into the mainstream. In addition, without a clear conceptual framework to start off with, assessment and management of the system becomes a difficult task.

The advantages of the systemic approach are that since it embarks on the process of change at once, there is more chance of old-style methods being dropped completely with less interference for the new system. Implementation can be achieved more quickly, and the underlying conceptual framework ensures consistency and credibility. The disadvantages lie in the fact that service delivery may be disrupted if the process is not carefully managed. Implementation across the board also requires a large skills base, and hence extensive training is required before it can proceed.

4.6 Summary

The challenge for successful implementation of budget reform lies in transforming the political, administrative and technical aspects of the budgeting system. At a political level it is important to secure support from both ministers and managers. Equally necessary is a coherent implementation framework and good quality leadership. At an administrative level, the appropriate delegation of responsibility and accountability, and the alignment of the organisational structure to the programme structure, are essential. It is believed that performance budgeting can be implemented successfully if there is sufficient institutional and managerial support and a well-co-ordinated implementation strategy.

5. Case Study - the Chief Directorate: Health in the Department of Health, Welfare and Gender Affairs of the Province of Mpumalanga

Mpumalanga is the second-smallest of the nine provinces of South Africa. It has a population of roughly 3 150 000 people, 7.3 per cent of the total population of the country. It is a new province formed from the splitting-up of the former Transvaal Province during the revision of provincial boundaries on the advent of the new Constitution of South Africa in 1994. Therefore all provincial, regional and district structures in Mpumalanga had to be newly constructed or adapted from those of the former Eastern Transvaal region. The Health portfolio in Mpumalanga is administered by the Chief Directorate: Health which falls under the Department of Health, Welfare and Gender Affairs (DHWGA).

This chapter will detail the structure and objectives of the Chief Directorate: Health. It will also outline the problems with the Chief Directorate's budgeting system as it was, and the consequent need for reform. Information for this and the following chapter was obtained from, amongst others, open-ended interviews with officials of the Chief Directorate: Health who were directly involved with implementing the new system, as well as the consulting team that developed and helped implement the performance budgeting system. Members of the Chief Directorate: Health interviewed included:

- the Assistant Director of District Health Services;
- the Assistant Director at the provincial office responsible for Information Management;
- the Director of Financial Management Support Services;
- the Deputy Director of Expenditure Control;
- the Central Network Administrator; and a
- Budgeting Manager.

The consulting team included two fiscal economists, a management specialist and a computer specialist.

5.1 Objectives and structure of the Chief Directorate: Health [4]

The Chief Directorate: Health of Mpumalanga had inherited a fragmented health system which was inaccessible to the majority of the population and oriented to curative and hospital-based rather than preventive and clinic-based medicine. Resources were unequally distributed along geographic and racial lines, with most health care facilities concentrated in the urban areas.

The Chief Directorate has since undertaken to implement the policy guidelines set out by the National Department of Health which include:[5]

- decentralisation of services to the regions and districts to bring the services close to the people;
- adoption of the district health system as the vehicle for health care delivery in the province;
- the choice of primary health care as the strategy for the delivery of universal health care to individuals, families and communities in the province;
- the need to involve stakeholders in planning and delivery of health services to the communities through meaningful community participation; and
- the need and desire to create a health service that cares for and is responsive to client needs.

In order to achieve the above objectives, the Chief Directorate embarked on a major restructuring process. This involved reorganisation from a regional basis to a district-based system.

5.1.1 Goals and objectives

The new focus of the Chief Directorate: Health in Mpumalanga is to improve the manner in which health services are delivered. In order to achieve this, the broad goals of the Chief Directorate, as noted in DHWGA (1997), are:

- designing a health service delivery system which can reach the majority of the people;
- employing measures to prevent and treat preventable diseases and conditions;

4. This section is drawn from DHWGA (1997).
5. Department of Health of the Republic of South Africa (1994), *A Policy for the Development of a District Health System for South Africa*, Pretoria: Government Printer.

- redirecting the thrust of health care in the broader context of development; and
- providing a caring, compassionate service.

In order to achieve these goals and transform the health system into a comprehensive and integrated one, a strategy based on primary health care is being implemented. The first step has been to restructure the Chief Directorate: Health to decentralise health services to districts. There was also a move towards adopting programme budgeting. However, as will be discussed in Section 5.2 in more detail, the budgeting system had not been reformed to a satisfactory extent.

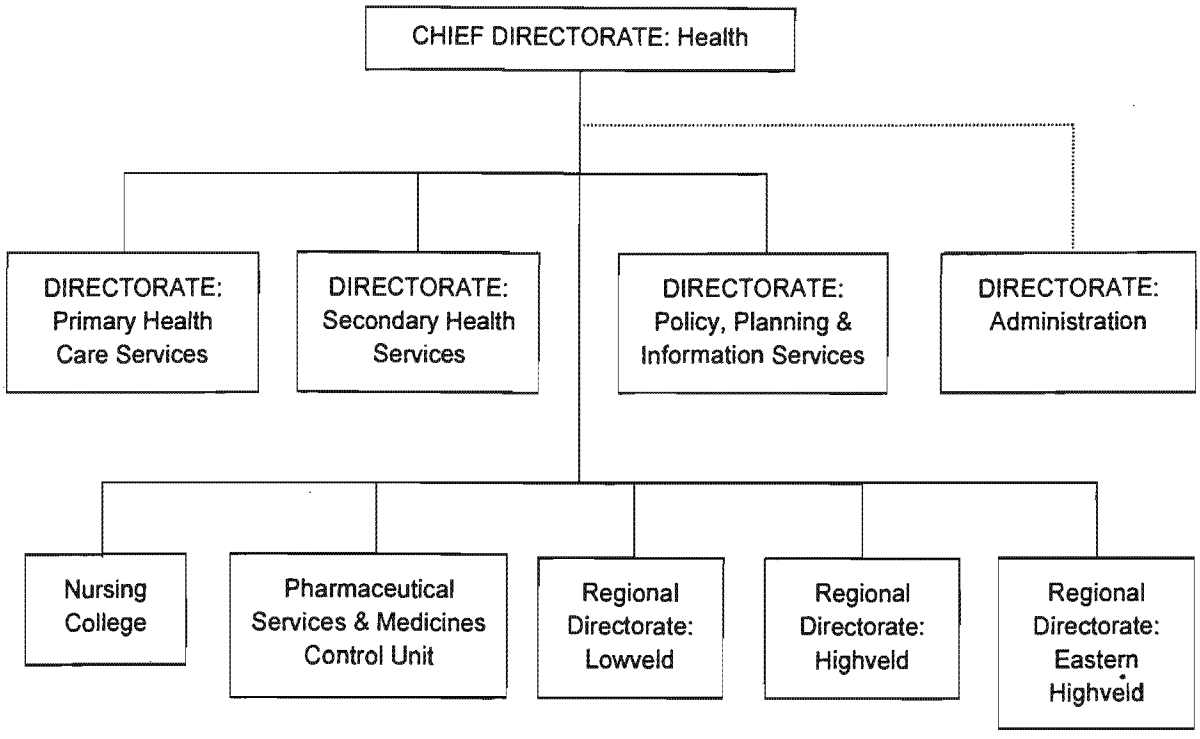
5.1.2 Organisational structure of health services

The Department of Health, Welfare and Gender Affairs of Mpumalanga has as its political head a Member of the Executive Council (MEC). Reporting to the MEC is the Deputy Director-General (DDG) who is the chief executive of the Department. The Chief Director for Health, who is accountable to the DDG, is responsible for the management of the health services in the province. The Chief Directorate: Health is structured along three levels: provincial, regional and district.

The Provincial Health Office, which is located in Nelspruit, the capital of the province, is headed by the Chief Director. The Chief Director receives administrative support from the Directorate of Administration, which is shared between the Chief Directorates of Health, Welfare and Gender Affairs within the DHWGA. The functions of this directorate include formulating policy with regard to administration and financial matters, determining norms and standards, and the handling of personnel administration, transport and auxiliary services, finance, provisioning and procurement.

Reporting to the Chief Director are three directorates: Primary Health Care Services; Secondary Health Services; and Policy, Planning and Information Services (see Figure 5.1). The purpose of these directorates is to provide a service development support function in each of their respective areas. Their main functions include formulating policy, determining norms and standards, monitoring and evaluation, planning support, and human resource development support.

Figure 5.1 The organisational structure of the Chief Directorate: Health



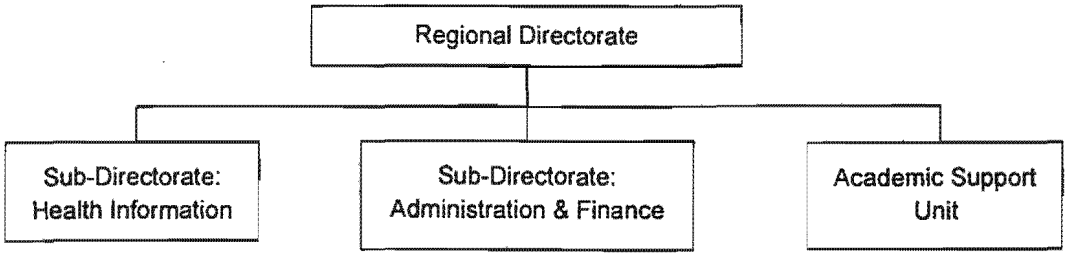
Source: DHWGA (1997), ***Primary Health Care in Mpumalanga: guide to district-based action***, Durban: Health Systems Trust

Also falling under the Chief Director is a Pharmaceutical Services and Medicines Control Unit, which is responsible for the operations, monitoring and policies regarding pharmacies and pharmaceuticals; a Nursing College, which is responsible for human resource development in the nursing profession; and three Regional Directorates: Lowveld Region, Highveld Region, and Eastern Highveld.

The Regional Directorates each form part of a Regional Health Office (RHO) which is responsible for managing its region. The main functions of the Regional Directorates include translating health policies and strategies into operational plans, co-ordination and support in developing health plans and service delivery, liasing between health services and academic institutions, inter-sectoral collaboration, and co-ordinating emergency services. Also included in the RHO is a Sub-Directorate for Health Information which provides support to districts in developing health and management information systems; a Sub-Directorate for Administration and Finance which is responsible for providing support to the

districts regarding budgets and financial management, staff development and management, and the provision of support services; and an Academic Support Unit which has agreements with three universities regarding academic support services in the province. The composition of the RHOs is illustrated in Figure 5.2.

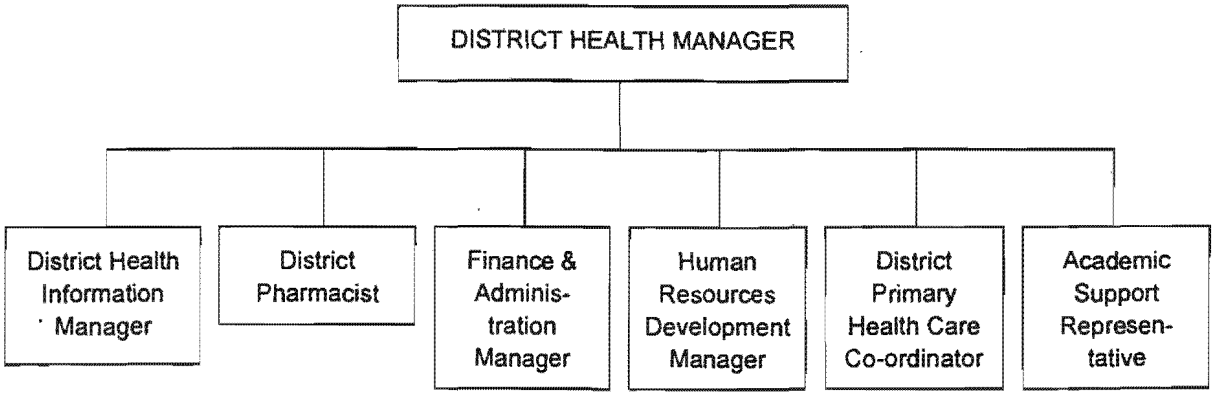
Figure 5.2 Composition of a Regional Health Office



Source: DHWGA (1997), ***Primary Health Care in Mpumalanga: guide to district-based action***, Durban: Health Systems Trust

Each region is further divided into a number of districts which are managed through the District Health Office by a District Health Management Team (DHMT). The DHMT is responsible for the provision and management of district health services. Its focus is to plan, deliver and manage an integrated and comprehensive health care service. The composition of the DHMT is shown in Figure 5.3.

Figure 5.3 Composition of a District Health Management Team



Source: DHWGA (1997), ***Primary Health Care in Mpumalanga: guide to district-based action***, Durban: Health Systems Trust

The District Health Manager plays a key leadership, managerial and technical role in co-ordinating district health programme planning and implementation. This role is supported by the various members of the DHMT. Ultimately, the functions of the district health office are ensuring health service delivery to the communities; ensuring proper management and utilisation of resources; managing and developing personnel; and developing, maintaining and managing the district health information system.

The basic aim of the restructuring process was to decentralise decision-making, resource control and service co-ordination to the district level and thus closer to the community. Since the implementation of performance budgeting, however, it has been acknowledged that the above organisational structure is not aligned with the budget programme structure, resulting in the crossing of management responsibilities and an inability to control programme budgets. Consequently, the desired aim of decentralisation has not been achieved, impacting on the ability to improve accountability in service delivery. The Chief Directorate: Health is thus in the process of setting up a new organisational structure which is more closely aligned to the new budget structure in terms of management and financial accountability.

The alignment of organisational structure with the new budget structure is particularly important because the budgeting system plays such a vital role in realising the aims of decentralised decision-making and resource allocation. Without a system that specifically deals with outputs for service delivery, there is no mechanism for ensuring that delivery will take place effectively and efficiently. This is discussed in Section 5.2.

5.2 The budgeting system and the need for reform

The budgeting system of the Chief Directorate: Health in Mpumalanga, prior to the introduction of reforms, was based on programme budgeting. In effect, however, the structure consisted of only two programmes which were presented in line-item format. There were, therefore, serious shortcomings with the system (discussed in Section 5.2.2) which urged those in charge to start engaging in serious budget reform initiatives.

5.2.1 The budget process and structure

The budget process for the Chief Directorate: Health is part of the broader national and provincial budget processes. As explained by Chief Directorate: Health (1998), the process begins with the national pool of revenue being split by the Budget Council[6] into a share for national, provincial and local governments. The provincial share is then split amongst the provinces according to a formula, and each province thus receives an indicative global budget allocation. It is then up to each provincial Executive Council to approve the division of the indicative budget allocations to their various provincial departments.

Once the Chief Directorate: Health within the DHWGA receives its allocation, the finance section gets each facility, the head office and the district offices to prepare their own specific budgets. During this stage, there is continuous negotiation between the provincial treasury and the individual departments, as well as between the provinces and the Budget Council. It is only once the final allocation from the Budget Council is received that the allocation accruing to the Chief Directorate: Health can be finalised. Adjustments are then made in order to reconcile the individual budgets of sub-programmes and institutions with the available funds. These adjustments should be based on the priorities set by the provincial department. The final budget is reflected in the White Book and tabled as the Health Vote.

As the DHWGA (1997) points out, programme budgeting has been the system used. Funds are allocated according to specific programmes in such a way as to realise the aims and objectives of the Chief Directorate: Health, and "... every programme must have clearly defined objectives and a detailed budget showing expected revenues and expenditure" (DHWGA, 1997, p.35). However, in practice, prior to the introduction of performance budgeting this did not appear to be the case. The Health Vote in Mpumalanga had only two programmes, and the format of the budget was basically a line-item approach within each programme (see Appendix 2, which contains the 1998/99 Health Vote for Mpumalanga). The programmes were extremely broad and there were no clearly defined objectives. For example, Programme 2 of the 1998/99 Health Vote, Community Health and

6. The Budget Council consists of the Minister of Finance and the nine provincial MECs for Finance.

Hospital Services, aimed to render both primary health care services and hospital services on primary, secondary and tertiary levels. This programme included such disparate functions as school health services, community nursing, oral health services, environmental health services and hospital services. Furthermore, the benefits of decentralisation to the district level were not captured at all in this budgeting system, as it did not provide a mechanism for health districts to formulate their own budgets.

5.2.2 Problems with the system

Apart from remaining an essentially line-item based budget, there were a number of problems associated with the former budgeting system. There was no link between inputs and outputs as there were no specified outputs for the programmes. The main areas of concern discussed in Chapter 2, especially that of a lack of integration between planning and budgeting, and a lack of monitoring and evaluation, applied to this case as well. There was also no medium-term expenditure framework specified in the budget at all.

Specific shortcomings of this budgeting system, raised by members of the Chief Directorate: Health and the consulting team who developed and facilitated implementation of performance budgeting, were that the budget system was just a line-item system which concentrated only on inputs. There was no specification of outputs or outcomes, and therefore no way to measure performance or whether an impact was being made or not. There was a lack of integration between planning and budgeting; in particular, budgeting was not informed by the strategic planning of the Chief Directorate: Health. Although management had done a great deal of strategic thinking, there was no clear mechanism for translating this into action throughout the Chief Directorate. It had also not filtered down to the budget structure: the budget was merely an increase on the previous year's figures. This also meant that there was no procedure for priority setting, and no way to channel funds to priority programmes. There was also no management of service delivery, and no correlation between clients' needs and the budgeting process.

From an operational point of view, there was no provision of management information. There were no detailed reporting procedures, which made it difficult

to determine the impact of expenditure or detect the source of errors when they occurred. For example, in an individual clinic there would be no reporting of actual personnel expenditure in relation to budgeted personnel expenditure. This had direct implications for management, since it made it extremely difficult to detect variances from budgeted expenditure, find out the causes, and act upon them. The existing reports presented the data in such an aggregated manner, not even broken down by institution or region, that it was impossible to determine where the funds were being spent. Consequently, no-one seemed to pay any attention at all to these expenditure reports. There was no sense of responsibility for managing expenditure, as it always became "someone else's problem"; the lines of responsibility and accountability were unclear, which made it easy to shift the blame. Moreover, without capturing outputs and linking the inputs with outputs, it was difficult for health service officials to conceptualise what the funds were really there for, and what their responsibilities were in relation to those funds.

In terms of management, there was essentially no link between health sector management and financial management and budgeting. There was no connection between the way money was managed and the objectives of the Chief Directorate: Health. No appreciation existed on the health management side about how important finance was, and conversely no appreciation existed on the finance side of the need to support service delivery. There was also insufficient knowledge within the Chief Directorate: Health of where the finances were spent at a micro level in terms of staffing, drugs, procurement, etc. The organisational and management structures, as well as the lines of accountability, did not allow for proficient financial management.

In terms of the budget structure, line functions were confused with management functions. For example, the Health Sciences Programme was responsible for administering health bursaries, whereas they should rather have been responsible for health bursary policy. Consequently, management was more concerned about intervening in line functions, rather than what they should be doing - strategic planning, monitoring and evaluation. The structure was also economically irrational in that functions such as laundry were centralised at the provincial level

rather than being decentralised to each hospital. Decentralisation is necessary to facilitate the tracking of costs and the elimination of theft and wastage.

From a technical perspective NEWFIN, the computerised financial management system for budgeting used in Mpumalanga, is not a user-friendly system. In addition, because the Chief Directorate: Health does not have ownership of the system, it is difficult to deal with technical problems that arise. The system is reliant on consultants to customise and maintain it. The NEWFIN system was inherited from the provincial government of the former Transvaal Province, the Transvaal Provincial Administration (TPA), and it is now outdated and ineffective. It is essentially an accounting system which is unable to determine how much resources cost for a specific output, and which has no focus on service delivery.

5.3 Summary

The problems discussed in Sections 5.1 and 5.2 above prompted the recognition that a fundamental restructuring of the budgeting system used by the Chief Directorate: Health in Mpumalanga was required. It was necessary to keep policy formulation in the management domain and devolve line functions to the point of service delivery, i.e. district level. This would coincide with current strategic thinking, as well as with the principles of performance budgeting. Accordingly, the implementation of a performance budgeting system was undertaken.

6. The Implementation of Performance Budgeting in the Chief Directorate: Health, Mpumalanga

As discussed in Chapter 5, the decision to adopt the performance budgeting system (PBS) arose primarily out of the district restructuring process. There was no budgeting structure or system in place for the districts and it was recognised that a new approach to health management, planning and budgeting was necessary. The District Health Systems Directorate thus took up the challenge of introducing a new system which would fundamentally change the budgeting, financial planning and management systems for the districts.

The Chief Directorate: Health employed a team of consultants which included two fiscal economists, a management specialist and a computer specialist. Together they formulated a project proposal to implement PBS in the department. The original purpose of the project was to "... generate and help implement a system of budgeting, financial planning and management, with a special focus on district health services" (Abedian and Strachan, 1998, p.1). However, once it became clear that the districts did not function in isolation from the rest of the Chief Directorate: Health, and that there were anomalies in the way the Chief Directorate's budget was structured, it was decided to extend the adoption of PBS to the entire Chief Directorate: Health. This chapter will review the three phases of the implementation process. It will then analyse the issues encountered during the implementation process according to the framework set out in Chapter 4. Finally, it will discuss the issues still outstanding for successful implementation.

6.1 The implementation process

Project implementation began in September 1997, and incorporated three conceptual phases. Phase I comprised the preparation of top management, which entailed extensive interaction with the senior management of the Chief Directorate: Health and other managers at hospital, district, regional and provincial levels. The aim of this phase was to ensure a clear understanding of the

budgetary issues involved, and those management and policy issues that had direct budgetary ramifications. Phase II comprised development of a new budgetary structure; this involved collaboration with the management structures to define a new format for the budgetary allocations of the Chief Directorate: Health. In other words, a new programme and sub-programme structure was to be developed, with activities, for the Chief Directorate as a whole (not only the district health system as originally intended). Phase III comprised software development and installation of the new system; this entailed the development and installation of a computer software system that interfaced with the NEWFIN system. This phase also included the development of a manual for the new system and the training of users in the system (Abedian and Strachan, 1998). A series of workshops and training courses was organised during the period September 1997 to September 1998 to accomplish these objectives.

6.1.1 Phase I: Preparation of Top Management

The first step taken in preparation of management was to obtain support and commitment from the MEC for Health, the Chief Director of the Chief Directorate: Health, and the other programme managers. Endorsement of the new system by top management, as well as a commitment to the implementation process, was required. This proved an immense task, due to uncertainty regarding the new system and a reluctance to change. However, the support of the Directorate of District Health Systems, one of the largest programmes within the Chief Directorate: Health, assisted notably in this process. The support of the Provincial Treasury had also to be obtained to secure approval of the system. Mnisi (1998) states that this was not easy; there was much resistance to the innovation due to a lack of understanding of the proposed system and its implications for service delivery.

The next step was to make sure that each level of management had a clear understanding of the budgetary issues involved, including management and policy issues. This was achieved via training workshops, in which the conceptual framework of performance budgeting was conveyed to participants. The strategic objectives of the Chief Directorate: Health had been formulated outside the context of budgeting and fiscal constraints. These objectives now had to be matched with

the performance budgeting system in such a way that the essence of the strategic objectives were compatible with the structure of performance budgeting.

6.1.2 Phase II: New Budgetary Structure

Once top management was committed to the process, the next stage was to develop the new budgetary structure; this included defining programmes, sub-programmes and activities. In this regard, national health care standards and requirements had to be taken into consideration. The restructuring process also had to ensure that the budget structure would correctly align the respective accountabilities of health services management and financial management. In addition, the budget had to be structured according to the seven programmes of the National Department of Health. According to Mnisi (1998), this was a mammoth task which took more than a year to complete.

Phase II involved a number of workshops with the consulting team, top management, middle management, and a significant number of district managers. In these workshops views were exchanged between the consulting team and the department officials, in order for the consultants to understand the perceptions of management and for management to understand the budgeting system's constraints (Abedian, 1998). After the initial contact between the consultants and the department, there was a gestation period of between four to five months in which the budget structure was meant to be developed (Ajam, 1999). However, not much was achieved in this period because many managers did not fully understand what was required of them, and those that did have a clearer vision of what was required were not able to translate this into operational activity. Ajam (1999) adds that at this stage the project was considered to be largely experimental, and there was therefore a hesitancy to take the necessary decisions as it was not certain whether the project was actually going to proceed to full operational implementation.

However, after further interaction and the elucidation of the importance of the project, the budget structure began to evolve. Initially, Ajam (1999) states, there was a tendency to repackage current programmes without really considering the relationship between inputs and outputs. Health services managers would simply

list a large number of activities within their programmes because they wanted to appear busy and not have their budgets cut, without realising that each activity had to have a corresponding output identified with it. Often several activities listed by them actually led to only one output. Consequently, the defining of the budget structure was a slow, evolving process. Mnisi (1998) adds that a large amount of time and planning was invested in the process, as it was essential to go right down to the point of delivery and determine the specific needs of the clients of health services. Only then was it possible to decide which activities should be developed in order to satisfy clients' expectations. Not only were the technical difficulties time-consuming, but there were also managerial difficulties. The budget restructuring led to a redefinition of certain organisational objectives and structures which had to be dealt with in this process. Moreover, the new organisational and budget structure led to a re-definition of management roles. For example, the District Health Systems programme now included entities (such as hospitals and clinics) which had not previously been under its management, which in turn diminished the "power" of other programmes.

The next step was to define outputs in order to develop performance indicators. According to Pond (1998), this was not too difficult when defining outputs for service delivery such as immunisation. However, when it came to defining outputs for managerial activities this proved to be more difficult.

Finally, once the structure had been developed and outputs defined, it was necessary to cost the inputs for each activity. The costing process involved preparing the various managers to review the standard item costs such as salaries, medicines, transport, etc., and apportion them across activities. This, in itself, proved to be a daunting task. According to Abedian (1998), costing was based on the existing establishment, which dealt only with expenditures and not costs. The difference between expenditures and costs is that expenditures, in the past, did not include depreciation or maintenance costs, and therefore the true value of the cost incurred was not reflected. The costing process should make allowance for capital costs, as well as provision for the maintenance of newly-acquired and existing assets over time. In this case, due to the lack of appropriate information,

expenditure had to be used as a proxy for cost. It was, however, recognised that the costing process is ongoing and will have to be refined over time.

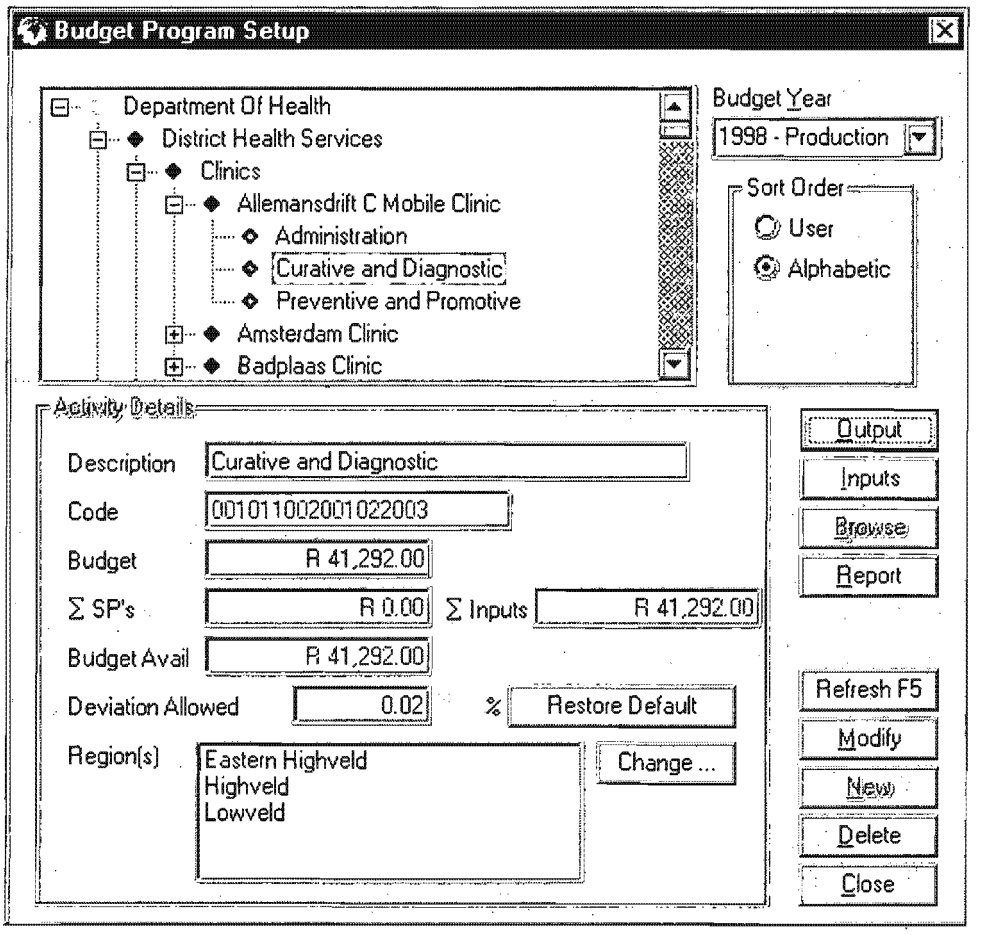
6.1.3 Phase III: Software Development and System Installation

Software development for PBS began conceptually as a spreadsheet exercise. It was then realised that much more detail was necessary, and a computer software developer was invited to join the consulting team. The software was then further developed using Visual Basic® and SQL Server language. The PBS software is an interface that runs on top of the existing NEWFIN system. The NEWFIN system was retained as the day-to-day accounting system, as accounting is not a part of the PBS functionality. It was also a requirement of the provincial treasury that the budget continue to be formulated in NEWFIN to ensure compatibility with the rest of the province. Development of the PBS software occurred in consultation with members of the Chief Directorate: Health, so as to ascertain the exact nature of end-user requirements. This happened concurrently with the development of the budget structure.

As Chief Directorate: Health (1998) points out, the functionality of the PBS software includes two main objectives. The first objective is the ability to budget in successive steps. This involves developing objectives and activities, identifying outputs and performance measures, costing activities, developing a multi-year budget, and making budget adjustments after departmental decisions have been finalised. The second objective is the ability to manage finances in relation to operational delivery. This comprises implementing requisitions; allocating budget and expenditure for personnel, equipment and transport to activities; reporting on expenditure and performance; and improving cost-effectiveness of delivery (option appraisal).

An example of the programme, sub-programme and activity set-up screen in the PBS software is shown in Figure 6.1. (It should be noted that all amounts referred to in this and the following examples are used for illustrative purposes only, and do not necessarily correspond to the actual values of the items concerned.)

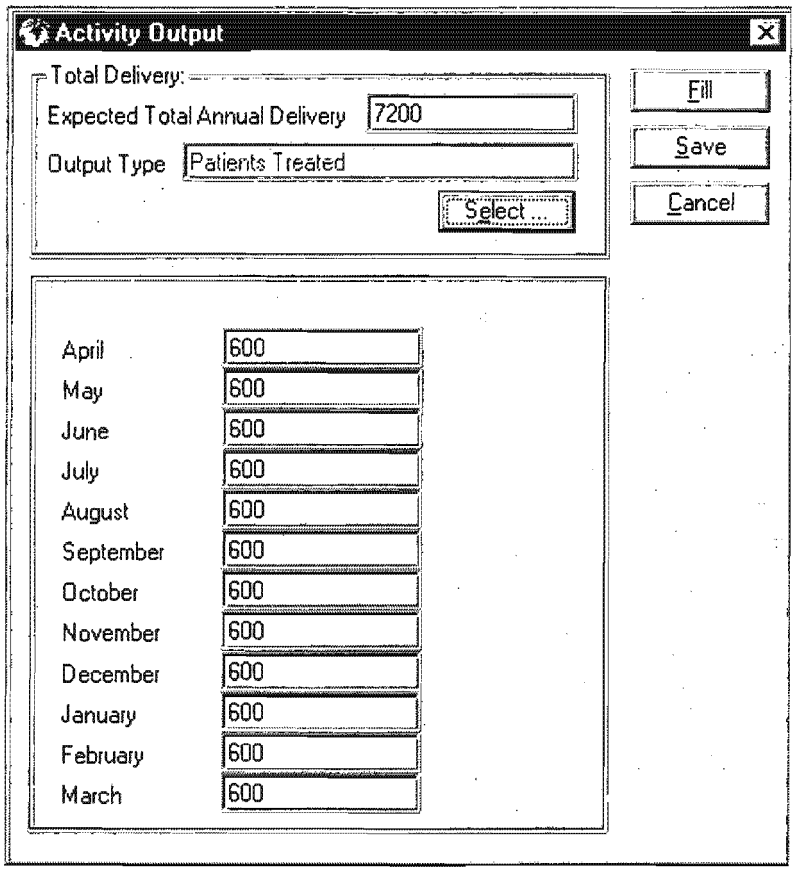
Figure 6.1 Budget Programme Set-up down to Activity Level



Source: Chief Directorate: Health, DHWGA, Mpumalanga (1998)

Figure 6.1 illustrates the budget set-up for the activity "Curative and Diagnostic", which falls under the District Health Services Programme, Clinics sub-programme, and Allemansdrift C Mobile Clinic sub-sub-programme. The budget of R41,292.00 is the indicative budget for that particular activity, i.e. the budget constraint. If this was the budget for a programme, then the field "ΣSPs" would indicate the sum of the budgets of all the sub-programmes relating to that particular programme. "ΣInputs" denotes the sum of all the line items at a particular level, be it activity, sub-programme, etc. The "Budget Avail" at a programme level would denote the difference between the indicative budget of the programme and the sum of its sub-programmes. The output button on the screen pictured in Figure 6.1 allows for the specification of the service delivery output for the particular activity. This in turn is shown in Figure 6.2

Figure 6.2 Activity Output screen

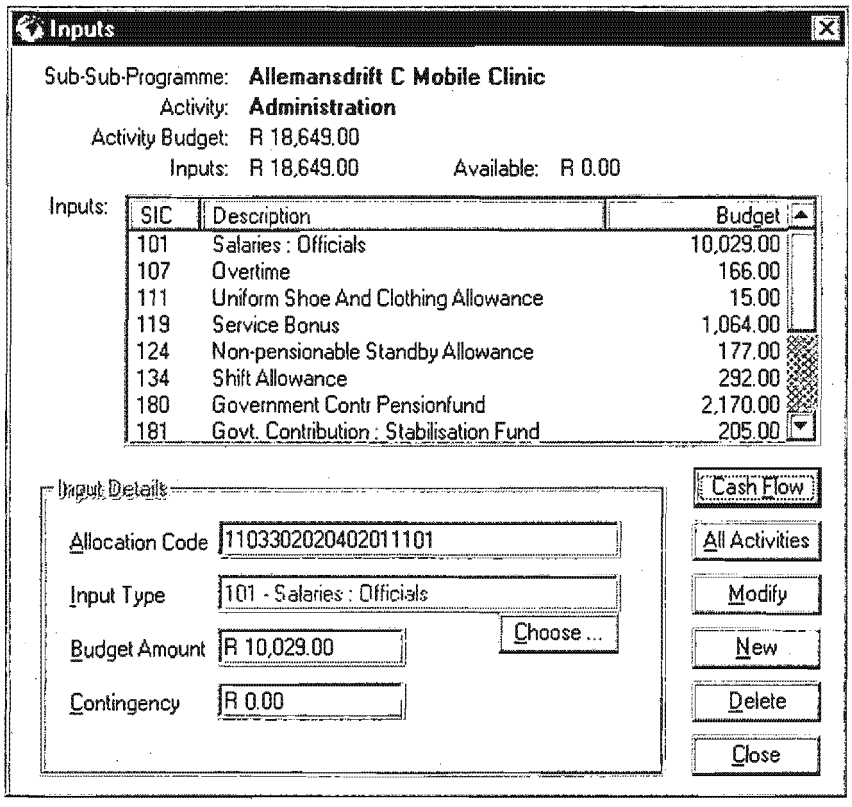


Source: Chief Directorate: Health, DHWGA, Mpumalanga (1998)

Figure 6.2 illustrates the specified output type, i.e. patients treated for the activity shown in the previous screen, i.e. Curative and Diagnostic. The total planned output for that activity for the year is 7200 as indicated in the "Expected Total Annual Delivery" field. The monthly distribution over the year is also shown.

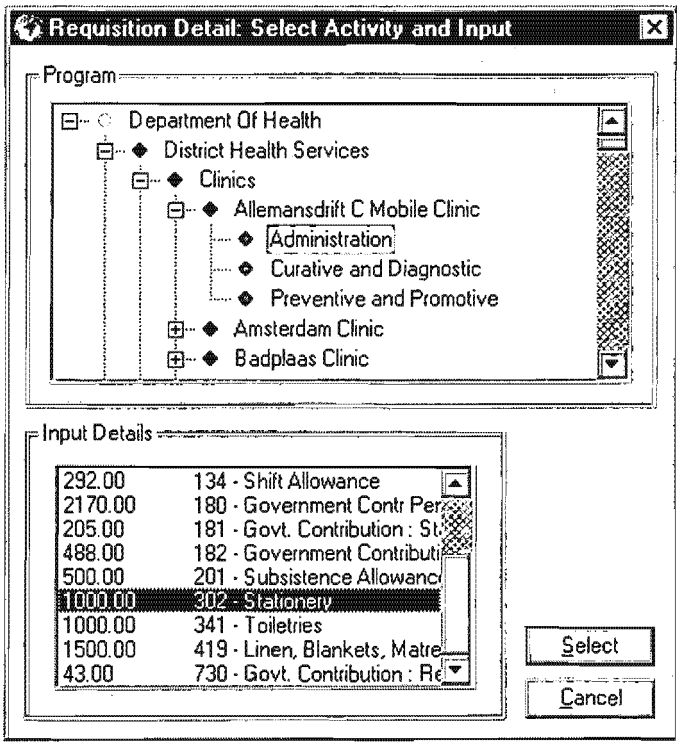
The "Inputs" button shown in Figure 6.1 produces details of the line-item inputs for that particular activity, illustrated in Figure 6.3. In this particular example the line-item budget for the activity Administration is shown. The total of the inputs (line-items) must equal the activity budget (in this example, R18,649.00) and will also be reconciled with the NEWFIN line-item budget. If the entire budget has not been allocated the 'Available' field will indicate how much money is still available for inputs in the activity budget.

Figure 6.3 Line-Item Inputs



Source: Chief Directorate: Health, DHWGA, Mpumalanga (1998)

Figure 6.4 Requisition Input and Activity Detail



Source: Chief Directorate: Health, DHWGA, Mpumalanga (1998)

An example of a line-item requisition detail form is shown in Figure 6.4. This form shows the exact activity and input for a particular district's line-item budget. The capturing of requisitions would have been allocated to the appropriate sub-sub-programme and activity as specified by the user.

After the software had been developed, it was then installed in the Chief Directorate: Health. Installation began with the head office and was then extended to the district offices. Technical delays were encountered along the way, especially when dealing with remote rural areas. Delays were also encountered when trying to link the PBS software with the existing NEWFIN system. At the same time, the training of staff members began. Training had to be done on two levels. Firstly, there was theoretical training in the conceptual framework of performance budgeting. Secondly, staff were trained in how to use the computer system. The latter was done in a practical hands-on manner with trainees performing exercises such as setting up budgets, allocating personnel, creating requisitions, etc. Once the training began, however, it became quite clear to all involved that the process of implementing an entirely new system was much more difficult than originally expected, and it was recognised that training would have to be an ongoing process. It was then decided to form a PBS Management Team which would be responsible for ensuring the successful implementation of the system, as well as the necessary training of staff.

The development of a training manual was also completed in this phase. The manual suffered numerous delays resulting from the fact that it was not meant to be generic, but rather was meant to fit the specific programme structure of the Chief Directorate: Health of Mpumalanga (Ajam, 1999). Therefore it could not be completed until the structure had been approved.

At the time of writing, the implementation of the performance budgeting system was not complete. Phase I had been completed, but Phases II and III had not been fully realised. Installation of the system in certain districts was not complete, and staff training was still needed. The process had taken longer than anticipated, and the time frame for implementation had to be extended. The delays are, however, understandable: this was the first time in South Africa that such a project had been initiated, and neither the Chief Directorate: Health nor the consulting team had

been aware of, or prepared for, the enormity of the task. Section 6.2 will describe the problems encountered during the implementation process.

6.2 Issues encountered during the implementation process

As expected, numerous problematic issues arose once the implementation process had begun. These have been grouped in the categories of political, administrative and technical issues.

6.2.1 Political

The political issues that arose during the implementation process related to the culture of transformation, the coherency and consistency of the process, the acceptability of the new system, and the quality of leadership. Each of these is discussed in turn.

6.2.1.1 The culture of transformation

Generally, people are resistant to change, and it is a difficult task to convince them that change will result in a positive outcome. They tend to see change as a threat, and this can be extremely problematic when trying to implement a new system. The perception existed among staff of the Chief Directorate: Health that, as in the past, treasury would continue to cut budgets, and hence that implementing a new system would not bring about the required changes. Another important issue was the fact that top management are fearful of 'letting go'. According to Mnisi (1998), it was a challenge to convince managers that performance budgeting is a system that would help to manage resources. Pond (1998) agrees and adds that it is extremely difficult to shift the way people think, especially when trying to impart new concepts. He states that the challenge has been to get people to understand that PBS is not just about accountability and tight controls, but rather that it should be seen as a management tool to improve service delivery. In times of uncertainty, it is beneficial to have key leaders who are enthusiastic and who can encourage those who might not otherwise have been interested. Many say they are interested in the system, but are not really committed to the detail of getting it to work. Therefore, they need to be shown exactly how the system works and how it enables them to obtain value for money in service provision.

An associated issue is the slow pace at which top management internalised the implications of the transformation process. Abedian (1998) maintains that top management could see the benefits of the new system, but did not appreciate the effort it would require to realise these benefits. He adds that the culture of transformation in this country has been for top management to make the fundamental decision to transform, and then to delegate the implementation to some lower levels of management without the concomitant authorisation powers. This proved to be a major obstacle, as each step of the way high-level decisions needed to be taken. Top management was not available to make these decisions, and lower-levels managers felt that they did not have the authority to make them. This resulted in significant delays in the implementation process.

6.2.1.2 Coherency and consistency

The implementation of the system was not conceptualised thoroughly enough. To make the process run more smoothly it would have been necessary to document fully and in detail exactly what the Chief Directorate: Health expected in terms of the concept, the end product and the necessary steps to be taken to achieve this. In other words, a detailed project implementation plan should have been developed, with both the consultants and the Chief Directorate providing input. It would also have helped, in this regard, to have had a situational analysis performed for the Chief Directorate: Health to determine exactly what existed in terms of capacity, infrastructure, existing systems, etc. In such a situation it is especially important to ascertain who the financial managers are, what they are currently doing, and what their understanding is of what they currently do. This will facilitate training and the strengthening of management competence.

6.2.1.3 Political acceptability

Officials in the Chief Directorate: Health were initially hesitant to adopt a new system because national systems had not changed (Strachan, 1998). It was also felt that if the National Department of Health had overtly supported the performance budgeting system, it would have been easier for the province to accept the system. Provinces with relatively weak management capacity are less willing to adopt systems that are not driven from the top. They cannot cope with the existing

situation, and they are therefore less likely to adopt a new system which is both a major challenge and departs from traditional practice. Strachan (1998) adds, however, that fortunately the Manager of District Health Systems in the Chief Directorate: Health, who is a strong and confident manager, was not overwhelmed by the challenge and was willing to experiment and adopt a new system. "The make-or-break issue is the commitment of top managers, and their willingness to allow the PBS Management Team to get in, and get the thing moving. Once we've been given the permission to get in and moving, the rest will follow" (Pond, 1998).

Agreement had also to be obtained from the provincial treasury. Abedian (1998) adds that this in itself was an obstruction to the process, as the treasury was not open to such systemic change. They tended to guard their control jealously, and thus retarded the process by inhibiting others and creating friction. A case in point was the technical link-up between PBS and the provincial financial system, NEWFIN. The development of this link required no more than a couple of hours of computer programming, yet it took the treasury five months to complete this task.[7]

6.2.1.4 Quality of leadership

There was a serious lack of management capacity at particular management levels in the Chief Directorate: Health. The current public sector environment, which does not encourage management initiative, did not allow for management to actually plan and manage. Therefore, managers appeared unable to make decisions, and were unwilling to be held accountable for any decisions made. In addition, they did not really want to change the *status quo*. Managers were not used to taking the initiative, and were therefore not pro-active.

There was also no culture of management: although they held the title of manager, staff in the Chief Directorate: Health administered rather than managed. Many of the people in the Chief Directorate had worked for the former Transvaal Provincial Administration for many years and were used to a particular way of doing things, which was laid down in financial regulations and prescripts. There was no questioning of why certain things were done. " 'So long as the financial

7. At the time of writing it is still not certain, after nine months, if this link really is in place.

regulations were followed, I needn't be a manager. I'm just a common provincial officer, so I needn't think. I will get paid anyhow' " (Vorster, 1998, describing how some managers see themselves.) She adds that this may be due to the fact that sometimes, under pressure, decisions are taken at Head Office level, without the necessary consultation with the district managers. This was a key problem with the implementation of PBS. PBS is a tool for management and therefore, in order for the system to function to its full potential, management capacity must be developed and specific training given in this regard.

6.2.2 Administrative/bureaucratic

The administrative or bureaucratic issues that arose were those relating to delegation of responsibility, lines of accountability, organisational design and implementation costs.

6.2.2.1 Delegation of responsibility

One of the major problems with the implementation process was that roles and responsibilities were not clearly defined from the outset. The process was not adequately driven from the provincial level. Once top management had given their support for the system, they assumed that implementation would happen without them having to give commitment to it or delegate true authority for it to the lower levels of management. According to Ajam (1999), devolution of responsibility to lower levels of management would have resulted in top management having to relinquish some of their power, and they were not always willing to do this.

It was also not always clear, in terms of implementation, which responsibilities lay with the implementation team and which lay with the consulting team. Ajam (1999) points out that the consultants were there to enable and facilitate the process, whereas the Chief Directorate: Health expected them to actually drive the process. Lack of clarity on roles and responsibilities is naturally problematic, as it can potentially lead to nobody taking the initiative, resulting in uncertainty, confusion and lack of direction. This was, however, soon recognised during the implementation process, and the result was the formation of a PBS Management

Team who would be responsible for carrying the implementation further. Clearly, a project implementation team who were totally committed was vital for the successful implementation of the system. Mnisi (1998) adds that it was also important to involve members of the Chief Directorate: Health in teamwork. If people see themselves as part of a team, it encourages them in the sense that they feel they have an important role to play. It also makes job descriptions clearer, and focuses staff on their objectives.

6.2.2.2 Accountability

Introducing PBS to the Chief Directorate: Health required fundamental change not only to the financial systems, but also to the organisational structure of the Chief Directorate. The top management of the Chief Directorate: Health appeared reluctant to assume responsibility and be held accountable for the new system. Ajam (1999) considers that ownership of the implementation project was never really taken by top management. If the project was to fail, they did not want to be held responsible. This resulted in a certain lack of commitment and a distancing of management from the project to a certain extent. Paradoxically, of course, this reluctance to take ownership would itself contribute to the possibility of failure in implementation, as the commitment and accountability of top management is crucial to the process of budget reform.

6.2.2.3 Organisational design

In order for implementation to succeed, it must become a part of the overall organisational and strategic plan of the department concerned. In the case of the Chief Directorate: Health in Mpumalanga, this was not possible, as there was no plan to begin with. Strachan (1998) suggests that the Chief Directorate was not in a 'management framework', and this became clear only after the project had begun. It was necessary to make it clear that one of the requirements for success was to have a clear organisational and strategic plan in place. In fact, the organisational structure of the Chief Directorate: Health changed during the course of implementation. At the outset, the Chief Directorate was organised according to regions, and district managers had not yet been appointed. A further obstacle in

this regard was the inability of the Chief Directorate to dismiss surplus labour or restructure the existing organisational design.

In addition, the staff of the health information services, a vital component of the provincial health services system, had not yet been appointed. While top management was trained, this capacity could not filter down to lower levels, as the latter structures were not yet in place. This naturally had an affect on the training component of the implementation plan: at lower levels of the provincial health services, where capacity for delivery is most important, not enough time and attention was given to training. In order for performance budgeting to function effectively as a planning, budgeting and management tool, it is crucial that management capacity be developed at lower levels of service delivery.

6.2.2.4 Implementation Costs

In terms of computer hardware, there were no major costs as the Chief Directorate: Health had a considerable amount of equipment to start off with. However, significant cost was incurred in training staff members; training was fairly intense, and in some cases repetitive. Training had to be gradual in order to give all staff members, especially the most computer-illiterate, sufficient time to absorb the skills involved.

6.2.3 Technical

Technical issues that arose during the implementation process revolved around defining the programme structures, the costing of inputs, defining performance measures and indicators, the lack of resources, poor information systems, the implementation strategy, and running the NEWFIN and PBS systems simultaneously.

6.2.3.1 Defining programme structures

As noted in Section 6.1.2, defining programme structures was an enormous task which took a great deal of time. This was partly due to lack of direction on the part of management, and a lack of self-confidence among the members of the Chief Directorate: Health (Ajam, 1999). If staff did not understand what was required of them, they tended to do nothing. Other problems encountered were time and

information constraints. It was therefore necessary to compromise, with the result that the final breakdown of the Chief Directorate's programme structure does not comply strictly with performance budgeting. The programmes and sub-programmes are very broad, and their objectives too vague. There is also no true notion of activities. At the time of designing the programme structure, full information was not available, and it was therefore not feasible to have a full set of activities for clinics, hospitals, etc. For example, laundry should be defined as an activity, but it is currently defined as a sub-programme. Defining true activities has to be seen as a process whereby information is generated by the system in order to be fed back into the system. Consequently, it was decided to aggregate activities at first, which would then evolve over time. The result was three main activities, *viz.* Administration, Promotive and Preventive, and Curative and Diagnostic, which are not actually activities, but groups of activities. The programme structure of the Chief Directorate: Health as it was at the time of writing, including sub-programmes, sub-sub-programmes and activities, is detailed in Appendix 3.

6.2.3.2 Costing of inputs

The costing of inputs was an extremely complex task, as there was no precedent from which to work: in the past, costs had not been apportioned to specific activities or outputs. Previous budgets had been compiled according to expenditure, and therefore expenditure had to be used as a shadow cost even though in most cases it was very significantly greater than true cost. Abedian (1998) states that there is no 'quick fix' in determining the costs of inputs; it would be an exercise of at least three years' duration. In the first year cost measures would be developed to form a benchmark; these costs would be verified by the programme managers. The costs would then be systematically refined over the following two years until the true costs were attained. Consequently, in the implementation of PBS by the Chief Directorate: Health, there was no real process of costing from the bottom up. It was agreed that it had to be an evolving process and that it was easiest to begin by using a formula for each programme. An example of the formula for Programme 2 "District Health Services" is 20 per cent for Administration, 40 per cent for Promotive and Preventive, and 40 per cent for Curative and Diagnostic.

6.2.3.3 Defining performance measures and indicators

Defining performance measures and indicators was extremely difficult due to the aggregated nature of the activities. These measures need to be realistic and achievable, and should in some way measure the desired outputs of an activity. In the case of the Chief Directorate: Health, protocols or standards for service delivery which were previously non-existent, had to be defined. There is also a risk of defining perverse incentives. For instance, if a performance measure is defined as number of patients seen per day, it might encourage doctors to give less quality time to each patient so as to increase numbers attended to. Defining performance measures for management or administration was a complex assignment, as these were not as tangible as service delivery measures. However, defining the measures and indicators is an evolving process which should be refined on an ongoing basis.

6.2.3.4 Relevant resources

Human capacity was a problem; there was a lack of basic administration and financial management skills in the Chief Directorate: Health. Staff therefore had to be trained in both the conceptual and technical details of PBS. Some officials were not computer literate at all, and therefore had to be given computer training as well as training in the use of PBS. Vermaak (1998) suggests that it was assumed that a certain level of knowledge about the system existed among staff, which was in actual fact not the case. This was problematic, as it made the staff members concerned feel undermined and not useful, as they did not really understand the issues at hand. In implementing PBS it is also important that people are trained for the specific functions that they are to perform. They need a general overview of the system, but it is unnecessary to train everybody in all the different applications such as requisitions, budgets, etc. Abedian (1998) adds that the lack of quantitative skills in the Chief Directorate: Health played a role in hindering the implementation process. A significant number of key people were not numerically competent or confident, and this tended to slow the process down.

Both Abedian (1998) and Ajam (1999) point out a lack of training facilities, which limited the number of staff who could be trained at any particular training session.

This inevitably had implications for the training budget, as it became more expensive to run numerous training sessions.

Shilowane (1998) states that the lack of infrastructure was a problem in some remote rural areas. Communication of information to these areas, as well as rendering necessary information technology services, is difficult because the infrastructure required for electronic communication is not in place. These problems are, however, not insurmountable, and it is a matter of time before all the remote areas have telecommunications connections. Van Heerden (1988) adds that the development of communication between the PBS software and NEWFIN caused delays, because at times it was not possible to continue with the implementation process until certain programming had been completed by the NEWFIN programmers.

6.2.3.5 Information systems

Information systems are vital to the success of PBS. For example, gathering appropriate, accurate and reliable data required for performance measurement is a complex task. In the initial strategic planning phase of the implementation of PBS in the Chief Directorate: Health, it appeared that only the top management of the Health Information Directorate was included. Vermaak (1998) points out that this was problematic, as details of the implementation did not filter down to district level, and top management was not fully aware of what information was being collected at ground level. Clearly, departmental information services must be included at the outset of PBS implementation, and they must know exactly what indicators are being measured as they are the ones who collect the information at the point of service delivery. They will also be able to ascertain if the required information is readily available and if not, the cost of obtaining it.

On the technical side, Vermaak (1998) states that there may be time frame difficulties. Currently service delivery information was being entered into the computer system of the Chief Directorate: Health a month after capture. In other words, January's information was computerised in February. This is due to the facts that there is a large amount of information collected, the collection of data is complex, and the reconciliation of any inconsistencies is time-consuming because of large travelling distances between service delivery and data processing points.

6.2.3.6 Implementation strategy

Implementation of PBS should be carefully planned. Part-implementation, which is done in stages, may be too drawn out. If implementation is prolonged, enthusiasm tends to wane, staff may become demotivated, and the credibility of both the implementing agents and the system itself is prejudiced. In this eventuality there is a danger of the entire process collapsing. It is thus crucial to develop a project implementation plan which defines a set time period that can be devoted entirely to implementing the system. It is also important to do this for one particular section of the department concerned, which can then be used as a demonstration for the rest of the department. As Shongwe (1998) puts it, "Implementation is a process which takes time and energy. The results may really only be seen in the year 2000".

6.2.3.7 Running two systems simultaneously

A transitional implementation problem was the switch from NEWFIN to the PBS software. Initially there was confusion and misunderstanding while the two software systems were run in parallel. Certain districts were under the impression that there were actually two budgets available, one on NEWFIN and one on the PBS software. When the entire budget had been allocated on the NEWFIN system it was thought that there were still budget funds available on the PBS system. Another problem was that transfers and reallocation of funds would be made in NEWFIN and not in the PBS software, or *vice versa*, and the two budgets would be mutually inconsistent. These issues are, however, transitional, and once the PBS software is functional access to budgeting directly through NEWFIN will be disallowed and the PBS software will act as the gateway or interface between users and NEWFIN.

6.3 Issues still outstanding

In order for PBS to function with full effectiveness, several requirements must be fulfilled. Firstly, the department concerned should draw up a detailed model of how the system should work to realise its full potential, including all the necessary information this may require (Strachan, 1998). Following this, a detailed plan should be devised which details how to achieve and implement the model; this

implementation plan should specify training requirements and necessary organisational changes. Formulation of the implementation plan should involve all stakeholders within the department, as they need to understand their involvement in the implementation process. Abedian and Strachan (1998) state that the implementation plan should include issues such as refining objectives, programmes, sub-programmes and activities based on the experience of working with the system and budgeting activities from zero. In particular, it should incorporate the setting of objectives for districts, which has not yet been done and is needed in order to refine the District Health Programme activities. It should also make provision for further development and refinement of performance measures, indicators and reporting systems.

Secondly, it is necessary to get the department's top management to commit to the implementation plan and its requirements in terms of development, training and organisational change. This commitment by top management is also important for the reason that there will most likely be members of the department who try to sabotage implementation of the system as it begins to highlight financial discrepancies. If there is no-one from top management who is consistently committed to the implementation process, there is a significant risk that it could fail. As with the implementation of any new system, if the change is not firmly routed in the organisational management process and driven from the top, it will not happen.

Thirdly, the management capacity of lower-level managers, for example at district level in the case of a provincial government department, needs to be developed. Since delivery happens at this level, it is vital that the managers concerned understand the system and are able to use it to its full potential in order to improve the delivery of services to the community.

6.4 Success to date

Despite the challenges of implementation discussed in Sections 6.2-6.3 above, the implementation of PBS in the Chief Directorate: Health is well on its way. By the end of February 1999, nearly all districts had been brought on-line and are operational in the first and major section of PBS, i.e. allocating personnel to

activities. A number of these districts have also used PBS for the 1999/2000 budget cycle. The system now allows managers to print staffing numbers and budgets by region and by district. In this way, they are able to detect unusually large expenditures and the misallocation of staff members. This has been put into practice, and one example (among many) of a discrepancy which was found is that three members of staff in the Chief Director's office were being charged to Tonga Hospital.

There have also been immediate spin-offs in terms of managerial expertise learned from the implementation process itself. Managers now know exactly what activities are being performed in their particular programmes and sub-programmes, as well as which staff members have been allocated to these activities. The longer-term benefits from the system as a whole, however, are still to be realised.

6.5 Summary

The implementation of performance budgeting began by obtaining support from top management and ensuring that each level of management had a clear understanding of the budgetary issues involved. The new budgetary structure was then developed via a number of workshops and training sessions. At the same time, the computer software was developed and the system installation began. Numerous challenges were encountered during the implementation process, ranging from political issues to technical operational issues. It is, however, important to recognise that transformation is a slow and ongoing process; in this case, an entire department is being transformed not only in the conceptual framework of budgeting, but the entire organisational and managerial structure thereof as well.

7. Conclusion

7.1 The need for change

In an era of increasingly scarce resources and where service delivery has become a critical issue, traditional budgeting systems are no longer adequate tools for allocating government funds. Both incremental and zero-based budgeting are concerned only with financial inputs, having scant regard for the outputs these are intended to deliver. Under such circumstances budgeting is an instrument for expenditure control, rather than a financial management tool. The result is a lack of accountability for efficient and effective service delivery, and a high probability that policy objectives will not be achieved.

Moreover, decision-making regarding the allocation of resources tends to be highly centralised: there is no process whereby management at lower levels - the points of actual service delivery to clients - can inform the resource allocation process. Managers therefore tend to *administer* rather than *manage* budgets. There is very little articulation between financial planning and budgeting. A lack of formal monitoring and evaluation systems impedes the information flow which should inform the planning process. In effect, therefore, the integrated components making up a budgeting system appropriate for efficient and effective service delivery, namely effective planning, financial management and monitoring and evaluation, are lacking under the traditional budgeting systems.

7.2 Systemic transformation

Performance budgeting is an alternative budgeting system which attempts to address the inadequacies of the traditional system. It proposes to enhance service delivery by setting up a budgeting system within a performance management framework. The performance budgeting system consists of a number of components, i.e. strategic planning, financial planning, expenditure management, performance management, and organisational design, which are articulated in such a way as to form an integrated system for efficient and effective service delivery.

The implementation of performance budgeting begins with the strategic planning phase, in which policy-makers define strategic goals and objectives, ranked according to priority, in order to achieve particular policy directives. This phase forms the framework for the programme structure which is developed in the subsequent financial planning phase. The aim of this phase is the detailed allocation of resources according to programmes, sub-programmes and activities in terms of inputs, outputs and outcomes. The next phase is one of expenditure management. Here the focus is on the operational execution of the decisions made in the preceding phases. To ensure effective implementation the appropriate human resources, information systems and financial management systems are required.

Last, but by no means least, is the performance management phase. This is extremely important, as it deals with measuring, monitoring and evaluating performance in terms of resource allocation, delivery and management. Information from monitoring and evaluation plays a significant role in informing practice in the previous phases. Organisational design, although not a part of performance budgeting, plays a critical role in the effective functioning of the financial planning and expenditure management phases. It is important to ensure that managers have the relevant decision-making powers, control and responsibilities in order to manage their programmes efficiently and effectively.

7.3 The South African situation

In South Africa, government budgeting has historically been performed according to the traditional line-item budgeting system. However, recognising the limitations of this system, an attempt was made to move towards programme budgeting. At present budgets are drawn up in programme format, but in essence remain incremental, line-item-based budgets. Programmes do not appear to be set up to achieve any specific objectives, and there is no link between inputs and desired objectives (outputs). The result is a hybrid of traditional incremental budgeting and programme budgeting, with no substantive budget reform having been achieved. Consequently, there is still a distinct lack of integration between planning and budgeting. It also remains difficult to monitor and evaluate the

effectiveness and efficiency of public service delivery via the current budget system. The forthcoming ***White Paper on Budget Reform*** will apparently advocate a move towards performance budgeting based on the recommendations of the Presidential Review Commission (1997).

The Chief Directorate: Health in Mpumalanga, in order to overcome the obstacles to efficient and effective service delivery posed by the shortcomings of the prior budgeting system, has embarked on an initiative to implement performance budgeting. Implementation, in itself, has to be seen as an iterative process. Since this was the first time in South Africa that such a project had been attempted, it was inevitable that it would be a learning process. At each workshop or training session, the consultants would learn more about the structure and functioning of the Chief Directorate: Health, and the members of the Chief Directorate would learn more about the requirements and implications of the performance budgeting system. The outcome was a continual refinement of ideas and practice from both sides. A further implication of this 'learning by doing' was that the implementation process took a lot longer than expected.

7.4 Obstacles encountered

Due to the enormity of the task at hand, it was inevitable that a number of obstacles would be encountered during the implementation process. Firstly, there were political issues which arose, the most notable being the nature of transformation itself, which intrinsically evokes apprehension. Many people perceive change as a threat, and it becomes increasingly difficult to alter these perceptions when it implies a shift in the *status quo*. Associated with this reluctance to change was the fact that obtaining political acceptability and commitment for the project took time. There was a hesitancy to embark on this type of project as, at the time, it was not overtly supported by the National Department of Health or the National Department of Finance. Furthermore, the lack of a detailed implementation plan led to confusion regarding expectations of the end product and the necessary steps that would need to be taken in order to achieve this. Finally, quality of leadership was an issue: in certain directorates and at certain management levels, management capacity was lacking. Managers who had not

been exposed to new management techniques tended to follow administrative methods based on precedent rather than take any personal initiative.

The second set of obstacles which arose relate to administrative and bureaucratic issues. In this instance, roles and responsibilities were not clearly defined from the outset. The fact that the necessary responsibility was not delegated to lower levels of management retarded the implementation process. Administrative structures remained hierarchical and decisions kept having to be referred to higher levels for resolution. The change in the budget structure, resulting from the implementation of the new system, changed the relationship between top levels of management and others. New lines of accountability had to be instituted as well as restructuring the organisation in line with the budget structure. The implications for the organisational structure were such that institutions such as clinics and hospitals were now structured into the District Health Services programme. Furthermore, there was uncertainty regarding accountability for implementation. There was a hesitancy on the part of top management to take ownership of the project, due to the fear of project failure.

Thirdly, technical problems hampered the implementation process. Defining programme structures was a difficult and time-consuming task. There was a lack of understanding of the relationship between activities, outputs and objectives as defined in PBS, and this led to confusion when trying to define activities within sub-programmes and programmes. Due to the shortage of available information the final programme structure did not conform to the definition of performance budgeting, as many activities had to be aggregated. However, the restructuring task is ongoing, and the programme structure will be regularly refined over time. In addition, the lack of relevant information made it difficult to cost the inputs for specific activities. This is also a systematic process which will be refined as more information becomes available. Moreover, the nature of the aggregated activities made it more difficult to define performance indicators. A lack of resources meant inevitable delays. With respect to human resources, it meant delays due to training and capacity building; in regard to physical resources, delays were experienced due to infrastructural inadequacies, especially in rural areas. The lack of adequate

information systems and reliable information also played a role in retarding the implementation process.

7.5 Recommendations for implementation

In light of the above examination of the implementation process the following recommendations are suggested for the successful implementation of performance budgeting.

7.5.1 Situational analysis

To ensure successful implementation it is vital that, prior to any action being taken, a detailed situational analysis of the department is performed. The aim of the analysis would be to improve the understanding of the current situation and to provide a common reference point for the forthcoming transformation. The analysis should include a comprehensive evaluation of the current budget and organisational structure. This evaluation should clearly define *inter alia* responsibility for functions, responsibility for finances, types and numbers of service facilities, utilisation information and the desired degree of centralisation in decision-making. It should also itemise the type and quantity of available resources such as finance, personnel, buildings, equipment and transport. If at all possible, the analysis should attempt to provide some evaluation of the efficiency and effectiveness of the current budgeting system in terms of service delivery. Finally it should describe the relationship of the department with central departments such as the treasury, finance and personnel administration. Once all this information is documented, it becomes easier to determine where the organisation would like to be, and to devise a plan of how to get there. A situational analysis may also aid the development of the new programme structure, as it provides clarity regarding the activities of the organisation.

7.5.2 Implementation plan

Developing an implementation plan is important for ensuring the appropriate timing and sequencing of intended reforms. The implementation plan should set out the actions to be taken as well a time frame in which these will happen. It is

necessary to identify any particular resources that may be required, as well as potential bottlenecks and delays in the implementation process. The time frame of implementation should be realistic, as delays are not only problems in themselves but cause significant cost overruns and frustrated expectations on the part of departmental staff.

In addition, the plan should detail exactly who is responsible for each set of actions to be taken. This is important for guaranteeing accountability and transparency and to ensure that there is no confusion in terms of what is expected from external consultants and what is expected from within the department. An implementation plan is also useful to avoid deviation from policies originally agreed upon and to prevent a shift in priorities, as these should be documented in the plan from the beginning. It will be beneficial to form an implementation management team at the outset, who will be responsible for co-ordinating and managing the development and implementation of the plan. Functions of this team might include:

- working closely with the top management of the department to clarify any policy issues that arise regarding the reforms;
- acquiring top management support for the necessary training or retraining of staff throughout the department;
- acquiring the support of external bodies such as the treasury or other departments; and
- ensuring that those held responsible for certain tasks accomplish them within the allocated time frame.

7.5.3 Personal involvement from top management

Not only is it important to obtain approval from top management, but it is also crucial that they are personally involved in the implementation process so that momentum for the reform initiatives is not lost. At various stages during the implementation process, high-level decisions will need to be made. If top management are not available or are not personally involved in the process, there is a high probability that the taking of decisions will be deferred, causing further delay.

7.5.4 Managing change

As transformation is such a contentious issue, it would be to the benefit of all stakeholders if the process of change is well managed. All role-players, from top management through to service delivery, should be continually informed of the current status of the project and the progress attained at each stage. Consultation should occur, where appropriate, so that no-one feels excluded from the process. If staff enjoy a sense of ownership of the project, fears will be allayed and there will be less inclination to attempt to retain the status quo. It may also be useful, early on in the process, to identify the likely supporters of the new project and enlist their assistance in convincing others of the benefits of the new system.

7.5.5 Documenting the process

It may also be advantageous to document the process as it takes place. This should include both actions taken and decisions made, by whom and when. The document would then act as a checklist to ensure that implementation has occurred as planned, and also as a reference for any queries which may arise regarding the implementation process. Furthermore, the document can form the basis for the monitoring and evaluation of the implementation process.

7.5.6 Developing management capacity

The importance of management capacity for successful implementation cannot be overemphasised. No matter how good the system is, if management capacity is lacking, it will fail. It is therefore crucial to train personnel in managerial skills. If the organisation is based on a decentralised model, such as the district health system in the case of the Chief Directorate: Health in Mpumalanga, it is especially important to develop managerial skills at all levels, from top management down to district level management. It is also necessary that managers are made aware of the need to devote time and energy to the implementation process. If managers are seen to be committed and involved in the process, the rest of the organisation will follow.

7.6 *Conclusion*

This dissertation has revealed that implementing a new system is a process which takes time and commitment. The Chief Directorate: Health of Mpumalanga have

managed to overcome the numerous obstacles encountered during the implementation process, and there is both support and commitment for the continued implementation and operation of the new performance budgeting system.

A final comment from two members of the PBS Management Team:

> "We don't expect PBS to be perfect the first time round. In the second and third years, or even the years ahead, that's where we will see the system giving us the results we need. If you read what has been experienced in other countries, you'll see that some of them took eight years or more. From their experiences we can learn and try and avoid some of those problems."
>
> "I'm not used to being the one who walks in front like a leader with a new thing. It's all new to us. But it's exciting."

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Health—continued
Gesondheid—*vervolg*

Presentation according to standard items			Aanbieding volgens standaarditems
Items	1998/99	1997/98	Items
	R'000	R'000	
A Personnel expenditure	991 000	727 033	A Personeeluitgawes
B Administrative expenditure	40 027	46 352	B Administratiewe uitgawes
C Stores and livestock	244 061	274 351	C Voorrade en lewende hawe
D Equipment	91 482	114 655	D Toerusting
E Land and buildings	193	171	E Grond en geboue
F Professional and special services	135 637	115 315	F Professionele en spesiale dienste
G Transfer payments	124 903	126 898	G Oordragbetalings
H Miscellaneous expenditure	14 150	15 299	H Diverse uitgawes
	1 641 453	1 420 074	
Less: Internal charges	28 453	16 981	*Minus:* Interne heffings
Less: Works function	47 000		*Minus:* Werke funksie
Amount to be voted	1 566 000	1 403 093	Bedrag wat bewillig moet word

Details of Medium Term Expenditure Framework | **Besonderhede van Medium Termyn Uitgaweraamwerk**

Programme	1997/98 Voted/ Bewillig	Adjustments Estimate/ Aansuiweringsbegroting	Improvement of conditions of service/ Verbetering van diensvoorwaardes	Adjusted appropriation/ Aangesuiwerde bewilliging	1998/99 Voted/ Bewillig	1999/2000	2000/2001	Program
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	
1 Health administration	43 608		48 707	92 315	55 730	55 730	55 730	1 Gesondheidsadministrasie
2 District health services	588 831	2 176		591 007	638 363	711 363	711 363	2 Distriksgesondheidsdienste
3 Regional and specialised hospital services	400 977			400 977	465 021	459 321	459 321	3 Streeks- en gespesialiseerde hospitaaldienste
4 Central hospital services	290 164			290 164	350 283	345 983	345 983	4 Sentrale hospitaaldienste
5 Health Sciences	52 322			52 322	44 592	44 592	44 592	5 Gesondheidswetenskappe
6 Health care support services	27 191			27 191	12 011	12 011	12 011	6 Gesondheidsondersteuningsdienste
7 Health facilities and capital stock								7 Gesondheidsfasilitelte en kapitalevoorraad
	1 403 093	2 176	48 707	1 453 976	1 566 000	1 629 000	1 629 000	
Increase/(Decrease)					112 024	63 000		Toename/(Afname)
Classification of expenditure								Klassifisering van uitgawes
Current								Lopend
Personnel expenditure	727 033		48 707	775 740	991 000	1 031 000	1 031 000	Personeeluitgawes
Other current expenditure	605 875	2 176		608 051	523 826	546 826	546 826	Ander lopende uitgawes
Capital	70 185			70 185	51 174	51 174	51 174	Kapitaal
Total	1 403 093	2 176	48 707	1 453 976	1 566 000	1 629 000	1 629 000	**Totaal**

PROGRAMME 2: DISTRICT HEALTH SERVICES

AIM: To render primary health care services

PROGRAMME DESCRIPTION:

District management

service planning, administration, co-ordination and monitoring, district health services also rendered by local authorities and non-governmental organisations

Community health services

rendering primary health care services in respect of mother and child care, family planning, health promotion, geriatric services, occupational therapy, physiotherapy, pediatrics, speech therapy, nutrition, environmental health, forensic services, oral health, communicable diseases, chronic disease and mental health

Emergency medical services

rendering emergency services and selective patient transport

District hospitals

rendering a level 1 hospital service

PROGRAM 2: DISTRIKSGESONDHEIDSDIENSTE

DOEL: Om primêre gesondheidsorgdienste te lewer

PROGRAMBESKRYWING:

Distriksbestuur

diensbepaling, administrasie, koördinering en monitering van distriksgesondheidsdienste wat ook deur plaaslike owerhede en nie-regeringsorganisasies gelewer word

Gemeenskapsgesondheidsdienste

lewering van primêre gesondheidsorg ten opsigte van die moeder en kind, gesinsbeplanning, gesondheidssorgbevordering, geriatriese dienste, arbeidsterapie, fisioterapie, pediatrie, spraakterapie, voeding, omgewingsgesondheid, mondgesondheid, oordraagbare siektes, kroniese siektes en geestesgesondheid

Nood mediese dienste

lewering van nooddienste en selektiewe vervoer van pasiënte

Distrikshospitale

lewer 'n vlak 1 hospitaaldiens

Programme structure	Current Lopend		Capital Kapitaal		Transfers Oordragte: Current Lopend		Transfers Oordragte: Capital Kapitaal		Total Totaal		Programstruktuur
	1998/99	1997/98	1998/99	1997/98	1998/99	1997/98	1998/99	1997/98	1998/99	1997/98	
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	
District management	22 184	19 740	510	597					22 694	20 337	Distriksbestuur
Community health services	285 966	252 722	5 081	5 731	78 894	86 528			369 941	344 981	Gemeenskapsgesondheidsdienste
Emergency medical services	14 846	7 126	4 150	4 746	32 224	34 678			51 220	46 550	Nood mediese dienste
District hospitals	191 708	173 794	2 800	3 169					194 508	176 963	Distrikshospitale
	514 704	453 382	12 541	14 243	111 118	121 206			638 363	588 831	

PROGRAMME 2—continued **PROGRAM 2—vervolg**

Presentation according to standard items			Aanbieding volgens standaarditems
Items	1998/99	1997/98	Items
	R'000	R'000	
A Personnel expenditure	361 308	264 648	A Personeeluitgawes
B Administrative expenditure	20 000	24 391	B Administratiewe uitgawes
C Stores and livestock	88 000	99 811	C Voorrade en lewende hawe
D Equipment	21 747	24 701	D Toerusting
E Land and buildings	190	167	E Grond en geboue
F Professional and special services	32 500	50 413	F Professionele en spesiale dienste
G Transfer payments	111 118	121 206	G Oordragbetalings
H Miscellaneous expenditure	3 400	3 494	H Diverse uitgawes
	638 363	588 831	

Appendix 2: Mpumalanga Health Vote 1998/99

VOTE 11 **HEALTH**

937 700

AIM : To promote and render health and related services which have been assigned to the Mpumalanga Province in terms of legislation

ACCOUNTING OFFICER : Head of Department - G.N Sibeko

Presentation according to programmes	Current		Capital		Transfers Current		Transfers Capital		Total	
Main divisions	1998/99	1997/98	1998/99	1997/98	1998/99	1997/98	1998/99	1997/98	1998/99	1997/98
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
1 Administration	64 696	115 019	22 608	103 445	2 942	1 501			90 246	219 965
2 Community Health and Hospital services	738 274	551 472	24 796	8 276	84 384	79 984			847 454	639 733
AMOUNT TO BE VOTED	802 970	666 491	47 404	111 721	87 326	81 485			937 700	859 698
Increase	136 479				5 841				78 002	
Decrease			(64 317)							

Presentation according to standard items		
Items	1998/99	1997/98
	R'000	R'000
Personnel expenditure	536 683	409 068
Administrative expenditure	66 570	35 941
Stores and livestock	122 251	177 561
Equipment	58 763	20 312
Land and buildings	24 057	
Professional and special services	82 540	135 331
Transfer payments	7 716	01 485
Miscellaneous expenditure	39 121	
Amount to be voted	937 700	859 698

HEALTH - continued

11 - 2

DETAILS OF CAPITAL SPENDING

Presentation according to programmes	Land		Buildings and Structures		Equipment		Other		Total	
Main divisions	1998/99	1997/98	1998/99	1997/98	1998/99	1997/98	1998/99	1997/98	1998/99	1997/98
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
1 Administration					11 491	3 445	11 117	100 000	22 608	103 445
2 Community Health and Hospital services					23 628	8 276	1 168		24 796	8 276
					35 119	11 721	12 285	100 000	47 404	111 721

PROGRAMME 1 : ADMINISTRATION

AIM : To conduct the overall management of the Health Services in the Province of Mpumalanga

PROGRAMME DESCRIPTION

- Management and auxiliary services
- Policy formulation by the Minister and other members of the management
- Organizing the Health Services Department, managing its personnel and financial administration, determining working methods and procedures and exercising control
- Rendering centralized professional, administrative and general auxiliary services

Programme structures	Current		Capital		Transfers				Total	
					Current		Capital			
	1998/99	1997/98	1998/99	1997/98	1998/99	1997/98	1998/99	1997/98	1998/99	1997/98
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
Administration	64 310	115 019	22 608	103 445	2 942	1 501			89 860	219 965
Statutory	386								386	
	64 696	115 019	22 608	103 445	2 942	1 501			90 246	219 965

Presentation according to standard items		
Items	1998/99	1997/98
	R'000	R'000
Personnel expenditure	40 120	99 260
Administrative expenditure	8 984	8 434
Stores and livestock	4 092	2 858
Equipment	12 092	3 950
Land and buildings	24 037	
Professional and special services	1 501	105 962
Transfer payments	1 440	1 501
Miscellaneous expenditure		
	90 246	219 965

PROGRAMME 2 : COMMUNITY HEALTH AND HOSPITAL SERVICES

AIM : To render primary health care services, and hospital services on primary, secondary and tertiary levels

PROGRAMME DESCRIPTION

- School health services: Rendering of school health services
- Community nursing : Rendering a primary health care service by nurses outside local government areas
- Community health centre services : Rendering a primary health care service from community health centres
- District surgeon services : Rendering a primary medical and medico-legal service
- Oral health services : Rendering a treatment service to needy patients
- Family planning services : Rendering preventative, counselling and promotional services to needy patients
- Environmental health service : Rendering environmental health services to the community
- Hospital services : Rendering hospital service at primary, secondary and tertiary levels

Programme structures	Current		Capital		Transfers				Total	
					Current		Capital			
	1998/99	1997/98	1998/99	1997/98	1998/99	1997/98	1998/99	1997/98	1998/99	1997/98
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
Community Health & Hospital Services	738 274	551 472	24 796	8 276	84 384	79 984			847 454	639 733
	738 274	551 472	24 796	8 276	84 384	79 984			847 454	639 733

Presentation according to standard items		
Items	1998/99	1997/98
	R'000	R'000
Personnel expenditure	496 563	309 808
Administrative expenditure	59 606	29 507
Stores and livestock	118 159	174 703
Equipment	46 671	18 362
Land and buildings	20	
Professional and special services	81 039	29 369
Transfer payments	6 275	79 984
Miscellaneous expenditure	39 121	
	847 454	639 733

Appendix 3: Programme Structure of the Chief Directorate: Health, Mpumalanga

Key:

Programme 1: Provincial Management	-	Programme title
Sub-Programme 1.1: Strategic Management	-	Sub-programme title
1.1.1: Office of the MEC	-	Sub-sub-programme title
Provide administrative support to the MEC	-	Activity description

Programme 1: Provincial Management

Sub-Programme 1.1: Strategic Management

1.1.1: Office of the MEC
- Provide administrative support to the MEC

1.1.2: Office of the DDG
- Manage goals and objectives in terms of performance

1.1.3: Office of the Chief Director: Health
- Ensure development and implementation of health policy
- Co-ordinate policies national, intra-provincial and local government
- Ensure and account for the provision of health services
- Ensure co-ordination of Sub-programmes 2-5, and Programmes 2-7
- Implement intergovernmental contracts
- Co-ordinate media relations, speeches and parliamentary questions
- Conduct financial control audit / inspections
- Conduct value-for-money audits
- Plan an evaluation system for health services
- Audit and analyse quality of health service
- Inspect and licence public and private health facilities

Sub-Programme 1.2: Financial Management

1.2.1: Budgeting division
- Co-ordinate budgets
- Send cash-flow to Treasury
- Maintain suspense account; reconcile bad debts
- Consolidate item budget for Province
- Support districts training for financial competencies
- Liase with National on Budgets
- Manage revenue and tariffs

1.2.2: Expenditure Control Division
- Manage cheques
- Manage petty cash
- Monitor personnel expenditure
- Manage creditors accounts and claims
- Monitor capital projects and recurrent expenditure
- Attend audit queries
- Introduce performance budgeting system in department
- Modify spending in bi-laterals with managers

Sub-Programme 1.3: Management Support

1.3.1: Management Support Services
- Develop norms and standards for security services
- Develop norms and standards for rentals
- Develop norms and standards for (medical) equipment
- Develop norms and standards for stores
- Develop norms and standards for assets
- Prepare all head office requisitions for procurement
- Provide registry services
- Provide secretariat services
- Develop guidelines for management support

1.3.2: Personnel Administration
- Recruit, select and appoint staff
- PERSAL management
- Manage grievance procedures and labour disputes
- Facilitate IOD and WCA claims
- Provide community media productions

Sub-Programme 1.4: Health Informatics

1.4.1: Health Informatics
- Establish and maintain provincial health information
- Collate and report health information
- Co-ordinate and support health service research
- Establish and maintain a provincial health library
- Geographic information services
- Technology support and advice/helpdesk
- Health information system training of personnel
- System security and control
- Development and maintenance of an optimal set of Database Management

Sub-Programme 1.5: Policy Co-ordination

1.5.1: Policy Co-ordination and legal service
- Co-ordinate the development of health policy
- Prepare draft legislation
- Provide legal opinion ombudsman/public protector
- Complaints
- Litigation

Sub-Programme 1.6: Statutory

1.6.1: Statutory (MEC)
- Present budget speech and annual report

Sub-Programme 1.7: Regional Management

1.7.1: Lowveld Regional Management: Admin Support
- Provision of interim administrative assistance

1.7.2: Highveld Regional Management: Admin Support
- Provision of interim administrative assistance

1.7.3: Health Programmes Management: Highveld
- Provision of Health Programmes admin support

1.7.4: Eastern Highveld Regional Management: Admin Support
- Provision of interim administrative assistance

Programme 2: District Health Services

Sub-Programme 2.1: Clinics

2.1.1: Driefontein Old Stand
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.2: Middelburg Kanhym
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.3: Volksrust Primary Health Care
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.4: Mbuzini Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.5: Mmametlhake Mobile Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.6: Standerton Mobile 1
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.7: Trichardt TLC
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.8: Standerton Mobile 2
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.9: Amsterdam Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.10: Dirkiesdorp Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.11: Iswepe/ Commondale Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.12: Thandukukhanya Local Authority Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.13: Piet Retief Town Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.14: Piet Retief Mobile Units
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.15: Perdekop
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.16: Evander TLC
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.17: Middelburg Gate
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.18: Middelburg Mobile 1 Taute
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.19: Secunda TLC
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.20: Middelburg Mobile 2 de Jager
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.21: Middelburg Mobile 3 Schoeman
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.22: Allemansdrift C Mobile Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.23: Middelburg Mobile 4 Coetzee
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.24: Middelburg Mobile 5 Erwee
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.25: Middelburg Roossenekal
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.26: Middelburg Roossenekal Mobile
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.27: Kinross TLC
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.28: Block B Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.29: Block C Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.30: Figtree Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.31: Masibekela Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.32: Mbangwane Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.33: Ndindindi Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.34: Steenbok Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.35: Mmamethlake Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.36: Highveld Ridge 1
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.37: Amersfoort TLC
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.38: Highveld Ridge 2
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.39: Langverwacht
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.40: Leandra
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.41: eZamokuhle TLC
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.42: Daggakraal Mobile
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.43: Standerton Mobile 3
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.44: Belfast Mobile 1
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.45: Standerton Mobile 4
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.46: Standerton Mobile 5
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.47: Lydenburg Mobile 1
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.48: Dullstroom
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.49: Lydenburg Mobile 2
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.50: Lydenburg Mobile 3
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.51: Lydenburg Mobile 4
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.52: Lydenburg Mobile 5
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.53: TLC Middelburg District
Preventive and Promotive
Curative and Diagnostic

2.1.54: Waterval Boven Mobile 1
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.55: Burgersfort Mobile 1
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.56: TLC Hendrina Middelburg District
Preventive and Promotive
Curative and Diagnostic

2.1.57: Burgersfort Mobile 2
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.58: Lydenburg Gate Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.59: Nthorwane Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.60: Katjiebane
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.61: Witlaagte Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.62: Vaalbank Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.63: Troya Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.64: Seabe Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.65: Pankop Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.66: Boulders Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.67: Bloedfontein Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.68: Lefisoane Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.69: Nokaneng Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.70: Barberton Mobiles
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.71: Loding Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.72: Kanyamazane Mobile
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.73: Haakdooringlaagte
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.74: Brondal Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.75: Zwelisha Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.76: Tekwane Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.77: Sibuyile Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.78: Renee Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.79: Nkwalini Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.80: Nelspruit Mobiles
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.81: Msogwaba Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.82: Mpakeni Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.83: Luphisi Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.84: Kaapsehoop Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.85: Kaapmuiden Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.86: Glenthorpe Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.87: Mthimba Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.88: Eziweni Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.89: Clau-Clau Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.90: Carolina Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.91: Badplaas Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.92: Kromdraai Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.93: Tjakastad Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.94: Lochiel Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.95: Redhill Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.96: Nhlazatshe Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.97: Diepdale Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.98: Fernie 2 Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.99: Fernie 1 Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.100: Mayflower Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.101: Dundonald Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.102: Glenmore Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.103: Swallusnest Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.104: Vlakplaas Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.105: Eerstehoek Mobile Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.106: Hartebeeskop Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.107: Nhlazatshe No 6
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.108: Eerstehoek Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.109: Bettysgoed Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.110: Mooiplaas Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.111: Breyten Clinic
Administration
Preventive and Promotive

2.1.112: Town / Cassim Park Clinic
Preventive and Promotive
Curative and Diagnostic

2.1.113: Kwazanele Clinic
Preventive and Promotive
Curative and Diagnostic

2.1.114: Sead Clinic
Preventive and Promotive
Curative and Diagnostic

2.1.115: Du Plooy Clinic
Preventive and Promotive
Curative and Diagnostic

2.1.116: Kriel Town Clinic
Preventive and Promotive
Curative and Diagnostic

2.1.117: Ermelo Clinic
Preventive and Promotive
Curative and Diagnostic

2.1.118: Dwaleni Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.119: Lothair Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.120: Davel Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.121: Ouklip Clinic
Preventive and Promotive
Curative and Diagnostic

2.1.122: Emthonjeni Clinic
Preventive and Promotive
Curative and Diagnostic

2.1.123: Morgenzon Clinic
Preventive and Promotive
Curative and Diagnostic

2.1.124: Mbonisweni Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.125: Chrissiesmeer Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.126: Lows Creek Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.127: Bethal Mobiles
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.128: Kriel Mobiles
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.129: Ermelo Mobiles
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.130: Rietspruit Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.131: Thubelihle Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.132: eMzinoni Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.133: Khumbula Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.134: Ermelo Dental Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.135: Bethal Dental Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.136: Gutshwa Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.137: Legogote Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.138: Matsulu
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.139: Jerusalem Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.140: Boschfontein Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.141: Manzini Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.142: Shabalala Cliinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.143: Hazyview Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.144: Skukuza Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.145: Driekoppies Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.146: Jeppes Reef Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.147: Jeppes Rust Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.148: Kamhlushwa Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.149: Langeloop Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.150: Mgobodi Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.151: Middleplaas Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.152: Mzinti Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.153: Phiva Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.154: White River Mobiles
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.155: Schoemansdal Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.156: Sihlangu Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.157: Sikhwahlane Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.158: Themba Mobile
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.159: Bourkes Luck Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.160: Elandsfontein Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.161: Makoko Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.162: Graskop Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.163: Boekenhouthoek Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.164: Witbank/Delmas Mobile 1
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.165: Witbank/Delmas Mobile 2
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.166: Witbank/Delmas Mobile 3
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.167: Eadie Street Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.168: Eadie Street Mobile 1
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.169: Eadie Street Mobile 2
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.170: Eadie Street Mobile 3
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.171: Eadie Street Mobile 4
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.172: Elandsdoorn Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.173: Moloto Mobile Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.174: Family Health and Nutrition Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.175: Vrisgewaagt Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.176: Ekangala Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.177: Family Planning Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.178: Groblersdal Mobile 2 Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.179: Groblersdal Mobile 3 Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.180: Groblersdal Mobile 4 Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.181: Kameelrivier A Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.182: Vlaklaagte No,1 Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.183: Kameelrivier B Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.184: Verena Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.186: Kwaggafontein A Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.189: KwaMhlanga Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.191: Marble Hall Mobile 1 Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.193: Goederede Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.195: Outsource Groblersdal Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.197: Philadelphia Mobile 1 Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.199: Philadelphia Mobile 2 Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.201: Philadelphia Mobile 3 Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.203: Philadelphia Mobile 4 Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.205: Philadelphia Mobile 5 Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.207: Pieterskraal Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.209: TLC Groblersdal Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.211: TLC Marble Hall Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.213: Klipplaatdrif Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.214: Valsfontein Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.215: Weltevrede Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.216: Makeepsvlei Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.217: Witfontein Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.218: Toitskraal Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.219: Wolwekraal Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.220: Groblersdal Mobile 1 Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.221: Moloto Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.222: Mathysenloop Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.223: Tweefontein M Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.224: Leeufontein Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.225: Tweefontein D Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.226: Tweefontein C Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.227: Tweefontein H Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.228: Ekangala Mobile Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.229: Mangweni CHC
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.230: Tweefontein A Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.231: Gemsbokspruit Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.232: Naas CHC
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.233: Kameelpoortnek Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.234: Wakkerstroom TLC
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.235: Vukuzakhe TLC
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.236: Pilgrimsrest Clinic
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.237: Sabie Mobile
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.238: Elandsfontein Mobile
Administration
Preventive and Promotive
Curative and Diagnostic

2.1.239: New Scotland Clinic
Preventive and Promotive
Curative and Diagnostic

Sub-Programme 2.2: District Health Office

2.2.1: Volksrust District Office
Administration
Program Coordination

2.2.2: Tonga District Office
Administration
Program Coordination

2.2.3: Highveld Ridge District Office
Administration
Emergency Medical Services
Programme Co-Ordination

2.2.4: Lydenburg District Office
Administration
Program Coord

2.2.5: Middelburg District Office
Administration
Program Coordination

2.2.6: Piet Retief District Office
Administration
Emergency Medical Services
Program Coordination

2.2.7: Standerton District Office
Administration
Programme Coordination

2.2.8: Mmamethlake District Office
Administration
Emergency Medical
Programme Coordinator

2.2.9: Nelspruit/Barberton District Office
Administration
Services
Programme Coordination
Linen

2.2.10: Ermelo / Bethal District Office
Administration
Programme Coordination

2.2.11: Shongwe District Office
Adminstration
Emergency medical services
Program coordination

2.2.12: Eerstehoek District Office
Administration
Emergency Medical Services
Programme Coordination
Laundry and Linen

2.2.13: Kabokweni/Sabie District Office
Administration
Programme Coordination

2.2.14: Witbank/Delmas District Office
Administration
Program Co-ordination

2.2.15: Philadelphia Health District Office
Administration
Emergency Medical Service
Program Coordination
Laundry and Linen

2.2.16: Kwamhlanga District Office
Administration
Programme Coordination
Laundry and Linen

Sub-Programme 2.3: Community Health Centres

2.3.1: Waterval Boven CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.2: H A Grove CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.3: Driefontein New Stands CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.4: Embalenhle CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.5: Marapyane CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.6: Lebohang CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.7: Burgersfort CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.8: Siyathemba CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.9: Allemansdrift CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.10: Kanyamazane CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.11: Emjindini CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.12: Phola Nsikazi CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.13: Lynville Poly CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.14: Phola-Ogies CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.15: Waterval CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.16: Zaaiplaats CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.17: Siyabuswa CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.18: Ekangala CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.19: Kwaggafontein CHC
Administration
Preventive and Promotive
Curative And Diagnostic

2.3.20: Vlaklaagte CHC
Administration
Preventive and Promotive
Curative And Diagnostic

Sub-Programme 2.4: District Hospitals

2.4.1: Barberton Hospital
Administration
Peadiatrics
Surgery
General medicine
Obstretics and Gyneacology
Referrals
Rehabilitation and Physiotherapy

2.4.2: Piet Retief Hospital
Administration
Paediatrics
Surgery
General Medicine
Obstetrics Gyneacology
Rehabilitation and Physiotherapy
Laundry

2.4.3: Elsie Ballot Hospital
Administration

2.4.4: Amajuba Memorial Hospital
Administration
Paediatrics
Surgery
General Medicine
Obstetrics and Gyneacology
Referrals
Rehabilitation and Physiotherapy

2.4.5: Lydenburg Hospital
Administration
Pediatric
Surgery
General Medicine
Obstetric and Gynoc
Referrals
Rehabilitation and Physiot

2.4.6: Rob Ferreira Hospital
Administration
Peadiatrics
Surgery
General medicine
Obstretics and Gyneacology
Referrals
Rehabilitation and Physiotherapy

2.4.7: Evander Hospital
Administration
Paediatrics
Surgery
General Medicine
Obstetrics and Gyneacology
Referrals
Rehabilitation and Physiotherapy
Laundry

2.4.8: Middelburg Hospital
Administration
Paediatrics
Surgery
General Medicine
Obstetrics and Gynaecology
Referrals
Rehabilitation and Physiotherapy
Laundry

2.4.9: Standerton Hospital
- Administration
- Paediatrics
- Surgery
- General Medicine
- Obstet. and Gynecology
- Referals
- Rehabilitation and Physiotherapy
- Laundry

2.4.10: Mmamethlake Hospital
- Administration
- Surgery
- General medical
- Obstetric and Gynaecology
- Referrals
- Rehabilitation and Physiotherapy
- Laundry

2.4.11: Sabie Hospital
- Administration
- Paediatrics
- Surgery
- General Medicine
- Obstretics and Gynaecology
- Laundry
- Referrals

2.4.12: Tonga Hospital
- Administration
- Paediatrics
- Surgery
- General Medicine
- Obstetrics and Geneacology
- Referrals
- Rehabilitations and Physiotheraphy
- Laundry

2.4.13: Ermelo Hospital
- Administration
- Paediatrics
- Surgery
- Gen Medicine
- Obstetrics and gyneacology
- Referrals
- Rehabilitaition and Physiotherapy

2.4.14: Embhuleni Hospital
- Administration
- Paediatrics
- Surgery
- General Medicine
- Obstetrics and Gynaecologist
- Referrals
- Rehabilitation and Phisiotherapy
- Laundry

2.4.15: Bethal Hospital
- Administration
- Paediatrics
- Surgery
- General Medicine
- Obstetrics and Gyneacology
- Referrals
- Rehabilitation and Physiotherapy

2.4.16: Carolina Hospital
- Administration
- Paediatrics
- Surgery
- General Medicine
- Obstetric and Gynaecologist
- Referrals
- Rehabilitation and Phisiotherapy

2.4.17: Shongwe Hospital
- Administration
- Paediatrics
- Surgery
- General Medicine
- Obstetrics and Gyneacology
- Referrals
- Rehabilitation and Physiotherapy
- Laundry

2.4.18: Matibidi Hospital
- Administration
- Paediatrics
- Surgery
- General Medicine
- Obs and Gyno
- Referrals
- Rehab and Physio
- Laundry

2.4.19: Themba Hospital
- Administration
- Paediatrics
- Surgery
- General Medicine
- Obstetrics and Gynaecology
- Referrals
- Rehabilitation and Physiotherapy
- Laundry

2.4.20: Bernice Samuel Hospital
- Hospital Administration
- General Medicine
- Referrals
- Laundry

2.4.21: Philadelphia Hospital
- Administration
- Paediatrics
- Surgery
- General Medicine
- Obstetrics and Gyneacology
- Referrals
- Rehabilitation and Physiotheraphy
- Laundry

2.4.22: Groblersdal Hospital
- Administration
- Paediatrics
- Surgery
- General Medicine
- Obstetrics and Gyneacology
- Referrals
- Rehabilitation and Physiotherapy
- Laundry

2.4.23: Kwamhlanga Hospital
- Administration
- Generall Medicine
- Rehabilitation and Physiotherapy
- Laundry

Sub-Programme 2.5: Provincial Management

2.5.1: District Health System Management
- Determine and formulate norms and standards for districts
- Provide technical support for planning and development
- Provide support for planning and development
- Facilitate and formulate norms and standards
- Facilitate academic support and development
- Facilitate intersectoral collaboration
- Monitor and evaluate implementation

2.5.2: District Health System Developement
- Support and ensure the development of norms
- Support the development of district health management
- Support the planning of PHC services
- Monitor and evaluate implementation

2.5.3: Provincial Primary Health Care Programme Co-ordination
- Establishment of support and ensure development
- Co-ordinate the implementation of an integrated programme
- Monitor and evaluate the implementation of an integrated programme
- Monitor and support planning and development

Sub-Programme 2.6: Health Programmes

2.6.1: Curative and Diagnostic
Administration

2.6.2: Nutrition
Administration

2.6.3: Health Promotion
Administration

2.6.4: Environmental Health
Administration

2.6.5: Communicable Diseases
Administration

2.6.6: Eye Programme
Administration

2.6.7: Mental Health
Administration

2.6.8: Occupational Health
Administration

2.6.9: Rehabilitation
Administration

2.6.10: Malaria Control
Administration

2.6.11: Emergency Medical Services
Administration

2.6.12: Mother, Child and Women Health
Administration

Sub-Programme 2.7: Emergency Medical Services

2.7.1: Philadelphia District
Administration
Preventive and Promotive
Curative and Diagnostic

Sub-Programme 2.8: Community Health Services

2.8.1: Highveld Ridge District community services
Administration
Preventive and Promotive
Curative and Diagnostic

Programme 3: Regional and Specialised Hospitals

Sub-Programme 3.1: Witbank Hospital

3.1.1: Level 1
Hospital Management
Oral Health
Information
Internal Medicine
Surgical
Orthopaedics
Obs and Gynae
Paediatrics
Psychiatry
Theatre Services
Radiology
Casualty
GOPD
Rehabilitation

3.1.2: Level 2
ICU
Oral Health
Information
Internal Medicine
Surgical
Orthopaedics
Obs and Gynae
Paediatrics
Psychiatry
Theatre Services
Radiology
Physiotherapy
Occupational Therapy
Speech Therapy
Human Nutrition
Occupational Health

3.1.3: Specialised support to Districts
Administration

3.1.4: Academic Liaison
Administration

Sub-Programme 3.2: NGO SANTAS

3.2.1: H J E Shultz
Administration

3.2.2: W F Te Water
Administration

3.2.3: Barberton Santa
Administration

3.2.4: Sesifuba Emelo
Administration

Sub-Programme 3.3: Provincial Management

3.3.1: Dr Keith Michael
Administration

Sub-Programme 3.4: Provincial TB Hospital

3.4.1: Bongani Hospital
Administration
General Medicine
Referrals

Programme 4: Human Resource Dev and Health Sciences

Sub-Programme 4.1: Kabokweni College of Nursing

4.1.1: Curriculum development and implementation
Develop and implement norms and standards

4.1.2: Statutory Liaison
Liaise with statutory bodies (SANC, SAMDC, etc)

4.1.3: Orientation and induction
Standardize programmes for orientation

4.1.4: Training co-ordination
Co-ordinate all nursing training in the province

4.1.5: Inservice support
Support continuing education and in-service training

Sub-Programme 4.2: Ambulance Training College

4.2.1: Basic Ambulance course
Corodinate basic ambulance training

4.2.2 Advanced Ambulance course
Coordinate advanced ambulance course

Sub-Programme 4.3: Bursaries

4.3.1: Career guidance
Market health careers to schools

4.3.2: Bursary management
Co-ordinate the provision of bursaries

4.3.3: Monitoring of student progress
Vet student exam results
Liaise at universities re student progress

Sub-Programme 4.4: Provincial Management

4.4.1: Human Resource Strategy
Develop strategic plans for Health human resources

4.4.2: Norms and Standards
Develop guidelines for HRD

4.4.3: Co-ordination of Division
Ensure coordination of health training colleges