

https://dspace.org/

Understanding managers' experiences of public financial management policies and reform: a qualitative study from a South African provincial department of health

Wishnia, Jodi

2022
https://hdl.handle.net/10539/34346

Downloaded from a DSpace repository. https://dspace.org/

Understanding managers' experiences of public financial management policies and reform: A qualitative study from a South African provincial department of health

Jodi Wishnia

Thesis submitted for the degree: Doctor of Philosophy

School of Public Health

Faculty of Health Sciences

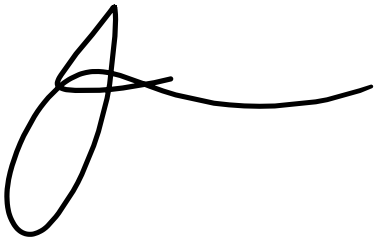
University of the Witwatersrand, Johannesburg

Date: 6 May 2022

DECLARATION

I, Jodi Wishnia, declare that, in accordance with Rule G27, this thesis is my own work. This thesis is being submitted for the degree of Doctor of Philosophy at the University of the Witwatersrand, Johannesburg, and has not been used as a submission for any other degree or submitted at any other university.

The signed Senate Plagiarism Policy declaration can be found in Appendix 1.

Signature: 

Date: 6 May 2022

DEDICATION

This PhD is dedicated to my life partner, Jesne. You have taught me the meaning of true love. Thank you for loving me wholeheartedly, through every milestone and challenge this process has brought.

To the world's best doggos Saroo and Max. Thank you for your cuddles, for taking me on walks and for bringing so much joy to my life.

To my family (biological[i] and chosen[ii]) - thank you for believing in me, reading my papers, and accepting me for who I am. I feel lucky to have you all in my life.

To my incredible support network of friends[iii], thank you for your unwavering belief in me, countless pep talks and patience. I am so grateful to each of you.

To everyone working in the South African public health system who believes they can make a difference, thank you for inspiring me.

[i] Mom, Dad, Gomes, and Daniel. All my aunts, uncles, and cousins.

[ii] Uncle Barry, Aunty Selvy, Prevani, Shahen, Kellen, Lashven, Kersan and Annie (and everyone's dogs!)

[iii] Danielle, Mike, Callie, Julia, Roi, Stillers, Shivani, Dave, Meg, Maya, Ayesha, Nik, Sarah, Greg, Ben, Michelle, Meg H, Holly, Nikki, Arel, Kerena, Sam, Namrata, Pat, Rachel, Jenna, Benjy, and Kelli (and everyone's babies!).

ACKNOWLEDGEMENTS

I extend my gratitude to the following important role players in my PhD:

- My supervisor, Prof Jane Goudge. Thank you for taking a chance on me and for the kind ways in which you pushed me to aspire for greatness.
- To the province I did my research in and all the managers who participated and opened their offices and hearts to me. I will forever be indebted to you all.
- To A/Prof Sue Cleary and Dr. Nonhlanhla Nxumalo for their feedback on draft papers and my interim seminar- your insights helped strengthened this PhD.
- To all the humans who work and study in the Wits School of Public Health and Centre for Health Policy. Special mention to Paul Bohloko who was often my only other lifeline to the School- thank you for your kind and compassionate demeanour.
- To my community of fellow PhD students and friends: (Dr!) Teurai Rwafa-Ponela; (Dr!) Thea de Gruchy; (Dr!) Ruth Castel-Branco; Meg Finn and Dave Francis. Thank you for being my work buddies, my sounding boards and for helping me show up to work even when the motivation just wasn't there. You made the PhD experience that little bit less lonely for me.
- To my friends who already have PhD's who helped to normalise me, support me, and encourage me: Dr Carmen Christian-Lopes and Dr Anja Smith. Thank you for being the absolute best versions of what academia should be about.
- To my work family at Percept. Thank you for making space and sacrificing so much so that I could pursue this PhD dream. A special mention must go to my soul-friend Shivani, who showed up for me on the days when I couldn't do it for myself. I will forever be grateful for all our talks, the shared love and admiration that runs between us, and your belief in me.

ABSTRACT

Introduction

Public financial management (PFM) is the vehicle through which public funds are spent in pursuit of delivering public services, like healthcare. PFM and health service delivery have historically remained siloed. Health departments can receive an unqualified audit opinion, signalling good PFM, alongside poor health outcomes and ailing infrastructure. This could be due to insufficient funds that do not allow for optimal service delivery. It could also signal a health system where the PFM processes are strong but are not enabling service delivery sufficiently.

This research aimed to understand South African provincial department of health (PDoH) managers' experiences of PFM reforms and practices. The research elicited evidence of how PFM reforms, and their enforcers, influenced organisational culture and power dynamics. It also sought to examine how the culture shaped the actions and choice of strategies used to improve service delivery during a period of constrained funding and rising medical negligence claims that further deplete the health budget.

Methods

The research was qualitative, using an ethnographic case study design. The data were collected over one year in one South African PDoH. Thematic analysis was used to analyse the data. Trustworthiness was ensured through peer debriefing; prolonged engagement; and member checking.

Results

Negligence claims have negatively impacted on available funds and illustrate how power has shifted toward finance managers because of their control of the health budget. This control was linked to their role in the health system as the protector of public funds and the team responsible for all financial management outputs. This desire to centralise PFM during periods of constraint was attributed to the low appetite for risk of finance managers and the strongly regulated PFM environment which uses punitive, bureaucratic accountability mechanisms. The centralisation reform negatively impacted on organisational culture and reduced opportunities for

collaboration. However, ways of working that supported ‘authentic collaboration’- wherein engagement is intentional and active - were more successful.

Conclusion

This research showed interdependencies between power, trust, collaboration, and accountability. ‘Authentic collaboration’ was found to be transformative in being able to bring together managers whose relationships are generally marked by mistrust and a power imbalance.

ACRONYMS

In alphabetical order

Acronym	Explanation
CEO	Chief executive officer
CPM	Collaborative Public Management
DCST	District Clinical Specialist Team
DHO	District Health Office
DHS	District Health System
DMT	District Management Team
DoH	Department of Health
DoRA	Division of Revenue Act
G&S	Goods and Services
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HPSR	Health Policy and Systems Research
HREC	Health Research Ethics Committee
LMIC	Lower- and Middle-Income Countries
MTEC	Medium-Term Expenditure Committee
MTEF	Medium-Term Expenditure Framework
NDoH	National Department of Health
NHA	National Health Act
NHI	National Health Insurance
NRF	National Revenue Fund
OHSC	Office of Health Standards Compliance
OSD	Occupation Specific Dispensation
PDoH	Provincial Department of Health
PES	Provincial Equitable Share
PFM	Public Financial Management
PFMA	Public Finance Management Act
PHC	Primary Health Care
SAG	South African Government
UHC	Universal Health Coverage
VFM	Value for Money
WBPHCOT	Ward-based Primary Health Care Outreach Team

DEFINITION OF KEY TERMS

In alphabetical order

Term	Definition
Accruals	Accruals represent all services that have been purchased but not yet paid for.
Actors	The term 'actors' is used in the HPSR literature as a catch-all term to refer to anyone who is employed by the health system - from administrative managers to frontline workers.
Authentic collaboration	Authentic collaboration refers to all partners working together for the achievement of something in which they all have a vested interest. Authentic collaboration is only possible if power is shared equitably among those involved.
Finance manager	In this PhD, finance manager refers to all managers in the PDoH, district health office and public health facilities whose primary role is the management of public health funds on a day-to-day basis. All these cadres are in administrative roles.
Goods and Services	Goods and Services (G&S) are budget items that are generally tangible and support the activities of the department of health, such as procuring catering services for patients in hospitals or purchasing stationery for administrators.
Health policy and systems research	Health policy and systems research (HPSR) is an emerging field of research which, by its nature, is interdisciplinary, and blends social science concepts (like political science, organisational management, public health, etc.) to understand how different health system actors relate to one another, influence policy design and implementation, and are influenced by policies and the socio-political environment they are working within.
Managers	In this PhD, 'managers' is the catch-all term for any managers in the health system (at a facility or administrative level), irrespective of discipline/profession. The term finance manager or service delivery/clinical manager is used to distinguish the discipline/profession of the manager, where it is meaningful to do so. A service delivery/clinical manager can be situated at the facility or administrative level. In the province studied, the finance

Term	Definition
	managers were all situated at the administrative level (in the PDoH head office or district health office).
Medical negligence claims	Medical negligence claims occur when a patient attempts to sue a health facility or clinician for compensation due to perceived negligent care. In South Africa, these are referred to as medicolegal claims, but the internationally accepted terminology has been used throughout this thesis. In the South African public health sector, the provincial department of health is litigated against and not the individual clinician/s.
Non-Negotiables	The non-negotiables were determined in 2014 and represent a list of ring-fenced G&S that the department is meant to ensure has sufficient budget. Items such as vaccines, blood services and security services form part of the 12 non-negotiables.
Provincial equitable share (PES) formula	The PES formula is a mathematical calculation used to distribute nationally raised revenue across the nine provinces in an equitable manner considering both the need and demand for public services.
Public financial management	Public financial management (PFM) refers to the regulations and systems related to four key processes: **budget planning; spending; expenditure monitoring**; and financial audits (accounting for funds used). It is often referred to as the 'PFM cycle' as all countries with PFM systems go through these steps in the cycle during the financial year. This PhD focuses on the three processes in bold which regularly bring finance and service delivery managers together during the year.
Service delivery/clinical manager	In this PhD, service delivery/clinical managers refer to all those managers who are responsible for the policy design and implementation of health service delivery in the PDoH, district health office or at public health facilities. These managers can be clinicians or administrative managers. Hospital chief executive officers are mentioned separately but fall within this service delivery manager category.
State Capture	State capture is the term used by most to describe the years presided over by President JG Zuma wherein large-scale corruption was systemic to the country through a network of political actors.

Term	Definition
Universal Health Coverage (UHC)	UHC aims to ensure that all people have access to quality healthcare services without financial hardship, including health prevention, promotion, treatment, rehabilitation, and palliative care. UHC is described as providing quality essential health services and financial coverage to the *entire population*.
Value for money	Value for money can be used as a method to assess whether health spending has yielded improved outcomes, and therefore value. This assessment is determined through either a cost-benefit or cost-effectiveness economic analysis.

TABLE OF CONTENTS

Declaration ii

Dedication iii

Acknowledgements iv

Abstract v

Acronyms vii

Definition of key terms viii

Preface: Motivation for pursuing a PhD xvi

Thesis overview and structure xviii

Original Papers xx

CHAPTER 1. Introduction 1

CHAPTER 2. Aim and objectives 3

2.1 Research question 3

2.2 Aims and objectives 3

CHAPTER 3. Literature review 5

3.1 Health systems software 6

3.2 Power in health policy and systems research 8

3.2.1. Overview of key power theorists 8

3.2.2. The use of power frameworks in HPSR 10

3.3 Organisational management theory and its application in HPSR 14

3.3.1. Institutional work 15

3.3.2. Organisational culture 17

3.4 Public administration literature 21

3.4.1. New Public Management 21

3.4.2. Collaborative management 22

3.4.3. Public financial management in health systems 24

CHAPTER 4. Study context 32
4.1 The South African health system 32
4.2 Public financial management in the South African health system 35
4.2.1 Revenue mobilisation and resource allocation 35
4.2.2 Resource allocation within a health department 36
4.2.3 The PFM regulatory and oversight environment 37
4.2.4 Changes in South Africa's available funding for health 39
CHAPTER 5. Summary of the research method 43
5.1 Study design 43
5.2 Negotiating access 45
5.3 Study site 45
5.4 Ethics 46
5.5 Data collection tools 47
5.6 Data collection 47
5.7 Data analysis 49
5.7.1 Approach to thematic analysis for integrating narrative in the thesis 49
5.8 Engaging with theory 50
5.9 Trustworthiness of the research 52
5.9.1 Credibility 52
5.9.2 Transferability 53
5.9.3 Dependability 53
5.9.4 Confirmability 54
5.10 Changes to the original aims and objectives of the research: reflecting on the qualitative research journey 54
CHAPTER 6. The struggle between clinical and finance managers: A qualitative case study of one South African Department of Health's response to its medical negligence claims crisis 59

CHAPTER 7. Impact of financial management centralisation in a health system under austerity: A qualitative study from South Africa 82
CHAPTER 8. Strengthening public financial management in the health sector: A qualitative case study from South Africa 92
CHAPTER 9. Integrating narrative 103
9.1 Framing the findings 103
9.2 Discussion 105
9.2.1 Power: “Sometimes, financial controls override service delivery needs.” 105
9.2.2 Accountability: “The only way to be accountable, is to have delegations.” 109
9.2.3 Trust: “We don’t trust them sometimes.” 113
9.2.4 Collaboration: “It brings us together as a team.” 115
9.3 Implications of the findings 117
9.4 Recommendations 118
9.4.1 Recommendations specific to the provincial department of health studied 119
9.4.2 Recommendations specific to the South African health system 120
9.4.3 Recommendations for global health systems and policy research environment 120
9.5 Contribution of this PhD 121
9.6 Strengths and limitations 121
9.7 Areas for further research 122
CHAPTER 10. Conclusion 124
References 125
Appendix 1: Senate Plagiarism Policy 146
Appendix 2: Permission for reproducing published articles in this thesis 147

Appendix 3: University of Witwatersrand Human Research Ethics Committee (Medical) Approval 149
Appendix 4: Provincial Ethics Approval (De-Identified) 150
Appendix 5: Informed consent leaflets 151
Appendix 6: Faculty approval for change of thesis title 158
Appendix 7: Observation guide 159
Appendix 8: Grand Tour Interviews 162
Appendix 9: Turnitin report 168

LIST OF TABLES

Table 1: Conferences at which research was presented xxi
Table 2: Objectives and the related research papers 3
Table 3: Matrix of theories' overlapping contributions 5
Table 4: GLOBE study dimensions of culture and definitions[72] 20
Table 5: Organisational practices[73] 21
Table 6: Key institutions and roles in the South African health system 34
Table 7: Demographic characteristics of interviewees, by level of management and health system[143] 48

LIST OF FIGURES

Figure 1: Framing for health system software investigations[13] 6
Figure 2: Representation of influence of actor interfaces on policy implementation[48] 12
Figure 3: Gaventa's Power Cube[35] 13
Figure 4: Forms of institutional work[55] 16
Figure 5: Schein's organisational culture conceptual framework[59] 17
Figure 6: PFM processes[97] 25
Figure 7: Shared objectives of PFM and health financing[96] 26
Figure 8: Control vs flexibility quadrant[105] 28
Figure 9: Assessing value for money in health systems[107,108] 30

Figure 10: Key themes and findings from the research 104
Figure 11: Summary of integrating narrative 117

LIST OF BOXES

Box 1: Original PhD title, aim, and objectives as described in protocol 55

PREFACE: MOTIVATION FOR PURSUING A PHD

I studied Occupational Therapy at the University of Cape Town and completed my community service[iv] in the same province in which this PhD research is situated. I worked in an extremely rural, level-1 hospital, and experienced first-hand the difficulties of trying to render quality care with limited financial resources. My experience made me realise that I wanted to effect change at a system, rather than individual patient level. Subsequently, I completed the Master's in Public Health (MPH) programme at the University of Pretoria and left the programme feeling inspired to find a space where I could contribute to systems change in the South African public health environment. Within four months of starting my first job (after the MPH), I was seconded to the South African National Department of Health (NDoH). I arrived with limited practical experience and my four years at the NDoH shaped my interest and trajectory in the South African public health space. For the first two years, I was seconded to the policy and planning unit. I then moved into the provincial financial management support (PFMS) unit within the NDoH for the next two years. My experience in both units shaped the research question for this PhD.

In my finance role, I travelled across the country engaging with service delivery and finance managers, trying to play a bridging role across the apparent siloes between these units in the health system. The PFMS team I was based within attempted to bring in service delivery metrics and measures to finance discussions and reports but this didn't appear to change engagement between the two on the ground. We also tried to carve out a new role within the finance unit inside the NDoH organogram for this bridging role (akin to the historical but now defunct health economics unit) but this was unsuccessful.

I realised I needed to deepen my understanding of the public financial management environment within the South African public health system to better contribute to improving it and make a stronger case for the bridging role I wish to play in the health system. I attended the Health Systems Global Conference in 2014 and

[iv] This is a mandatory, paid year of service for health-science graduates in South Africa.

identified a PhD supervisor whose interests (and values) aligned with mine, and formally joined the PhD programme in 2016.

My passion to contribute to the South African public health sector has been the driving force behind this research. During the research process, I provided some technical support to the provincial department of health studied because it was needed and it allowed me to shape my research to be as valuable to the system as it could possibly be. I worked full-time throughout this PhD and my work has provided multiple opportunities to deepen my technical skills and knowledge of the health system, which has supported the richness of this research.

By doing this PhD through publication, I hope to add to the small, but growing, body of accessible literature on how public financial management influences and impacts on the health system. I firmly believe in the need for more health system actors who are ‘boundary-crossers’, allowing them to see the world through each other’s perspective. This thesis represents a small fraction of what I have learned and how I have grown as a person, researcher, and technical expert. I plan on using all I have learnt to contribute to the improvement of the South African health system.

THESIS OVERVIEW AND STRUCTURE

This thesis was completed by publication and an integrating narrative approach has been used for the write up. There are ten chapters: Chapter 1 is the introduction and outlines the research question. Chapter 2 details the aim and objectives of the study. Chapter 3 serves as the literature review and provides an overview of key literature pertinent to this research. Chapter 4 gives a brief overview of the South African health and PFM systems and provides information on the study context. Chapter 5 is a summary of the methods used. The methods are also described in each of the papers in chapters 6-8.

Paper 1 illustrates the dire financial management context in the province studied. The paper describes how the constrained financial environment has impacted on quality of care as evidenced through rising medical negligence claims. It also illustrates how the financially constrained climate, coupled with rising negligence claim pay-outs has shifted power in the PDoH. The data are framed using Veneklasen and Miller's (2002) 'expressions of power' framework.[1]

Paper 2 centres on the impact of financial management centralisation on organisational culture. The paper discusses why the province decided to centralise financial management and the impact this has had on organisational culture and functioning. The paper uses a relatively new organisational culture framework specific to health policy and systems research (HPSR), developed by Mbau and Gilson (2018). The framework includes a power lens, furthering the analysis in paper 1 of the power dynamics influencing the ways of working in the PDoH.[2]

Paper 3 analyses four strategies employed by the PDoH to strengthen PFM processes. Agranoff and McGuire's (2001) collaborative public management theory[3] is used to understand why some were more successful than others. The paper provides practical examples of how a PDoH can facilitate supportive PFM, even within organisations with a centralised and sub-optimal culture. However, it highlights the negative impact of concentrated power and authoritarian management styles on 'authentic collaboration'. Trust, which is eroded in these types of environments, is shown to be a prerequisite for authentic collaboration, making the building or repairing of trust integral for health system functioning.

Chapter 9 is the discussion and serves as the integrating narrative of the thesis. The chapter discusses the overarching findings of this PhD and the cross-cutting recommendations emanating from the research. This chapter also outlines the strengths and limitations of this research. Chapter 10 concludes the thesis.

ORIGINAL PAPERS

1. The struggle between clinical and finance managers: A qualitative case study of one South African Department of Health's response to its medical negligence claims crisis

Candidates' role: Conceptualisation, data collection, data analysis, primary writer of the paper with input and guidance from supervisor.

Under revision (responding to reviewer comments) with the International Journal of Health Services.

2. Impact of financial management centralisation in a health system under austerity: A qualitative study from South Africa

Candidates' role: Conceptualisation, data collection, data analysis, primary writer of the paper with input and guidance from supervisor.

Published in BMJ Global Health: **Wishnia. J** and Goudge. J. Impact of financial management centralisation in a health system under austerity: A qualitative study from South Africa. *BMJ Global Health* 2020;5:e003524. doi:10.1136/bmjgh-2020-003524

Permission for reproducing the article in this thesis was not required as it was published using the Creative Commons Licence (see Appendix 2).

3. Strengthening public financial management in the health sector: A qualitative case study from South Africa

Candidates' role: Conceptualisation, data collection, data analysis, primary writer of the paper with input and guidance from supervisor.

Published in BMJ Global Health: **Wishnia J**, Goudge J. Strengthening public financial management in the health sector: a qualitative case study from South Africa. BMJ Global Health 2021;0:e006911. doi:10.1136/ bmjgh-2021-006911

Permission for reproducing the article in this thesis was not required as it was published using the Creative Commons Licence (see Appendix 2*).*

CONFERENCES

Table 1: Conferences at which research was presented

Year	Organising institution	Conference	Location	Contribution	Related PhD paper
2018	University of Witwatersrand	Public Health Research Day	Johannesburg, South Africa	Poster	Overall research topic
2018	Co-hosted by: Blavatnik School of Government (University of Oxford) and Ghana Institute of Management and Public Administration	Public Financial Management in Africa conference	Accra, Ghana	Opening plenary speaker	Paper 2
2018	Public Health Association of South Africa	Annual conference	Parys, South Africa	Oral presentation	Paper 3
2019	Public Health Association of South Africa	Annual conference	Cape Town, South Africa	Oral presentation	Paper 1
2020	Overseas Development Institute	Public Financial Management for better public services conference	London, United Kingdom	Oral presentation	Paper 3
2021	International Public Policy Association	5th International Conference on Public Policy	Barcelona, Spain (virtual due to Covid-19)	Oral presentation	Paper 2

CHAPTER 1. INTRODUCTION

Public financial management (PFM) comprises four main processes: budget planning (formulation); budget approval; spending (budget execution); and, expenditure monitoring (budget evaluation). PFM is the vehicle through which public funds are spent in pursuit of delivering public services, such as healthcare. PFM and health service delivery have historically remained siloed, each with their own growing body of evidence of how to best achieve their goals.[4,5] Health departments can receive an unqualified audit opinion, signalling good PFM, alongside poor health outcomes and ailing health infrastructure. This could be due to insufficient funds that do not allow for optimal service delivery. It could also signal a health system where the PFM processes are strong but are not enabling service delivery sufficiently.

The medium-term expenditure framework (MTEF) is one of the few tools used to try to ensure that the available budget is used most optimally in terms of the health needs of the catchment population.[6] The MTEF was widely rolled out in lower- and middle-income countries (LMIC) in the 1990s, with high expectations of how it would link service delivery to PFM, thereby improving health and financial outcomes.[7,8] However, the evidence shows limited impact in this regard.[6,8,9]

The shift to universal health coverage (UHC) has been the focus for health systems globally since 2010.[10] As countries contemplate the large set of health system reforms required, the discussion of how to better align PFM and service delivery has arisen again. PFM literature has begun to acknowledge the ways in which PFM processes can hinder service delivery, recognising how rigid PFM controls can create difficulties in the often unpredictable health environment.[4]

More evidence is needed to find ways to both safeguard public funds and facilitate an environment where service delivery needs are directing resourcing decisions. This is becoming even more challenging in the austerity climate globally, where funding for public health systems is declining alongside a growing burden of disease.[11] Health systems need to find ways to promote collaboration across finance and service delivery managers, such that the limited funding is used most efficiently to maximise available funds most effectively for service delivery.

This PhD aimed to add empirical evidence to the health policy and systems research (HPSR) body of literature by understanding what managers' experiences of public financial management policies and reforms are, and how these experiences impact on organisational culture and functioning.

Exploring trust and organisational culture at the managerial level is an under-represented area of research for health systems. In particular, investigating how finance managers influence and shape the culture represents a current gap in research which is critical especially as countries talk about moving towards purchaser-provider splits which could further fragment these two arms of the system. This research also aims to contribute to health policy and research systems praxis for lower- and middle-income countries, widening the available empirical evidence for LMICs on the relationship and functioning of finance and service in health systems.

CHAPTER 2. AIM AND OBJECTIVES

2.1 Research question

What are managers'[v] experiences of public financial management policies and reforms, and how have these experiences impacted on organisational culture and functioning?

2.2 Aims and objectives[vi]

The aim of this research was to examine how PFM-related reforms and strategies impact on the health system and its managers, through understanding the day-to-day experience of managers in one provincial department of health in South Africa that has been undergoing a financial management centralisation reform since 2015.

The objectives and associated research paper are described in Table 2 below.

Table 2: Objectives and the related research papers

Objective	Related paper
To understand how rising medical negligence claims, which reduce the available funds for healthcare, influence the use and distribution of managers' power and, financial management policy reform.	Paper 1: The struggle between clinical and finance managers: A qualitative case study of one South African Department of Health's response to its medical negligence claims crisis

[v] In this PhD, 'managers' is the catch-all term for any managers in the health system (at a facility or administrative level), irrespective of discipline/profession. The term finance manager or service delivery/clinical manager is used to distinguish the discipline/profession of the manager, where it is meaningful to do so. A service delivery/clinical manager can be situated at the facility or administrative level. In the province studied, the finance managers were all situated at the administrative level (in the PDoH head office or district health office).

[vi] Although the research question did not change, the aims and objectives have changed since protocol development primarily because the analytical framework I had selected for the research was embedded in the language used for the aim and objectives. I subsequently changed the analytical framework and this forced a reworking of the aim and objectives (see section 5.10 for more detail).

Objective	Related paper
To explain how financial management centralisation (and its associated processes) impacts on organisational culture, in particular the relationship between finance and service delivery units.	Paper 2: Impact of financial management centralisation in a health system under austerity: A qualitative study from South Africa.
To explore strategies and processes used to try to improve organisational functioning in response to financial management centralisation.	Paper 3: Strengthening public financial management in the health sector: A qualitative case study from South Africa.
To develop recommendations on ways of working that support greater alignment between finance and service delivery managers to improve organisational functioning.	Papers 1-3 and the integrating narrative in this thesis.

CHAPTER 3. LITERATURE REVIEW

The literature review below provides background evidence and theoretical grounding for the findings of this PhD. It starts with the **health systems software** literature, explaining how this line of research emerged and how it has been used thus far in similar research. The review then moves on to describe and frame **power** within its originating body of research and then within the context of HPSR. From the power frameworks reviewed, Veneklasen and Miller's (2002) Expressions of Power framework was selected for Paper 1.[1] The **organisational management** literature is then reviewed to connect system software and power theories within the organisational management theory environment, given that this research is situated within an organisation. Mbau and Gilson's (2018) framework for analysing the influence of organisational culture on health systems was selected to frame Paper 2 given its crossover between organisational management and health systems theory.[2] Lastly, the review narrows to **public administration** specifically and appraises the new public management, collaborative management, and PFM in health systems literature. The collaborative public management framework by Agranoff and McGuire (2001)[3] was selected from this body of literature to frame Paper 3 which showcased examples of effective collaboration between finance and clinical managers.

Table 3 provides a summarised matrix of whether the bodies of literature discussed in this literature review speak to the four cross-cutting themes of this research (power, accountability, trust, and collaboration)[vii]. This highlights the interplay and overlap of the literature selected and reviewed,

Table 3: Matrix of theories' overlapping contributions

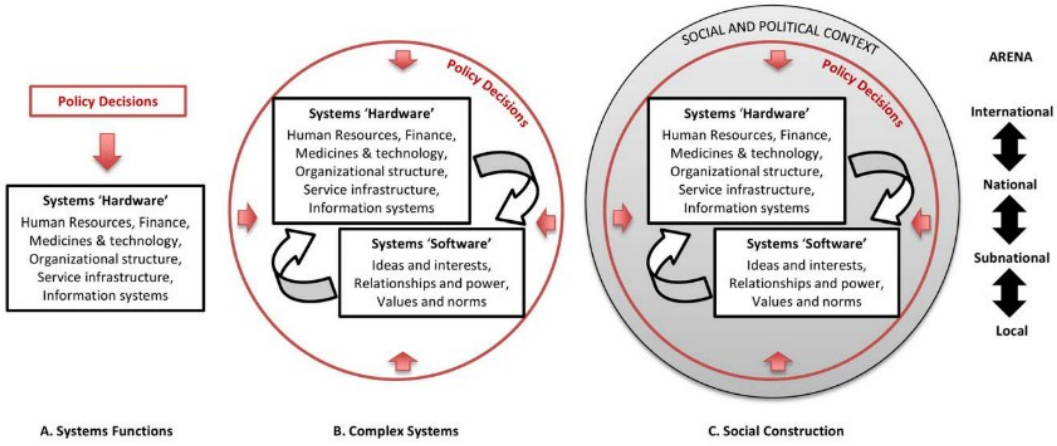
Theory	Power	Accountability	Trust	Collaboration
Health systems software	√		√	
Power	√			√
Organisational management	√	√	√	√
Public administration	√	√	√	√

[vii] How these four themes arose and the evidence for them is explored fully in Chapter 9

3.1 Health systems software

Health systems software is described as the 'ideas, relationships (and trust), interests, power, values and norms' that influence how people interact and relate to one another.[12,13] By using the health systems software lens, one can investigate how the people in an organisation influence its performance. Most of the health systems software literature relies on the Sheik et al (2011)[13] framing for research on the interpersonal and relational aspects of health system performance (Figure 1).[12,14,15]

Figure 1: Framing for health system software investigations[13]



Nyikuri et al (2017) found that focusing on system software, such as trust and motivation, during times of health system reform can improve policy implementation.[14] This is especially relevant in contexts like South Africa, where we are contemplating major reforms in support of UHC. Some authors have focused on only one or two of the components of system software (for example: motivation, power, values) rather than the full range proposed by Sheik et al (2011). These have provided valuable evidence for how important each of these specific components are to understand why some policies succeed and others don't.[16–19]

While trust is not specifically mentioned in the Sheik et al (2011) systems software framework, it continues to be an important line of inquiry in the HPSR systems software field. Trust in HPSR is most associated with Giddens' (1990) definition of trust, wherein trust is described as an act of faith in the eye of uncertainty or the expression of commitment.[17] Gilson's (2006) seminal work on trust in LMIC health systems provided a starting point for investigating the role of trust. She drew the link

between a lack of trust between managers and frontline health workers and how the frustration this causes may be passed down to healthcare users - detracting from their experience of care.[17] Erasmus et al's (2017) research, over 10 years later, found that where South African frontline workers trusted their hospital management team, there was greater buy-in of new organisational policies which supported policy implementation.[20]

In a study on the relationship between workplace trust and quality of care in Zambia, the authors found that low workplace trust arose when resources were scarce and leadership was perceived to be weak.[16] Similar to Gilson's (2006) findings, a lack of trust between healthcare providers and management had a knock-on negative effect on patient care and staff attitudes towards healthcare users.[16,17] Therefore, workplace trust had an impact on quality of care.

There has been limited research on the 'values' aspect of health systems software.[13] Recently, Whyle and Olivier (2020) published an important systematic review of the available evidence on values in HPSR and found a dearth of empirical evidence and theoretical grounding for this often-mentioned determinant of policy implementation and system change.[21] In HPSR (and in organisational culture literature as explored later in this chapter), social values are described as the underlying rationale for why people in health systems and organisations behave as they do. Whyle and Olivier (2020) found that social values shape health system actors'[viii] willingness to collaborate.[21]

Whyle and Olivier (2020) also found that priority setting (to cope with limited funds and/or ensure efficiency and effectiveness of spending) was the most frequently apparent theme in the available body of social values research in HPSR.[21] The acknowledgment of how financing and resource allocation impact on health systems is re-emphasised in their systematic review and proposed as an area where social values play an important role in decision-making. The authors also encourage HPSR researchers to investigate and engage with existing social science research to deepen the theoretical grounding of the systems software literature.[21]

[viii] The term 'actors' is used in the HPSR literature as a catch-all term to refer to anyone who is employed by the health system - from administrative managers to frontline workers.

The software lens in HPSR also supported the development of the 'everyday resilience' literature. The concept of resilience first arose as a way to understand how health systems cope with acute shocks, like Ebola.[22] 'Everyday resilience', however, is focused on the day-to-day adaptations that health system actors make to cope with chronic stressors (such as constrained funding environments). Everyday resilience research aims to understand how a health system can nurture resilience more systemically, through the everyday challenges of running a health system. The original everyday resilience theory puts forward three organisational capacities that relate to whether a health system is resilient to chronic stressors: cognitive, behavioural, and contextual capacity.[23] Cognitive capacity relates to the system becoming aware of an issue and devising a plan for managing it effectively. Behavioural capacity is about the system's ability to enact and implement the plan. Lastly, contextual capacity speaks to the availability of resources in the system, both hardware (infrastructure and finances, for example) and software (values and relationships, for example), that health system actors can use to exercise cognitive and behavioural capacity.[24]

Those with the power to decide how the system adapts and responds to chronic stressors will influence the type and range of decisions considered and the success of the response[25]- showing the intimate link between system software, resilience and power.

3.2 Power in health policy and systems research

Power as a determinant of successful policy implementation only surfaced in HPSR as a core area of interest in the late 2000s.[19,26,27] Gore and Parker (2019) show that the analysis of power in health systems research is still limited and often disconnected from its originating body of social science literature.[27]

3.2.1. Overview of key power theorists

Many scholars have attempted to explain and describe power and its role in organisations (and societies at large). Dahl (1961) and numerous other early power scholars conceived power as having ***influence over*** someone or something (for example, government policy).[28] This first 'face' of power has been described by many scholars, and some of the other terminology for this type of power include: 'power over', 'transitive' power or 'episodic' power.[29] These forms of power are

considered negative - where someone could make someone else do something that they otherwise would not do.[29] The work of Bachrach and Baratz (1962) came soon after Dahl's and suggested a second face of power, which related to the decisions that went unmade to maintain the status quo (what they referred to as 'non-decision-making').[28,30]

Shortly thereafter, in 1974, Lukes developed the 'Three Faces of Power' (sometimes also referred to as three-dimensional power) framework.[31] The first face of power relates to Dahl's (1961) perception of power (i.e. influential power). The second face of power aligns to the Bachrach and Baratz (1962) framing and proposes that power is evident in the decisions that aren't opened for discussion and in who is invited to participate in decision-making.[28] Lukes' third face of power considers 'preference-shaping', and has also been referred to as hegemonic or invisible power.[32] The third face of power was seeded in Gramsci's (1971) theory of invisible power, which centres on the need for people to create a new 'hegemony' that is rooted in their beliefs and values, to truly transform power dynamics.[33,34] This third face of power is grounded in Marxist theory and suggests that power is also exerted through the dominant culture (socio-political-economic), which favours some groups, values or beliefs, over others.[35] Lukes' second and third faces of power highlight the ways an organisation can shut down alternative views, maintain the current belief system and limit people's power primarily through exclusion from decision-making spaces.

In 1975, Michael Foucault advanced the theory that power exists 'above' the individual, and surfaces in even the smallest interactions between people. These small interactions all reinforce the broader power regime in the society and act to create norms of what is acceptable. Foucault also theorised on power in modern governments and suggested that power was entrenched through the development of social norms, wherein these are monitored and those who do not abide by them are removed or excluded.[36] Foucault also believed that resistance to social norms was inevitable, particularly from those the existing regime marginalised, and that this resistance is how power shifts over time to rectify previous systems of oppression.[34]

Shortly thereafter in 1977, Pierre Bourdieu introduced his theory of power and cultural capital.[28] Bourdieu's theory of power centres on the 'habitus', which was his philosophy of how social norms and constructs uphold certain power dynamics.[28,32]

Bourdieu believed that the habitus is unconsciously created, durable over time, and developed through a social rather than individual process.[37] Bourdieu spearheaded the concept of 'cultural capital' and 'symbolic capital'.[38] He suggested that these two forms of capital (aligned to more recent literature on 'social capital'[39]) perpetuate power inequities in society in more invisible ways than material forms of capital (i.e. money and resources).[38]

In 2005, Lukes republished his three faces of power theory but this time with additional evidence around the third face of power, which was amended to include Foucault and Bourdieu's work on power.[28,34] To date, many of the commonly used power frameworks are still grounded in Lukes' three faces of power theory.

3.2.2. The use of power frameworks in HPSR

When examining policy implementation challenges in health systems, the 'top-down' or 'bottom-up' paradigm is often used.[40] Top-down policy implementation is possible because often power is exerted from the 'top' in organisations (usually a central office) and that power is used to control or otherwise coordinate the actions of others at the lower levels of the system.[26] Bottom-up policy implementation has highlighted the role of discretionary power used by frontline staff to block top-down policy, advocate for a bottom-up approach and/or adapt ill-suited policy.[26,41–43] While a helpful start, the top-down or bottom-up dichotomy was not sufficiently nuanced to provide researchers with a clear understanding of the power processes in play that may have influenced implementation. Erasmus and Gilson (2008) were some of the first HPSR researchers to actively bring in a power lens, beyond this top-down, bottom-up approach, in their policy research.[26] They found that power influences policy processes and understanding how power is leveraged to support or thwart policy implementation is critical to understanding how policy transforms (or doesn't) during its implementation.[26,44]

Long's (1999) actor interface framework has been used in HPSR literature to understand how frontline staff in health systems influence policy implementation.[45] Long proposes that power manifests in 'interfaces' between actors or spaces that separate one group from another.[45] It is a helpful framework for deciding where to focus a power analysis, as Long suggests focusing on spaces of 'known contestation'.[45] At these interfaces, researchers are looking for evidence of

'collaboration, resistance, negotiation and domination' as actors attempt to re-shape policy to suit their needs and context.[44] Long's framework focuses on the individual and their power status (sometimes referred to as 'micro practices of power'[46]) and the organisational culture they are situated within.[44]

In an analysis of a community health worker programme in South Africa, Lehmann and Gilson (2013) used Long's framework to frame their findings. The authors found that all actors involved in the policy design and implementation exerted some form of power to either uphold the original policy intention or subvert it to better fit their context (i.e. resistance) - creating tension and providing an explanation for why the final policy implementation looked so different from its initial conception.[41] This evidence supports the idea that while policy priorities and goals should be designed at higher levels of the system, the way these polices are implemented (the 'how' of policy implementation) should be left to those closer to the ground to determine.[41]

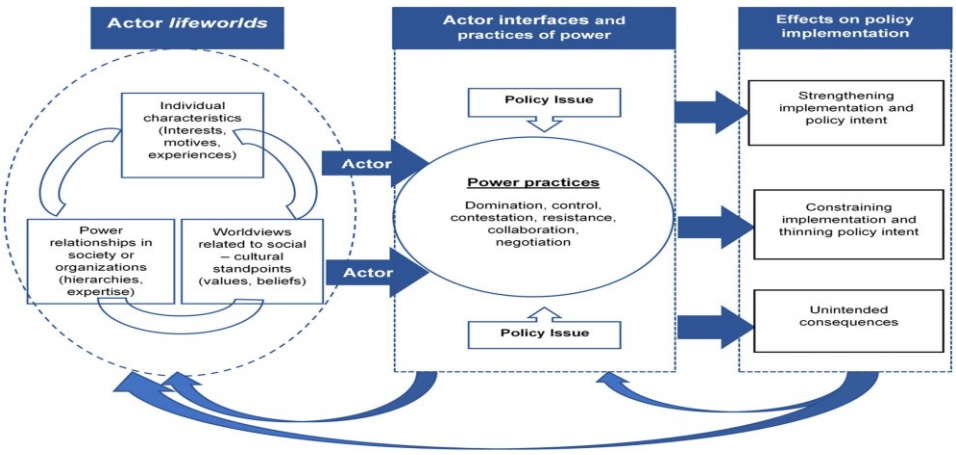
Another South African study supported these findings in its investigation of how health promoters re-determined their role after the introduction of the community health worker cadre.[47] Health promoters (frontline workers) were not given clear guidance on how the two cadres should work together and yet the authors found that these two cadres were able to find ways to support one another and meaningfully adapt their roles.[47] However, the authors recommend that best practice would be clear policies and guidelines from the top-level of the system, that frontline workers are then *encouraged* to adapt for their local context.[47]

In Gilson, Schneider and Orgill's (2014) interpretive synthesis review of the use of discretionary power (or 'micro practices' of power) by frontline health workers during policy implementation, they find that applying a power lens allows for a greater understanding of the gap between policy and implementation.[46] The authors' found that managers can influence how frontline health workers exercise their discretionary power during policy implementation. For example, by ensuring there are additional resources (human and financial) to enact the policy on the ground and that incentives are aligned to support policy implementation as it was initially conceptualised. This might mean changing key performance indicator measures for certain staff so that expectations of them in terms of roles and responsibilities is

aligned to the reality on the ground.[46] These are some of the ways that policy-makers can facilitate and encourage adaptation during implementation.

Long's (1999) framework was also used more recently to understand how power influenced the uptake of a new policy to provide free access to maternal and child health services in public hospitals in India.[48] Parashar et al (2020) developed a valuable conceptual framework that shows how individuals (as represented by actor life worlds) and the practices of power in interactions between health system actors (the second column in Figure 2) influence health policy implementation. The framework shows a dynamic relationship between the three columns, illustrating how policy also impacts on actors and the way they perceive the world or relate to one another. This bidirectional flow of influence is useful for policy makers to understand and to better facilitate the use of positive or constructive practices of power that support policy implementation. Power as a positive construct to achieve health goals is often overlooked in research, but, it is just as valuable to analyse how positive expressions of power support implementation.[48]

Figure 2: Representation of influence of actor interfaces on policy implementation[48]



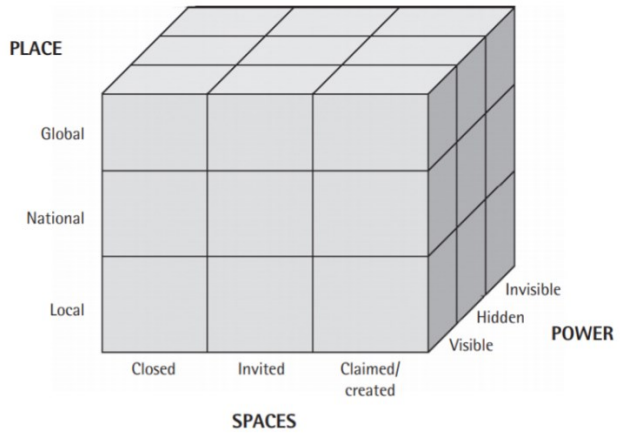
Source: Parashar et al (2020)

McCollum et al (2018) used Gaventa's (2005) 'power cube' framework, coupled with Veneklasen and Miller's (2002) expression of power framework, to analyse how power influenced priority setting within the Kenyan health system, post devolution.[49] The 'power cube' (Figure 3) brings together episodic and systemic forms of power and has three domains (place, spaces and power).[19,35] Episodic power is when

power is exercised by an individual, while systemic power is when practices and culture inside an organisation buoy certain power dynamics. The place and spaces domains allow researchers to contextualise where actors stand within the broader power dynamic of the organisation. It also supports analysis of where power imbalances lie and helps to capture any shifts in power during policy implementation.[35]

The power cube's classification of visible, hidden, and invisible power is also valuable in understanding how power manifests in organisations. Visible power is tangible and often bestowed by virtue of title in organisations. Hidden power is about who gets to set the agenda of the organisation and revolves around an analysis of who has been excluded from decision-making spaces (the second face of power in Lukes' conceptual framework). Invisible power links to the systemic power paradigm, and deals with how the culture and values of an organisation shape who has power.[1,35]

Figure 3: Gaventa's Power Cube[35]



Source: Gaventa (2005)[35]

The power cube has also been seeded with Veneklasen and Miller's (2002) expression of power framework, and therefore McCollum et al's (2018) use of both is prudent.[49] There are four 'expressions of power': 'power over', 'power to', 'power with' and 'power within', and these are widely used in several power conceptual frameworks.[1,29,35,50] 'Power over' is the first 'face' of power. It is expanded by 'power to' which is described as a capacity someone has - their ability to act. 'Power with' is about networks, relationships, and coalitions and how these are leveraged to

generate power, particularly amongst individuals who have less power. 'Power within' is how much an individual believes in themselves and their own personal power.[1] The 'power over' lens (i.e. influential power) would fall squarely into episodic power models. Systemic power (akin to the third face of power) is less tangible/visible and links closely to organisational culture models that unpack how the organisation itself (through its 'institutions'/practices) facilitates a particular power dynamic and culture.[51]

Ultimately, the Veneklasen and Miller framework was selected for Paper 1 because of its amalgamation of the frameworks that came before it and because it allowed for both positive and negative conceptualisations of power, providing nuance to the analysis. Veneklasen and Miller's framework was comprehensive for the purposes of unpacking and examining how negligence claims shifted power dynamics between and within PDoH managers.

In their study of how power influenced priority setting, McCollum et al (2018) were able to observe shifts in power from the central head office to the sub-national levels (places) as a result of the move to devolve responsibility to the local level.[49] The authors also found a relationship between the leadership style of senior policy makers and the degree to which decisions were made in closed spaces that excluded other stakeholders. This provides more empirical evidence for the inter-relationship between management style and the distribution of decision-making power. Lastly, Slack and Hinings (2004) suggest that power is often positively linked to those who control the distribution of scarce resources.[52] In public health systems, where resources are often constrained, researchers have started using power analyses to understand how this contributes to the way decisions are made, what resourcing decisions are made, and how these decisions shape, or are shaped by, organisational culture.[19,26,41,53]

3.3 Organisational management theory and its application in HPSR

The organisational management body of literature was explored to further understand how systems software and power play out in organisations. This section of the literature review focuses on two major research areas within organisational management: (1) the institutional work body of literature, that aims to understand the

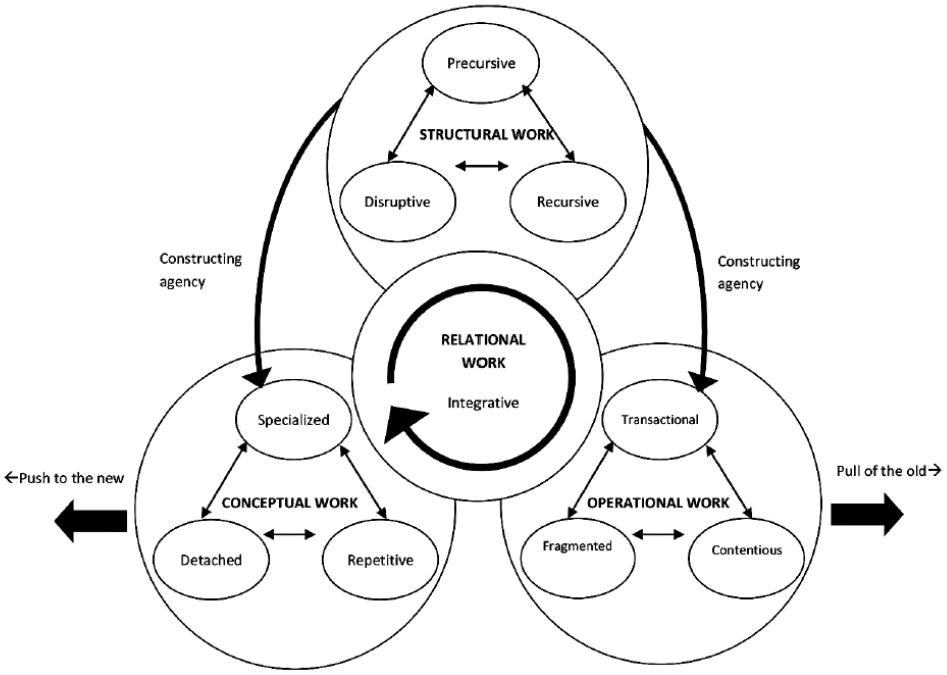
efforts made by managers to either maintain, disrupt or transform their organisations[54] and, (2) the organisational culture literature which describes the influence of organisational culture on both the performance of the organisation and relationships between managers within organisations.

3.3.1. Institutional work

Institutional work is described as the efforts made by individuals to maintain, change or transform the 'institutional structures' they work within.[54] Institutional structures are akin to organisations, but, institutions, within this body of literature, refers to "a set of practices reliably reproduced across social space and time".[54(p370)] Therefore, institutional work is about how individuals try to influence the everyday practices (institutions) of their organisations (institutional structures).

Cloutier et al (2016) developed a framework that used institutional work theory to understand how managers in organisations influence policy implementation (Figure 4).[55] Their framing is valuable because it includes the relational factors (akin to system software theory in HPSR) to understand why there is policy slippage. Cloutier et al (2016) describe four forms of institutional work used by managers: conceptual, structural, operational, and relational.[55] Conceptual work relates to the design of the new policy/reform. The translation of conceptual work to the organisational context can be tricky given that this work is often done by specialists at the top levels of organisations. Structural work pertains to the organisational context and ensures that the environment will support the new policy/reform. This often requires changing the existing institutions (practices), which can cause conflict. Operational work relates to the implementation of the policy on the ground and investigates the way that managers support or hinder implementation depending on their own perspectives of the value of the reform. Relational work, which is the work done to build trust and collaboration between the different stakeholders involved, plays an integrative role for the other three forms of institutional work and can help to explain why there is policy slippage.[55]

Figure 4: Forms of institutional work[55]



Source: Cloutier et al (2016)

The importance of relational work for policy implementation has also been advanced by other organisational management scholars. For example, Topal (2015) explores the important role of power in determining who is able to change an organisation's practices (institutions) and how managers interact and relate to one another in the course of their duties. The author suggests that levelling out power between managers can assist in reducing the amount of disruptive institutional work in an organisation.[56]

A power lens has also been used to understand the institutional work taking place in an organisation. Currie et al (2012) investigated the role of power in maintenance institutional work.[57] In their paper, they showed how specialist medical professionals employed risk-avoidance (due to the fear of negative outcomes) as a strategy to maintain the status quo on how things are done in the United Kingdom's National Health Service.[57] A further example is the concept of 'street level bureaucracy', which highlights the important role of frontline workers in policy implementation. By excluding this cadre of health personnel in decision-making, policy-makers risk their policies being undermined by these stakeholders who may not have political power but do have substantial implementation power.[58]

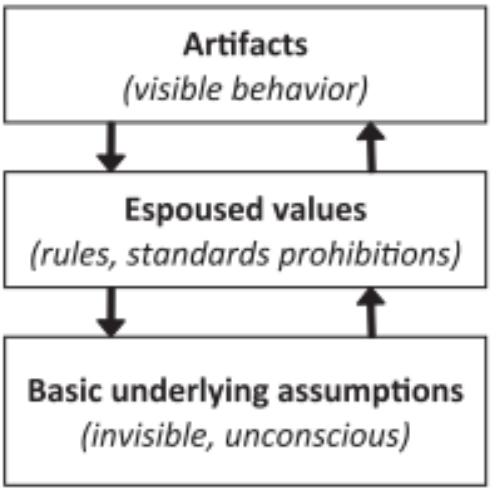
There are parallels in the concepts of relational institutional work and health systems software. Both endeavour to capture the human-related factors that influence organisational performance. The same is true of organisational culture theory, which aims to understand how and why people behave in certain ways in organisations, and the impact this has on organisational functioning.

3.3.2. Organisational culture

Organisational culture is described by Schein (1985,2010) as the generation of a pattern of shared assumptions in an organisation as it performs its functions.[59,60] These 'shared assumptions' held by the individuals inside the organisation influence how they perceive the organisation. Organisational culture has been shown to be a key determinant of organisational performance.[20,59] Therefore, by understanding the organisational culture, one can shed light on why the organisation performs at the level it does.[61]

Edgar Schein is one of the forefathers of organisational culture theory and his definition of organisational culture (given above) is used widely. Schein (1985,2010) proposed three main levels of culture that can be analysed: artifacts; espoused values; and, basic underlying assumptions (Figure 5).[59]

Figure 5: Schein's organisational culture conceptual framework[59]



Artifacts are all the aspects of culture that can be seen, heard, or felt by someone entering the organisation for the first time. While artifacts of culture are easy to observe, they are often difficult to understand or interpret without further

investigation.[59,60] The espoused values in an organisation are the norms and beliefs that the organisation, and its members, believe to be true. Sometimes, there can be a disconnect between this level and the artifacts level, where, for example, the espoused values may centre on having open communication but the visible behaviour (artifacts) is that communication channels are closed between members of the organisation. The last layer, basic underlying assumptions, provides more insight into the real reasons for the artifacts of culture observed. The basic underlying assumptions guide what the organisation sees as the only way to do certain things.[59]

Erasmus et al (2017) used Schein's definition of organisational culture, paired with a second quantitative organisational culture framework, to investigate how organisational culture influenced the implementation of two policies in two South African public hospitals.[20] The authors found that organisational culture had a direct relationship with effective implementation.

In a meta-ethnography of organisational culture in several high-income country health systems, the authors found that culture can vary not only between different organisations but even within units/teams in the same organisation.[62] This finding aligns to organisational culture theory of how one organisation can have several sub-cultures as a result of how organisations intersect with their socio-political context.[59,62,63] These sub-cultures can be made up of homogenous professional groups (i.e. finance managers), members of similar demographic characteristics and/or members of the same organisational unit/team.[62]

Schein and other organisational management scholars also suggest that organisational culture can be viewed as a 'stabiliser', preventing change and maintaining the status quo.[60,64] Schein (1985) created the term 'anxiety avoidance' to describe those within an organisation who are resistant to change and actively work to maintain the existing culture (similar to the maintenance institutional work discussed earlier).[59,64] In an Australian study that investigated how mental health services staff experienced their organisation's culture during periods of organisational change (and fiscal constraint), the authors found that the culture was relatively stable over the long-term (3-years in this study).[65] However, they caution that an organisations' ability to cope with change and stressors is not infinite, and as a result, leadership should be careful to manage the timing and intensity of the

change(s) they load the organisation with.[65] This is pertinent for health systems which are often undergoing several reforms at one time, alongside budgetary constraints and other stressors which may negatively impact on organisational resilience.[24]

The stable and robust nature of organisational culture does not mean it is unchangeable. In a review of organisational culture theory that aimed to support health promoters in knowing how to effect organisational culture change, the authors propose that health promoters need to account for the different sub-cultures in organisations in order to more successfully effect organisational change. This means tailoring engagements and consensus-building for the different organisational groups (sub-cultures) in the organisation. This recommendation is true not only for health promoters but for all actors who wish to change the organisational culture. Understanding how members of the sub-cultures may perceive the value of the change and working to unify these disparate groups through an accepted vision, is critical for managing successful cultural change.[66,67]

Changes to organisational culture also need to be actively sustained. Willis et al (2014) conducted a literature review of LMIC health systems to assist the health ministry in Saskatchewan province (Canada) to embed the cultural changes that had taken place in health departments as a result of introducing the 'LEAN' management approach.[68] The authors found six guiding principles that can help an organisation to manage and sustain changes to its culture:[68] alignment of the vision and actions; incremental changes; supporting distributed leadership; facilitating staff engagement; fostering collaborative relationships; and creating a continuous assessment and learning environment

Since the 1980s, many scholars have attempted to capture the generalisable dimensions and/or 'types' of organisational culture through quantitative tools.[69] The 'GLOBE' study, for example, aimed to develop organisational culture and leadership dimensions that were applicable across the world (Table 4).[70,71] The dimensions were developed using quantitative research methods but have since been applied in the qualitative study of organisational culture, too.

Table 4: GLOBE study dimensions of culture and definitions[72]

Dimensions	Definitions
Power distance	The degree to which members of an organisation or society expect and agree that power should be shared unequally.
Uncertainty avoidance	The extent to which members of collectives seek orderliness, consistency, structure, formalised procedures, and laws to cover situations in their daily lives.
Institutional collectivism	Level at which a society values and rewards collective action and resource distribution.
In-group collectivism	Level at which a society values cohesiveness, loyalty, and pride, in their families and organisations.
Humane orientation	Ideas and values and prescriptions for behaviour associated with the dimension of culture at which a society values and rewards altruism, caring, fairness, friendliness, generosity, and kindness.
Performance orientation	Level at which a society values and rewards individual performance and excellence.
Assertiveness	A set of social skills or a style of responding amenable to training or as a facet of personality.
Gender egalitarianism	Level at which a society values gender equality and lessens role differences based on gender.
Future orientation	The extent to which members of a society or an organisation: believe that their current actions will influence their future; focus on investment in their future; believe that they will have a future that matters; believe in planning for developing their future; and, look far into the future for assessing the effects of their current actions.

Source: House et al (2004)

Jaako et al (2010) used the GLOBE study dimensions of organisational culture to investigate how organisational culture influenced health managers' use of evidence for decision-making in Burkina Faso, a low-income West-African country.[73] Their adapted GLOBE dimensions of culture were then found to be either positively or negatively associated with four types of organisational 'practices', namely: performance assessment; open communication; participation in decision-making and leadership style (Table 5).[73] The practices are all positively associated with the use

of information for decision-making. The authors' conceptual framework suggests that a particular dimension of organisational culture can either advance or hinder these organisational practices, thereby affecting organisational functioning.[73]

Table 5: Organisational practices[73]

Organisational practices	Explanation
Performance assessment	The use of management tools to assess managers' performance against their expected duties.
Open communication	Referring to open communication across levels of the health system and between managers of different seniority.
Participation in decision-making	A wide array of managers, beyond just the immediate leadership team, are invited to participate in decision-making.
Leadership style	Leadership where managers are focused on both the task at hand and the interpersonal relationships that will help support successful task completion.

Source: Jaako et al (2010)

The framework selected for Paper 2 was a new framework by Mbau and Gilson (2018) who adapted Jaako et al's (2010) framework specifically to investigate the influence of organisational culture on LMIC health system functioning.[2] Their adaptation was selected because it offered an organisational culture framework that had been used and specifically adapted for LMIC health systems and because of its ability to draw out both the visible practices and less visible dimensions of culture to facilitate a rich understanding of organisational culture.

3.4 Public administration literature

3.4.1. New Public Management

Public administration literature was also reviewed, given that the organisation under study was a public sector health department and it was important to understand the relationship between financial management practices and public administration.

New public management (NPM) theory, introduced in the 1980s, refers to the reform of public sector organisations to more business-like institutions in an attempt to improve economic efficiency.[50,74,75] NPM focused on the role of competition in generating efficiency and suggested new ways of allocating government resources to public sector institutions to support this shift.[50]

Decentralisation is one of the NPM reforms suggested to improve efficiency of public sector organisations.[76] There are four types of decentralisation: delegation; deconcentration; devolution; and, privatisation.[77,78] Devolution is posited as the strongest type of decentralisation, where elected local officials are responsible to local beneficiaries for services.[79] Deconcentration only moves responsibility to lower levels of government. While this could allow for more local responsiveness, it does not have the same strong accountability to the local population as devolution. Delegations are the weakest form of decentralisation as they shift some responsibilities between managers of different levels in the system but the original manager remains the accountable officer.[76]

NPM was widely critiqued as a myopic way of viewing public sector organisations, given its exclusive focus on efficiency and outputs, its assumption that private sector management practices are better than public, and its preference of the individual over the collective.[75,80] As a result, a new set of reforms was proposed, referred to as 'post-NPM'. The post-NPM reform acknowledged the important role of organisational culture and the relational aspects of public sector management in achieving efficiency and better governance.[74] Post-NPM theory found collaborative management to be integral to the success of public sector organisations.[74,81]

3.4.2. Collaborative management

Collaborative management is premised on the inter-dependency of different organisations and actors in producing solutions for problems that are not easily answered by only one entity.[82] NPM was viewed as too internally focused, and the onset of collaborative management as part of the post-NPM movement started the discussions of how public sector organisations could collaborate with one another and with external organisations and sectors to solve complex problems.[81]

The extent of collaboration in the public sector is often investigated within the continuum of co-operation, coordination and collaboration - where co-operation is the lowest form of collaboration.[75] Collaboration, and collaborative public management (CPM), is the recommended approach when a problem can best be solved by a variety of actors or organisations.[3,83] Its hallmark feature is 'boundary crossing' to achieve common goals.[84] Most literature refers to CPM's transformative capacity in solving 'wicked' or intractable problems by leveraging a multidisciplinary and

multisectoral skillset, in a structured way.[3,83] However, collaboration requires a level of interdependency and mutual trust that can be difficult to achieve.[75]

CPM is generally associated with collaborative efforts across public sector organisations, for example the health and basic education departments' collaboration in the rollout of South Africa's Human Papilloma Virus vaccine for girls in Grade 4.[85] However, CPM as an approach has also been found to be valuable *within* organisations, to help build trust and a more participatory style of leadership and decision-making, although this has been less explored.[86] Authoritarian styles of leadership have been seen to lessen opportunities for intra-organisational collaboration, showing the relationship between the distribution of power and authority and, collaborative management.[86] While one may assume that achieving consensus on a shared goal (a key measure of successful collaboration) would be simpler within an organisation than it is across organisations, this is not always the case, in part due to the sub-cultures discussed in the section above.

Collaboration can be difficult to achieve, especially in hierarchical, and bureaucratic organisations. Communication and feedback inside organisations, a prerequisite for effective collaboration, is intimately linked to the power and relationships inside these organisations; a large power distance has been shown to negatively impact on collaboration.[87,88] Downe et al (2010) find that trust is critical for collaboration, and suggest that creating multiple opportunities for professionals to foster trust and build interpersonal relationships with one another can create a 'positive feedback loop' that supports 'authentic collaboration'.[89]

'Authentic collaboration' refers to all partners working together to achieve something in which they all have a vested interest.[90,91] Authentic collaboration therefore requires an equitable sharing of power amongst members.[91] Power, and in particular, those who wish to retain their power over others, is one of the key threats to successful collaboration.[92]

Achieving successful intra-organisational collaboration can be transformative. Tyosvold and Poon (1998) found that where an organisation has been able to create a shared goal amongst its managers, these managers have been more resilient and able to perform their roles more successfully, even when dealing with difficult conditions like financial constraints.[93] Collaboration and team work has also been

shown to have a positive impact on an organisation's ability to be innovative and creative.[94] Other factors, such as: open communication; empowerment; decentralised decision-making; and, a continuous learning culture were also found to have a positive impact on innovation and creativity.[94] Carlström (2012), showed the value of a collaborative culture and a participatory leadership style in the implementation of electronic health records (EHR). EHR are being implemented in many public health systems globally in a bid to improve healthcare quality.[64,9564]

Despite the focus on collaborative management that the post-NPM reforms brought, there was limited impact on the PFM practices and processes in public sector organisations. Research into the ways PFM can support or hinder collaborative efforts in public sector organisations therefore remains critical. To further this body of research, Agranoff and McGuire's (2001) collaborative public management framework was selected to unpack the role of collaboration in strengthening public financial management. Their framework is one of the few CPM frameworks available and CPM has not been widely (if at all) applied in health systems theory, it therefore presented a novel contribution to the field.

3.4.3. Public financial management in health systems

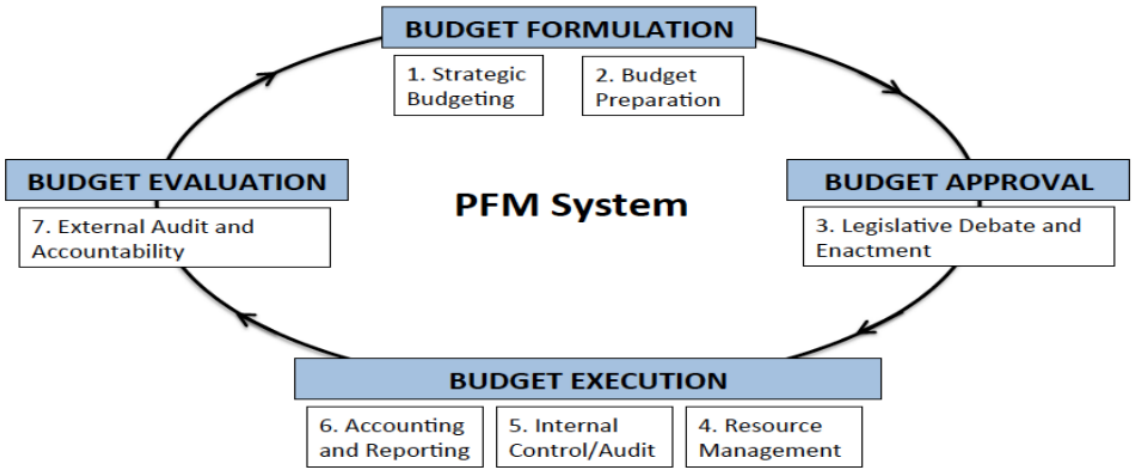
NPM supported a shift to auditing of financial performance and strong regulations to ensure adherence to PFM rules. The intention was to improve the efficiency of spending in the public sector.

Public financial management comprises four broad processes[ix]; budget planning (formulation), budget approval, spending (budget execution) and expenditure monitoring (budget evaluation).[96] This PhD research focused on the budget formulation, spending, and expenditure-monitoring processes as the parts of the process where service delivery managers are (or should be) most involved. Figure 6 shows the usual activities involved under each process.[97] The activities included in

[ix] The number of processes included in the PFM cycle varies between three and eight depending on the focus of the researcher. However, the four included here are the most commonly included and the most pertinent for the South African health system. While in some countries, revenue mobilisation forms a key part of the PFM cycle, in South Africa revenue mobilisation takes place mainly at the national level (see section 4.2).

this study were: budget preparation; resource management; and, accountability within the three processes investigated.

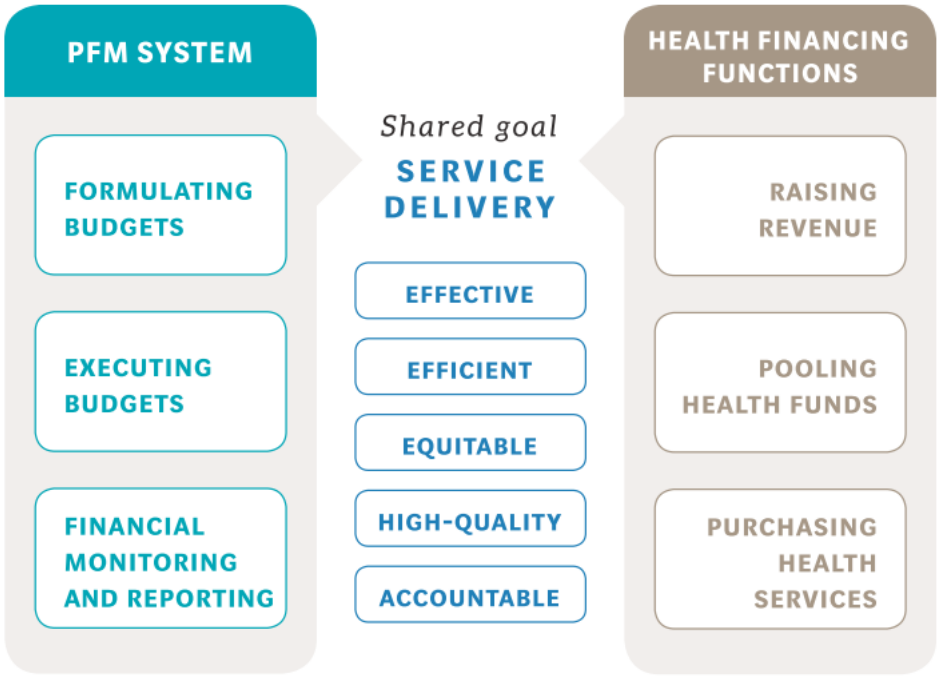
Figure 6: PFM processes[97]



Source: Andrews (2014)

Until recently, PFM has been viewed separately to the health financing literature, which is predominantly occupied with the collection of funds for healthcare, the pooling of these funds into risk pool/s and the purchasing and provisioning of healthcare services.[96] As countries contemplate the move to UHC, which requires substantial reform to change the way funds are collected, pooled and spent (along with the introduction of a purchaser-provider split), experts have attempted to clarify the relationship between PFM and health financing which should be mutually fulfilling (Figure 7).

Figure 7: Shared objectives of PFM and health financing[96]



Source: Cashin et al (2017)

While health financing is unique to health systems, PFM is applicable to all public entities that use public funds to operate.[98] As a result, the generic nature of PFM rules can sometimes be ill-suited for the health environment. An important publication by Cashin et al (2017) has attempted to outline the major issues for PFM in the health sector. The most pertinent for the South African health system include:[96]

- Unpredictable budget ceilings due to ineffective budget planning.
- Misaligned (or too ambitious) policy goals for the available funding envelope or misalignment in the timing of policy goal communication to ministries of finance.
- Budget classification that does not speak to the service delivery or policy goal the funding is meant to support. This makes it difficult for health managers to gauge the impact of funding on the achievement of health policy goals.

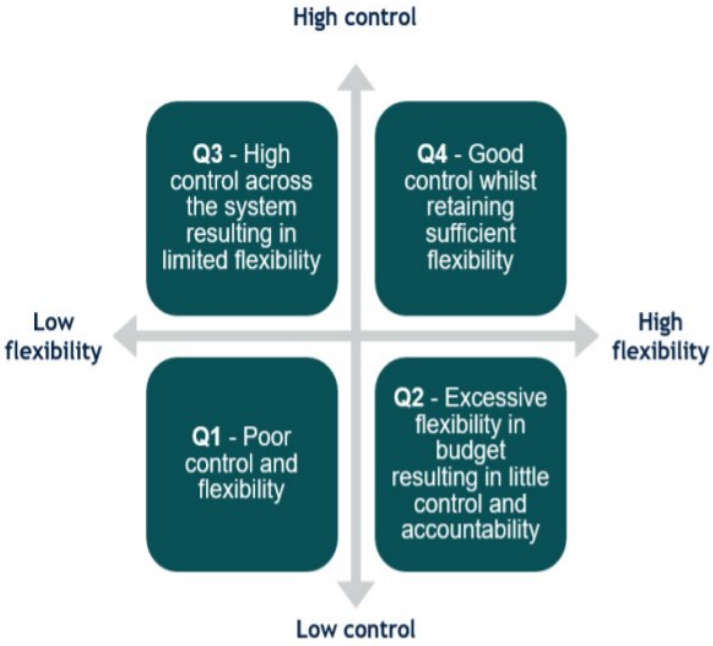
- Inflexibility of PFM processes to adapt to strategic purchasing mechanisms, which require, for example, innovative models beyond the traditional salaried model of payment for health providers.

As a result of these challenges, an emerging body of research has surfaced that aims to investigate ways to better marry PFM to health financing and service delivery.[96,99,100]

Common findings from these investigations is the inflexibility of PFM processes for the 'unpredictable' health sector.[4,96,99,101] This unpredictability is predominantly related to: (1) a seemingly constant introduction of new interventions and policies that aim to improve quality and/or shift health systems toward UHC, (2) an increasing demand for healthcare as the burden of disease shifts and (3) rising costs of providing care due to medical inflation and salary increases above inflation for healthcare workers, which constrain the available funds for healthcare resulting in the need to regularly re-prioritise spending to maximise value.

The key consideration for PFM policy is the trade-off between control and flexibility. This trade-off hinges on the level of accountability the PFM system needs to safeguard public funds (Figure 8). PFM controls remain important, especially in LMICs, where issues of corruption, poor governance and weak accountability mechanisms are still key challenges for health system functioning.[102–104] Quadrant 4 in Figure 8 is considered best practice, where PFM controls are sufficient to safeguard public funds but still allow a moderate degree of flexibility to ensure services are able to be responsive to changing needs by re-directing funds when needed.[105]

Figure 8: Control vs flexibility quadrant[105]



Achieving this balance between flexibility and control has been a constant challenge for health systems and remains a primary source of tension and misalignment between finance and service delivery in health systems.[99] This tension is often visible in the relationship between finance and health departments, which is often marked by ineffective communication and unproductive discussions given the lack of understanding of one another's context.[5,96] This has led to several suggestions of how to improve dialogue between these two critical stakeholders, including[96]:

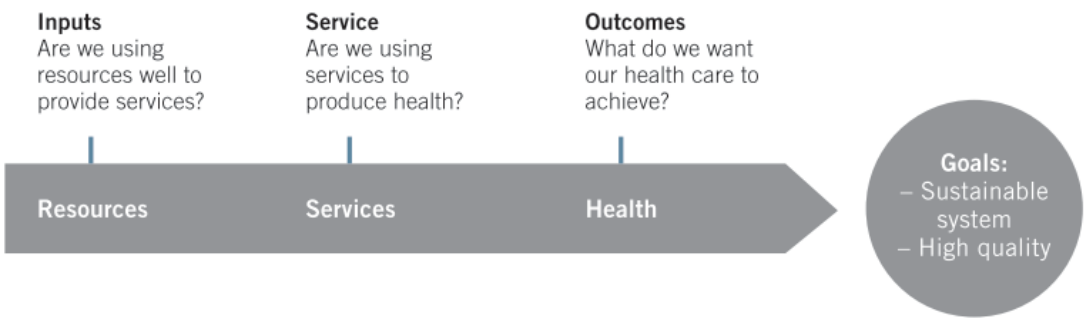
- Health managers become more familiar with the PFM regulatory environment
- Health managers become more engaged in the broader PFM reform context and undertake to understand how changes to the PFM system will affect the health sector
- Health managers take a greater interest in communicating the ways in which the PFM environment doesn't serve them and provide treasury's an opportunity to adapt their systems in response.
- Finance managers become more familiar with the health sector, context, and policy environment such that they are able to guide the health sector when PFM reforms take place

- Finance and health departments shift away from bureaucratic methods of reporting on expenditure and develop more responsive ways of managing public funds effectively through open communication channels.

Programmatic budgeting (along with the medium-term expenditure framework) has been implemented in many health systems across the globe, South Africa included, to try and improve the linkage between health budgets and stated health priorities and goals.[106] Even within so called programmatic budgeting, spending is often categorised by line items that are generic and unresponsive to the particular programme within which the money is to be spent. While programmatic budgeting has allowed for monitoring of spend at a broad health-programme level, it is still insufficiently detailed to support an understanding of how funds are linked to the achievement of health outcomes and therefore whether the funding levels are appropriate.[106] This makes it difficult for service delivery managers to interrogate proposed budget allocations from a service delivery perspective, other than being able to see whether the overall envelope is more, or less, than previous years. This limits their ability to truly participate in resource allocation decision-making, reducing service delivery managers' interest in the process. This lack of interest is sometimes interpreted as limited technical understanding of PFM rules and processes, and this perception leads finance managers to exclude service delivery managers from financial management fora.[101]

Value for money (VFM) is sometimes suggested as a method to assess whether health spending has yielded improved outcomes, and therefore value (Figure 9).[107] Within the VFM paradigm, value is determined through either a cost-benefit or cost-effectiveness economic analysis. This entails looking at the input costs and comparing them to the intended health outcomes to decide whether the spend resulted in the outcomes and whether the spending level was appropriate for the level of achievement.[107] To conduct a VFM analysis, one needs granular data matching spend to the specific intended outcome. The current PFM systems often do not support this level of analysis, making it difficult to know whether funds have been used most efficiently and effectively.

Figure 9: Assessing value for money in health systems[107,108]



Source: CABRI (2011) adapted from Health Council Canada (2009).

The inclusion of service delivery managers in budget planning could support a better understanding of how health spending is supporting improved health outcomes. Allowing service delivery managers to direct and redirect (if priorities have changed during the funding cycle) funding decision-making, with support from finance managers, may improve the value for money of public health spending.

The effect of excluding service delivery managers from the budget planning process, for example, is that budgets are often unrelated and unresponsive to the way health service platforms (primary, secondary and tertiary care) need to adapt in response to local needs.[101,106] Frequent requests to transfer funds between line items or programmes during the year can appear to undermine the value of the PFM process of budget planning. However, the attainment of targeted health outcomes and goals should drive how the budget is allocated, and therefore shifts between line items, so long as they support the service delivery goals, are not necessarily indicative of poor planning.

Because service delivery managers do not have financial delegations, they often have to request for a transfer of funds from centrally located finance managers, which can result in delays that negatively impact on health system performance. To try and remedy this problem, there has been a wide array of attempts to decentralise financial management across LMICs, even in the post-NPM era.[109–112] Despite decentralisation being hailed as a panacea for improved service delivery, given the local-level decision-making control it should foster, the results have been disappointing[110–112] and there are few examples globally of systems with successful decentralisation.[113]

The role of PFM in health systems is here to stay and finding ways for PFM to be an enabler for service delivery, while still maintaining important financial controls, remains a key challenge for public health systems globally.[4,114]

CHAPTER 4. STUDY CONTEXT

4.1 The South African health system

Prior to the onset of democracy in 1994, the Apartheid-era government forcibly moved Black people out of the urban centres to more remote, rural areas, now known as the 'former homelands'. There were 10 former homelands and the Apartheid government attempted to allocate people to a homeland based on their ethnicity.[115] The population living in these areas were forced to live in close confines, with limited access to basic amenities.[115] The available public facilities were under-resourced and far below acceptable standards.

At the end of Apartheid in 1994, the first democratic government moved to dissolve the former homelands and re-include them into the nine provinces. However, the legacy of Apartheid and a lack of clear direction from the new government on how public institutions should be run and managed, left each province to determine its own ways of working.[116] Provinces that had to incorporate former homelands were at even more of a disadvantage, given the extent of the decline in (and lack of) infrastructure and the South African Government's (SAG) decision to allow some former homeland leaders who did not have the requisite skillsets to take up key leadership positions in the provincial departments.[116]

Despite these challenges, the South African health system has transformed substantially since 1994.[117] The removal of user fees for primary healthcare services and the expansion of the number of public health facilities across the country has had a positive impact on access to and availability of health services.[118]

The country is now governed through a quasi-federal system, where the national sphere of government (National Department of Health for the health sector) is responsible for policy making and oversight, and the provincial departments of health play the oversight and policy making role for the provincial health system and hold the responsibility (and therefore the accountability) for the implementation of health services.[119] South Africa has 52 health districts[120] and these act as the implementing arm of their respective PDoHs, ensuring the district health system (DHS) functions optimally and according to the policy directives.

The DHS, first envisioned in the 1997 White paper entitled 'Transformation of the Health System'[121], is meant to be a decentralised function of the PDoH, that facilitates autonomy and decision-making power at the local level.[122] Each health district has its own district health office, complete with a district manager and leadership team comprising finance, supply-chain and service delivery (health programmes like HIV or primary healthcare) senior managers. This leadership team is called the district management team (DMT). Each unit in the district health office has representation on the DMT and supporting staff who ensure the functions of the units are successfully implemented. The DMT is responsible for managing primary healthcare services and the district (level 1) hospital platform.

The promulgation of the National Health Act (NHA) in 2004 assisted in formally establishing the district health system and clearly outlined the roles and responsibilities of the national and provincial departments of health.[123] Despite this, South Africa is struggling to achieve the DHS as envisioned in health policy documentation (spanning from 1997-2017).[124–126] Most district health systems' have not been given the requisite autonomy or financial delegations to be able to effectively manage and run their local health system. This is driven by multiple factors including: ineffective governance and leadership at all levels of the health system; poor financial management controls that have made PDoHs less inclined to decentralise; sub-optimal management systems that make it difficult to monitor spending at the local level; poor service delivery performance; and, a lack of technical capacity at the district level given its perception as the lowest ranking tier of the health system, influencing who chooses to work there.[122]

These challenges have resulted in a health system marred by weak governance and leadership, centralised control (including of public health finances) at the provincial level and poor health outcomes.[122,127] Nevertheless, in 2011, South Africa announced its intention to pursue universal health coverage (UHC).[125] The country has called its policy for UHC 'National Health Insurance' (NHI), and its key features are: its single-purchaser model administered through an NHI Fund; a purchaser-provider split; and a strong district health system that is able to select providers based on quality and need.[121,128] Despite ambitious targets, complete with a three-phased approach for the rollout of the financing and funding mechanism, the country has not progressed as quickly as it hoped.[129,130] The first phase, which aimed to

improve quality and pilot several of the proposed initiatives under NHI (like private-provider contracting) was evaluated by an external party to the National Department of Health. Their report found that there had not been much progress in terms of the intended quality improvements nor expansion of services through community-based teams such as the District Clinical Specialist Teams (DCST) and the Ward-based Primary Health Care Outreach Teams (WBPHCOT).[131]

This lack of progress has impacted negatively on public trust of the government's ability to achieve UHC[132–134] and the latest NHI Bill (2019) was poorly received as unattainable predominantly due to its affordability and because it lacked clarity on how the new policy will be enacted, particularly within the current low-quality public health environment.[127,133,134]

6 below shows some of the key institutions and roles in the South African health system to guide the reader on where decisions are made and by whom.

Table 6: Key institutions and roles in the South African health system

Institution/role	**Function**
National Department of Health	All health policy making for the country. Oversight of performance and responsibility for National Health Insurance design, risk pooling and funding.
Provincial Department of Health	Implementation of national policy. Able to adapt policy for local context and to design province-specific policy that does not contradict national policy. Oversight of provincial performance.
District Health Office (DHO)	Responsible for implementation and for the district heath system platform (outreach, primary health care and district hospitals) .
Head of Provincial Department of Health	Accounting Officer for the provincial health department, responsible for overall financial and health management.
Chief Financial Officer (PDoH)	Responsible for ensuring the accounting officer is able to sign off on accurate financial records. In practice, responsible for all financial decision-making in the province.

Institution/role	Function
Head: Clinical Services (PDoH)	Responsible for all service delivery in the province, coordinates all managers responsible for the primary, secondary and tertiary/quaternary level of care.
District Manager (DHO)	Responsible for the district health system and service delivery for primary health care and district hospitals.

4.2 Public financial management in the South African health system

This section provides an overview of what revenue is collected for the provision of public sector services and how this revenue is allocated across the provinces and sectors. It then provides background into the PFM regulatory space and the relationship between the regulatory environment and impact of medical negligence claims on the available funding for public health services. The final section outlines how South Africa's available funds for public health services has changed from 1994 to date, as a result of the available revenue and PFM regulatory environment.

4.2.1 Revenue mobilisation and resource allocation

The National Revenue Fund (NRF) is made up of revenue from the national, provincial, and local spheres of government. The largest share of funds arises from the national government, predominantly through value added tax (VAT), tax, and customs duties. The provincial government can generate income from hospital fees and other taxes (like excise and gambling), but these are generally very small amounts, comparatively.[135] Local government receives some funding from property rates and surcharges on service fees, but, the national government is responsible for the lion's share of revenue mobilisation in South Africa.

The process of resource allocation takes place through multiple steps at the national, provincial treasury and provincial health level. First, the SAG uses the funds in the NRF to pay/service any debts, after which, the SAG must agree on how to divide the remaining revenue. This is enacted annually through the 'Division of Revenue Act' (DoRA). The DoRA contains the decision on how to divide funding vertically across the three spheres of government (national, provincial, and local). It also contains the

results of the provincial equitable share (PES) formula which determines how much to allocate to provincial governments (which is received by the provincial treasury via the provincial revenue fund; PRF) - this is referred to as the horizontal allocation.[136]

The PES is based on a mathematical formula that attempts to estimate provincial resource need and allocate resources more equitably based on this need. The PES is intended to have a dual purpose. The first is to direct the NRF on how to allocate funds across the provinces. The second is for the PES formula to guide the provincial treasuries on how to allocate funds across the health and education departments, two of the most critical social services.

However, the provincial treasuries, unlike the NRF, can go against the PES recommendations and allocate provincial funds across the public sector departments in their respective provinces as they see fit. The provincial treasuries have established an annual medium-term expenditure committee (MTEC) 'hearing' wherein all provincial public sector departments present their budget needs for consideration by the provincial treasury before the final allocations are completed.[137] The final allocations to provincial departments and entities are enacted through the Appropriations Act and the funds are thereafter transferred from the provincial revenue fund to the respective provincial departments. The lack of regulatory guidance/policy on how provincial treasuries should allocate PRF funding has established the provincial treasury as a key financial decision-maker for health systems.

4.2.2 Resource allocation within a health department

All provincial departments of health consist of eight budget programmes. Of the nine, three are directly service delivery related (Programme 2: District Health Services (DHS), Programme 4: Regional Hospitals and Programme 5: Tertiary/Central Hospitals). The DHS programme includes primary healthcare facilities and district (level 1) hospitals. Programme 4 includes level 2 hospitals and specialised hospitals like mental health facilities. Programme 5 includes level 3 and 4 hospitals.

South Africa has been trying to move its funding from a hospi-centric model to a primary healthcare model- and gradually the share of funds going to programme 2 has increased from ~35% in 1996/1997 to just under 50% by 2019/20.[138] This does,

however, include the district hospital spending which somewhat skews the picture of the funding going to primary healthcare activities only.

Generally, resource allocation to the different budget programmes is based on historical expenditure. This renders health budgets unresponsive to changing policy environments-for example, despite a push toward out-of-facility care, the cadre who conduct these visits have no dedicated budget sub-programme and insufficient funding to cover their travel and medical equipment requirements. Given the reliance of South Africa's National Health Insurance (NHI) policy on outreach services[139], this misalignment in the budget programme and funding environment to the policy context is likely to impede achievement.

4.2.3 The PFM regulatory and oversight environment

The Public Finance Management Act (PFMA) of 1999 brought with it a strengthening of the PFM framework and South Africa has been hailed as having one of the best PFM systems on the African continent.[4,140] However, the PFMA and its supporting regulations have also come under criticism for being inflexible and punitive, making managers nervous to delegate financial responsibility for fear of being held accountable for others' actions.[141] The centralised control of public health funds at the provincial health level has been buoyed by this perception of the PFMA as highly punitive.[141]

Recognising this perverse incentive, in 2013 the National Treasury and the Department of Public Service and Administration released a Cabinet memorandum that aimed to explain and encourage how to delegate financial management responsibly.[142] (Delegations can be introduced on their own, or as part of a broader decentralisation effort.) The Cabinet memorandum was also explicit that when a function is delegated downwards, the original accountable managers should remain in close communication, in perpetuity, to safeguard the process.[142] This, along with the instruction that accountability remains with the original person responsible, undermined the memorandum's message. As a result, PDoH senior managers have remained wary to delegate their functions to district-level managers, despite there being finance managers at this level of the system to provide technical support.[143]

The PFM processes of budget planning, spending, and expenditure monitoring are driven by finance teams inside the PDoHs and district health offices. These teams,

particularly at the PDoH, interface regularly with their provincial treasury, who perform the financial regulatory oversight function. The provincial treasuries play a strong oversight role, particularly in provinces where there is a history of financial mismanagement, and this has resulted in PDoH finance teams feeling like they respond to two 'masters', both the head of the provincial health department and the provincial treasury. This dual responsibility has contributed to finance teams' feeling separate to the rest of the health system and the organisational siloes within PDoHs.

Medical negligence claims

In the South African public health system environment, the rigid PFM environment has also contributed to the negative impact of medical negligence claims on available health funding. Medical negligence claims occur when a patient experiences sub-optimal care (referred to as a patient-safety incident) that they believe was due to negligent behaviour by the facility/clinician.[144,145] Where a claim is successful, compensation is sought from the health system or clinician and this compensation is justified in terms of the harm experienced. Many countries have begun to explore alternative mechanisms for claim adjudication and payment, to support both swifter justice and reduce the financial burden on the health system.[146,147] It remains a careful balance between safeguarding funds for service delivery and quality improvements, while also acknowledging the need to redress and compensate patients for negligent care.

New Zealand and Australia provide useful examples of how this balance can be achieved.[148,149] They use a 'no-fault' system, where any person who has experienced a medical injury (irrespective of whether it was the result of negligent care), can apply to receive financial compensation, so long as the injury was directly caused by the medical intervention. If this causality is proven, the payment is made using public funds that sit outside of the health system. The medical professional is not liable for any payments but they can still be found to be negligent (in a separate process) and tried criminally or undergo disciplinary procedures through their professional bodies. This allows the injured person to pursue investigations of negligence where they feel it is justified, without having to wait for that process to complete before receiving compensation.[150]

South Africa has a rising burden of medical negligence claims.[151] While all the provinces experience claims to some extent, as can be expected in any health system, three of the nine provinces (Eastern Cape, Gauteng and KwaZulu-Natal) have a much higher claims burden than the others. South Africa's current PFM laws prevent health systems from being able to budget for potential negligence claims.[152] The PFM laws also currently only allow for 'once and for all' payments, wherein the full claim must be paid in full, with no room to design more effective payment models, particularly for patients who require ongoing medical care.[151]

Because provincial departments of health are not allowed to budget for these claims, the funds to make claim payments must be taken from the existing, and already allocated, health funds. This has a deleterious effect on available funds for service delivery, which impacts on the quality of care that can be provided, further making the system vulnerable to patient-safety incidents and subsequent claims (as discussed in more detail in Paper 1). This, coupled with the rising accruals explained further below, have contributed to the precarious financial state in the province studied. It therefore arose as a key challenge for both service delivery and finance managers in the province and influenced how financial decisions were made.

4.2.4 Changes in South Africa's available funding for health

South Africa is unique on the African continent as its overall total health expenditure (THE) is relatively high (~8.5% of GDP).[153] However, the THE is almost evenly split between the public and private health sectors and *public* health spending (which needs to support ~84% of the population's healthcare needs) sits at only ~4% of GDP in South Africa.[153] A study conducted across 48 'developing' countries in 2008 found that South Africa's public health spending is lower than many of its LMIC counterparts.[118]

Since the onset of democracy in 1994, the SAG has made a concerted effort to increase funding for the public health sector to improve access and availability of health services across the country.[118] Over 1,600 public health facilities have been constructed or renovated since 1994. Between 1994 and the global recession in 2008, South Africa showed positive economic growth each year, ranging between 0.5% and 5%, which supported this additional investment in health infrastructure.[154]

Between 2006 and 2009, the SAG introduced the 'occupation-specific dispensation' (OSD) for key cadres in the public sector.[155] The intention of OSD was to increase healthcare workers earnings so as to keep them in the public health system and prevent emigration to countries with higher compensation levels for human resources for health (HRH).[11] The process of introducing OSD took longer than anticipated and its rollout continued into the 2012/2013 financial year, adding severe pressure to a now-constrained budget environment given the 2008 global recession.[11] Between 2005/2006 and 2012/2013, the average cost per PDoH employee grew by almost 40%.[11] By 2019/2020, South Africa's total HRH expenditure comprised ~62% of total provincial health spend nationally, which is close to the global average of 65-70%.[156] However, the increased cost per employee brought on by the OSD policy means that spending at accepted global levels is not necessarily buying the right skills mix or number of HRH. For example, while Limpopo has the highest proportional spend on HRH (72% of Limpopo's health budget), it has the second lowest ratio of doctors per 10k population uninsured in the country.[157]

Partly due to the global recession and partly due to mismanagement of public funds as a result of 'state capture'[x][158], South Africa began to experience a decline in economic growth (GDP) in real terms from 2011.[159] The health sector needed to find ways to reduce spending as the country grappled with the resulting decrease in available funding for public services. This proved difficult given that the wage bill had just increased dramatically. South Africa is a strongly unionised environment and it is difficult for the public sector to retrench staff or to change the nature of employment contracts.[117] Furthermore, nationally-run wage agreements for public sector servants lock all public sector departments into agreed upon wage increases, usually over three-year periods.[11] These agreements remain in place even if health budgets decline in real terms. Non-replacement of vacated posts is one of the only ways that provincial departments of health and treasury have at their disposal, within the current PFM environment, to control the wage bill. This has resulted in a high number of vacant posts in provincial departments of health, which not only creates

[x] State capture is the term used by most to describe the years presided over by President JG Zuma wherein large-scale corruption was systemic to the country through a network of political actors.[158]

critical staffing shortages but also frustrates service delivery managers who attempt to advertise and hire when posts that were previously filled become vacant, only to be told the post is now 'frozen'.[11,160,161]

The relationship between the political economy of the broader South African context, and the South African health system in particular have largely been overlooked when analysing health system functioning and the country's (non)achievement of UHC. The relationship between the National Treasury and health department's displays a power imbalance, where treasury can prevent health departments from hiring personnel, for example, as a way to curtail public expenditure. A political economy analysis would strengthen the understanding of why certain PFM reforms have taken place or are more popular, and provide further insight into the relationship between the macro political climate and the micro health system environment.[162]

It is difficult to control 'goods and services' (G&S) expenditure in health systems, too. As funding has become more constrained, the sector has tried to safeguard the budget for G&S items that directly impact on service delivery. In 2014, the NDoH labelled 12 G&S budget items as 'non-negotiable' (e.g. medicines, laboratory services, blood services, patient food). Identifying the items most critical for healthcare as 'non-negotiables'[163] was meant to assist PDoHs in deciding where to allocate their limited funds.[164] Despite this status, funding for the non-negotiables has remained constrained (for a variety of reasons including insufficient G&S budget, medical negligence claims and health system inefficiencies). Often, provinces procure these items without the requisite funds, and so the payments are deferred, generating accruals[xi]. Accruals create pressure in the following financial year as they must be paid first before resources are further allocated - a vicious cycle.

The strength of the South African Rand to the US Dollar has also declined over the past decade. This has created budgetary pressure particularly for medicines, for which materials are imported.[165]

The latest budget speech in South Africa (February 2021) shows a real decline in the total available funding for public health over the next three years (-5.1% in real terms in the 2022/2023 financial year).[166] This decrease has been blamed on the COVID-

[xi] Accruals represent all services that have been purchased but not yet paid for.

19 pandemic, its effects on the economy and the associated costs of vaccine procurement. South Africa is currently trying to pass the new National Health Insurance Bill (2019), which will move the country toward a single purchaser for healthcare services and includes other related interventions to ready the system for universal health coverage.[167] This is being widely contested given the economic reality in the country and the real decline in health budgets over the next three years.

South Africa's health outcomes have remained relatively poor and some may be tempted to blame this entirely on the constrained financial environment.[161] However, research by Hlafa, Sibanda and Hompashe (2019) has shown that it is not only available funds that have an impact on health outcomes.[161] Health system software elements like management and leadership, communication, and trust have been shown to improve organisational performance[20,161], which in the health sector would translate to improved health outcomes and better quality of care. Therefore, understanding both the real impact of a declining funding envelope and the organisational culture and context within which available funds are spent, is critical for a full understanding of health system performance.[2,20]

CHAPTER 5. SUMMARY OF THE RESEARCH METHOD

5.1 Study design

This PhD research was qualitative in nature. Qualitative research is suited for studies that aim to understand how people make sense of their context and their experience of living or working in a particular setting.[168] Qualitative research is by nature more flexible, allowing the researcher to adjust the data collection tools or sample as new information comes to light.[168,169] This does not allow the researcher to 'cherry pick' a preferred narrative, the intention is to ensure that the resulting data are reflective of the participants' experiences rather than the researcher's assumption or expectation of what the data might yield.[169] A hallmark of strong qualitative research is the identification of diverse or discrepant themes, which do not fit the major thematic areas seen.[169] This increases the validity of the research by showing that the researcher has not been biased or selective in what she chooses to pay attention to.[170] Awareness of these discrepant themes is supported by constant data analysis throughout the data collection period and strong reflexivity practices.[171]

There are several well-established qualitative research designs,[172] of which four were considered during the design phase of this PhD. Grounded theory is inductive and data is constantly analysed (using an approach called 'constant comparative analysis') during collection to inform what further data needs to be collected in order to uncover a theory that has arisen (or is grounded from) the data collected.[173,174] Fundamentally, grounded theory is best used for research questions that hope to generate *new* theory from the data collected.[175] Phenomenology is best suited for research questions that aim to understand the meaning of individuals' experiences.[176] It is focused only on the subjects experience of the particular 'phenomenon' being studied and there are several types of phenomenological research which are each steeped in a different philosophical paradigm.[176] The analysis process of this type of research is referred to as 'explicitation' and involves multiple readings of the data. Between the readings, the researcher uses reflective writing to elicit their understanding of the participants' experiences and then re-reads the data to learn more, expand or correct their understanding.[176] Phenomenology is

inductive and subjective and this approach is most useful when a researcher wants to understand an experience from the individual's perspective. The case study approach stands on its own in both quantitative and qualitative research design methods.[177] As a qualitative methodology, it has come under criticism for being too broad, lacking rigour and failing to account for the researcher's bias and assumptions.[177,178] Case studies are useful for qualitative research as a mechanism to compare discrete cases against one another or as a tool to understand a particular case deeply and interpret it fully. Case study research is most useful when the researcher already has a theory they would like to develop or expand through the study of relevant case(s), it is therefore often paired with another methodology to better bring out comparisons across cases.[177]

After reviewing these, ethnography was selected as the most appropriate research design for this study. Ethnography is valuable for when a researcher would like to understand how and why people behave a certain way in a particular setting[179], and is useful for research that aims to study the culture (such as organisational culture) within a group.[180] A 2022 special issue in Social Science & Medicine also showcased the value of ethnography particularly in understanding how health system's function and the guest editorial introducing the special issue noted the role of ethnography in really bringing out the relational and interpersonal characteristics of an organisation.[181] Ethnography was therefore well suited to this study that aimed to understand managers' experiences relating to one another within the PDoH studied. Ethnography uses multiple methods of data collection to allow the researcher to compare what she is observing to how participants explain their experiences and perceptions.[182] Ethnographic methods require a researcher to spend time embedded in the study setting, so as to observe participants in their 'natural setting'.

In applied health systems research, ethnography is adapted from its more traditional approach.[183] The approach used often involves the use of accepted ethnographic methods like participant-observation, reflexivity and in-depth interviewing, but there is not the same expectation of extremely long data collection periods or the same level of immersion in the setting that the more traditional ethnographic method encourages.[179,183] This is partly a practical adaptation, given that many health researchers also work within the health systems they study and therefore there is not the same distance between participants and researchers. It is also partly an

adaptation to ensure that research generated is pragmatic and shaping current discussions and praxis around health policy and system management.[183]

5.2 Negotiating access

Gaining sufficient entry into a study setting to allow for ethnographic research can be difficult, given that the researcher becomes a part of the setting for the duration of the research. The study site was chosen because I had worked with the managers in that province in my capacity as a health financing consultant. My consulting work was not paid for by the province and I worked on small projects on an *ad hoc* basis over a period of four years (2013-2016). I had visited many of the province's facilities and worked extensively with their service delivery data (utilisation statistics) and finance data. Through this, I had developed a level of trust with some of the managers and was very familiar with the province and its performance.

I approached a senior finance manager, whom I had worked with on a hospital-costing project previously, to discuss the research. This manager then took my research protocol (which included proof of ethical approval from the University of Witwatersrand and the research office of the province) and discussed it with the executive management of the province, who subsequently gave their approval for the research. The senior finance manager became the gatekeeper for the study site and my primary relationship with the study site.

After executive management approval, I was invited to attend a meeting to discuss the research with managers in the province. I presented the aim and objectives of the research and managers were able to ask clarifying questions. This session familiarised the managers with the research and what to expect. It also acted as an introduction between myself and the managers, to facilitate my asking for interviews or to sit in on meetings.

5.3 Study site

The setting for this research included the PDoH head office, two of the district health offices and four public hospitals. The province studied has both rural and urban areas and is well known to be a deprived and impoverished region.[184] This province has a high multiple-deprivation index[185], which has been shown to have a

detrimental effect on health[186], making this population vulnerable to poor health outcomes and in need of a strong public health system.

The province also struggles with ailing infrastructure. During an audit by the office of health standards compliance (OHSC; South Africa's fledgling health facility accreditation body), only two of the initial 25 primary healthcare facilities that were assessed in 2015/2016 in the province's National Health Insurance pilot district met the accreditation standards.[187] Despite the province having one of the largest complements of available human resources for health in the country, an assessment in 2015/2016 found that 60% of the primary healthcare facilities did not have a dedicated facility manager. Furthermore, a relationship was found between accreditation status and availability of a facility manager, with a vacant post being correlated to a worse accreditation outcome.[188] This is evidence for the role of non-financial factors on health system performance.

In 2015, the PDoH hired a new chief financial officer (CFO) who had not previously worked in the public sector. The CFO was tasked with turning around the poor financial audit outcomes in the province, and the provincial treasury had made it clear to the PDoH that if the CFO was not successful, they would undergo financial administration. There was immense pressure on the CFO and the PDoH to prevent this from happening.

5.4 Ethics

Both the University of Witwatersrand's Human Research Ethics Committee (HREC: Medical: M170346) and the provincial research committee (RP45_623) approved the research (Appendix 3 and Appendix 4). Informed consent leaflets were used when collecting data through observation and interviews (see Appendix 5).

The study site has been anonymised throughout this thesis and all associated publications. Ethics approval was given on the guarantee of anonymity in the research findings and confidentiality was assured before any data collection took place (irrespective of the data collection tool used).
Participants were assured of anonymity and this allowed them to be honest and authentic in their responses to interview questions and while I was a participant-observer in meetings. During protocol development, the University of

Witwatersrand's human research ethics committee had asked for the provinces to be studied to be placed in the title of the research. However, once data collection was completed and I had decided to do more in-depth data collection in only one province, it became necessary to change my research title so as to de-identify the province and the participants, as had been committed to in my consent leaflets. This change was approved by the University of Witwatersrand (Appendix 6) and communicated to the ethics committee and the province.

5.5 Data collection tools

Participant observation and semi-structured interviews were used to collect data for this research. The participant observation was guided by an observation guide (Appendix 7). The semi-structured interviews employed a 'grand tour' approach (see Appendix 8).[189] A grand tour approach allows the researcher to set the scope for the interview, but the interviewees decide which topics within that they want to focus on. It is useful for eliciting a thick description from participants and a particularly valuable interview technique for ethnographic research which aims to lessen the researcher's influence on the data collected and encourages the participants to be detailed in their responses.[190] It facilitates an in-depth interview.

While one can, and must, prepare for data collection, by its nature ethnographic research has to be able to respond to what the researcher is observing and learning, rather than her preconceived ideas of what she may find.[191] I analysed the data during the data collection period to look for emerging themes. I was able to see when my interview schedule was not eliciting in-depth enough data and I chose to revise the schedule during the study to ensure sufficiently rich data was collected. It also made me aware during the data collection period already how the data emanating was different from what I had thought would emerge. This allowed me to follow unexpected lines of inquiry and discover patterns and ways of working in the PDoH I hadn't anticipated.

5.6 Data collection

I collected data over one year (July 2017-June 2018), physically travelling to the province. I began by being a participant-observer in several meetings to which my gatekeeper had invited me. I then used purposive sampling to identify other

meetings that I thought would be valuable to observe and identified managers who I thought would be able to speak to the research question. Documentation from or pertaining to these meetings were collected to form additional background information on the meeting content and context. These documents included, for example, financial data, policy documentation and minutes from previous meetings. From there, snowball sampling was used to expand the interview and observation pool, using recommendations from interviewees. No one refused to participate, however, some managers did not respond to several requests. The interviews were one-on-one and mostly took place at the person's workstation with the door closed for privacy. The interviews ranged from 20 to 60 minutes and were audio-recorded where permission was granted. Repeat interviews were not conducted but the grand tour questions were revised during data collection to accommodate the information coming out during data collection.

By the end of the data collection period, I had been a participant observer in ten meetings where a total of 60 individuals agreed to be observed. These ten meetings ranged from routine financial management meetings to service delivery planning meetings. I also interviewed 30 managers across the study setting (Table 7). With my supervisor, I determined when data saturation had been reached by identifying when no new information was arising.[192] I then concluded the data collection period.

Table 7: Demographic characteristics of interviewees, by level of management and health system[143]

Management level	Provincial	District	Hospital	Finance/ support services	Clinical	Female	Total
Senior	7	3	4	8	6	6	14
Middle	4	8	0	6	6	10	12
Junior	0	4	0	4	0	2	4
Total	**11**	**15**	**4**	**18**	**12**	**18**	**30**

5.7 Data analysis

Observation notes, financial data, other planning documents (such as annual performance plans) and interview transcriptions formed the dataset to analyse. The interview recordings were de-identified and transcribed. After data collection was completed, the complete dataset was re-analysed. This included multiple readings and reflexive journaling of what I felt was emerging.

Thematic analysis methods were used to analyse the data. The aim of thematic analysis is to find patterns and shared meaning across the data to identify key themes that answer the research question. Using this method, I identified three high-level themes, supported by my supervisor, which formed the basis for the three papers in this PhD.

The dataset that fell within each high-level theme was then re-analysed again, using deductive methods once a suitable conceptual framework had been found to frame the findings.

5.7.1 Approach to thematic analysis for integrating narrative in the thesis

Ahead of writing the integrating narrative chapter for this thesis, I conducted another thematic analysis using the three papers emanating from this research. I did this to ensure that the integrating narrative was responsive to the overall findings and cross-cutting themes from the research, rather than just a repetition of the findings in the papers. I approached the thematic analysis for the integrating narrative section as follows:

1. Several readings of the papers as a cohesive set, testing out the ordering of the papers. I determined the order of the papers based on the way they built on one another to best answer the research question. The rationale for the ordering of the papers was as follows: The medicolegal claims paper (Paper 1) is about how the province landed up in its constrained financial position, and the frustration between clinicians and finance managers that arose as they tried to solve for the claims crisis. This partly contributed to the decision to centralise financial management - because there was an outpouring of service delivery funds to pay claims and the lack of trust in service delivery

managers to deal with funds responsibly. The effects of this decision to centralise financial management are then discussed in paper 2, explaining the impact of this decision on the PDoH's culture (Paper 2). The third paper discusses how the PDoH can improve its functioning, and what it could do differently even within a centralised, and financially constrained environment. Therefore, the paper order reflects the chronological order of the PFM reforms.

2. Once I had determined the order, I drew out the key findings from each paper. These were determined during the deductive data analysis and write-up phase for each paper. I documented these on a mind map, so I could analyse all the findings and themes in one place.
3. I then looked for similarities and overarching thematic areas across the papers to determine the high-level themes for the integrating narrative. I did this on the mind map, using different colours to represent the different themes and arrived at four themes from this PhD research that answered the research question and objectives of this research.

5.8 Engaging with theory

During protocol development, I had selected an analytical framework for this research. As data began to emerge, I realised that the framework chosen was not optimal. As a result, I re-engaged with the literature during data collection and analysis to find more suitable theory to frame the data within.

I started with the HPSR Methodology Reader (2012) to further explore the field of HPSR, within which this PhD is situated.[180] The HPSR body of literature is multidisciplinary by nature. The system software and resilience bodies of research within HPSR led me to the organisational management literature, as I wanted to further understand the social science theory these frameworks were seeded within. This afforded me the opportunity to explore several areas of research, strengthening my understanding of HPSR theory and allowing me to further contribute to it.

Using the EBSCOhost multidisciplinary database, I used search terms such as organisational management, public management, and institutional theory to identify relevant organisational management literature. I linked these terms using boolean operators with the systems software components (for example: "organisational

management" AND "power"). I also followed references within certain key papers, which expanded the range of literature reviewed.

Given that this research focused on managers' experiences of public financial management, which is a key function of public administration, the literature review was expanded to include any relevant public administration theory that may support the framing of my data. I used Google Scholar and EBSCOhost with the search terms 'public administration' and 'public financial management' to review the pertinent literature. I also linked these terms using boolean operators with the systems software components to narrow the boundaries of my search.

In the end, the frameworks chosen for papers 1 (Veneklasen and Miller's (2002) expression of power framework) and 2 (Mbau and Gilson's (2018) framework of the relationship between organisational culture, practices and policy implementation) had been used in HPSR literature before. These frameworks are seeded in the power and organisational management social science theory, and my review of social science literature strengthened my ability to engage and use these frameworks in my research.

Veneklasen and Miller framework was selected for Paper 1 because of its amalgamation of the power frameworks that came before it and because it allowed for both positive and negative conceptualisations of power, providing nuance to the analysis. Mbau and Gilson's (2018) framework for analysing the influence of organisational culture on health systems was selected to frame Paper 2 given its crossover between organisational management and health systems theory.[2] The drawing together of these two disciplines was novel and was suited to this research that also aimed to elicit evidence on the way that organisational culture influenced health system functioning.

The framework used in Paper 3 (Agranoff and McGuire's (2001) collaborative public management framework), to my knowledge, has not been applied in HPSR literature before, and is drawn from the public administration body of literature. It was selected to allow this research to contribute to the gap in understanding of how to facilitate a more collaborative and participatory culture. It also allowed for practical recommendations of how to improve health systems functioning, ensuring this research contributed not only to theory but also to health system praxis. All three

frameworks have strong relational and systems software components that provide a unifying thread through the three papers.

5.9 Trustworthiness of the research

In qualitative research, rigour is most often referred to as 'trustworthiness'. Trustworthiness is assessed using four criteria: credibility, transferability, dependability, and confirmability.

5.9.1 Credibility

Credibility refers to whether others (researchers who have read your data or study participants) find the same patterns and themes from the data and agree with the interpretations made during analysis.[193] In this research I ensured credibility in four ways:

Audit trail

An audit trail allows another researcher to easily follow the decisions and choices made by the primary researcher during the research period.[193] Documenting notes, interview transcriptions, key decisions during the research process and decisions with regard to key themes emerging all form part of the audit trail for qualitative research. I used a clear audit trail during this PhD to support credibility.

Peer debriefing

My supervisor read and appraised my coding of all the transcriptions. She was not present in the interviews, but was familiar with the study setting, and therefore she was able to assess whether the interpretation was accurate and fair, given the presented data.

The research (anonymised) was also presented to the head of health at the National Treasury, an independent, expert health system researcher and a senior researcher at the University of Witwatersrand who has spent substantial time in the province. Both were able to confirm that the themes and broad findings accorded with their understanding of the challenges managers experiences as a result of PFM reform and practice.

Prolonged engagement

By focusing the research on one province, I was able to continue data collection over a full year, allowing for deeper immersion and more opportunities for observation (participant and non-participant) and interviewing as new information came to light. This supported data saturation as well.

Member-checking

A member-checking workshop was used to discuss the research findings with the PDoH. Everyone within the head office, the two district health offices and the four public hospitals studied were invited to the workshop. The workshop was held over one day and was interactive, asking participants to engage on the findings and give their opinion on the proposed recommendations. The managers supported the findings as a true reflection of their contributions and an accurate representation of the major challenges for the PDoH within the financial management environment.

5.9.2 Transferability

Transferability is intended to support other researchers who may want to use the findings from this research and test or apply them in a different setting.[193] It is facilitated through a 'thick description' of the data. Thick description means that the researcher gives details on the study setting and provides the context for her interpretations and findings. The researcher includes the meaning and motivations behind interactions by providing 'rich' details of the situation. The three case studies in this PhD provide these thick descriptions to facilitate transferability.

5.9.3 Dependability

Dependability is difficult to truly achieve in qualitative research, as many have argued that the data are 'frozen in the ethnographic present', making it difficult for anyone else to replicate even with the same participants, study setting and questions.[194] However, Lincoln and Guba (1985), the founders of the trustworthiness criteria for qualitative research suggest that credibility is strongly linked to dependability and using multiple methods and triangulation of data is sufficient for dependability of qualitative research.[195] This research achieved this through the mix of data collection methods, including interviewing, observation and document analysis.

5.9.4 Confirmability

In qualitative research, confirmability refers to the research being a true reflection of the study site and participants' experiences.

Reflexivity

One way to safeguard confirmability is to have a strong reflexivity practice during research, where the researcher documents her biases and assumptions during data collection that can help to colour or explain her interpretations or perceptions of the data during analysis.[194]

I kept a reflexive journal during data collection, wherein I documented aspects about myself (values, beliefs, my background and relationship to the study site and participants) as well as my thoughts during data collection and analysis. In the journal entries I identified biases kept notes on the meaning I was making from the observations and interviews conducted and described my feelings on the research process (ease of entry, engagement with participants and content I was unsure of or was different from what I had heard before). During data analysis, I also wrote down a short reflection after reading each interview transcription for the first time ("memoing"), documenting what I thought had emerged from the interview and any notable features of my interview style or the way the interviewee responded during the interview. I, with the help of my supervisor as an objective voice, constantly tried to interrogate the way my presence was influencing the data being collected (or my interpretation of it), particularly given that I was known to many of the participants.[196]

5.10 Changes to the original aims and objectives of the research: reflecting on the qualitative research journey

The title, aim, and objectives of this PhD had to be re-worked once data collection was complete because the initial conceptual framework I had chosen during my protocol development phase (Cloutier et al (2016)[55] described in section 3.3) was not ideal for the data that emerged. Furthermore, the institutional work theory language had been embedded in the aim and objectives framing, requiring rewording to make them less specific to that particular analytical framework. However, the research still ultimately aimed to answer the same question around how managers across different units in the PDoH experienced the tensions between service delivery and

financial management and the impact of this on the ways they worked together in the organisation. Therefore, the research question and intention of the study remained the same, and the data collection tools were not reworked because of the initial conceptual framework being dropped. In Box 1, the original aim and objectives of this research are documented.

Box 1: Original PhD title, aim, and objectives as described in protocol

Original title (de-identified): The impact of institutional work on policy implementation in South African Departments of Health, with a focus on financial management, planning, and service delivery units.

Original aim: To describe, explain and compare the practices ("institutions") occurring within financial management and related units, the institutional work being done by middle managers and support personnel, and to examine the impact of this on policy implementation.

Original objectives:

1. To describe the 'practices' of financial management and related planning and service delivery units within the National DoH, two provincial DoHs and four district health offices
2. To describe, explain and compare, across the different departments of health (DoHs) and district health offices (DHO) studied in objective one, the following:
    - 2.1 How the organisational context (e.g. availability and mix of staffing, management style, communication strategies) affects the practices of financial management and related units
    - 2.2 The institutional work (conceptual, structural, operational, and relational) taking place in financial management and related planning and service delivery units in the implementation of new (e.g. NHI) and existing (e.g. PFMA) policies
    - 2.3 How the institutional work taking place coupled with the organisational context impacts policy implementation within financial management and related planning and service delivery units

3 To conduct a literature review of institutional work in public bureaucracies in low- and middle-income countries (LMIC) to explore the existing body of knowledge and contribute to gaps in understanding through the findings of this PhD.

4	To use the findings from objectives 1-3 to build on the existing conceptual framework used in this study, to describe how institutional work impacts policy implementation in financial management and related units.
5	To develop recommendations on how DoHs across and within all levels could improve their functioning by understanding what institutional work is taking place and how to respond to this to improve the success of policy implementation.

At the time of writing the PhD protocol, I had worked for four years at the National Department of Health as a secondee from the Clinton Health Access Initiative: South Africa. In that role, I joined the policy-coordination and integrated-planning unit for the first two years and then moved to the provincial financial management support unit, for the last two years. Both units were inside the NDoH and in both roles I travelled extensively to public health facilities, district health offices and PDoH head offices. I was fortunate enough to be involved in efforts to improve the relationship between planning and financial management and in building mathematical ways to measure the relationship between finance and service delivery outcomes.

I decided to start a PhD because I wanted to capture some of the challenges I had witnessed that made it hard for finance and service delivery managers to work seamlessly together to conduct the business of a department of health. I was particularly interested in the health system software theory, best described by Sheik et al (2011)[13], that provided a lens for me to understand some of the reasons behind the fragmented way of working between finance and service delivery-facing teams of which I had become acutely aware.

At the time of writing my protocol, I felt that the institutional work body of literature would best capture my findings. The institutional work literature, and particularly Cloutier et al's (2016) contribution, highlighted a firm dependency on 'relational work' for policy implementation success.[55] Therefore, the system software element was well-represented. Institutional work focuses on how actors are able to maintain, disrupt or transform their institutional structures.[197] Given the anticipated rollout the National Health Insurance (NHI) in South Africa, and the expected health sector reforms that would emanate, Cloutier et al's (2016)[55] use of institutional work to understand public sector reform appeared apt for my PhD research. I had anticipated being able to use their framework to unpack and understand how existing practices

were being disrupted or transformed and how new NHI-related policy was being developed and designed. Particularly, because UHC is deeply reliant on an effective public financial management system, I expected policy reforms in the name of NHI and more broadly, UHC, to create opportunities for examining institutional work related to PFM in provincial departments of health. Furthermore, from my work across the country, I had anticipated hearing about how staffing and resource shortages hampered the PDoHs' ability to implement policy - expecting to see sound policy design fall short in the implementation space. These expectations and hypotheses resulted in my five objectives for the PhD.

I started data collection in one province, with the intention of moving onto a second province. However, I never received ethical approval for the second province (despite multiple attempts and a conversation wherein they supported the research). This presented an opportunity to become deeply embedded in the first province and follow the PDoH and its staff over the course of a full year.

I learned quickly during the data collection period that at a provincial level, fitting national policy into provincial contexts was difficult. The rollout of the district clinical specialist teams (DCSTs) provides an example. The DCSTs formed part of the preparations for NHI and required the PDoH to hire new medical and nursing specialists to strengthen district clinical governance. However, in parallel to this, the PDoH had begun a process to consolidate their organogram and downsize their staffing complement, as per the provincial treasury's advice to the PDoH to bring its employee costs down. While in the beginning, the funding of the DCSTs came from NDoH, the expectation was that the province would take this funding over relatively soon. The result was a PDoH divided - with a clinical team desperate to attract specialists to a rural province and a finance team desperate to decrease the wage bill. I found that participants really wanted to talk about how financial management centralisation and the narrowing budget for health had fractured the working relationship between the finance team in the PDoH and the rest of the health system.

During data collection I conducted data analysis as data emerged using thematic analysis, which allowed me to find patterns and key themes in the data. I allowed my preliminary analysis to guide me as I continued data collection and I did not attempt

to ‘fit’ my data to the chosen framework. Rather, I continued to observe and interview participants, deepening my understanding of their experiences and my findings.

Once data collection was complete, I re-analysed and engaged with my data. After multiple readings, thematic analysis, and sense-making discussions with my supervisor, I felt the institutional work body of literature was not the most suitable framing. To be richly applied, the framework requires specifics on policy implementation from conceptualisation through to the implementation. Given that I had come in after centralisation had already been implemented, I was missing crucial information on the conceptual and structure institutional work that had taken place.

My research had elicited rich findings on the organisational culture and power dynamics of the PDoH and I re-engaged with the social science and HPSR literature to situate my findings within the appropriate theoretical body of literature. This process of sense-making is not unusual for qualitative research and unwillingness to apply an ill-suited framework to your data improves the trustworthiness of the findings.[195]

Although my process turned out to be more iterative than intended, I feel my findings have been enriched, and the trustworthiness of the research strengthened, by my final choice of theoretical frameworks.

CHAPTER 6. THE STRUGGLE BETWEEN CLINICAL AND FINANCE MANAGERS: A QUALITATIVE CASE STUDY OF ONE SOUTH AFRICAN DEPARTMENT OF HEALTH'S RESPONSE TO ITS MEDICAL NEGLIGENCE CLAIMS CRISIS

Jodi Wishnia and Jane Goudge

(Undergoing revisions with the journal)[xii]

[xii] This article is currently in draft as I work through reviewer comments. The version in this thesis is therefore not the final published paper.

International Journal of Health Services

Journal:	*International Journal of Health Services*
Manuscript ID	IJHS-21-0414
Manuscript Type:	Original Research Article
Keywords:	power, medical negligence, public financial management, health systems

The struggle between clinical and finance managers: A qualitative case study of one South African Department of Health's response to its medical negligence claims crisis

ABSTRACT

While many governments in lower- and middle-income countries' (LMICs) have successfully expanded access to services, quality has not improved to the same extent. In most LMICs, medical negligence claims go through the 'fault-based' civil law process with no payment ceilings, and the number and size of claims have grown in the last decade. South Africa, a middle-income country, is attempting to improve quality of care in the public health sector as it grapples with a high number of negligence claims which divert health funding. A case study design with ethnographic methods was used. We show the extent of the negligence claims problem at a country level to provide context and then provide a case study from one of the affected Provincial Departments of Health (PDoH). We analyse the PDoH's response to its claims crisis, and the underlying power dynamics that determined the success (or not) of the chosen strategies. Finance managers had substantial power given the constrained financial environment and the shift to financial centralisation. Power struggles between finance and clinical managers occurred during the selection, design, and implementation of the chosen strategies. A lack of engagement and consensus-building on the strategies between these managers resulted in resistance from clinical managers for some of the strategies, further weaking the possible positive impact. The exploration of the distribution of power in designing the PDoH's response its claims crisis provides evidence of the importance of a power lens in health policy analysis.

Running head: The struggle between clinical and finance managers in responding to a medical negligence claims crisis

INTRODUCTION

The goal of universal health coverage (UHC) is focused on reducing catastrophic health expenditure and improving access to quality care.[1] While many governments in lower- and

middle-income countries' (LMICs) have successfully expanded access to services, quality has not improved to the same extent[2,3]; the recent Lancet commission found that poor quality in LMIC public health systems has become more of an impediment to preventing mortality than a lack of access to care.[4] The World Health Organization (WHO) estimated that it would cost approximately USD923-1,471 billion in additional health funding between 2016-2030 to achieve the health related Sustainable Development Goals in 67 LMICs[5] and is optimistic about middle-income countries' (MIC) ability to fund the necessary improvements.[5]

In many high-income countries, a more empowered patient population, aware of their rights to quality care, combined with weak regulation for managing malpractice claims, led to a substantially higher number, and quantum, of medical negligence claims (for example Australia and the United Kingdom).[6,7] This led to a shift to a 'no-fault' system for dealing with claims in some countries, or the establishment of payment 'ceilings' to control costs if the 'fault-based' legal system remained.[8–10]

However, in most LMICs, negligence claims go through the 'fault-based' legal system with no payment ceilings, and claims have continued to grow over the past decade (e.g. Malaysia, India, Bangladesh and Nigeria).[9,11,12] If the litigation is directed at public health departments (rather than individuals), already constrained health budgets can come under pressure, and the resources available to make the required improvements in the quality of care are reduced. Countries with active legal industries (more common in MICs than LICs) that have become aware of the vulnerability of health departments to litigation, are more likely to experience a growing number of claims. And so, it is critical to explore ways to mitigate the impact, and reduce the number of claims, especially where fault-based legal systems, without payment ceilings, remain in place.

South Africa, a middle income country, is attempting to improve quality of care in the public health sector[13] despite a narrowing fiscal envelope.[14] The number of medical negligence claims is high and has continued to rise[15] and the country has failed to implement payment ceilings or move away from its 'fault-based' system. This has created pressure on departments of health to determine a strategy for curtailing and managing negligence claims. In this paper, we explore the power struggles that took place between finance and clinical managers in one provincial department of health (PDoH) while crafting and implementing their negligence claims strategies. We examine the influence of these managers' power using Veneklasen and Miller's (2002) 'expressions of power'[16] framework, and its impact on the effectiveness of the chosen strategies.

BACKGROUND

Poor quality care can result in high levels of mortality (death) and morbidity (disability)[17] and can expose health authorities to the risk of litigation. Medical negligence is commonly understood as actions, or inaction, by a healthcare worker (HCW) that resulted in a patient safety incident (PSI). This is referred to as 'discrete' negligence. 'Systemic negligence', also known as 'vicarious liability' takes into account the systemic challenges in health systems (for example, staffing shortages and inadequate medical equipment) that can coalesce to result in a PSI.[18,19]

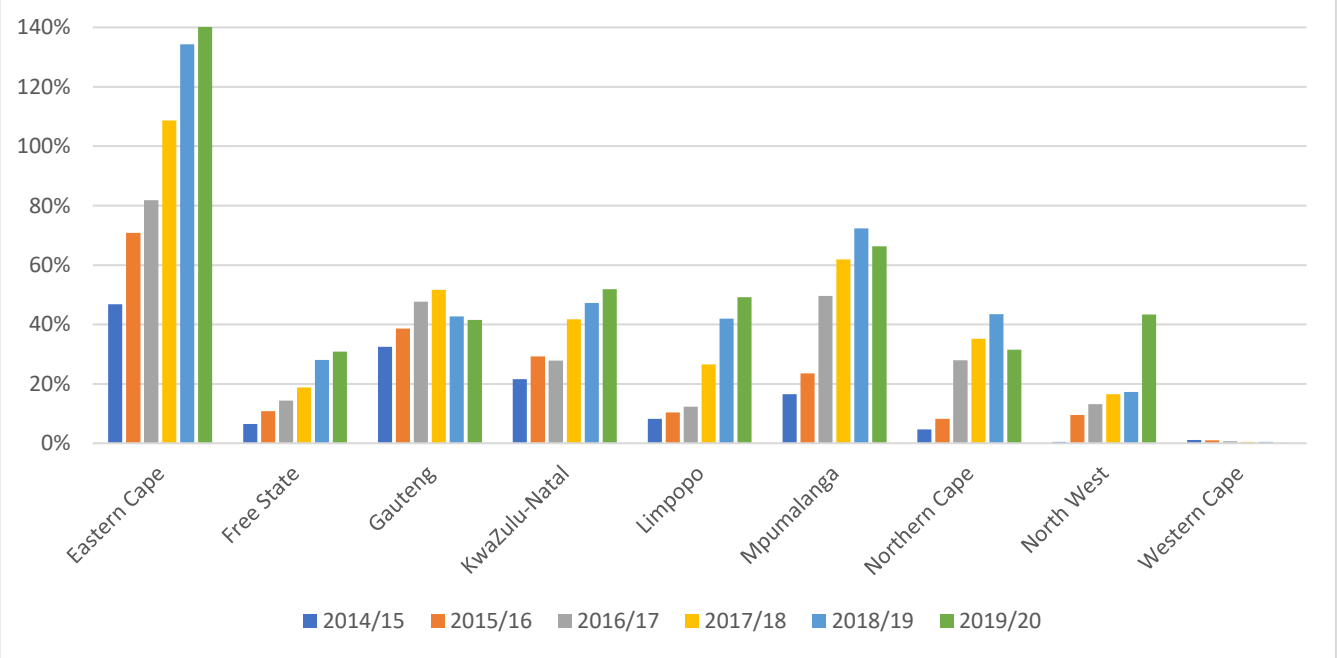
Most countries use one of two main systems for medical negligence claims. The no-fault system is where a person is compensated without having to prove negligence through the court system. The quantum of payments in a no-fault system are regulated, making them more predictable, which allows the government to control the costs better.[20] Most importantly, it makes the process of claiming easier, with no associated legal fees.[10] The fault-based system is where patients need to prove negligence, and this is done through the courts, with a heavy reliance on lawyers and subsequent legal fees for the claimants and defendants.

Medical negligence litigation in South Africa

In the South African public health sector, claims are levelled at the PDoH (not individual HCWs) and are paid from the PDoH's budget.[21] Contingent liabilities are claims that have been made against the PDoH but have not yet been settled. The total contingent liability is always higher than the actual amount due after settlement, as some of the claims may be false or without merit. This is partly driven by the 'no win, no fee' strategy introduced by the legal industry which both supports case-finding and removes financial barriers to litigation[i].[22] Once settled, these convert to liabilities in the public financial management (PFM) environment. The detail of these liabilities are not published by the PDoHs and the amount paid each year is more often a function of the PDoH's available cashflow, rather than what is due. This makes it difficult to understand the true impact of claims on the health system.

In the 2018/2019 financial year, the provinces with the highest contingent liabilities were the Eastern Cape (EC), KwaZulu-Natal (KZN), and Mpumalanga (MP) (Figure 1).[15] Notably, the EC and MP show contingent liabilities greater than half their annual budgets (respectively 134% and 72%). In the same year, the EC, Gauteng (GP), and KZN showed a substantially higher than average claim value, as compared to the country average (respectively 151%, 48% and 41% higher). This reflects the lack of standardisation and/or payment ceilings, in claim pay outs. The better governed provinces tend to provide higher quality care and have more effective medical negligence response teams. This results in lower levels of contingent liabilities, and lower average claims, as they are better able to defend themselves. As a result, lawyers submit a lower number, and value, of claims. For example, the Western Cape (WC) has established a dedicated interdisciplinary (clinical, finance and legal) medical negligence unit that ensures all claims are investigated for validity, money is disbursed appropriately and funding is returned when the claimant passes away, avoiding unnecessarily high claim pay-outs.[23] This stronger process is reflected in the province's relatively low number of contingent liabilities.

Figure 1: Contingent liabilities as a proportion of provincial health budgets: 2014 – 2020

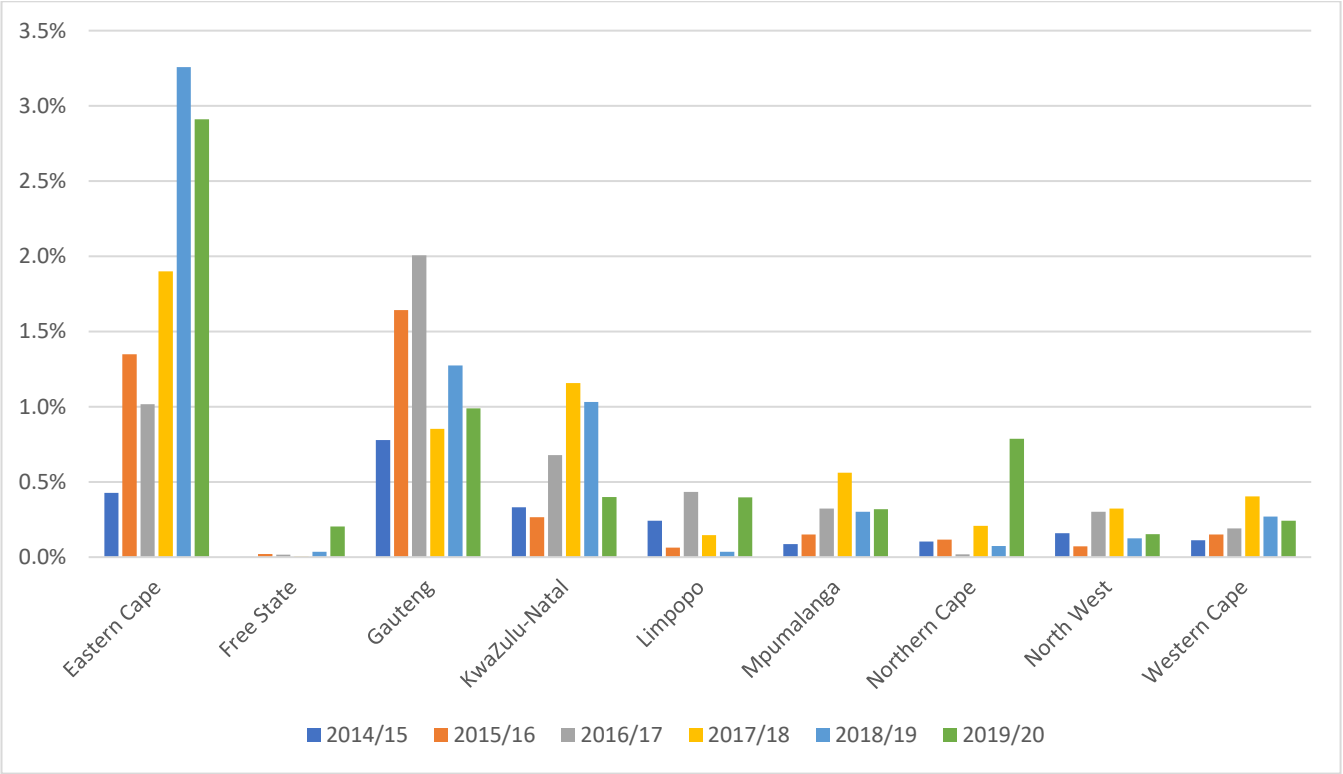


Data source: Actuarial Society of South Africa's 2021 report[15]

[i] We support patients' right to justice in the event of medical negligence, however there is a limit to which public health systems can pay from their existing budgets and continue to provide quality care. Therefore, in the current legal system, there needs to be a balance between justice and affordability, to ensure the public health system can still provide quality care for all who are reliant on its services.

Three provinces (EC, GP and KZN) have had to pay out the largest share of claim pay outs between 2014 and 2020 - an indication of the growth in negligence liabilities in these provinces (Figure 2). The EC is a mostly rural province, with ailing infrastructure and poor health outcomes; in the past five years the amount paid out in claims has risen to 3% of the total health budget, although total negligence liabilities likely represent a far higher proportion. GP, the urban heartland, has the largest and fastest growing population and an overstretched public health system; it paid 2% of its health budget to settle negligence claims in 2016/2017, but this dropped to 1% in 2019/2020.[24] KZN has the highest burden of HIV in the country and also has rural facilities that require major overhaul. In 2017/2018 it paid just over 1% of its health budget toward negligence claims, but this dropped to less than half a percent in 2019/2020.[25] All three have a history of poor governance.[26] The Northern Cape (NC), a sparsely populated, predominantly rural province, shows a concerning increase in 2019/2020 (0,1% to 0,8%). This could be driven by the relatively small health budget the NCDoH receives, which means that large claims have a more profound impact on the health budget.

Figure 2: Amount paid for claims as a proportion of provincial health budgets: 2014-2020



Data source: Actuarial Society of South Africa's 2021 report[15]

Claim payments are most often made from the 'goods and services' (G&S) budget (which includes, for example, medication, infection control and cleaning supplies). Settled, but unpaid claims accrue interest at 10.5% per annum in the PDoH studied, and these late payments further increase the PDoHs financial liability and reduce available funding for health services and improvements, creating a vicious cycle.

The causes of medical negligence claims in South Africa centre on five broad areas: (1) changes to the South African Road Accident Fund that led malpractice lawyers to shift attention to medical malpractice cases where there was less scrutiny, (2) a fault-based system that situates medical negligence claims within the common law, leading to escalating costs of claims, (3) a lack of reform even within the fault based system to impose payment ceilings to ensure standardisation across claim types, (4) improved understanding of patient rights and the

heavier weighting toward patient autonomy and care evident in South Africa's legislative environment, which leads to more frequent judgments in the patient's favour and, (5) declining quality in the public health sector due to financial constraints, corruption and poor governance (which result in systemic negligence).[21,27,28]

Since 2012, South Africa has been attempting to reform the way negligence claims are dealt with. The State Liability Amendment Bill (tabled in parliament for comment in 2018) suggests that PDoHs be allowed to pay for claims using 'structured payments', over the period of the claimants lifetime, lessening the financial impact in the immediate term and ensuring payments intended for care and care-giving continue only for as long as the claimant is alive.[22,29,30] In 2021, the Constitutional Court (the highest court in South Africa) amended two pieces of legislation that would allow PDoH's to pay for claims in tranches rather than in one lump sum and would allow for non-financial compensation. These rulings are likely to start impacting on the way claims are adjudicated and begin to both lessen the financial impact and ensure victims receive compensation in a more timely manner, as the PDoH's can start the payment process without having to have the full amount available upfront.

Despite this recent success, the State Liability Amendment Bill has been returned for further work due to concerns that victims would not receive their due compensation because PDoHs would not have the sufficient administrative capabilities to make these regular payments reliably. The Road Accident Benefit Scheme (RABS) Bill attempted to shift South Africa's Road Accident Fund (from which South Africans are allowed to claim compensation) from a fault-based to a no-fault based scheme.[31] The Bill was unanimously rejected for very similar reasons. The experience from both Bills has highlighted the strength of the private legal sector (who played a strong lobbying role around citizens' rights to legal recourse) and the concern that the State would be allowed to continue to provide poor quality with no consequences, with many believing that the negligence claims were a way to incentivise better behaviour. Citizens and associated organisations voiced concerns that the victims would not be able to claim or wouldn't receive due compensation under the no-fault or structured payments environment (without the enforcement by the court), impacting on their access to justice, a constitutional right in South Africa.

Since the 2008 global recession, the South African Treasuries have been trying to reduce spending due to a worsening economic climate as a result of slower economic growth and an almost doubling of its debt ratio.[32] This has resulted in only small real increases in the health budgets per province between 2010 and 2019, and Treasury forecasts a contraction over the medium term (2021-2024).[14,33] South Africa also experienced a period of 'state capture' between 2009 to 2018, wherein large-scale corruption was systemic to the country through a network of political actors.[34] This further reduced available funds for service delivery, impacting on both quality and availability of public health services.[35] The resulting shortages of clinical and support staff and essential goods and services increase the risk of patient safety incidents. The political economy of South Africa's health system has largely been overlooked, and the political dynamics that have been illustrated through the emerging 'state capture' analysis provides insight into how the macro-political environment has influenced health service delivery (policies and practices).[36] This includes how corrupt practices have made the health system more susceptible to negligence claims, both from the perspective of touting lawyers and health personnel who may sell confidential health records to lawyers, rendering the department unable to defend itself adequately.

In response, PDoHs have begun to overspend on their budgets, generating high levels of accruals for services received but not yet paid for. These accruals grow year on year as the department has insufficient budget to settle these liabilities in the new financial year (Table 1). A proportion of the accruals is for medical negligence claims and the remainder is for services

procured (e.g., patient food) but not yet paid for. While GP, Limpopo and Mpumalanga show a positive trajectory in reducing their accruals between 2016/2017 and 2019/2020 (-42%, -64%, -70%), the EC, Free State, NC and WC show the highest growth in accruals (99%, 79%, 71% and 71%) respectively. In EC, NC and North West, accruals amount to 10% or more of annual expenditure.

Table 1: Growth in unpaid accounts, 2016/17 to 2019/20 (ZAR'000)

PDoH	2016/17 Unpaid accounts	2019/20 Unpaid accounts	Growth in unpaid accounts: 16/17-19/20	Accruals as a proportion of 19/20 expenditure
Eastern Cape	1 914 103	3 808 168	99%	15%
Free State	375 337	672 292	79%	6%
Gauteng	7 023 682	4 093 273	-42%	8%
KwaZulu-Natal	1 306 421	1 585 784	21%	4%
Limpopo	1 099 444	390 871	-64%	2%
Mpumalanga	794 682	239 826	-70%	2%
Northern Cape	294 518	503 672	71%	10%
North West	751 711	1 240 480	65%	10%
Western Cape	301 119	515 282	71%	2%

Source: South African National Treasury 2020

The South African public health sector has embarked on initiatives to improve quality of care, including efforts to accredit public health facilities and standardise quality.[13,37] For example, the "Ideal Clinic" project aims to ensure all primary healthcare facilities in the country provide the same quality care and almost all the public PHC clinics have been assessed and have plans for their improvement.[37] Another example is the introduction of an electronic system to alert facility managers when medicine stock needs replenishing, to avoid stock-outs.[38] However, many of the negligence claims arise from incidents that happened ten years or more ago[22] and so the efforts to improve quality today, will only bear fruit in several years' time. This therefore requires retrospective and prospective strategies for medical negligence claims.

CONCEPTUAL FRAMEWORK

Improvements in quality and/or the attainment of UHC are intrinsically linked to the quality of leadership and management in a health system.[5] Leadership that focuses on interpersonal relationship building and distributes power more equitably has been shown to be more effective.[39] Using power analyses in health policy and systems research (HPSR), still relatively new[40], allows for a greater understanding of how and why decisions are made and by whom, and the impact of these decisions.[41]

In this paper, we use Veneklasen and Miller's (2002) 'expressions of power'[16] to understand the PDoH's choice of strategies and their implementation by managers in the health sytem. This framework argues for a 'relational' view of power, recognising that the way power is expressed is intimately linked with a person's context, relationships and personal interests.[41] The four expressions of power are power within, power to act, power with and power over. While the original framework was developed to support the analysis of power across many different stakeholders, in this paper we focus only on two key stakeholders - finance and clinical managers in the PDoH. These two groups are critical roleplayers in determining how the claims crises affects the health system on a day to day basis.

'Power over' is the most commonly analysed form and it relates to the ways in which people use their power over one another to exert their will. It is always perceived as negative because it

uses hierarchy rather than consensus. ‘Power within’ relates to an individual’s belief in their own ability to effect change according to their values. ‘Power to act’ is when an individual has sufficient power to be able to do something to effect the change they wish to see and links closely to ‘power with’, which describes how people use their alliances with others to achieve common goals. We have grouped ‘power to act’ and ‘power with’ for the purposes of this paper (Table 2).

Table 2: Adapted from the expressions of power framework[16]

Power type	Definition
Power over	Power over is often seen as the most negative expression of power. It is undemocratic in its approach and inherently hierarchical as it is most often used by senior managers/leaders.
Power within	Power within is about an actor’s self-belief that they are capable, knowledgeable, and able to effect change.
Power to act and power with	Power to act is when an individual has sufficient power to be able to do something to effect the change they wish to see. ‘Power with’ is shared power with others to achieve these changes.

METHODS

Study design

In this paper, we used a case study design coupled with ethnographic methods. This approach is useful when a researcher would like to understand a particular pattern of behaviours and actions.[42] The research was collected within the participants’ everyday setting. This facilitated a deeper understanding of the relationships between actors and how power influenced the strategies chosen and their effectiveness.

Study setting and positionality

The case study took place in one of the nine PDoH’s in South Africa. JW knew many of the senior and middle management in the PDoH from her previous role in the South African National Department of Health through which she conducted many oversight visits from a health planning and financial management perspective. JW has an in-depth understanding of the province’s financial and service delivery performance, and her positive working relationships facilitated easy rapport and trust-building during data collection. JW approached a senior finance manager (the gatekeeper) about the research and the gatekeeper then sought approval from executive management, after which approval was granted. She was able to recruit more finance managers than clinical (18 vs 12) given more substantial work in the financial management space.

Both the provincial research committee and the University of Witwatersrand’s Human Research Ethics Committee (Medical) approved the research (M170346). Informed consent leaflets were used when collecting data, wherein participants were assured of anonymity both individually and of the province studied.

Participant selection

The research was conducted at the PDoH head office, two of the district health offices (DHOs) and four public hospitals. JW was a participant observer in ten meetings through which 60 individuals were observed. These ten meetings ranged from routine financial management meetings to service delivery planning meetings.

JW began with purposive sampling, contacting officials who she knew were involved in the province's claims strategy. From there, she used snowball sampling to expand her interview pool to other managers working in a clinical or finance team. No one refused to participate, however a few managers never responded to several requests. Table 3 shows the demographic characteristics of the 30 interviewees.

Table 3: Demographic characteristics of interviewees, by level of management and health system

Management level	Provincial	District	Hospital	Finance/ support services	Clinical	Female	Total
Senior	7	3	4	8	6	6	14
Middle	4	8	0	6	6	11	12
Junior	0	4	0	4	0		4
Total	**11**	**15**	**4**	**18**	**12**	**18**	**30**

Data collection

JW collected data over one-year (July 2017-June 2018). Participant observation, document analysis, observation notes and semi-structured interviews were used. The document analysis included data that showed the province's financial standing with respect to claims, published by the PDoH and by external sources. For the observations and the interviews, data was collected in-person. JW used an observation guide to structure her insights and a semi-structured interview guide that employed a 'grand tour' approach for her interviews. A grand tour approach sets a scope for an interview, but allows the interviewees to decide which topics within the scope they want to focus on. It is useful for eliciting a thick description. JW and JG developed a set of grand tour questions for each level of the health system. The interviews were one-on-one and mostly took place in the person's office with the door closed. The interviews ranged from 20 to 60 minutes and were audio-recorded with permission. Only one interviewee refused to be recorded; they felt this would allow them to be more open in the interview. Repeat interviews were not conducted but the grand tour questions were revised during data collection.

JW and JG discussed when no new data was emerging and ended data collection when saturation had been reached.

Data analysis

Observation notes, financial data, policy documents and interview transcriptions made up the dataset. The interview recordings were de-identified and transcribed by an external company, which JW reviewed afterwards for accuracy.

During data collection, JW analysed the data using content analysis methods, and manually looked for emerging common themes. After data collection, JW and JG re-analysed the data and discussed the emergent codes and JW then grouped them into high level themes. Medical negligence claims emerged as one of the high-level themes. For this paper, the authors then

selected the Veneklasen and Miller (2002) framework. We used Dedoose™ to deductively re-code the data, using the four expressions of power as the codes.

Participants are anonymised; a 'p' denotes the PDoH head office, 'd' for the DHO and an 'h' for a public hospital. Observations informed the analysis and coding of the data.

A total of 51 people were invited to attend a member checking workshop, all of whom worked at either the head office, the two DHOs or one of the four public hospitals studied. The one-day workshop was interactive, asking participants to engage on the findings and give their opinion on the proposed recommendations. This ensured credibility and confirmability of the findings.

Reflexivity

JW wrote down her thoughts and potential biases after every interaction with health system actors, documenting her research process.[43] She also wrote a reflection after reading each interview transcription for the first time, documenting what she thought had emerged and any notable features of her interview style or the way the person behaved. JW, with the help of JG, constantly interrogated the way her presence was influencing the data being collected, particularly given that she was known to many of the participants. These notes and insights were used during data analysis to ensure the content analysis was a true reflection of the participants' experience.

RESULTS

The province implemented four strategies to try and mitigate the medical negligence claims crisis: contracting with a private law firm to reduce the liabilities; financial centralisation to contain the financial impact of the claims and generally reduce expenditure where possible; the implementation of a priority hospital strategy that redirected funds to the hospitals with the highest number of claims; and strengthening clinical audits of patient safety incidents (PSIs) that are likely to result in a claim.

Contracting a private law firm

Many managers believed that the rising claims in the province were partly due to weaknesses in the State Attorney's office. The province contracted a private law firm to support the State Attorney to mediate, settle out of court or defend claims in court. The firm managed to reduce the claim amounts due in the first half of 2018/2019 from ZAR1.2 billion (USD80 million) to ZAR548 million (USD36.5 million), a 46% reduction, through a mixture of better administrative capacity and more effective mediation. There was widespread support for this strategy: *"[…] In one case, the department paid R90million, but the original legal opinion was that we can defend the case! That it was not negligence! We are bullied by the defence lawyers about how much it will cost us to hire experts to defend ourselves in courts. […] So, at least now we have got someone who knows what they are talking about. They won't be taken advantage of."* [iH30]. Given the extent of agreement on this strategy, finance and clinical managers worked together to provide the law firm with the information needed to defend the department.

While clinical and finance managers supported this strategy, they also felt the State Attorney was not being held to account for their poor performance and lack of expertise in defending the province: "*The province has begun auditing all the negligence cases, which is good, because they are going to find out what happened. Usually, we just pay the claim! When you arrive in a culture where people do not hold each other accountable, I think that's a problem."* [iP9]. There was conflict about whether this strategy was cost-efficient, especially in the financially constrained environment, given that this function should already be played by the State Attorney.

Financial management centralisation
The financial management centralisation strategy was implemented in 2015 due to the rising medical negligence claims, constrained funding, and associated poor audit outcomes: "*When the medical negligence claims started to flow into the Department, I think the CFO was under pressure, [he] wanted to monitor all expenditure."* [iP1].

Centralisation shifted power to the PDoH top management team (consisting of finance and clinical managers) who made all expenditure decisions. Because the 'centralisation committee' was chaired by the chief financial officer (CFO), it also shifted power within the top management team to the finance managers: *"Sometimes, financial controls override service delivery [needs]. That is where I find this [centralisation] not to be working well." [iP6].*

Most clinical managers felt that the finance team, and to some extent all managers at the provincial level, were not sufficiently knowledgeable about the service delivery context to be making these kinds of decisions: *"If you talk with a manager that comes from a facility, or the district office, that person would know all the challenges at all the levels of the system. But when you talk to someone from the provincial head office, […] you can hear that they don't understand the challenges we are facing." [iH20].*

District and facility managers regularly told the finance team at province that their biggest struggle was not having decision-making power and even finance managers expressed concern: *"With the financial management centralisation policy, the CFO has taken on a responsibility that, I think, is quite risky for him. He's making life and death decisions and he's a CFO; he's not a doctor!" [iP4].* The loss of financial control to the provincial head office affected some managers' perspectives of their own power, with some hospital CEOs removing themselves from financial decision-making: *"It's quite scary, a hospital CEO was asked a question by a PDoH finance official, and she said: 'why are you talking to me? I am not finance; I am the CEO!' I was so shocked."* [iH3].

Priority hospital strategy
Clinical managers wanted to increase the finance team's understanding of how the resource constraints effected service delivery: *"We are burnt out because we are trying to serve patients in a very constrained environment, where you don't have money on a day-to-day basis. I spend my time trying to get money [from the head office] and begging from other hospitals [for resources], just to keep the service going!" [iH30].*

They suggested the finance and provincial treasury teams visit the hospitals most affected by claims to see the impact. They had hoped this would contextualise the reasons for high claims (changing finance and treasury's perceptions that it was purely discrete negligence) and convince treasury of the need for more financial resources across the hospital platform to prevent future claims.

During these visits, the provincial treasury was able to see how the resource shortages were contributing toward PSIs; however, without understanding that communication and collaboration between health care workers played a role in preventing PSIs, the resulting strategy focused solely on providing resources to hospitals with a higher number of claims. This strategy set up a perverse incentive where the more claims made against a hospital, the more additional funding the hospital received, penalising those who, despite inadequate resources, managed to have fewer PSIs. 'Non-priority' hospital CEOs felt punished for learning how to cope with less: "*Each and every time I ask [for something], I am told 'you are not a priority hospital' […] Even when they are procuring medical equipment, they will take the equipment to the priority hospitals only, forgetting that there are patients here! It's very frustrating!"* [iH20]. While clinical managers and CEOs were unsuccessful in changing the

strategy, they did use their power with each other to undermine it: *"We gave our neighbouring hospital some ECG machines because at least when you receive four and there's someone who has none, you prefer to share." [iH20].*

Clinical audit strategy

The last strategy was to conduct clinical audits for every new claim lodged. Clinical audits assess whether care is being provided according to clinical protocols.[44] Health care facilities in South Africa conduct clinical audits in the form of morbidity and mortality (M&M) meetings. The M&M team conducts an audit of the patient folder, and any issues are discussed. The team then decides whether the PSI was avoidable or not. An avoidable event means that there was either clinical (discrete) negligence or systemic negligence (such as not enough staff), rendering the health system liable for any losses suffered by the client.

Despite its name, often only deaths are investigated in the M&Ms, due to time and resource constraints that make it difficult to coordinate these meetings regularly. The long lag time between the PSI and a claim being lodged means it is difficult to find records, or the involved staff, to be able to conduct a comprehensive audit.

Finance managers expressed a distrust of clinicians' ability to self-investigate: *"We have begun auditing all the medical negligence cases, which is good, because they are going to find out what exactly happened. […] Consequence management means you should be able to hold people to account for their actions, but I don't think the Department is doing that because they are coming from the same discipline; they are all doctors!"* [iP9]. Clinical managers acknowledged that clinicians often did not hold each other to account for negligent behaviour: *"I think the nursing manager is not performing her duty to manage negligent staff because she understands when someone says, 'I was [too] busy'."* [iH20]. Clinicians supported one another to avoid unfair disciplinary action, because they believed that PSIs were more often driven by system challenges.

Clinical and finance managers disagreed on the cause of claims in the province. Clinical managers felt that PSIs were predominantly driven by resource shortages: *"Many times, the problems are systems related. It is very rare that you would find that it was because of a lack of skill. It's the resources; human and material."* [iD23]. Finance managers, however, did not believe that one could assume this to be the case: "*Was it negligence or was it a question of [an] under resourced hospital?' If you don't have that investigation, you are going to say you are short-staffed!"* [iP9].

As a result, the provincial head office team decided to use the district clinical specialist teams (DCST), medical specialists and specialist nurses, to conduct the audits for new negligence claims. The DCSTs role in the South African health system is to improve clinical governance at the district level and the head office team hoped the DCST-led M&Ms would result in more accurate, and actionable, findings. Clinical managers supported this strategy because they knew that the DCSTs, who came from clinical backgrounds, were aware of the service delivery context. A DCST member gave her perspective on the most common cause for PSIs: "*Sometimes you find that the flaw is on the clinical side, and that they have not adequately done the monitoring. But mostly, you would find that it was with the system. Yes, a woman has been in this prolonged labour but there was no ambulance and there was no second doctor to do a caesarean section at the hospital."* [iD23]. The DCSTs were able to ensure that the M&Ms took the systemic challenges into account, preventing individual clinicians from being punished for events out of their control: "*If we feel it was negligence [by a clinician], a report is written and filed. But, if it was not out of negligence, if the incident happened because they could not make stones into bread, they did what they could, it is treated as such!" [iD23].*

Clinical managers and DCSTs did also acknowledge that there were avoidable cases that were unrelated to the resource shortages: *"A client came to maternity already having given birth […]. The nurses, even if they were busy, instead of taking that patient and checking if everything had gone well […] they said, 'oh you've delivered, you can go back to your clinic.' The clinic was about twenty kilometres away and when the lady arrived at the clinic [the baby] was dead!" [iH20].* A district manager reflected on what options were available in cases of individual clinical negligence: *"Anybody who has acted negligently is put through a disciplinary hearing. We may take them to their health professions council where he or she is struck off [the roll] by that registering council." [D19].* However, often nothing is done: *"I don't want to lie, there's no consequence management. I think that makes things worse, because a person would know that even if I do this, there's nothing that will be done to me."* [iH20].

The role of power in the success of the strategies

We summarise the expressions of power for the three medical negligence strategies where there was some disagreement in Table 4.

Table 4: Expressions of power observed in each strategy

Strategy	Power over	Power within	Power to act and power with
Financial management centralisation	• Despite wide-spread dissatisfaction with centralisation, finance managers were able to enact and continue this reform. • This power was assumed due to the financial constraints being faced in the department. This illustrated the power associated with managing public funds in the PDoH.	• Hospital CEOs lost confidence in their ability to manage their facility's finances. • After the reform, some CEOs handed over financial decision-making to their finance managers. • This created the illusion of support for the centralisation reform from some hospital CEOs.	• Finance mangers felt emboldened to make service-delivery facing decisions under the centralisation reform. • This strategy left very little space for clinical managers to adapt or resist- lessening power for managers below the provincial head office.
Priority hospitals	• Provincial treasury and PDoH finance exerted power over clinical managers by designing this strategy without consultation. • This resulted in the unintended consequence of penalising those hospitals which managed to provide quality care despite equally constrained budgets.	• Hospital CEOs believed they would be able to convince the provincial treasury and PDoH head office of the role of systemic negligence in the rising claims. They were therefore open to the site visits and expected the result of these visits to be additional funding for the hospitals.	• Once it became clear that only some hospitals would benefit from additional funding, hospital CEOs collaborated to find ways to undermine the strategy. • This resistance took the form of sharing resources and equipment between priority and non-priority hospitals, subverting the strategy.
Clinical audits	• The status quo power dynamics persisted in the system (clinicians protecting one another, insufficient response to evidence of systemic challenges due to centralisation), weakening the positive impact of this strategy.	• The DCSTs felt well-placed to perform this function given their clinical governance role in the districts. They were comfortable running and writing up the audits.	• The DCSTs displayed power with both finance and clinical teams, which lead to their success in leading this strategy • The DCSTs felt well-placed to support facilities in clinical governance improvements arising from the clinical audits, but they were not given sufficient power to act to do so.

DISCUSSION

The PDoH finance team used their power as the holder of the 'purse strings' to design the province's response. Where there was little collaborative planning and power was exerted over others, strategies were not supported or successful. When service delivery, not an area of expertise for the finance team, was directly affected, clinical managers did their best to resist the strategies. The centralisation strategy made resistance very difficult, given the revocation of power, but there was evidence of resistance and collaboration to undermine the priority hospital strategy. The priority hospital strategy only responded to finance-related challenges, missing an opportunity to learn from better performing hospitals, weakening its impact in the priority hospitals and demotivating staff in the non-priority hospitals. The clinical audits presented another opportunity to deepen the provincial head office's understanding of the reason for claims, but insufficient power given to the DCSTs and a lack of remedial action due to poor accountability rendered this strategy suboptimal, too.

The financial management centralisation strategy was the most contentious and there was evidence of the imbalance of power between finance and clinical managers, given the reduction in decision-making and autonomy for clinical managers. The reform was successful in improving financial audit outcomes by curtailing over-expenditure, however, the strategy showed no success in stemming/mitigating claims, evidenced by the continued growth in liabilities. It was also unsuccessful in improving service delivery quality, due to both the curtailment of available funds and the shift in decision-making power away from the facility-level. The skewed distribution of power that resulted in this strategy contributed to its failings. In the pursuit of better managed health systems, centralisation for some activities can provide the benefit of expenditure control and economies of scale in procurement. Decentralisation, however, has been put forward as the best way to ensure health systems are patient-centric, and resources used most effectively for the need- creating some tension between financial best practices and health system best practices.[45] Where decentralisation has been implemented in health systems, it has shown muted success.[46,47] One of the reasons put forward for this is that the transfer of power has been incomplete- central offices and finance managers retain their control with only limited delegations being given to lower level and clinical managers.[46,48] The sharing of power, whether in a hybrid or fully decentralised environment, has been shown to be a key determinant of policy success in health systems.[40]

The priority hospital strategy provided ample evidence for the ways in which clinical managers resisted the strategies that were created without consultation or collaboration. Clinical managers' power to act against the strategy happened below the level of the provincial department, contributing to the gap between policy intention and its actual implementation. Furthermore, the lack of consultation resulted in a strategy that embedded perverse incentives (the more claims you have, the more additional funding you receive), which reduced its effectiveness. The combination of top-down power, that lead to a lack of consultation, and bottom-up resistance, which lead to an 'implementation gap', undermined this strategy. In their interpretive review, Gilson, Schneider and Orgill (2014) suggest that one way to prevent the implementation gap is to understand how discretionary power by frontline managers during policy implementation takes place.[49] They suggest value alignment workshops and other consultatory processes to support these managers in understanding the policy and tailoring it for their particular context. These processes can also be used for clinical managers outside of the facilities (and finance managers, too), building more feedback loops and trust between the levels of the health system.[49]

The finance and clinical managers both supported the clinical audit strategy with its new role for DCSTs, making this strategy easier to implement. The finance team intended to bring in a more objective third party into the auditing process, expecting that this would break-up the power alliances between clinicians and clinical managers. They hoped that

this would begin to root out individual clinicians who were providing poor quality care, reducing the PDoHs vulnerability to future claims. Because the DCSTs were familiar with the clinical context of the PDoH, and aware of the resource constraints, their reports were more readily accepted by clinicians and a more accurate representation of both systemic and discrete negligence. The DCSTs were able to de-politicise the clinical auditing process, increasing the number of M&Ms for PSIs that did not result in death. Freeing the clinical audit space from blame and fault-finding, has been shown to greatly improve clinicians honesty, which in turn provides more opportunity for learning and improvement.[50] One of the recommendations to achieve this is to institute a standardised clinical audit structure, to ensure cases are comparable and trends in improvements or quality issues are easily identifiable.[51] Jepkosgai et al (2022) studied the power dynamics in clinical audit (M&M) meetings in three hospitals in Kenya. They found power to be a limiting factor in facilitating effective clinical audits and suggest that senior managers role model a blame-free culture by both supporting open discussion (of both the positive and negative findings) and by ensuring the remedial actions are implemented.[51]

The generalised financial constraints in South Africa have stifled national quality improvement activities. South Africa promulgated a new accreditation body (the Office of Health Standards Compliance; OHSC) but its work has been limited due to a lack of funds, and no formal process established for how to manage or fund quality improvements needed, a common problem in accreditation programmes globally.[52] Thailand, however, provides a hopeful example of how financial incentives and focusing on process improvements, rather than outcomes, at the start of the accreditation process, can overcome some of these constraints.[53] South Africa's public health system is also funded predominantly through global budgets, and there is no split between purchaser and provider, although this is planned.[54] This has limited changes to reimbursement mechanisms that can incentivise quality care.

The recent Lancet Global Health Commission on High Quality Health Systems concluded that populations must be more empowered to demand and seek out quality care from the public health system.[4] This may result in an increase in medical negligence claims, requiring countries to find ways to better manage claims, at the same time as improving quality. Electronic record-keeping (and a linked electronic health record) is one of the core recommendations. It is crucial for being able to fully assess what happened after the event and provides regular and accessible data that can help highlight gaps in quality across the system or within a particular facility. Paper-based record-keeping is often incomplete, hampering clinical audits and making it difficult to defend the public health system in negligence court cases (especially when cases arise several years after the PSI as is common in South Africa). Mediation has also been shown to be an effective method for managing negligence claims, and can coexist in a fault-based system without requiring legal reform.[55] Mediation can reduce the quantum of the claim, through trust-building between claimants and the clinicians, and the exclusion of the courts and their associated legal fees.[55,56] Mediation is successfully used in many high income countries and its use or the exploration of its use has also grown in middle income countries like South Africa[57], Malaysia[56] and Nigeria[58] as well, as they grapple with rising claims within a fault-based system.

The case study in this paper provides evidence for the ways in which finance and clinical managers can be at odds during periods of crisis, such as the medical negligence context in South Africa. This tension can create a battle for power in health systems, such that a gap may arise between stated policy and its actual implementation.[59] This can be detrimental to health system performance, preventing the system from being able to respond effectively to the stressor or crisis. Ways to ameliorate these power struggles include fostering a more collaborative environment and ensuring more distributed power to allow for localised tailoring and decision-making (to prevent resistance from clinical managers at the coalface).[49]

Limitations
JW was unsuccessful in getting an interview with the State Attorney, who may have been able to shed further light on why the PDoH studied had become so vulnerable to claims. JW also did not live in the study province, which reduced the time she could spend conducting interviews and participant-observations. This was mitigated through longer data collection periods in the field and data being collected over a full year.

CONCLUSION

In a constrained funding environment, senior finance managers may use centralisation to control expenditure, for which they are held accountable. If this choice is made, a collaborative environment is particularly important to ensure policy design and its implementation tackle the causes, are contextually appropriate and are implemented as intended. Middle income countries are likely to see a burgeoning of medical negligence claims, as South Africa has, as patients become more aware of their rights and lawyers become more aware of the State's inability to defend itself in a paper-based and weak governance environment. Therefore, MIC health systems should start the process of shifting to no-fault systems as soon as possible, invest in strong mediation (and medical negligence response) teams and improve on the State's ability to administer complex financing systems as will be necessary under UHC as well to build trust in the State's administrative capacity.

ACKNOWLEDGEMENTS

The authors would like to acknowledge the provincial department of health and all participants for their invaluable contribution to this paper.

REFERENCES

1. World Health Organization. *The Global Push for Universal Health Coverage*.; 2014. Accessed July 20, 2018. http://www.who.int/health_financing/GlobalPushforUHC_final_11Jul14-1.pdf?ua=1

2. National Academies of Sciences Engineering and Medicine. Embedding Quality Within Universal Health Coverage. In: *Crossing the Global Quality Chasm*. The National Academies Press; 2018:227-268. doi:https://doi.org/10.17226/25152

3. Forde I, Colombo F. *Situating Health Care Quality Measurement and Improvement with the UHC Agenda*.; 2014.

4. Kruk ME, Gage AD, Arsenault C, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. *Lancet Glob Heal*. 2018;6(11 The Lancet Global Health Commission on high quality health systems in the SDG era):e1196-e1252.

5. Stenberg K, Hanssen O, Tan-Torres Edejer T, et al. Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries. *Lancet Glob Heal*. 2017;5:e875-e887. doi:10.1016/S2214-109X(17)30263-2

6. Australian Medical Association. How the crisis unfolded. 2016. Accessed July 18, 2021. https://www.amansw.com.au/how-the-crisis-unfolded/

7. Zinn C. Australian government tries to solve doctors' indemnity crisis. *BMJ Br Med J*. 2003;327(7406):72. Accessed July 18, 2021. /pmc/articles/PMC1150943/

8. Cardoso R, Zarin W, Nincic V, et al. Evaluative reports on medical malpractice policies in obstetrics: a rapid scoping review. *Syst Rev*. 2017;6(181). doi:10.1186/S13643-017-0569-5

9. Saha K, Shetty D. Are large compensation payouts for negligence good for medicine in

India? *Br Med J*. 2014;(349). doi:10.1136/bmj.g5229

10. World Bank. *Medical Malpractice Systems around the Globe: Examples from the US-Tort Liability System and the Sweden-No Fault System*.; 2013. Accessed May 16, 2019. http://siteresources.worldbank.org/IntRussianFederation/Resources/Malpractice_Systems_eng.pdf

11. Kassim PNJ, Najid KM. Medical negligence disputes in Malaysia: resolving through hazards of litigation or through community responsibilities? *Int J Soc Manag Econ Manag Eng*. 2013;7(6):742-750. http://irep.iium.edu.my/31974/

12. Iyioha I. Medical negligence and the Nigerian National Health Insurance scheme: Civil liability, no-fault or a hybrid model. *African J Int Comp Law*. 2010;18(1):46-77. doi:10.3366/E0954889009000504

13. South African Lancet National Commission. *Confronting the Right to Ethical and Accountable Quality Health Care in South Africa: A Consensus Report*.; 2019. http://www.health.gov.za/index.php/2014-03-17-09-09-38/strategic-documents/category/532-2019-strategic-documents

14. Blecher M, Daven J, Kollipara A, Maharaj Y, Mansvelder A, Gaarekwe O. Health spending at a time of low economic growth and fiscal constraint. In: Padarath A, Barron P, eds. *South African Health Review 2017*. ; 2017:25-40.

15. Whittaker G. *Medical Malpractice in the South African Public Sector*.; 2021.

16. Veneklasen L, Miller V. Power and Empowerment. In: Budlender D, Clark C, eds. *A New Weave of Power, People & Politics: The Action Guide for Advocacy and Citizen Participation*. World Neighbours; 2002:39-58. Accessed September 7, 2020. www.wn.org

17. World Health Organization, Organization for Economic Cooperation and Development, The World Bank. *Delivering Quality Health Services: A Global Imperative for Universal*

Health Coverage.; 2018. Accessed July 12, 2021. http://apps.who.int/bookorders.

18. Chakraborti C. Systemic Negligence: Why it is morally important for developing world bioethics. *Dev World Bioeth*. 2015;15(3):208-213. doi:10.1111/DEWB.12063

19. Jhaveri S. Constructing a framework for assessing public authority liability in negligence: the role of public norms, private law norms and policy arguments. *Tort Law Rev*. 2011;19(1):3.

20. Rai S, Devaiah VH. The need for healthcare reforms: is no-fault liability the solution to medical malpractice? *Asian Bioeth Rev*. 2019;11(1):81-93. doi:10.1007/s41649-019-00081-7

21. Malherbe J. Editorial: Counting the cost: consequences of increased medical malpractice litigation in South Africa. *South African Med J*. 2013;103(2):83-84. doi:10.7196/SAMJ.6457

22. South African Law Reform Commission. *Project 141: Medico-Legal Claims*.; 2017. Accessed November 16, 2018. http://salawreform.justice.gov.za

23. Western Cape Government: Health. *Western Cape Provincial Department of Health Current Strategy: Risk Management and Medical Malpractice Case-Handling*.; 2019.

24. Health Systems Trust. Profile: Gauteng Province. In: *District Health Barometer 2018/19*. ; 2019.

25. Health Systems Trust. Profile: KwaZulu-Natal Province. In: *District Health Barometer 2018/19*. ; 2019.

26. Rispel L, De Jager P, Fonn S. Exploring corruption in the South African health sector. *Health Policy Plan*. 2015;0(0).

27. Pienaar L. Investigating the reasons behind the increase in medical negligence claims. *PER/PELJ*. 2016;19.

28. Howarth GR, Carstens P. Can private obstetric care be saved in South Africa? *South African J Bioeth Law*. 2014;7(2):69. doi:10.7196/sajbl.319

29. Republic of South Africa. *State Liability Amendment Bill*. Department of Justice and Correctional Services; 2018. doi:10.1163/9789004272224_029

30. Motsoaledi A. Doctors call for lawyers to get out of hospitals. *South African J Bioeth Law*. 2015;8(1):4. doi:10.7196/sajbl.409

31. Department of Transport. *Road Accident Benefit Scheme Bill*. Republic of South Africa; 2017.

32. Hausmann R, Sturzenegger F, Muci F, Barrios D. *Macroeconomic Risks after a Decade of Microeconomic Turbulence: South Africa 2007-2020*.; 2022.

33. South African National Treasury. *Division of Revenue Bill*. National Treasury; 2021.

34. Bhorat H, Buthelezi M, Chipkin I, et al. *Betrayal of the Promise: How South Africa Is Being Stolen*.; 2017.

35. Brooke-Sumner C, Petersen-Williams P, Kruger J, Mahomed H, Myers B. 'Doing more with less': a qualitative investigation of perceptions of South African health service managers on implementation of health innovations. *Health Policy Plan*. 2019;34(2):132-140. doi:10.1093/HEAPOL/CZZ017

36. Stuckler D, Feigl AB, Basu S, Mckee M. The political economy of universal health coverage . In: *Global Symposium on Health Systems Research*. World Health Organization; 2010. Accessed April 27, 2022. www.hsr-symposium.org

37. Hunter J, Thoovakkunon M, Asmall S, Tucker JM, Ravhengani N, Mokgalagadi Y. The Ideal Clinic in South Africa: progress and challenges in implementation. In: Padarath A, Barron P, eds. *South African Health Review 2017*. ; 2017.

38. Meyer JC, Schellack N, Stokes J, et al. Ongoing initiatives to improve the quality and

efficiency of medicine use within the public healthcare system in South Africa: A preliminary study. *Front Pharmacol*. 2017;8(751). doi:10.3389/FPHAR.2017.00751/BIBTEX

39. Nzinga J, Boga M, Kagwanja N, et al. An innovative leadership development initiative to support building everyday resilience in health systems. *Health Policy Plan*. 2021;0(0). doi:10.1093/heapol/czab056

40. Sriram V, Topp SM, Schaaf M, et al. 10 Best Resources on Power in Health Policy and Systems in Low- and Middle-Income Countries. *Health Policy Plan*. 2018;33(4):611-621. doi:10.1093/heapol/czy008

41. Lehmann U, Gilson L. Actor interfaces and practices of power in a community health worker programme: a South African study of unintended policy outcomes. *Health Policy Plan*. 2013;28(4):358-366.

42. Yin RK. *Case Study Research: Design and Methods*. Fifth. SAGE Publications, Inc; 2013.

43. Nowell LS, Norris JM, White DE, Moules NJ. Thematic analysis: striving to meet the trustworthiness criteria. *Int J Qual Methods*. 2017;16.

44. Esposito P. Clinical audit, a valuable tool to improve quality of care: General methodology and applications in nephrology. *World J Nephrol*. 2014;3(4):249. doi:10.5527/wjn.v3.i4.249

45. Smoke P. Rethinking decentralization: assessing challenges to a popular public sector reform. *Public Adm Dev*. 2015;(35):97-112. doi:10.1002/pad

46. Liwanag HJ, Wyss K. What conditions enable decentralization to improve the health system? Qualitative analysis of perspectives on decision space after 25 years of devolution in the Philippines. *PLoS One*. 2018;13(11).

47. Liwanag HJ, Wyss K. Optimising decentralisation for the health sector by exploring the

synergy of decision space, capacity and accountability: Insights from the Philippines. *Heal Res Policy Syst*. 2019;17(1). doi:10.1186/s12961-018-0402-1

48. Tsofa B, Molyneux S, Gilson L, Goodman C. How does decentralisation affect health sector planning and financial management? A case study of early effects of devolution in Kilifi County, Kenya. *Int J Equity Health*. 2017;16(151).

49. Gilson L, Schneider H, Orgill M. Practice and power: a review and interpretive synthesis focused on the exercise of discretionary power in policy implementation by front-line providers and managers. *Health Policy Plan*. 2014;29(suppl_3):iii51-iii69.

50. Sinitsky DM, Gowda SB, Dawas K, Fernando BS. Morbidity and mortality meetings to improve patient safety: A survey of 109 consultant surgeons in London, United Kingdom. *Patient Saf Surg*. 2019;13(1):27. doi:10.1186/s13037-019-0207-3

51. Jepkosgei J, Nzinga J, Adam MB, English M. Exploring healthcare workers' perceptions on the use of morbidity and mortality audits as an avenue for learning and care improvement in Kenyan hospitals' newborn units. *BMC Health Serv Res*. 2022;22(1):1-10. doi:10.1186/S12913-022-07572-8/TABLES/1

52. Mate KS, Rooney AL, Supachutikul A, Gyani G. Accreditation as a path to achieving universal quality health coverage. *Glob Heal 2014 101*. 2014;10(1):1-8. doi:10.1186/S12992-014-0068-6

53. Tangcharoensathien V, Limwattananon S, Patcharanarumol W, Thammatacharee J, Jongudomsuk P, Sirilak S. Achieving universal health coverage goals in Thailand: the vital role of strategic purchasing. *Health Policy Plan*. Published online 2014:1-10. doi:10.1093/heapol/czu120

54. National Department of Health. *National Health Insurance Bill*. Government Gazette; 2019. Accessed August 15, 2019. https://www.gov.za/sites/default/files/gcis_document/201908/national-health-insurance-

bill-b-11-2019.pdf

55. Claassen N. Mediation as an alternative solution to medical malpractice court claims. *SAJBL*. 2016;9(1):7-10.

56. Ambaras Khan H, Bastiampillai A, Mon SW. Mediation as a Suitable Dispute Resolution Method in Medical Negligence Cases: Special Reference to the Malaysian Position. *Soc Sci Humanit*. 2020;28(3):2309-2323.

57. Lerm H. Medical malpractice litigation: do we need a paradigm shift in our approach to handling medical negligence disputes? *Obiter*. 2017;38(2):324-341.

58. Ehikhamenor E, Obani P, Azodo CC. Application of Alternative Dispute Resolution (ADR) in trauma care in a Nigerian tertiary hospital Infection control View project. *Int J Med Biomed Res*. 2017;6(2). doi:10.14194/ijmbr.6.2.3

59. Parashar R, Gawde N, Gilson L. Application of “Actor Interface Analysis” to Examine Practices of Power in Health Policy Implementation: An Interpretive Synthesis and Guiding Steps Systematic Review. *Int J Heal Policy Manag*. 2021;10(7):430-442.

CHAPTER 7. IMPACT OF FINANCIAL MANAGEMENT CENTRALISATION IN A HEALTH SYSTEM UNDER AUSTERITY: A QUALITATIVE STUDY FROM SOUTH AFRICA

Wishnia. J and Goudge. J. Impact of financial management centralisation in a health system under austerity: A qualitative study from South Africa. *BMJ Global Health* 2020;5:e003524. doi:10.1136/bmjgh-2020-003524

BMJ Global Health

Impact of financial management centralisation in a health system under austerity: a qualitative study from South Africa

Jodi Wishnia , Jane Goudge

To cite: Wishnia J, Goudge J. Impact of financial management centralisation in a health system under austerity: a qualitative study from South Africa. *BMJ Global Health* 2020;**5**:e003524. doi:10.1136/bmjgh-2020-003524

Handling editor Stephanie M Topp

Received 23 July 2020
Revised 6 September 2020
Accepted 18 September 2020

Check for updates

© Author(s) (or their employer(s)) 2020. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ.

Centre for Health Policy, Faculty of Health Sciences, School of Public Health, University of the Witwatersrand, Johannesburg, South Africa

Correspondence to
Jodi Wishnia;
jodiwishnia@gmail.com

ABSTRACT

Introduction International calls for universal health coverage (UHC) have led many countries to implement health sector reforms, however, since the 2008 global recession, economic growth has slowed in many lower-income and middle-income countries. In a renewed interest in public financial management (PFM), international organisations have emphasised the importance of giving spending control to those responsible for healthcare. However, centralisation is a common response when there is a need to cut expenditure due to a reduced budget; yet failure to decentralise often hampers the achievement of important goals. This paper examines the effect of centralising financial decision-making on the functioning of the South African health system.

Methods We used a case study design with an ethnographic approach. Primary data collection was conducted through participant-observation and semistructured interviews, over 1 year. Member checking was conducted.

Results New management implemented centralisation due to a reduced budget, a history of financial mismanagement, the punitive regulatory environment financial managers face, and their fear of poor audit outcomes. The reform, together with an authoritarian management style to ensure compliance, created a large power distance between financial and clinical managers. District managers felt that there was poor communication about the reform and that decision-making was opaque. This lowered commitment to the reform, even for those who thought it was necessary. It also reduced communal action, creating an individualistic environment. The authoritarian management style, and the impact of centralisation on service delivery, negatively affected planning and decision making, impairing organisational functioning.

Conclusion As public health systems become even more financially constrained, recognising how PFM reforms can influence organisational culture, and how the negative effects can be mitigated, is of international importance. We highlight the importance of a participatory culture that encourages shared decision making and coproduction, particularly as countries grapple with how to achieve UHC with limited funds.

Key questions

What is already known?

- Health systems are facing demands for improved access to care in the context of constrained fiscal space.
- Decentralisation of financial control to managers responsible for service delivery should, in theory, improve the use of funds.

What are the new findings?

- A fear of poor audit outcomes can lead finance managers to hold onto financial control; this fear is exacerbated in austerity climates and in systems with a history of financial mismanagement.
- Finance and clinical managers often do not have a shared vision of the goal of the health system, and this drives tension and impacts negatively on relationships.
- This leads to an organisational culture that is competitive and dismissive of the needs of the collective.
- This further weakens the health system.

What do the new findings imply?

- Austerity can lead to radical public financial management reforms to attempt to control expenditure.
- Finance and clinical managers need to find more opportunities to coproduce the shared goals of the department to ensure policy reform is aligned to systems goals—this can be done through multidisciplinary committees.
- Relational accountability, which is fostered by working more closely together, can increase acceptability of decentralised control, which would improve participation and ultimately health systems functioning.

INTRODUCTION

In the last decade, international calls for universal health coverage (UHC), coupled with the Sustainable Development Goals' inclusion of UHC, has led many countries to implement health sector reforms. However, fiscal space for public services has narrowed during this period given the 2008 recession, leading to a renewed interest in public

financial management (PFM), given its intention to support service delivery, while controlling expenditure.[1]

The World Bank and World Health Organization (WHO) have re-emphasised the importance of giving spending control and flexibility to those responsible for healthcare such as facility managers and district health offices (DHOs). The aim of this decentralisation is to achieve more efficient use of funds.[2] The reasons why this shift in control has not been widely implemented vary from a lack of capacity at the lower levels of the health system, to poor accountability mechanisms.[3] Centralisation of financial decision making is in fact a more common response when there is a need to cut expenditure in line with a reduced budget. It is also likely to be a widespread response to the austerity that will follow the COVID-19 pandemic.[3] However, failure to decentralise decision-making is likely to hamper the functioning of health systems, constraining their ability to maximise value from limited resources.

Since the 2008 global recession, South Africa (SA), like many other lower-income and middle-income countries (LMICs) has been experiencing low, or no, economic growth.[4] The government has instituted widespread austerity measures, particularly to reduce the public sector wage bill.[5] In 2012, the South African National Department of Health (NDoH) announced its intentions to implement UHC, through a national health insurance (NHI) scheme.[6] As a result, the health system is grappling with how to responsibly manage public funds while responding to the new UHC policy goals,[7] a problem that has come to the fore in many LMICs.[8] In this paper, we examine the effect of centralising financial decision making on the functioning of a South African provincial department of health (PDoH), in an environment of health system reform.

Country context

SA is a middle-income country with a federal system of government. Until financial year 2012/2013, SA had been able to largely protect its social services sectors (eg, health, education) from the effects of slower economic growth and a decline in tax revenue. However, since 2014, this has no longer been possible and the social sector has been negatively affected by declining budgets in real terms, despite an increasing burden of disease. The austerity climate in the country has substantially worsened since 2019, due to attempts to recover from a period of widespread corruption.[9] SA has a quadruple burden of disease which increases the need for health services.[10] However, quality of care remains poor[11] due to insufficient budgets and ineffective use of funds.

SA has an NDoH, nine PDoHs and 52 DHOs.[12] Figure 1 illustrates the levels and responsibilities of the health system and shows that it is the responsibility of the PDoH to delegate financial decision-making to districts and facilities.

SA's health sector has a long history of trying to decentralise governance to the DHOs, with the National Treasury and the NDoH encouraging PDoHs to deconcentrate power.[13 14] Most of the PDoHs have experimented with 'delegations', which legally allows a lower level official to be responsible for a task that has been assigned to a more

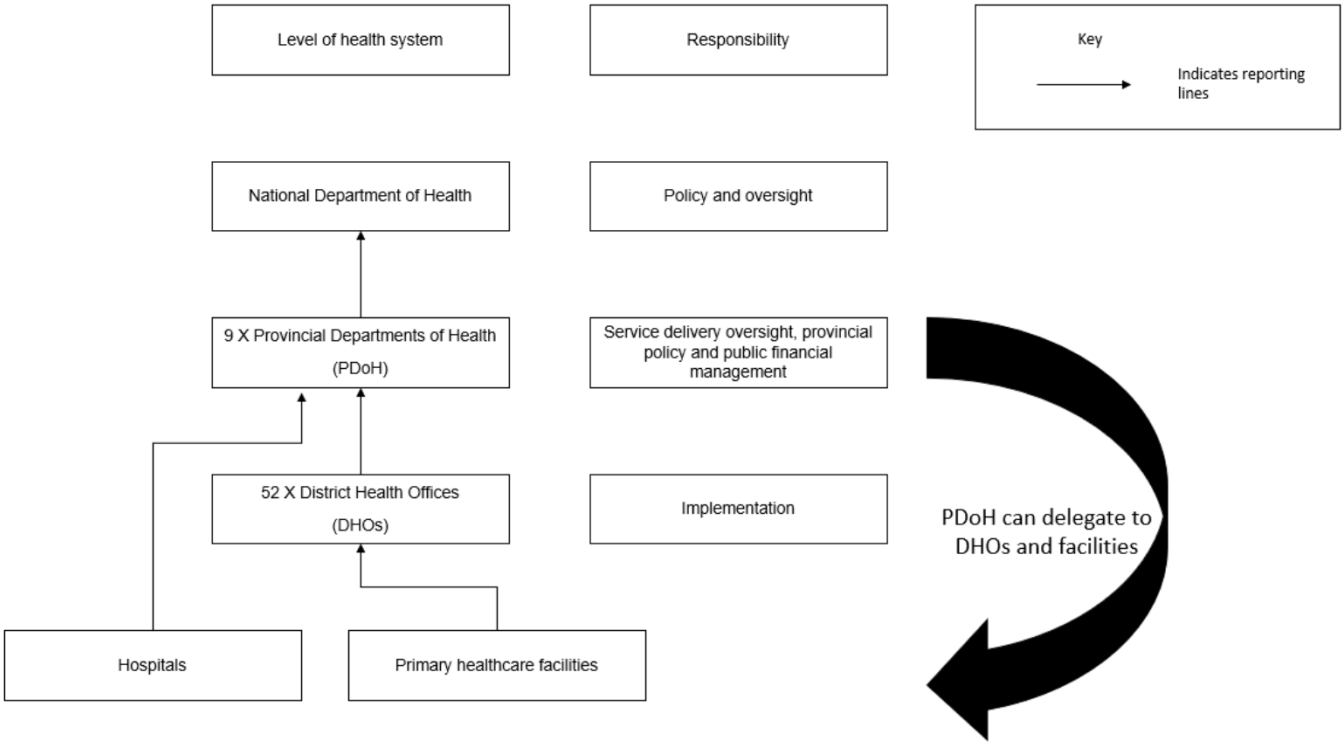


Figure 1 South African health system structure.

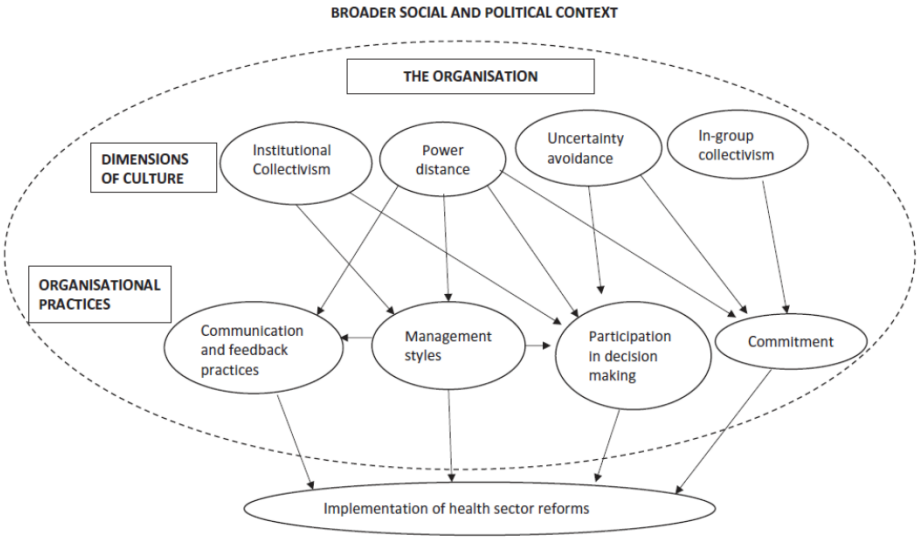


Figure 2 Conceptual framework: Mbau and Gilson (2018).

senior manager. However, the use of delegations remains limited. With NHI, the NDoH plans to shift financial accountability away from provinces to districts, essentially forcing decentralisation onto the health system.

Conceptual framework

Since the 1980s, the field of organisational management has studied how people influence their organisation's performance.[15] 'Organisational culture' (OC), a theoretical construct within organisational management science, is generated as an organisation performs its functions, creating a pattern of shared assumptions. This culture governs the way people perceive, experience and, in turn, influence how the organisation functions.[16] OC can answer questions about how decisions are made and offer possible reasons for why implementation is difficult despite an organisation having all the requisite infrastructure and resources ('hardware').[17] OC is often seen as the connector between individual and collective behaviours and therefore is a useful paradigm when trying to analyse systemic policy failure.[18] Within health systems and policy research, it is widely accepted that the functioning of a health system is influenced by the people working within it, and their relationships ('software').[19] However, framing this phenomenon using OC is relatively new in the field. Therefore, a recent synthesis of evidence by Mbau and Gilson (2018) has been valuable in determining an analytical framework through which to analyse OC in LMIC health systems. Their framework illustrates the ways in which OC influences organisational functioning in LMICs (figure 2).[20]

The framework contains two layers: 'dimensions of culture' and 'organisational practices'. Table 1 describes the dimensions of culture[21] (we have renamed three of the dimensions for clarity), and table 2 the organisational practices.[20] The dimensions and practices are interrelated. For example, managers, afraid of poor outcomes, may adopt an authoritarian management style to avoid uncertainty and control outcomes, resulting in a large power distance between managers and employees. A participatory management style, on the other hand, increases managers familiarity with the lower levels of the organisation, and so can reduce their fear of uncertain outcomes by improving their understanding of the challenges at lower levels. The resulting collective

Table 1 Dimensions of culture

Dimensions of culture	Description	Terminology used here
Uncertainty avoidance	Degree to which the members of an organisation avoid unknown outcomes by depending on accepted practices, rules, or procedures.	Fear of uncertainty
Power distance	The difference in (decision-making) power between higher and lower levels of an organisation, and whether that power difference is found to be acceptable and appropriate.	Power distance
Institutional collectivism	Extent to which the organisation encourages and rewards communal action (working together).	Communal action
In-group collectivism	Level of pride, satisfaction and loyalty shown by members towards their organisation.	Loyalty

Table 2 Organisational practices

Organisational practices	Definitions
Communication and feedback	The extent to which, and how, staff are informed about policy reform processes.
Management styles	Authoritarian (most negative), consultative or participatory (best practice) management.
Participation in decision-making	To what extent employees across the system are involved in decision making.
Commitment	The extent to which employees support the reform.

process facilitates better communication and feedback, increasing participation in decision making. It also fosters communal action across, and commitment to, the organisation.

METHODS

Study design

We used a case study design, with ethnographic methods.[22] These methods are appropriate when looking to explain 'how' or 'why' events happened, and health systems actors' perspectives on them.[23] Case studies are particularly valuable for research looking to understand OC within a particular setting, like a PDoH.[24] Case studies allow for holistic research within the real context of the participants. It therefore pairs well with ethnography, which aims to understand the reality of participants from inside their context.[22]

Study setting and negotiating access

The PDoH studied is situated within a poor, predominantly rural province in SA. It has a long history of financial mismanagement and is one of the poorer performers in the country in terms of service delivery. The province has experimented with widespread delegations to the DHOs in the past but revoked them due to mismanagement. The austerity measures and PFM centralisation have been in place since 2015.

JW had previously worked with the province in her capacity as a health financing specialist and was known to many of the senior and middle managers. She met with one of the senior finance managers to ask whether the PDoH would be willing to participate in the study. From there, the research protocol was shared with the executive management of the province and the PDoH agreed to be involved.

Informed consent was obtained for all observations, interviews and audio recordings.

Participant selection

JW received informed consent from 60 individuals to be observed and was a participant observer in 10 meetings, which varied from routine financial management meetings to meetings with hospital chief executive officers (CEOs) at their facilities. In these meetings, she was allowed to ask questions and provided technical advice when invited to do so.

JW used purposive sampling for her interviews, contacting employees responsible for financial and clinical management at the PDoH head office, DHOs and public hospitals. She then used snowball sampling either through the introductions made at meetings or through a referral by an interviewee. No one explicitly refused to participate in the study, however, some never responded to several requests for an interview. She conducted 30 interviews (table 3).

Data collection

Data collection ran from July 2017 to June 2018. At the start of data collection, JW attended two 1-day meetings to introduce the research to key stakeholders.

JW collected all the data for the research. Data collection was conducted using participant observations and semistructured interviews. Data were collected by visiting the province for several days at a time. During these visits, JW attended meetings and conducted in-person interviews.

The majority of the observations and interviews took place either within the head office, DHO or a public hospital. For the observations, JW used an observation guide[25] to make detailed meeting notes.

A semistructured interview guide[26] was used for data collection. JW used a 'grand tour'[26] approach. Grand tour is useful when you want to elicit a thick description within case study research.[27] The grand tour questions were adapted for interviews at the different levels of the

Table 3 Demographic characteristics of interviewees, by level of management and health system

Management level	Provincial	District	Hospital	Finance/ support services	Clinical	Female	Total
Senior	7	3	4	8	6	6	14
Middle	4	8	0	6	6	11	12
Junior	0	4	0	4	0		4
Total	11	15	4	18	12	18	30

health system. The questions were designed to prompt participants to share their experiences in their own words. Some of the questions included: 'describe your average workday' and 'tell me about a time you interacted with the PDoH and how that impacted you'.

Interviews ranged from 20 min to over an hour. No one else was present at the interviews. Only one participant refused to be audio recorded; he felt this was necessary to be able to participate fully.

While repeat interviews were not conducted, the researchers did amend the interview questions during data collection to take into account knowledge already gained from previous interviews and observations. The authors discussed when no new information was emerging and determined data saturation had been reached.

Data analysis

JW wrote up her observation notes after each interaction. The audio files were deidentified and transcribed by an external company, and then checked for accuracy.

The authors read the data, with JW coding the data according to common themes, following which the authors discussed the emergent codes. JW then analysed the codes and grouped them into high-level themes. The authors interrogated these themes, discussing the strength of the evidence for each. We selected Mbau and Gilson's (2018) framework as a useful way to frame the data. We used Dedoose to deductively recode the data,[28] using themes from the framework, with a total of eight codes (four dimensions of culture and four organisational practice codes).

Identifiers are used to anonymise the quotations. We used 'i' for data gathered via an interview, followed by either a 'P' for PDoH, 'D' for DHO or 'H' for hospital. Observation notes were used to inform the analysis, but we do not use verbatim quotes from these.

Member checking was done through a participatory workshop to discuss the research findings. The invitation was extended to everyone within the head office, the two DHOs studied and the four public hospitals. The workshop was held over 1 day, with all attendees in the same workshop. The workshop was interactive, splitting attendees into groups to consider the research findings. These groups were heterogeneous, with at least one member from the different levels of the health system, as far as possible. Attendees gave input on whether the key themes were appropriate and engaged with the findings. The discussions at the workshop contributed to the proposed recommendations in this paper. This, along with the rigorous data analysis methods, have ensured the credibility and confirmability of the findings.[29]

Reflexivity

JW asked participants to clarify the background behind a statement, even though she was familiar with the history. This approach, combined with reflexive note taking and JG's interrogation of the data, enabled JW to separate her perceptions from the respondents' interpretations of events. JW also wrote down her thoughts on the quality of the interview and any insights that emerged.

Patient and public involvement

No patients or members of the public were involved in the research design, analysis nor dissemination of the findings; however, provincial managers contributed to the research focus in the planning stages, and provincial, district and hospital managers were involved in the interpretation of the findings.

FINDINGS

Delivering health services in an austerity climate

Finance and clinical managers agreed that the current budget was insufficient for the health needs in the province: *"The Department is underfunded, it might appear that it's getting a huge piece of the cake within the provincial allocation, but all sectors are underfunded."* [iP7]. Many participants echoed this view: "*It's a joke budget. There was no way we could use it for the whole year." [iH3].* Managers described their budgets as decreasing annually: "*Normally, when the budget comes, it's last year's budget plus a percentage, but most recently, it's last year's budget less [a percentage]!"* [iH3]. This has forced managers to purchase services that they do not have the funds for (resulting in accruals), to maintain service delivery: "*When you do not have any money left, you just borrow! So, we owe our suppliers from way back!"* [iH30]. As accruals from the previous year must be settled first; the impact of austerity is cumulative from one year to the next. A hospital manager highlighted the impact of this narrowing fiscal envelope for service delivery: "*At the beginning of the year, we had a R120 million gap between the authorised budget and expected expenditure, but we were only left with a R70 million budget shortfall at the end of the year. That means we cut expenditure by R50 million somewhere, either by reducing services, or compromising the quality of care."* [iH30].

Over the last decade, the province has been attempting to rationalise the service delivery platform (reduce the number of facilities), to bring down the running costs, but these attempts have been unsuccessful largely due to resistance from surrounding communities who did not want to lose their facility. In addition, the PDoH has experienced a proliferation of 'unfunded mandates' in the pursuit of UHC: "*A decision was made that we are […] to rollout the National Health Insurance (NHI) initiatives […] but there is no budget. When a decision is made by the political head, […] it must be implemented, so it is always at the expense of something else.*" [iP7]. As a result, recent service delivery plans have become divorced from the available funding: "*So, you would have ideas and plans, but they are then not implemented because you do not have the resources to carry them through.*" [iP6]. This has resulted in tension between finance and clinical managers. For finance managers, it was imperative that the PDoH work within the available budget: "*Of course I agree the budget is insufficient, but it does not mean we should not manage the one we've been allocated."* [iP9]. Clinical managers felt the burden of this approach,

given their proximity to service delivery: "*It's very stressful, […] we are trying to deliver [services] to communities, but one of the major challenges is resource constraints.*" [iP6].

Financial mismanagement, fear of uncertainty and centralisation

The province has a history of financial mismanagement and poor audit outcomes: "*The district managers were given financial delegations, but they would go out for meetings on consecutive days and they would leave the order books signed, and then anybody who wanted to buy anything would just fill in the particulars!*" [iP2]. The National and Provincial Treasury have had to intervene several times: "*If the Department can't manage their salary payments, then provincial treasury takes that function away.*" [iP4].

Emulating the Treasury's approach, the PDoH tends to revoke financial control from the lower levels when there is evidence of mismanagement. This is implemented across the board, not just for the offending manager: "*Something small happens, and then they just pull the delegations away! So, it's like a knee-jerk reaction!*" [iP4].

Since 2015, under new leadership, the PDoH has endeavoured to improve the financial audit outcomes by instituting a radical PFM centralisation reform. They established a 'centralisation committee', which is comprised of financial, clinical and support service managers who meet once a week to review expenditure and payment requests for the whole province. The committee is chaired by the chief financial officer (CFO), and its establishment revoked all delegations from the districts and facilities. Members of the committee are senior managers within the head office, with none from the DHOs or hospitals.

A hospital manager empathised with the rationale for the reform: "*I understand why [they instituted this reform], and maybe, I would feel inclined to do the same. Health is an underfunded mandate, so, on paper, we try and prevent unauthorised expenditure because the CFO and financial managers will lose their jobs.*" [iH30]. Several finance managers echoed the sentiment that the finance environment was very punitive: "*So, if we want to see some bloodshed, one needs to look within the finance department, where I think the greatest amount of correspondence is sent out in terms of financial misconduct and I think that's because Treasury has quite vigilant consequence management.*" [iP10].

Power distance, commitment to the reform and effect on relationships

Clinical managers within the head office reflected on the centralisation of power: "*Sometimes, when I engage fellow middle managers, I feel that they are not sure of certain decisions […], decision-making power is very much controlled at the executive management level.*" [iP12]. It was not only clinical managers who felt aggrieved by the centralisation, finance managers in the districts also felt shackled: "*I feel like head office are not giving you space. Even the district managers, the senior managers, are not given a space to cooperate and prove their worth or their capabilities.*" [iD18]. Hospital managers were also dissatisfied: "*To be a CEO in the department of health is a nightmare because we are given the responsibility, but you're not given the necessary authority; you don't have the financial delegations to do your job.*" [iH20].

Many managers lamented the inefficiency of the new committee: "*It can take a month for the committee to approve an order of a simple item, then there is the procurement, and then we still need the committee to approve the payment! It's a nightmare from the facility's point of view.*" [iP4]. Managers were reluctant to support the reform, even those who felt centralisation was acceptable: "*I feel the centralisation committee is necessary, but the committee does delay us. If communication were free flowing with actual turnaround times that are within reason, we wouldn't mind.*" [iD19]. Most managers felt centralisation was not the right solution and found it both inefficient and unfair to those who had not transgressed: "*[They said] everything had to be centralised. I am saying, 'that is not fair, why are we getting impacted in a negative way, it is not right.*" [iH30].

Clinical managers described the strained relationship between the finance teams and them: "*There is a huge discrepancy in understanding our individual roles and our team roles. We feel very strongly, from the clinical branch, that we should give direction, and then they should say how that can be supported. This is now not me alone [that holds this view], that I am sure of! We feel very strongly they are not a support to us. They are dictators.*" [iP6]. In turn, finance managers bemoaned clinical managers' lack of concern for the constrained fiscal environment: "*Why are all clinical needs given a much higher priority than staying within the budget, when services cannot operate if we have run out of money?*" [iP2].

To try and repair the relationship, the finance team at the head office assured managers that this reform was a short-term necessity to prevent continued financial disrepute. However, there has been no change to the reform in several years: "*There has been this verbal commitment to differentiate the delegations, but there has been no follow through. I am told that it is going to happen now, but I have been told it is going to happen for the last year and a bit.*" [iH30]. Once the audit outcomes begun to improve, finance managers cited fear of regression as the reason to maintain the reform: "*The delegations have not been cascaded in order to manage the risk of [audit] regression. It would be a catastrophe if we were to regress.*" [iP10]. This fear of uncertainty has permeated the department, impacting on relationships.

Management style

Head office admitted that they defaulted to an authoritarian management style to ensure compliance: "*We bully the districts, and they basically just do what we tell them to do. It's sometimes like malicious compliance; they just do it because they have to, but they don't see the value in it.*" [iP4].

The authoritarian management style created extra unnecessary work: "*I really feel that lots of work could be avoided if we have a 'bottom up' approach. We just hand over the paperwork for decisions that have already been made by the head office. We need to meet each other halfway and it's really not happening.*" [iP16]. The lack of a participatory

environment de-motivated staff: "*You are unable to take a decision; you are unable to deal with any challenges on your own. All the challenges are thrown to the seniors and then you are only told what to do. So, you become stagnant.*" [iP8].

Finance managers were sceptical about involving others in decision-making spaces: "*If you allowed a 'bottom up' approach, the Department would close tomorrow. Clinical managers see patients, rather than the resources. They don't seriously consider what is available, they want what they want.*" [iP9].

However, many clinical managers suggested that agile accountability mechanisms that are able to identify and correct mistakes quickly could help reduce financial mismanagement: "*If we are being wasteful or have done it incorrectly, then charge us! We will quickly do the right things!*" [iH30]. District finance managers also pushed for delegated control: "*They are saying we will mess up the budget, it won't balance, but I don't think that's true, [if there is a mistake] they know where to take that complaint to.*" [iD21].

The effect on communal action

Many managers reported feeling loyal to the organisation: "*I love what I do so, maybe that's why, even though it is stressful, there are things that cause you to wake up and come to work. Being a provider of a public service is not always easy, but I think passion drives us.*" [iD13]. This was not limited to clinical managers, finance managers felt similarly: "I*f I look at my job, it's a job that I love, that I'm absolutely motivated and inspired to be doing.*" [iP10]. This loyalty to the organisation appeared to be a major consideration for managers remaining in the organisation during exceptionally difficult circumstances.

However, the lack of a participatory management style affected organisational functioning: "*I find the misalignment comes […] when we are doing the annual performance plan (APP). The head office managers are not so in tune with what is happening at district […] The district health plans should find expression within the APP […] but they do not.*" [iP12]. Clinical managers reported not participating in budget related meetings: "*I stopped presenting at the provincial hospital forum because it's useless. I said to the head of hospital services, I can't understand the rationale behind the final allocation!*" [iH3].

By not attending these meetings, clinical and finance managers were not always aware of the needs of their peers, making it easier to turn inwards: "*People are territorial. If I am a district manager, and I have R50m budget, […] I will not use my R50m to save someone else who has a challenge.*" [iP1]. Managers reported competing for resources: "*We have had a 16% increase in patients coming through our hospital and yet the budgets have actually decreased, because we are competing with primary healthcare.*" [iH30]. One participant described how this competitive culture played out: "*A clinic was congested, staff seeing patients in every corner. There was an empty hospital, with a big outpatient department (OPD), but the CEO [of that hospital] said 'no, the clinics can't use the OPD to see the [overflow] patients.*" [iD17]. The absence of a participatory culture affected how the organisation functioned: "*People work in siloes and are protective of their status.*" [iP8].

Several managers expressed a desire for a more collectivist culture: "*We need interaction between both levels [of management] and understanding and [to be] working together. If I support the top manager, then it becomes easy for them, and if I'm an administrator at the lower level, if I get the support of my manager, then it becomes easy for me!*" [iP8]. The district management team (DMT) attributed some of their successes to the integration and communal action they have managed to foster: "*There's a team there with everybody in the DMT, the finance people, everyone, everyone with their specific duties.*" [iD11]. One hospital manager suggested a more participatory approach: "*If I was the Head of Department, my management team would not just be people from the head office. My team would be district managers and CEOs of the big hospitals. We would all drive implementation together. So, your planning and priorities come from that team in full cooperation and we are bound together.*" [iH30].

DISCUSSION

In this paper, we have described how centralisation was implemented in response to austerity and financial mismanagement, the punitive regulatory environment financial managers face and their fear of poor audit outcomes. The reform, together with an authoritarian management style to ensure compliance, created a large power distance. Managers felt that the committee gave insufficient feedback and that decision-making was opaque. This lowered commitment to the reform, even for those who thought, given the PDoHs financial history, the reform was necessary. It also reduced communal action, creating a more 'territorial'/individualistic environment. While many managers expressed their loyalty to the organisation and how this had kept them motivated, the authoritarian management style, and the impact of centralisation on service delivery, had negatively affected organisational planning and decision-making.

Problems with implementation are often attributed to misalignment and misunderstanding between actors in health systems.[30] Many managers in our study reported that the head office was disconnected from the rest of the health system, making them ill suited for centralised control. However, given the fear of uncertainty, finance managers remained wary of financial decentralisation, as is common during fiscally constrained periods,[31] and therefore, the reform has remained in place.

Different parts of an organisation often have their own subcultures that may be in conflict with one another. However, as long as the subcultures are aligned to the overarching organisational goals, this may not be a problem.[16] Studies of hospital wards have explored how a punitive PFM regulatory environment exacerbates the harmful effect of austerity on service delivery, and can lead to irrational purchasing decisions.[32] We have reported on the punitive subculture within the finance teams and the disagreement between finance and clinical teams on the organisation's goals. Where spaces for shared decision making were created, clinical managers

often refused to participate as their contributions were not truly considered, reducing communal action, and impacting negatively on departmental performance.

Organisations with an authoritarian management style often rely on 'bureaucratic' and punitive accountability mechanisms to ensure adherence to policies.[33] In contrast, 'relational' accountability theory points to the importance of positive supervisory relationships to exist alongside accountability measures for the latter to be effective. If the supervisor has a greater understanding of the challenges the supervisee is facing, a realistic compromise is possible.[33] Relational accountability requires a participatory management style and coproduction.

Changing to a participatory environment can, however, be difficult when an organisation's culture favours 'command and control' and top-down decision making,[34] as seen in the province studied. Our recommendations below centre on bringing diverse managers together more often, and in different settings, as a start toward building the relationships (and culture) needed for a functional organisation.

SA, like many other LMICs, envisions using capitation and similar methods for reimbursement under its NHI,[35] with predetermined limits on what can be spent, and financial accountability shifting to the district health offices. In preparation for NHI reform, managers could use a similar approach, even if just for a discrete list of items, to facilitate the shift to decentralisation. For example, a cost per capita for primary healthcare (PHC) services is fairly easy to determine given available data, and the province could decentralise sufficient funds to cover PHC visits, to the DHOs. This shifts spending power to the lower levels while still maintaining control over the spending ceiling, a core goal for successful PFM.

We suggest recommendations (box 1) that facilitate engagement and communication across finance and clinical managers, a key challenge especially for LMICs who are under the dual pressure of austerity and UHC implementation. In following these recommendations, PFM reforms can be developed collaboratively, which can ensure both reform success and safeguarding of OC and so, an organisation's functioning.

As we grapple with the COVID-19 pandemic, the austerity climate is bound to worsen. We need to be mindful of the ways in which austerity and the PFM policies it brings, can impact on OC, and so affect organisational functioning. The World Bank Group has already started publishing guidance for treasuries on how to be able to respond agilely to the needs of social sectors,[36] for example, by making it easier for facilities to access funds to procure needed goods and by allowing for more real time reporting of available cash. Our paper showcases the deleterious effects of a health system that is unresponsive and authoritarian and feeds into this new body of recommendations that call for greater collaboration across finance and clinical managers. The pandemic could further tip the scales of power toward finance managers, as they attempt to control the shrinking public purse. We caution against this and highlight the system benefits of a participatory culture, especially for effective PFM.

Box 1 Recommendations

For the study setting

- Include district managers and hospital chief executive officers in the provincial executive team.
- Rotate provincial finance managers through district health offices (DHOs) and hospitals to facilitate greater understanding of the challenges on the ground; this will allow for relational accountability.
- Rotate the chair of the centralisation committee on a weekly basis.
- Invite key stakeholders from the districts and facilities to sit on the centralisation committee, including members of the district centralisation committees, even if on an ad hoc/as possible basis, to build capacity at lower levels, and foster trust between the levels of the health system, in preparation for decentralisation and National Health Insurance.
- In time, the centralisation committee could determine a list of decisions that could be delegated to district-level committees. The time spent together should provide a foundation for relational accountability, which should improve public financial management.

For international application

- Finance managers should spend time in facilities and DHOs to better understand the reality on the ground.
- The time spent together on the ground would support relational accountability between clinical and finance managers.
- Once the relationship between clinical and finance managers begins to strengthen, finance teams should determine an initial list of decisions that can be delegated to the lower levels of the system to support a transition to decentralisation.

JWs access to managers was linked to her existing relationships and these were mostly with senior managers. This was a possible reason for only four junior managers agreeing to be interviewed. The distance between her home province and the study province restricted how often she could conduct data collection. This was mitigated through longer data collection periods. Lastly, the findings are limited to one province; while they cannot be generalised, the experiences documented are similar in other South African provincial departments of health and LMICs.

CONCLUSION

The PDoHs centralisation reform influenced its OC, reducing opportunities for participatory decision making and polarising finance and clinical managers. This not only hindered reform implementation, but also impacted negatively on the overall functioning of the health system. The pressure placed on the department by the socio-political context of austerity and financial mismanagement, had a direct bearing on reform choice and design. As public health systems become even more financially constrained, alongside the pressure to rollout massive system restructuring to support UHC, recognising the ways in which PFM reform can influence OC, and how the negative effects can be mitigated, is of international importance.

Twitter Jodi Wishnia @jodi_wishnia

Acknowledgements We would like to acknowledge the PDoH and all participants for their contribution.

Contributors Both authors conceived of and planned the paper. JW is the principal researcher and conducted data collection and primary data analysis. JG reviewed the data analysis results and provided expert guidance. JW was the primary manuscript writer, with JG providing detailed input. Both authors approved the final version of the manuscript.

Funding JW's research is funded by the South African Research Chair Initiative.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not required.

Ethics approval Ethical approval was granted by the University of Witwatersrand's Human Research Ethics Committee (Medical) (M170346) and the PDoHs research committee.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data relevant to the study are included in the article or uploaded as online supplemental information. All relevant data are included in the paper.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made indicated, and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/.

ORCID iDs
Jodi Wishnia http://orcid.org/0000-0002-2525-6964
Jane Goudge http://orcid.org/0000-0001-6555-7510

REFERENCES

1 Cashin C, Bloom D, Sparkes S, *et al*. *Aligning PFM and health financing: sustaining progress toward universal health coverage. health financing working paper*. Geneva: World Health Organization, 2017.
2 Barroy H, Piatti-Funfkirchen M, Fabrice S, *et al*. Let managers manage: a health service provider's perspective on public financial management: World Bank 2019.
3 Abimbola S, Baatiema L, Bigdeli M. The impacts of decentralization on health system equity, efficiency and resilience: a realist synthesis of the evidence. *Health Policy Plan* 2019;34:605–17.
4 Akintola O, Gwelo NB, Labonté R, *et al*. The global financial crisis: experiences of and implications for community-based organizations providing health and social services in South Africa. *Crit Public Health* 2016;26:307–21.
5 2019 budget review: South African national Treasury 2019.
6 National health insurance green paper: South African national department of health 2011.
7 Blecher M, Daven J, Kollipara A, *et al*. Health spending at a time of low economic growth and fiscal constraint. In: Padarath A, Barron P, eds. *South African health review*. Durban: Health Systems Trust, 2017.
8 Powell-Jackson T, Hanson K, McIntyre D. Fiscal space for health: a review of the literature: Resyst 2012.
9 von Holdt K. The political economy of corruption elite-formation, factions and violence working paper 10 Society, Work & Politics Institute; 2019.
10 Rispel LC*et al*. Analysing the progress and fault lines of health sector transformation in South Africa. In: Padarath A, King J, Mackie E, *et al*, eds. *South African health review*. Durban: Health Systems Trust, 2016.
11 South African National Department of Health. Confronting the right to ethical and accountable quality health care in South Africa; 2019.
12 Rispel LC, Moorman J. Federalism, interdependence, and the health care system in South Africa. In: Marchildon G, Bossert TJ, eds. *Federalism and decentralization in health care: a decision space approach*. University of Toronto Press, 2018: 117–48.
13 South African National Treasury. Principles of public administration and financial management delegations; 2013.
14 South African National Department of Health. National health insurance white paper; 2017.
15 Gordon GG, DiTomaso N. Predicting corporate performance from organizational culture. *J Management Studies* 1992;29:783–98.
16 Schein E. *Organizational culture and leadership*. Fourth ed. Jossey-Bass, 2010.
17 Yrjo-Koskinen J, Kagone M, Souares A, *et al*. The influence of organizational culture on information use in decision making within government health services in rural Burkina Faso. *Nord J Afr Stud* 2010;19:250–73.
18 Carlström ED, Ekman I. Organisational culture and change: implementing person-centred care. *J Health Organ Manag* 2012;26:175–91.
19 Sheikh K, Gilson L, Agyepong IA, *et al*. Building the field of health policy and systems research: framing the questions. *PLoS Med* 2011;8:e1001073–6.
20 Mbau R, Gilson L. Influence of organisational culture on the implementation of health sector reforms in low- and middle-income countries: a qualitative interpretive review. *Glob Health Action* 2018;11:1462579.
21 House R, Javidan M, Dorfman P. Project globe: an introduction. *Appl Psychol* 2001;50:489–505.
22 Hammersley M, Atkinson P. What is ethnography? In: *Ethnography principles in practice*. Routledge, 2007: 15–48.
23 Yin R. Designing case studies: Identifying your case(s) and establishing the logic of your case study. In: Knight V, ed. *Applied social research methods series*. 5th ed. London: SAGE Publications, Inc, 2014: 3–27.
24 Brown PA. A review of the literature on case study research. *CJNSE*2008;1.
25 Fox N, Hunn A, Mathers N. Trent focus for research and development in primary health care: how to use observations in a research project: Trent focus group 1998.
26 DeJonckheere M, Vaughn LM. Semistructured interviewing in primary care research: a balance of relationship and rigour. *Fam Med Community Health* 2019;7:e000057.
27 Mills A, Durepos G, Wiebe E. *Thick description. Encyclopedia of case study research*. SAGE Publications, Inc, 2013.
28 Lieber E, Weisner TS. Dedoose 2013.
29 Nowell LS, Norris JM, White DE, *et al*. Thematic analysis: Striving to meet the trustworthiness criteria. *Int J Qual* 2017;16.
30 Erasmus E, Orgill M, Schneider H, *et al*. Mapping the existing body of health policy implementation research in lower income settings: what is covered and what are the gaps? *Health Policy Plan* 2014;29 Suppl 3:iii35–50.
31 Cervero-Liceras F, McKee M, Legido-Quigley H. The effects of the financial crisis and austerity measures on the Spanish health care system: a qualitative analysis of health professionals' perceptions in the region of Valencia. *Health Policy* 2015;119:100–6.
32 Penn-Kekana L, Blaauw D, Schneider H. 'It makes me want to run away to Saudi Arabia': management and implementation challenges for public financing reforms from a maternity ward perspective. *Health Policy Plan* 2004;19 Suppl 1:i71–7.
33 Nxumalo N, Gilson L, Goudge J, *et al*. Accountability mechanisms and the value of relationships: experiences of front-line managers at subnational level in Kenya and South Africa. *BMJ Glob Health* 2018;3:e000842.
34 Mash RJ, Govender S, Isaacs A-A, *et al*. An assessment of organisational values, culture and performance in Cape town's primary healthcare services. *South African Family Practice* 2013;55:459–66.
35 National Health Insurance bill. B-2018 2018;2018:16–60.
36 Smithers NJ, Brumby JA, Farooq K. Agile Treasury operations during COVID-19 The World Bank; 2020.

CHAPTER 8. STRENGTHENING PUBLIC FINANCIAL MANAGEMENT IN THE HEALTH SECTOR: A QUALITATIVE CASE STUDY FROM SOUTH AFRICA

Wishnia J, Goudge J. Strengthening public financial management in the health sector: a qualitative case study from South Africa. BMJ Global Health 2021;0:e006911. doi:10.1136/ bmjgh-2021-006911

BMJ Global Health

Strengthening public financial management in the health sector: a qualitative case study from South Africa

Jodi Wishnia , Jane Goudge

To cite: Wishnia J, Goudge J. Strengthening public financial management in the health sector: a qualitative case study from South Africa. *BMJ Global Health* 2021;**6**:e006911. doi:10.1136/bmjgh-2021-006911

Handling editor Stephanie M Topp

Received 15 July 2021
Accepted 11 October 2021

Check for updates

© Author(s) (or their employer(s)) 2021. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ.

Centre for Health Policy, School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa

Correspondence to
Jodi Wishnia;
jodiwishnia@gmail.com

ABSTRACT

Introduction Effective public financial management (PFM) ensures public health funds are used to deliver services in the best way possible. Given the global call for universal health coverage, and concerns about the management of public funds in many low-income and middle-income countries, PFM has become an important area of research. South Africa has a robust PFM framework, that is generally adhered to, and yet financial outcomes have remained poor. In this paper, we describe how a South African provincial department of health tried to strengthen its PFM processes by deploying finance managers into service delivery units, involving service delivery managers in the monthly finance meeting, using a weekly committee to review expenditure requests and starting a weekly managers' 'touch-base' meeting. We assess whether these strategies strengthened collaboration and trust and how this impacted on PFM.

Method This research used a case study design with ethnographic methods. Semi-structured interviews (n=30) were conducted with participant observations. Thematic analysis was used to identify emergent themes and collaborative public management theory was then used to frame the findings. The authors used reflexive methods, and member checking was conducted.

Results The deployment of staff and touch-base meeting illustrated the potential of multidisciplinary teams when members share power, and the importance of impartial leadership when trying to achieve consensus on how to prioritise resource use. However, the service delivery and finance managers did not manage to collaborate in the monthly finance meeting to develop realistic budgets, or to reprioritise expenditure when required. The resulting mistrust threatened to derail the other strategies, highlighting how critical trust is for collaboration.

Conclusion Effective PFM requires authentic collaboration between service delivery and finance managers; formal processes alone will not achieve this. We recommend more opportunities for 'boundary crossing', embedding finance managers in service delivery units and impartial effective leadership.

Key questions

What is already known?

- Budget and service delivery planning cycles are often out of sync with one another, causing a misalignment between the two.
- Despite the evidence of the benefits, collaborative ways of working have remained difficult to implement in organisations.
- If service delivery managers are to make best use of available resources, and conform to the rules of public financial management (PFM), service delivery and finance managers need to work closely together, matching service delivery plans and available resources.

What are the new findings?

- Public financial management improvement strategies that do not take into account the service delivery context are unlikely to succeed.
- Trust (the repair and the building of it) is a critical factor for facilitating collaboration.
- Collaborative public management is a helpful framework for structuring new PFM process reforms.

What do the new findings imply?

- More opportunities for 'boundary crossing' are needed to facilitate a closer working relationship.
- We recommend a physical shift of finance managers into service delivery units as one way to support this.
- Finance managers need to undergo some training in health to support a better understanding of the health sector.
- The leadership of multidisciplinary committees needs to be carefully selected to ensure that the committee can reach decisions that support the strategic goals of the health system, which include both quality service delivery and effective public financial management.
- Authentic collaboration requires active effort, especially where there are historical trust deficits.
- New strategies need to respond and incorporate mechanisms to improve relationships between health system actors.

INTRODUCTION

Effective public financial management (PFM) ensures public funds are used in the best possible way to deliver public services. There is no consistent definition of PFM,[1] but its most broad definition includes four stages of PFM, each with associated processes.[2] These are: (1) budget planning/formulation, with

BMJ Glob Health: first published as 10.1136/bmjgh-2021-006911 on 2 November 2021. Downloaded from http://gh.bmj.com/ on November 3, 2021 by guest. Protected by copyright.

strategic budgeting and budget preparation processes, (2) budget approval, with legislative debate process associated, (3) budget execution, with the processes of internal control, resource management and accounting and reporting associated and lastly (4) budget evaluation, which includes the process of external auditing.[2] These are often consolidated into three broad processes for the purpose of clarity: budget planning, budget execution and expenditure monitoring and evaluation, and this paper follows this approach.[3] Given the global call for universal health coverage (UHC), and concerns about the management of public funds in many low-income and middle-income countries (LMICs), strengthening PFM has become critical as health sectors attempt this large scale reform.[3]

PFM in the health sector is complex because of the unpredictable nature of healthcare needs, its life and death consequences and the ever-shifting policies aiming to improve health outcomes. PFM processes, often viewed as inflexible, can be a barrier to health systems being able to respond to changing local circumstances.[3] Attempts to remedy this have included decentralisation to allow local decision-making,[4] combined with linking budgets to health outcome targets to make the goals of health spending clear.[5] The rising costs of healthcare, alongside constrained budgets, often leads to over expenditure and subsequent cash flow problems.[6 7] Moreover, compiling accurate budgets is a challenge as activities are frequently not costed.[8] Over time, cash flow constraints, and little or no information on the cost of activities, can make planning seem redundant.

If service delivery managers are to make best use of available resources, and conform to the rules of PFM, service delivery and finance managers need to work closely together, matching service delivery plans and available resources.[9 10] Organisational management and public administration literature have advocated for the use of collaborative approaches, like participatory decision-making and collaborative networks, to improve performance.[11–15] Despite the evidence of the benefits,[11 12] collaborative ways of working have remained difficult to implement.[16] We used collaborative public management (CPM)[17] theory to assess strategies used by the PDoH to strengthen PFM, and understand why some were more successful than others, and the lessons for other LMIC settings.

Country context

The South African health system is comprised of a National Department of Health (NDoH), nine provincial DoHs and 52 district health offices. The NDoH's role is to create policy and monitor the performance of the public health sector.[18] PDoHs are responsible for planning and delivery of health services and are allowed to create province-specific policy that aligns to the national policy.[18–20] The districts are the implementing arm of the PDoH.

South Africa's PFM framework is one of the strongest on the continent.[3] Public sector departments advocate for their resource needs at medium-term expenditure committee (MTEC) 'hearings' run by provincial treasuries. Once departments have received confirmation of their budget envelope, they finalise their medium-term expenditure framework (MTEF), which links the budget, at an aggregate level, to service delivery targets (PDoHs are not responsible for revenue mobilisation—all funding is received directly from the provincial treasury. We have therefore not included revenue mobilisation aspects of PFM in this paper.). Finalised finance and service delivery documents (Annual Performance Plans, Medium Term Strategic Frameworks, etc) are published annually, contributing to South Africa's high scoring on budget overview and transparency on the Global Open Budget Survey.[21] During the year, the monthly finance meeting (called the budget advisory committee), mandatory according to South Africa's PFM regulations, enables budget planning and execution and expenditure monitoring and evaluation; it is a critical space for strategic alignment between available resources and operational plans.

Despite the strength of the financial management framework, there are several problems (in the last decade, there has been widespread corruption in the South African public sector which has contributed to the austerity climate, however, this paper is concerned with suboptimal PFM processes, rather than illegal activities).[22] As policy development happens at the national and provincial levels, the details of implementation are often missing, so the costs are regularly underestimated, and the districts receive unfunded policy directives. Annual service delivery plans are usually not costed either, making it difficult for finance managers to compile overall budgets with reasonable estimates for key line items.

The districts and PDoHs rely on historical expenditure for their planning, which does not reflect the increasing cost of delivering care from 1 year to the next. Furthermore, the final provincial budget from national and provincial treasuries is provided at the same time as the final draft of the annual performance plan is due (figure 1), so plans are developed with insufficient knowledge of the funds available.

The province studied often experiences cash flow problems (common in other South African provinces) relating, first, to large accruals from the previous year. The province sometimes has to procure core items without the requisite funds, and so the payments are deferred, generating accruals. Second, the province has to pay out large amounts for medical negligence claims.[23] (In a companion paper to be published elsewhere, we describe the strategies used to manage the effect of these claims). Both the accruals and the negligence claims can cause reductions in the available funds even after yearly planning has been completed. Furthermore, austerity measures, in place for the health sector since 2012, have

BMJ Glob Health: first published as 10.1136/bmjgh-2021-006911 on 2 November 2021. Downloaded from http://gh.bmj.com/ on November 3, 2021 by guest. Protected by copyright.

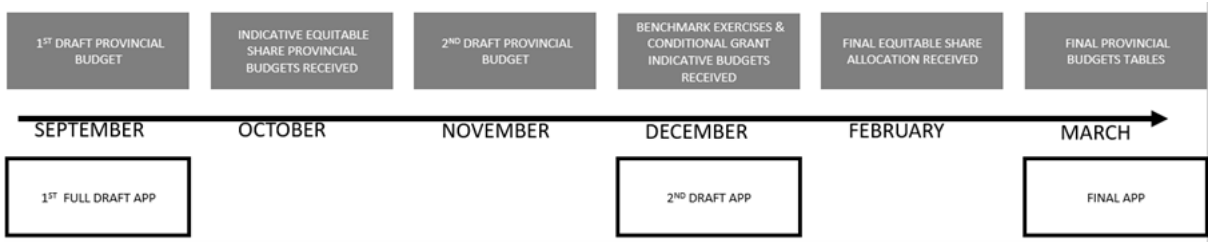


Figure 1 Milestones in the provincial budget and planning cycles. APP, annual performance plan.

resulted in a declining overall budget for health, exacerbating funding shortages.[24]

Centralised control of expenditure (which we described in another companion paper[25]), introduced to deal with these problems, helped the province achieve an unqualified audit opinion in 2015—the first time in 12 years. (In this paper, we do not analyse the auditing processes of PFM as this happens through an external body to the PDoH. This paper focuses on the internal control processes of PFM that support good audit outcomes.). However, the centralisation was not associated with improved service delivery. In the same year as the unqualified audit, the maternal mortality ratio (often used as an indicator for health system performance) remained higher than the national average and the province's own targets for reducing this indicator were not achieved.[26]

The combination of an uncertain budget ceiling, a misaligned planning and budgeting cycle, poor costing of service delivery activities, insufficient funds to cover core items and centralised financial decision-making reduces the value of time spent planning. Service delivery managers put little effort into the process, setting PDoHs up for suboptimal performance against their own targets. This poor planning and performance undermines the PDoHs efforts at the MTEC hearings. It also drives the misalignment between service delivery and financial management, causing distrust between the managers involved.

In this paper, we describe how a South African PDoH tried to strengthen its PFM processes by: deploying finance managers into service delivery units; involving service delivery managers in the monthly finance meeting; introducing a weekly committee to review expenditure requests; and starting a weekly managers' 'touch-base' meeting to coordinate activities (table 1). We assess whether these strategies strengthened collaboration and trust between service delivery and finance managers and whether they were able to overcome some of the challenges of PFM in health systems described above.

CONCEPTUAL FRAMEWORK

Bringing together multiple actors, with different skills and responsibilities, is critical for solving intractable problems.[17] The hallmark of CPM is 'boundary crossing', which aims to bring differently skilled actors into the same space to solve a problem that does not lie purely in one domain.[27] Given the disjuncture between finance and service delivery managers in the health system, and the impact of this on health system functioning, we have used CPM as a lens through which to analyse efforts to improve PFM.

Agranoff and McGuire refer to four processes that are required for successful CPM, these are participation, establishing ways of working, mobilising support and building trust.[15] (Agranoff and McGuire use the terms

Table 1 Strategies used in the province to try to improve public financial management

Strategy	Purpose	Frequency and site
Deploying finance managers into service delivery units ('deployment of finance managers')	To provide provincial service delivery managers with financial expertise to support better alignment between budget planning and service delivery priorities.	► Daily ► PDoH office
Involving service delivery managers in the monthly finance meeting ('monthly finance meeting')	To determine how to allocate the budget according to service delivery needs (budget planning); to ensure expenditure matches the prioritised service delivery needs (budget execution); to report on expenditure during the year so service delivery managers are aware of available funds (expenditure monitoring); and, to provide strategic direction for the weekly review meeting and the weekly touch-base meeting.	► Monthly ► District office
Weekly committee to review expenditure requests ('weekly review committee')	To review expenditure requests from facilities to assess whether the requests reflect decisions made at the monthly finance meeting, and whether there are sufficient funds.	► Weekly ► District office
Weekly managers' 'touch-base' meeting ('weekly touch-base meeting')	To ensure alignment of district wide activities for the coming week with the broader district strategy and approved resources.	► Weekly ► District office

BMJ Glob Health: first published as 10.1136/bmjgh-2021-006911 on 2 November 2021. Downloaded from http://gh.bmj.com/ on November 3, 2021 by guest. Protected by copyright.

Table 2 Processes of collaborative public management[14 15]

Process	Definition
Participation	Selecting the most appropriate people for the problem at hand and engaging them in their area of expertise.
Establishing ways of working	Developing a shared understanding of the roles and responsibilities of the group and establishing the leadership structure and a 'way of working'.
Mobilising support	Mobilising support not only refers to generating interest and motivation from those within the group but is also about generating support from those who are directly affected by the decisions made but are not within the group.
Building trust	How the group builds trust among themselves to facilitate working together effectively.

activation, framing, mobilising and synthesising; we have renamed them purely for ease of understanding.) Participation refers to selecting people with the most appropriate expertise for the problem at hand and who are accepted for this role by a range of stakeholders. Establishing ways of working relates to how the group works together, and agreement on the leadership and member roles. Mobilising support is about how much support the group generates both from inside the group and from those who sit outside it but are affected by the decisions taken. Lastly, building trust relates to how the group members build trust in one another, which, if achieved, facilitates better collaboration and so outcomes (table 2).

METHODS

Study design

This research used a case study design with ethnographic methods.[28] This approach facilitates immersion into the local context and a deep understanding of a particular problem or context within organisations.[28] This study design is appropriate when a researcher aims to explain 'how' or 'why' something occurred, and the perspectives from those within the system. These methods were therefore well suited for understanding how the strategies used to strengthen PFM processes in the provincial health system were experienced and why some were more successful than others.

Study setting and negotiating access

The PDoH studied has a long history of financial mismanagement and has both decentralised and recentralised financial management processes several times over the past decade in attempts to strengthen PFM. The province is large and predominantly rural, making it difficult for managers across the different districts to come together regularly. JW worked with the PDoH in her capacity as a health financing consultant periodically between 2013 and 2016, prior to the start of this research. She was familiar with many of the middle-level and senior-level managers and this allowed her to reach out to one senior finance manager to discuss the possibility of starting this research project with the province. After receiving the initial gatekeeper's support for the research, JW shared the research protocol with the executive management of the province and received approval for the study.

Informed consent was obtained for all observations, interviews and audio recordings and assured participants that their contributions would be de-identified.

Participant selection

PDoH employees responsible for financial or service delivery management at a district office, a public hospital or the PDoH office formed the study participants. The term service delivery manager includes service delivery managers at an administrative and facility level. JW initially used purposive sampling to recruit participants for the interviews, after which she used snowball sampling either through facilitated introductions or through a referral by an interviewee. No one explicitly refused to participate in the study, however 15 managers never responded to several requests for an interview. JW conducted 30 interviews (table 3) and attended routine departmental meetings as part of her participant observations.

Data collection

Data collection took place between July 2017 and June 2018. First, JW attended two 1-day meetings where she gave an overview of the research. The first meeting was with the top management of the PDoH and the second with key personnel from the PDoH and district offices where the research would take place. After this, data collection began, and all data was collected in-person by JW. Participant observations and semi-structured interviews were used to collect the data. Most of the observations and interviews took place either within the PDoH office, district office or a public hospital. JW used an observation guide[29] to make detailed meeting notes.

JW also used a semi-structured interview guide, employing a grand tour approach. The grand tour approach sets a scope for an interview, but allows the participants to decide which topics within the scope they want to focus on, this method is valuable for eliciting a thick description.[30] The authors slightly adapted the questions for managers at the different levels of the health system. Examples of the questions used include, 'tell me about a time where you felt you achieved something' and 'tell me about your experiences of working with the head office'.

Interviews lasted between 20 and 60 minutes and only JW and the interviewee were present. One participant did not consent to being audio recorded, he felt it would impede his contribution. The interview still went ahead, with JW taking hand-written notes. No one was interviewed more than once, but lessons learnt from prior interviews were used to amend the interview guide later during the data collection period. When the authors

BMJ Glob Health: first published as 10.1136/bmjgh-2021-006911 on 2 November 2021. Downloaded from http://gh.bmj.com/ on November 3, 2021 by guest. Protected by copyright.

Table 3 Demographic characteristics of interviewees, by level of management and health system

Management level	Provincial	District	Hospital	Finance/support services	Service delivery	Female	Total
Senior	7	3	4	8	6	6	14
Middle	4	8	0	6	6	10	12
Junior	0	4	0	4	0	2	4
Total	**11**	**15**	**4**	**18**	**12**	**18**	**30**

determined that data saturation had been reached, JW concluded data collection.

Data analysis

The audio recordings from the interviews were de-identified and transcribed by an external company. JW subsequently checked the transcriptions against the recordings for accuracy. JW also had the notes from the observations and her own notes on each interview and interaction with the PDoH. These data formed the data set for analysis.

The data set was read by both authors and JW coded the data into common themes. The authors then discussed these themes and re-analysed the dataset and coded the data in accordance with the emergent themes. For this paper, the authors used the CPM framework, with its four processes as the codes, to analyse the data. In the results section of this paper, identifiers are used to anonymise the verbatim quotations. An 'i' indicates data gathered via an interview. We also indicate the level at which the interviewee works at, either a 'P' for PDoH office, 'D' for district office or 'H' for public hospital. Observation notes strengthened the analysis, but no direct quotes from the notes are used.

The authors conducted member checking through a 1 day interactive workshop in the province. Everyone who was interviewed, or part of the observations was invited, including any other staff who were interested. We used heterogeneous small groups during the workshops to discuss the three major emergent themes from the research and elicited discussion and debate from the participants on whether the findings matched their understanding and experience. These discussions contributed to the final framing of the research findings and the development of the recommendations. The first author's prior knowledge and experience of the province and the topic, rigorous data analysis methods and member checking have contributed to the credibility and confirmability of the research findings.

Reflexivity

The first author and primary data collector (JW) is a South African woman with a master's in public health. JW used reflexive note taking during data collection and analysis. After each interview, JW wrote down her experience of the interview and any noteworthy issues about the quality of the interview or the behaviour of the interviewee. JG also interrogated this data and JW's findings to ensure that they were a true reflection of the data, to minimise JW's own perceptions colouring the interpretation.

Patient and public involvement

No patients or members of the public were involved in the research design, analysis nor dissemination of the findings. Provincial, district and hospital managers contributed to the focus of the study and were involved in the interpretation of the findings.

FINDINGS

Deploying finance managers into service delivery units

The finance team deployed finance managers to several service delivery teams in the PDoH office: "When you're in the health environment, your non-financial managers need urgent [financial] assistance […] I think it is important for our service delivery managers to have support in relation to financial analysis, financial interpretation and remedial measures." [iP10]. There were high levels of support for this strategy: "A lot of times [as a finance manager] you're seen as something different, whereas you should be integrated. I think the new structure works better." [iP4].

However, there was little consensus on the role of the deployed finance managers. The senior finance managers had hoped that it would result in better financial reporting and a reduction in expenditure. The service delivery managers hoped the finance managers' presence would lead to more compelling expenditure requests, and so more success in obtaining funds. Moreover, service delivery managers had expected to become the deployed finance staff's new line managers given the move into their unit, while the finance team felt their staff should remain under their leadership. However, the deployed managers became embedded in the service delivery teams, creating tension with their finance line managers: "It's a tough one, I'm a sell-out to the finance administrators. The objective of the finance guys is to make the books look good, but my objective is to ensure that service delivery is well resourced. […] I have had lots of confrontation. You have to have courage […] service delivery managers are looking to you to ensure that they've got adequate resources." [iP7].

The lack of consensus on the reporting lines and role of the deployed managers left those involved to craft the role together: "My role has been to educate my finance colleagues […] try to show them the perspective of the clinicians. But in the same breath, I also have to educate the clinicians. They have to understand that there are finance rules that must be upheld, and we need to follow those rules." [iP7].

BMJ Glob Health: first published as 10.1136/bmjgh-2021-006911 on 2 November 2021. Downloaded from http://gh.bmj.com/ on November 3, 2021 by guest. Protected by copyright.

Monthly finance meeting

This meeting provides a forum for PFM discussions during the year and includes finance and service delivery managers at the district and subdistrict level, and more recently the district hospital chief executive officers (CEOs). The meeting should provide strategic direction through planning, responsive PFM and strong oversight mechanisms to prevent over-spending. One of the goals of the monthly finance meeting is to limit the need to shift funds between line items too often during the year, by facilitating more realistic plans that are linked to service delivery needs.

In both districts studied, the district manager delegated the leadership of the monthly finance meeting to the senior finance manager (this position is the same rank as the district manager), to give him responsibility for his area of work. Because the district manager played a very limited role, the focus of the meeting was about conforming to finance-related rules rather than ensuring the finance function supported service delivery.

Several district finance managers expressed frustration at the poor-quality budget submissions from district hospitals. They believed that the CEOs were not sufficiently in touch with the needs of their facilities, resulting in a suboptimal budget planning process: "You'll find that there is medicine in stock, but because the CEO doesn't have a handle on what is happening, they request [more] medicines." [iP2]. The finance managers corrected the budgets, citing time constraints (related to the regulatory requirements for finalising the MTEF) for why they were unable ask the hospital CEOs for input into the corrections. As a result, the final hospital budgets were often very different from the original submission, and these changes were not communicated prior to finalising the budget. The PDoH finance managers were not convinced that the service delivery managers had the requisite PFM skills to contribute meaningfully to the monthly finance meeting: "You first need to empower the CEOs, and the district managers. They were given the responsibility to itemise their budgets, to avoid the need to shift funds during the year […]. But that has not improved, in fact it has become worse." [iP1]. They assumed that the remaining high number of requests to shift funds during the year was due to service delivery managers' poor understanding of PFM and their own service delivery environment, rather than their budgets being finalised without them and inappropriate decision-making by the district finance managers.

Hospital CEOs reported that they would often only hear about decisions after they had been taken. Nevertheless, they were still keen to try and influence decision-making: "You know if you don't speak, you'll regret it, at some stage you'll say: 'had I have spoken, maybe something would have changed'. […] If you give up, you won't enjoy the work." [iH20]. The finance team decided to use 'average length of in-patient stay' to determine district hospital resource allocation (which would create an incentive to keep patients in hospital longer to obtain more funding). After hearing this, the CEOs were able to convince them to change their plan, improving finance managers understanding of the service delivery environment.

Weekly district expenditure review committee

The role of the weekly review committee was to check the expenditure requests against strategic decisions taken at the monthly finance meeting, assess requests against available funds and ensure compliance with PFM rules, before sending them to the PDoH office expenditure review committee for approval.

The committee included only finance and supply chain managers and was not designed to be interactive: "It's not a meeting […] We only discuss a request when there is something that you don't understand […] that's the only time we interact with each other." [iD21]. The committee did not have a leader, each member reviewed a batch of requests to check the forms for completion, compliance and against the available budget. This should have worked well, given that the monthly finance meeting was in place for strategic discussion and consensus building. However, the monthly finance meeting did not give clear direction and any decisions taken were not communicated, and so the weekly review committee was left to prioritise requests with their limited view of service delivery needs.

Most finance managers were satisfied that the weekly review committee was addressing the previous challenges: "Now we are involved, now we are able to work together and save [money] for the department." [iD24]. However, the committee created delays and became a source of mistrust and tension: "The facilities get cross with you […] If I have submitted your request to provincial office, there's nothing more I can do." [iD21].

Weekly district 'touch-base' meeting

The aim of the touch-base meeting was to ensure weekly activities were in line with the district's strategic plan. The district manager chaired the meeting, and managers across the different teams actively participated. There were high levels of support for this meeting from those within and outside of the meeting: "If you are planning to visit a certain facility, [you will] hear whether there are challenges, or if anyone else is also going […]. It allows for continuity and it brings us together as a team." [iD13]. The meeting placed the district finance and service delivery managers in regular contact, facilitating a shared understanding and building trust: "We are able to hear the budget issues and we are able to address district issues, so it's a much-needed meeting." [iD15].

The district manager's leadership contributed to the success of this strategy, as all participants felt heard and participated equally. This sentiment extended to other fora where finance and service delivery managers were viewed as equal contributors to the meeting: "The district is so integrated. A programme is run by clinical staff, but you have someone from finance, someone from human

BMJ Glob Health: first published as 10.1136/bmjgh-2021-006911 on 2 November 2021. Downloaded from http://gh.bmj.com/ on November 3, 2021 by guest. Protected by copyright.

resources as part of the team. We do not have what they are experiencing at the PDoH office." [iD15].

However, the lengthy approval processes, in part due to the monthly finance team's inability to facilitate re-prioritisation in light of cash flow constraints, still generated tension among team members, as a finance manager recounted: "My team received an appointment letter for community health workers […] but I found an error, and so we sent the forms back. The district manager issued an instruction that over-rode my instruction and I felt I was not given space to operate in my own office. I was called to the District Manager's office […]. The meeting was very bad. The district manager even said we are sabotaging the district." [iD18].

Table 4 Comparison of strategies against collaborative public management framework

Strategy	Participation	Establishing ways of working	Mobilising support	Building trust
Deployment of finance managers	**Strong:** ► Service delivery and finance managers involved.	**Moderate:** ► Confusing reporting lines. ► Unclear objectives and divided loyalties. ► Informal ways of working established by those involved supported embeddedness.	**Moderate:** ► Support across the system. ► Finance managers began to understand the pressures and were motivated to ensure resources follow the need. ► Senior finance managers concerned that deployed managers were too embedded.	**Strong:** ► High levels of trust fostered between those involved by being part of same team. ► Improved costing for provincial policies and district activities.
Monthly finance meeting	**Moderate:** ► Finance and service delivery managers attended, but the latter not fully included.	**Weak** ► District manager delegates chairing to finance manager. ► Service delivery managers have limited influence. ► Key opportunity to enable service delivery and finance managers to work together is missed.	**Moderate:** ► CEOs felt their inclusion had improved resource allocation decision-making. ► Provincial management saw no improvement in PFM, reducing their support.	**Weak:** ► Relationships remained strained between service delivery managers/CEOs and district finance teams due to poor leadership.
Weekly review meeting	**Strong:** ► Only finance managers included because it is a PFM compliance step.	**Moderate:** ► Efficient way of working for a PFM compliance activity. ► Reliant on strategic direction from monthly finance meeting which was not forthcoming. ► This has given weekly review committee undue decision-making power.	**Moderate:** ► District finance satisfied that expenditure control has improved; acknowledge delays which cause frustration. ► Service delivery managers did not support the prioritisation role this committee landed up playing.	**Weak:** ► Added to existing tensions and trust deficits because of poor feedback and a lack of collaboration with other strategies.
Weekly touch-base meeting	**Strong:** ► All district managers included.	**Strong:** ► District manager as leader. ► Roles were clear.	**Strong:** ► Support for the meeting was evident.	**Moderate:** ► Better working relationships. ► Remaining trust deficits because of the tension between PFM processes and urgency of service delivery.

CEOs, chief executive officers; PFM, public financial management.

BMJ Glob Health: first published as 10.1136/bmjgh-2021-006911 on 2 November 2021. Downloaded from http://gh.bmj.com/ on November 3, 2021 by guest. Protected by copyright.

In table 4 we summarise how each strategy fared using the CPM framework. We use the labels strong, moderate or weak to denote the extent to which the requirements for each domain were met.

DISCUSSION

In the uncertain financial environment (declining budget envelope, accruals and medical negligence claims) the monthly finance meeting could have played an important feedback, consensus building and prioritisation role between service delivery and finance managers. The meeting's failure to do this, especially because the service delivery managers were eager to participate, eroded trust and reinforced finance managers' power in the system. In contrast, the deployment strategy and touch-base meeting illustrated the potential of multidisciplinary spaces and committees when members share power equally and feel part of the same team. The touch-base meeting also revealed the importance of impartial leadership. Using the district manager, or any manager who can play that strategic role, helped the touch-base meeting to decide on actions and use of resources in line with the strategic priorities. However, the failure of the monthly finance meeting to acknowledge and attempt to repair the historical trust deficit impeded efforts to build a collaborative decision-making space. This failure threatened to derail the other efforts to strengthen PFM, highlighting how critical trust is for enabling a collaborative environment.

Rycroft-Malone *et al* discuss 'authentic collaboration'—where efforts to be collaborative must facilitate real engagement across stakeholders.[31] They also emphasise that collaboration is not possible without active effort, particularly in contexts where there is historical mistrust and tension.[31] Therefore, strategies that do not acknowledge the extent of the disconnect and relational strain in the system, and which do not actively work to repair and build trust, will not succeed in achieving authentic collaboration. Establishing trust requires moving towards more participative methods of leadership, that foreground relationships and sharing of power.[32–34] The monthly finance meeting missed opportunities to use this regular meeting for real engagement and it was unsuccessful in achieving an authentically collaborative environment. This was evident in how service delivery managers often described PFM as a barrier to service delivery. This perception reduced managers' willingness to work together, further polarising finance and service delivery managers.

Finance managers in the health sector are often frustrated by what they perceive to be service delivery managers' lack of understanding of the PFM regulatory environment. While more recent PFM literature has encouraged learning across disciplines and siloes, there have been few successful documented examples.[35] Additionally, because other sectors are more predictable and easier to budget for, there is more robust evidence on how to manage finances for those sectors as compared to health.[35 36] Therefore, finance managers in the health sector need supportive structures to facilitate their understanding of the health environment. The value of contextual learning and embeddedness was seen in the deployment of finance managers strategy. The managers involved were able to support one another in ensuring optimal use of public funds from a place of shared understanding. Recently published research from Kenya has shown the positive potential of dedicated health systems training for health managers.[37] While the Kenyan research only included service delivery managers, the value of the training programme both in facilitating a better understanding of the complexity of the health system and in strengthening managers interpersonal skills would clearly be useful for finance managers in health systems too. This training programme could include a practical element, where finance managers are deployed to service delivery units for a period to contextualise their learning.

Since the 2008 global recession, austerity and the declining health budget that accompanies it, have challenged health systems to 'do more with less'.[38] The COVID-19 pandemic has further exacerbated these funding shortages, and threatened to push South Africa, and many other LMICs into an even more severe austerity environment. The resulting shortages of staff (clinical and support) and critical goods and services place patients at risk for poor health outcomes and reduce morale among managers.[38] If budget ceilings are communicated more timeously to service delivery managers, planning can be better aligned to the (although limited) available resources.[39] However, the cash flow difficulties in the South African setting (and many LMICs) result in budgets that are constantly in flux, requiring regular re-negotiation of spending priorities during the year. Improved communication in the periods between the monthly finance meetings could help to keep managers up to date on the available funds and the priorities on the ground. Therefore, even more so in austerity environments, finance and service delivery managers must find ways to work more closely together.

PFM can support better service delivery outcomes provided the PFM processes are oriented toward information sharing and provide flexibility through mechanisms such as decentralised financial management.[3 40 41] Our paper suggests that strategies to improve PFM should foreground the repair and building of trust, facilitate contextual learning for finance managers and create regular opportunities for engagement to solve this intractable problem in health systems (see box 1).

Limitations

The researcher was well known to the province and this may have influenced how people reported their experiences. However, this was mitigated by multiple observations, reflexive note taking and the first author immersing herself in the province during the year of data collection. The researcher was not based in the province studied and had to travel to conduct data collection. This limited how

BMJ Glob Health: first published as 10.1136/bmjgh-2021-006911 on 2 November 2021. Downloaded from http://gh.bmj.com/ on November 3, 2021 by guest. Protected by copyright.

Box 1 Recommendations

- Improving public financial management requires the repairing of trust between finance and service delivery managers. Senior finance and service delivery managers should create opportunities for their managers to work shoulder-to-shoulder in interdisciplinary teams.
- Rollout of a health systems training programme that focuses on the complexity of health systems and growing finance managers interpersonal skills, coupled with time spent in service delivery units, would enable finance managers to better manage public health funds.
- Multidisciplinary committees can be useful for aligning service delivery and finance managers, especially in uncertain financial environments, if the committee members are given powers to reallocate funding and reprioritise activities and this is then communicated to the rest of the system.
- Impartial leadership can help to breakdown disciplinary siloes, facilitating a more productive engagement in multidisciplinary spaces.

often JW could collect data. This was mitigated by longer periods of data collection to ensure the data was sufficiently rich.

CONCLUSION

Improving PFM processes in health systems is reliant on better collaboration; however this is difficult given the historical trust deficits. The strategies that equalised power and brought managers into each other's physical space regularly, showed greater potential for strengthening PFM processes. To prevent PFM from being seen as a barrier to service delivery, we recommend more opportunities for 'boundary crossing' and collaborative processes across these health system actors are found.

Twitter Jodi Wishnia @jodi_wishnia

Acknowledgements We would like to acknowledge the PDoH and all participants for their contribution.

Contributors Both authors conceived of and planned the paper. JW is the principal researcher and guarantor of the paper. She conducted data collection and primary data analysis. JG reviewed the data analysis results and provided expert guidance. JW was the primary manuscript writer, with JG providing detailed input. Both authors approved the final version of the manuscript.

Funding JW's research is funded by the South African Research Chair Initiative.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not applicable.

Ethics approval Ethical approval was granted by the University of Witwatersrand's Human Research Ethics Committee (Medical) (M170346) and the PDoHs research committee. Ethical approval was based on the province and all participant information being de-identified to protect those involved in the study.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data relevant to the study are included in the article or uploaded as supplemental information. Not applicable.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made indicated, and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/.

ORCID iDs
Jodi Wishnia http://orcid.org/0000-0002-2525-6964
Jane Goudge http://orcid.org/0000-0001-6555-7510

REFERENCES

1 Pretorius C, Pretorius N. *A review of PFM reform literature*. London: DFID, 2008.
2 Andrews M, Cangiano M, Cole N. *This is PFM*. Harvard University: Center for International Development, 2014.
3 Piatti-Fünfkirchen M, Schneider P. From stumbling block to enabler: the role of public financial management in health service delivery in Tanzania and Zambia. *Health Syst Reform* 2018;4:336–45.
4 Smoke P. Rethinking decentralization: assessing challenges to a popular public sector reform. *Public Admin Dev* 2015;35:97–112.
5 Andrews M. How far have public financial management reforms come in Africa? In: *HKS faculty research working paper series*. 18. RWP, 2010.
6 Powell-Jackson T, Hanson K, McIntyre D. Fiscal space for health: a review of the literature: Resyst 2012.
7 Doherty J, Kirigia D, Okoli C, *et al*. Does expanding fiscal space lead to improved funding of the health sector in developing countries?: lessons from Kenya, Lagos state (Nigeria) and South Africa. *Glob Health Action* 2018;11:1461338.
8 CABRI. Value for money in the health sector: policy and budget planning 2011.
9 Tsofa B, Molyneux S, Goodman C. Health sector operational planning and budgeting processes in Kenya- "never the twain shall meet".. *Int J Health Plann Manage* 2015;10.
10 Le Houerou P, Taliercio R. *Medium term expenditure frameworks: from concept to practice. Preliminary lessons from Africa*. World Bank: The World Bank African Region Working Paper Series, 2002.
11 Dorfman P, Hanges P, Brodbeck F. Leadership and cultural variation: The identification of culturally endorsed leadership profiles. In: House R, Hanges P, Javidan M, eds. *Culture, leadership and organizations: the globe study of 62 societies*. SAGE Publocations, 2004.
12 Yrjo-Koskinen J, Kagone M, Souares A. The influence of organizational culture on information use in decision making within government health services in rural Burkina Faso. *Nord J Afr Stud* 2010;19:250–73.
13 Mandell M, Keast R, Chamberlain D. Collaborative networks and the need for a new management language. *Public Manag Rev* 2017;19:326–41.
14 Mcguire M. Collaborative public management: assessing what we know and how we know it. *Public Adm Rev* 2006.
15 Agranoff R, McGuire M. Big questions in public network management research. *J Public Adm Res Theory* 2001;11:295–326.
16 Kozuch B, Sienkiewicz-Malyjurek K. Factors of effective interorganizational collaboration: a framework for public management. *Transylvanian Rev Admin Sci* 2016;47:97–115.
17 O'Leary R, Vij N. Collaborative public management: where have we been and where are we going? *Am Rev Public Adm* 2012;42:507–22.
18 Rispel LC, Federalism MJ. interdependence, and the health care system in South Africa. In: Marchildon G, Bossert TJ, eds. *Federalism and decentralization in health care: a decision space approach*. University of Toronto Press, 2018: 117–48.
19 Nxumalo N, Gilson L, Goudge J, *et al*. Accountability mechanisms and the value of relationships: experiences of front-line managers at subnational level in Kenya and South Africa. *BMJ Glob Health* 2018;3:e000842.
20 Coovadia H, Jewkes R, Barron P, *et al*. The health and health system of South Africa: historical roots of current public health challenges. *Lancet* 2009;374:817–34.
21 Partnership IB. Open budget survey, 2019. Available: https://www.internationalbudget.org/open-budget-survey/reports [Accessed 20 Jun 2021].
22 Rispel LC, de Jager P, Fonn S. Exploring corruption in the South African health sector. *Health Policy Plan* 2016;31:239–49.
23 South African National Department of Health. Confronting the right to ethical and accountable quality health care in South Africa 2019.
24 Blecher M, Daven J, Kollipara A. Health spending at a time of low economic growth and fiscal constraint. In: Padarath A, Barron P, eds. *South African health review*. Durban: Health Systems Trust, 2017.
25 Wishnia J, Goudge J. Impact of financial management centralisation in a health system under austerity: a qualitative study from South Africa. *BMJ Glob Health* 2020;5:e003524.

BMJ Glob Health: first published as 10.1136/bmjgh-2021-006911 on 2 November 2021. Downloaded from http://gh.bmj.com/ on November 3, 2021 by guest. Protected by copyright.

26 Matthews Z, Rawlins B, Duong J. Geospatial analysis for reproductive, maternal, newborn, child and adolescent health: gaps and opportunities. *BMJ Glob Health* 2020;4.
27 Geddes L. In search of collaborative public management. *Public Manag Rev* 2012;14:947–66.
28 Côté-Boileau Élizabeth, Gaboury I, Breton M, *et al*. Organizational ethnographic case studies: toward a new generative in-depth qualitative methodology for health care research? *Int J Qual Methods* 2020;19:160940692092690.
29 Fox N, Hunn A, Mathers N. Trent focus for research and development in primary health care: how to use observations in a research project.: Trent focus group 1998.
30 DeJonckheere M, Vaughn LM. Semistructured interviewing in primary care research: a balance of relationship and rigour. *Fam Med Community Health* 2019;7:e000057.
31 Rycroft-Malone J, Burton CR, Bucknall T, *et al*. Collaboration and Co-production of knowledge in healthcare: opportunities and challenges. *Int J Health Policy Manag* 2016;5:221–3.
32 Erasmus E, Gilson L, Govender V, *et al*. Organisational culture and trust as influences over the implementation of equity-oriented policy in two South African case study hospitals. *Int J Equity Health* 2017;16:164.
33 Gilson L. Trust in health care: theoretical perspectives and research needs. *J Health Organ Manag* 2006;20:359–75.
34 Cloutier C, Denis J-L, Langley A, *et al*. Agency at the managerial interface: public sector reform as institutional work. *J Public Adm Res Theory* 2016;26:259–76.
35 Miller M, Hart T, Hadley S. Public finance and service delivery: What's new, what's missing, what's next?: Overseas Development Institute 2021.
36 Cashin C, Bloom D, Sparkes S. *Aligning PFM and health financing: sustaining progress toward universal health coverage*. Health Financing Working Paper: Geneva: World Health Organization, 2017.
37 Nzinga J, Boga M, Kagwanja N, *et al*. An innovative leadership development initiative to support building everyday resilience in health systems. *Health Policy Plan* 2021;36:1023-1035.
38 Fana T, Goudge J. Austerity, resilience and the management of actors in public hospitals: a qualitative study from South Africa. *BMJ Glob Health* 2021;6:e004157.
39 Barroy H, Piatti-Funfkirchen M, Fabrice S. *Let managers manage: a health service provider's perspective on public financial management: World Bank*, 2019.
40 Scott G, Enu-Kwesi F. Role of budgeting practices in service delivery in the public sector: a study of district assemblies in Ghana. *Hum Resour Manag Res* 2018;8:23–33.
41 Abimbola S, Baatiema L, Bigdeli M. The impacts of decentralization on health system equity, efficiency and resilience: a realist synthesis of the evidence. *Health Policy Plan* 2019;34:605–17.

BMJ Glob Health: first published as 10.1136/bmjgh-2021-006911 on 2 November 2021. Downloaded from http://gh.bmj.com/ on November 3, 2021 by guest. Protected by copyright.

CHAPTER 9. INTEGRATING NARRATIVE

This chapter serves as the integrating narrative and discussion for this thesis. The aim is for the reader to understand how the three papers (in chapters 6-8) answer the overall PhD research question and to present the overarching findings from the research. The recommendations arising from this PhD are then documented for the South African health system and global health system context. In the final section, the contribution of this PhD to the health policy and systems research body of knowledge is outlined.

9.1 Framing the findings

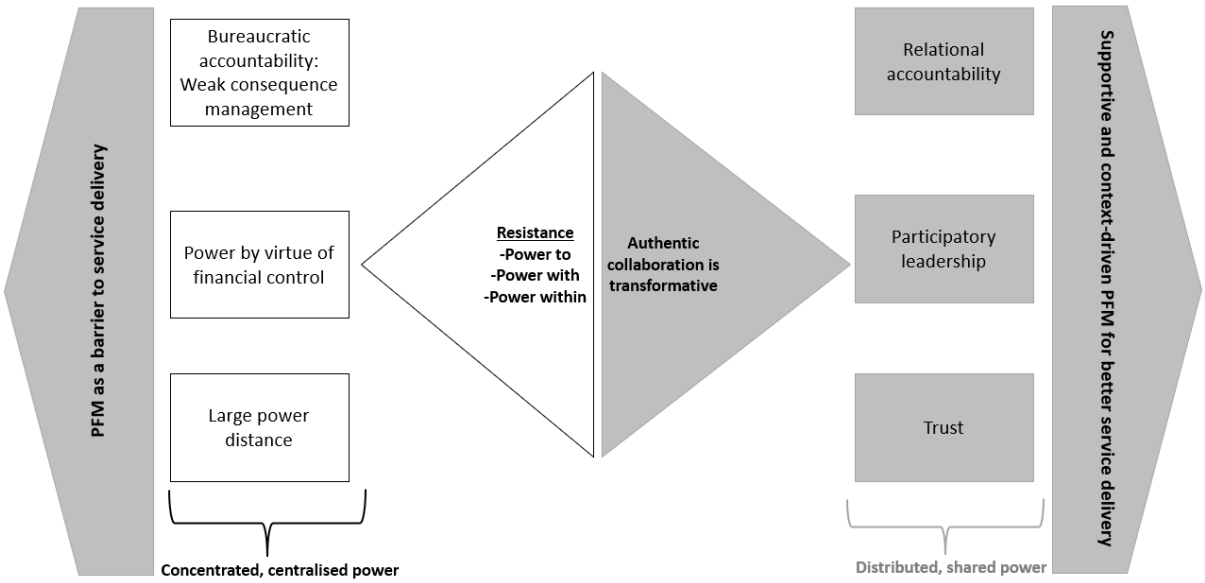
This PhD aimed to understand managers' experiences of PFM policies and reforms. This thesis intended to respond to a gap in knowledge within HPSR of how power, organisational culture and trust influence health system functioning, and in particular how PFM can inhibit or facilitate functioning. Paper 1 provides the background to the financial pressures the PDoH was under, partly due to the medical negligence claims crisis. The paper also uncovers the power dynamics in the health system by investigating the system's response to its claims crisis. In Paper 2, the influence of financial management centralisation, the largest PFM reform currently in place in the PDoH, on organisational culture is analysed. This paper broadens the power analysis from Paper 1, examining the distribution of power alongside other organisational culture dimensions and practices, to arrive at a holistic assessment of how centralisation has influenced the PDoH's culture and resultant functioning. Paper 3 investigates strategies used by managers to ameliorate their experience of financial management centralisation and improve the organisational culture and ways of working together. It provides practical recommendations for how to improve collaboration in health systems and share power more equitably, even in centralised health systems. Table 2 in section 2.2 shows which papers are linked to each of the PhD's objectives.

The thematic analysis described in section 5.7.1 lead to the identification of four major themes emanating from this research: power, accountability, trust, and collaboration. These four themes, and their corresponding key findings, were then used to develop a conceptual framework that illustrates what system software factors

can lead to PFM as either a barrier or a support for health system functioning (Figure 10). The framework shows how concentrated, centralised power results in a large power distance and more bureaucratic forms of accountability. This creates tension in the health system, resulting in service delivery and lower-level managers resisting the policies and decisions taken centrally, undermining their rollout. In this environment, PFM and finance managers are seen as barriers to quality service delivery and there is a breakdown of trust between finance and service delivery managers. On the other side of the diagram, distributed power is created through a participatory leadership style. Trust is built between teams and managers through relational accountability mechanisms and time spent working together to solve complex problems (for example, how to prioritise activities when funding contracts due to an unexpected pay-out of claims). The more opportunities there are for authentic collaboration (a shared problem, solved by everyone through equal participation), the more managers see the value in each other's perspectives and context, further building trust. This results in PFM and finance managers being seen as part of the health system team, and that their role is to enable and support the delivery of quality care in the most efficient and effective way.

This framework and the evidence behind it, both from my research and from similar literature, is discussed in the section below.

Figure 10: Key themes and findings from the research



9.2 Discussion

9.2.1 Power: "Sometimes, financial controls override service delivery needs." [xiii]

The research findings showed that in the PDoH studied, power was bestowed on finance managers because of their control of the health budget. This was partly due to the province's history of poor audit outcomes, and the effects of a new CFO who was tasked with turning around the financial management of the province. This new CFO was also new to the public service and therefore was learning about the 'way things work' from those who had supported his appointment and the broader finance team. The choice to centralise financial management in 2015 was not new, as the province has a history of vacillating between decentralised and centralised financial management.[143] Therefore, it is likely that the CFO was also influenced into making this decision by others who had been in the province for longer.

The Alliance for Health Policy and Systems Research (AHPSR) commented on the finding that individual leaders in many African countries departments of health show traits of authoritarian and bureaucratic leadership styles.[198] This has been connected with the often constrained financial environment and a culture of hierarchical decision-making and centralised power.[199] These characteristics were true of the CFO and the PDoH studied for this PhD research and have been found to be true for other South African PDoH's, too.[200] Both the individual leadership characteristics of the new CFO, and the organisational culture he was operating in seemed to buoy and further exacerbate the power imbalance within the senior leadership team and between finance and service delivery managers. Similar to the findings in Paper 3, Doherty, Gilson and Shung-King (2018) recommend leadership training for public health managers that foregrounds reflective practises that make managers aware of power imbalances, the value of collaborative decision-making and the importance of working in teams rather than alone or in siloes.[200]

[xiii] Verbatim quote from participant: iP6

The finance team's power was evident in their control of all expenditure decisions.[143] Furthermore, the primary agenda of the top-management team (comprised of finance and service delivery managers) was to improve financial audit outcomes and decrease the financial pressure on the department as a result of medical negligence claims. This agenda permeated the strategies and solutions put forward, allowing the provincial treasury and finance managers to conduct the problem-solving and policy/strategy-design process without meaningful input from service delivery managers and other key stakeholders in the health system (Paper 1). None of the medical negligence strategies selected focused on quality improvement (the most widely accepted way to reduce patient-safety incidents)[95], reinforcing the agenda and paradigm from which the strategies had been developed.

Paper 2 shed further light on the large 'power distance' in the province, between finance and service delivery managers but also between the head office and lower levels of the health system.[143] This power distance has influenced how these teams interface with one another and allowed a closed, and hierarchical way of working to emerge. The research findings from this PhD therefore supported Mbau and Gilson's (2018) framework, used in Paper 2, that shows a relationship between power distance and management styles.[2] Two examples of this include: the top-down decision-making environment demonstrated in the provincial centralisation committee (Paper 2) and the finance and provincial treasury teams' role in shaping the PDoH's medical negligence claims strategies (Paper 1). Managers across the system also reflected that the culture of the province's leadership style was not necessarily attached to one particular individual. Many spoke about the inherited role top leadership seemed to take on when assuming their duties in the province (Paper 2). This is evidence of the stability of organisational culture over time and the effort required to change (and sustain that change) an organisation's culture. This limitation of organisational change is not adequately address in Mbau and Gilson's (2018) framework (although it is a common refrain in organisational management theory from which the framework drew) and this PhD research offers some realism in terms of the work needed to change culture. This is particularly relevant for organisations with long-standing members and ways of doing things, such as South Africa's health departments.

Managers in the health system expressed their power in resistance to what they felt were top-down and centrally driven decision-making that thwarted their ability to provide quality care (Paper 1). These findings support the existing HPSR literature on discretionary power exercised by frontline managers to remake and re-define centrally designed policies to make them more applicable for the local context.[41] However, managers' belief in their own abilities (power within) had been somewhat eroded due to the centralisation reform and the other PFM strategies that excluded service delivery and lower-level finance managers from decision-making spaces.[143] The erosion of 'power within' has not been widely studied in HPSR and points to an important potential outcome of a 'negative' (bureaucratic, non-collaborative) organisational culture. This provides future researchers with an indicator to measure the effect of a negative organisational culture using a power lens, further generating empirical evidence for the importance of understanding the inter-relationship between power and organisational culture.

In recent years, several researchers have been studying the process of devolution in the Kenyan health system. Barasa et al (2016) used the expressions of power framework coupled with Long's (1999) Actor Interface framework to examine the resource-allocation process to county hospitals in Kenya.[53] They found that senior managers, particularly those in charge of the health budget had more decision-making power than middle managers, in hospitals with weak leadership. Furthermore, they found a power distance between hospital administrators and clinical managers, where clinical managers (and clinicians) were excluded from resource-allocation decision-making spaces. The paper concludes that these power differences (between administrators and clinicians) exist in health systems and need to be explicitly managed to be overcome. They suggested that administrators are taught some of the 'soft skills' that would allow them to build trust, motivate staff and support more inclusive leadership styles.[53] This aligns to the findings of this PhD, that the role of financial management can skew power relations, particularly where non-finance managers feel undermined (or don't believe in their own capacity) in their ability to contribute meaningfully. Mbau and Gilson's (2018) framework also showcased the dependent relationship between management styles, participation in decision-making and communication and feedback practices. This PhD research further explained how centralised, bureaucratic styles not only reduced participation

but also shut down communication lines between different levels of the health system. It therefore provided more evidence in support of the framework.

The overarching feeling by many managers in the health system was that the concentrated power at the head office, and particularly within the finance team, was ill-suited and a barrier to effective service delivery. This resulted in resistance, manifesting as the use of what little power these managers had with each other and in their facilities to adapt or transform ill-fitting policies for their context. Erasmus et al (2017) found that implementation was more successful in hospital's where management took the time to build relationships with implementing staff and explain how the policy aligned to the organisation's values – evidence of a participatory culture.[20] This approach could also be used to build support for new PFM strategies and structures.

In South Africa's anticipated National Health Insurance (NHI), the purchaser and provider roles are intended to be separated. This separation, which can result in greater efficiencies[201], is likely to create an even larger power distance between service delivery and finance managers given the physical separation and the further centralisation (to a national level) of finances. Ensuring that service delivery managers are given a voice and decision-making power within the purchasing unit (referred to as the NHI Fund) will require an intentional effort to build mechanisms for feedback and collaboration across the provinces and levels of the health system.

Given that the NHI Fund will be a new entity, there is the opportunity to create this type of organisational culture from its inception. However, the reality of the same players being moved across from PDoHs to the Fund presents a risk as they are likely to perpetuate the culture they are familiar with. This should factor into the selection and training of the NHI Fund management team. The design of the NHI Fund organisationally also should accommodate ways of working that support the distribution of power. For example, the creation of multidisciplinary NHI Fund teams/units, to ensure the service delivery lens is used for financial decision-making.

9.2.2 *Accountability: "The only way to be accountable, is to have delegations."*[xiv]

Accountability came up in two main ways in this research. First, a lack of accountability was given as one of the primary reasons for the need to centralise financial management and use leadership and management styles that were more authoritarian and top-down.[143] The second was the strong sense of accountability the finance managers felt, because of the pressure on them to uphold the PFM regulations and respond to the provincial treasury. This was experienced as highly punitive.[143] Senior PDoH finance managers reported that they felt under scrutiny from the provincial treasury, and other finance managers throughout the system felt the PDoH senior finance team were unforgiving as a result of the pressure they were under from the provincial treasury (Paper 2). In Paper 1, the financial implication of the negligence claims crisis makes clear the interconnectedness of service delivery and PFM. Given that claim payments are seen as 'fruitless and wasteful' in financial audits, which reflects badly particularly on the finance team, there was strong pressure to try and manage this financial risk. However, the strategies chosen were then all from the perspective of how to improve financial management- leaning heavily on bureaucratic methods of accountability (audits and annual performance management tools, for example). The case study in Paper 1 is critical in illustrating the importance of context in the design and development of even finance-related policies in public health systems. These findings also lend credence to the need for a collaborative management approach, like the one framed by Agranoff and McGuire (2001).[3] By including the right managers (and requisite skillset) and creating space to identify the problem and potential solutions together, a more appropriate strategy can be determined. Paper 1 therefore provides evidence of the risks of a non-collaborative approach to complex problems, particularly where power is skewed to one discipline or functional unit in an organisation.

Nxumalo et al (2018) suggest that relational factors, like the way people speak to one another and creating opportunities for constructive feedback are critical for supporting accountability.[202] The importance of relational-oriented accountability arose in this PhD research as well. Service delivery managers believed that finance

[xiv] Verbatim quote from participant: iP1

managers were not sufficiently aware of the context they were working within and that this resulted in unrealistic requests to cut activities or requests for resources. Similarly, finance managers felt that the service delivery managers did not pay attention to the constrained financial environment and requested funding for items that were 'non-essential'. Both felt misunderstood and frustrated by this lack of concern for each other's environment. The real decline in the budget for health over the next three years (discussed in section 4.2.4) is likely to create even more tension as finance managers attempt to manage an even smaller budget with the same (or perhaps even higher) demand for healthcare services.

The theme of accountability is intimately linked with a health system's willingness to decentralise financial management.[203] Papers 1 and 2 showed how the perception of a lack of accountability at the lower levels of the health system was a key reason given for centralisation.[143] However, Liwanag and Wyss (2019) show (building on previous work from Bossert (1998)[204]) that accountability, capacity building and decision-space are dimensions of the same dynamic pyramid, and the widening or strengthening of one, will also support the strengthening of the other.[205] Finance managers expressed that they would like to do some capacity building of service delivery and facility managers before they decentralised control. However, it is difficult to teach someone about accountability in the abstract[205] and this approach (of capacity building first) is unlikely to ever make the finance managers feel 'safe' enough to delegate because they will have no way of really knowing until they actually decentralise. Therefore, both the literature and managers in this study have emphasised the value of learning on the job.[113,143,206] Notably, in McCollum et al's (2018) paper, power was transferred to local politicians, rather than technical experts and/or service delivery managers, undermining the impact of devolution on health service delivery.[49] Giving delegations to the right managers is critical to yield the desired effect. If there is resistance to sharing power, it is more likely that efforts to decentralise will not yield the desired results. This research therefore also showcased the importance of using a power lens to understand why decentralisation has not been as successful hoped.

Opportunities for training on the job will be difficult to create if the provincial treasuries insist on maintaining their high level of involvement in the day to day financial administration of the department. As a result, the decision to delegate and

decentralise cannot be made by the PDoH team alone. Treasury and the PDoH finance team could experiment with oversight mechanisms, while testing out delegations, to determine a safe way to decentralise in the current South African climate which is marred by high levels of corruption and maladministration.[158] This could provide working examples for the future NHI Fund, too.

It is important to note that the current PFMA-regulated oversight mechanisms, such as the in-year management monthly report that PDoHs submit to their provincial treasuries have not managed to effectively protect public funds from nefarious spending. To date, financial audits are still positioned as the best way of measuring PFM performance, however, the high rate of corruption in South Africa shows up the audit process in its inability to timeously become aware of, investigate, and penalise corrupt activity.[207] The lack of accountability for corrupt spending also contributes to (honest) finance managers' fear of delegating financial control.

The South African National Development Plan (NDP): 2030 outlines the actions the country needs to take to achieve the type of State we envision by 2030. An important section of the Plan speaks to the need to shift from a political appointment system to a merit-based system.[117] This issue is one of the critical challenges driving corruption and maladministration in the country.[116,158,207] The history behind the political appointee system is complex, and rooted in the way the Apartheid government used leaders of the former homelands to try and legitimise these pseudo-states. The Apartheid government ensured that these leaders were given no formal training for these public service roles- leaving the nascent public service of South Africa's democracy with very little professional public service employees[116].

In the State's failure to intentionally redesign and reshape the organisational culture and upskill new employees of the public service at the start of democracy, Chipkin and Meny-Gibert (2012) argue that the new government appointees fell into the existing ways of doing things and that this further embedded networks of patronage and corruption.[116]

The NHI provides another opportunity, at least for the health system, to actively change the organisational culture and ways of working in the new entities that are planned. For example, the 2019 draft NHI Bill envisions the development of contracting units for primary healthcare (CuPs). The CuPs are intended to support

the NHI Fund in contracting with local healthcare providers.[208] To date, however, nothing has been written on where they will be housed, what type of professional skills one would need in these units and how these units should measure success.[133] The findings from this PhD have illustrated the challenges of a fragmented and siloed health system[143,209]- if the design of the CuPs is not done deliberately, there is a risk that these units will merely perpetuate the current ways of working, and use the same ineffective bureaucratic accountability mechanisms to performance manage the units. The CuPs will then just add another layer of bureaucracy in the health system, and are likely to exacerbate the siloes between PFM and service delivery, to the detriment of health system functioning.

There is strong evidence of how transformative relational accountability mechanisms can be from the deployment strategy described in Paper 3.[209] Despite the dearth of trust between finance and service delivery managers[143], those involved in the deployment strategy were able to restore trust and build a relationship that supported a greater understanding of each other's context and, ultimately, improve PFM.[209] This provides more nuance to Mbau and Gilson's (2018) framework which looks at organisational culture at a macro level. This PhD research shows that there can also be micro-cultures within an organisation that can begin to change ways of working at a 'local' or more granular level. The recommendations in Paper 2 also suggest that a distinct set of responsibilities is delegated to district and facility managers and that this is used for practical training and capacity building around the regulatory requirements for financial reporting and the use of public funds.[143] This would widen decision space, allow managers to feel more accountable and, through this practical experience, learn how to effectively manage their funds in accordance with the PFM regulations. This may also improve perceptions of power within for managers, improving their willingness to collaborate. It is worth noting that during this transition, the head-office team would need to have regular feedback sessions with the delegated managers to assist them where necessary to facilitate optimal PFM. As the delegated managers become more comfortable, the head-office team can reduce their input to strategic oversight - the intended role for PDoHs in health systems.

However, relational accountability is more difficult in large, rural provinces where there is limited technology infrastructure and the distances between the head office and district health offices make it difficult for managers to come together in person

regularly for support and oversight. This reality requires the health sector to think differently about where it places senior finance managers. In the current model, they all are employed at the head office and there is not a culture of regular site visits or engagements. One solution could be to employ senior finance managers at the district level (while still doing regional-level work and oversight), to provide closer on the ground support to service delivery units (Paper 3).[209]

Ensuring effective oversight while introducing financial management decentralisation is a stated priority in South Africa's NDP: 2030.[117] The NDP specifically mentions the role of trust- and relationship-building as critical for technical capacity building and optimal governance.[117(pp426)] The findings from this PhD suggest ways to improve organisational culture, which can help realise the country's effective governance goals.

9.2.3 Trust: "We don't trust them sometimes."[xv]

Trust, and the lack thereof, was a prominent theme in this research. Several finance managers alluded to the PDoH's lack of trust in the lower levels of the health system, and these managers' ability to adequately manage their expenditure. Hospital and district managers also expressed a lack of trust in the head office - showing how the trust deficit in the health system was bidirectional. This was detrimental to the organisational culture and supported Kodish's (2017) findings that in an organisation marked by mistrust, individuals become self-interested and struggle to co-operate and collaborate at the organisation-level.[210] This self-interest of actors in the health system was explored in Paper 2, through the organisational culture dimension of 'institutional collectivism'.[143] The paper describes how managers were shown to hold onto funds, even when others needed them more, because the resource-allocation process was found to be opaque and they didn't trust that funding would be shared equitably. If the NHI Fund embeds this same lack of transparency, it is likely that trust would be further depleted and managers and service delivery units would become even more protective of themselves, to the detriment of overall health system functioning.

[xv] Verbatim quote from participant: iP2

Trust was also eroded through the practices of the organisation, particularly in the lack of communication and feedback between the head office and the rest of the system.[143] Paper 3 discussed how efforts to collaborate fell short when feedback mechanisms failed.[209] Feedback and communication is supported in the literature as a key mechanism required for building trust.[83] Trust was also shown in this research to be dampened by a lack of participation and inclusion in decision-making[143], supporting other literature that found that higher levels of participation enabled greater levels of trust.[20,211] Trust has also been linked to power and management style, whereby trust is facilitated when power is shared more equitably and the style of management is more participatory and approachable.[16,18,20]

Trust building is also not a once-off endeavour, and is strengthened through every positive interaction (it is similarly weakened by negative experiences, making trust building a lifelong endeavour).[90] Trust has also been shown to have a direct relationship with policy implementation and this PhD research adds to the empirical evidence showing that trust is critical for successful collaboration in health systems.[209] Although implicit, neither Mbau and Gilson's (2018) framework nor Agranoff and McGuire's (2001) framework explicitly mention trust. This PhD research highlights how integral trust is to system functioning and need for these frameworks to explicitly name trust as a key dependency.

Recently, a research team tested a leadership training programme for health managers.[15] The intention was to support 'everyday resilience' in the health system by improving the 'software' in these systems. The programme had two core focuses, the first on health system theory and context and the second on communication and emotional competency (the so called 'soft skills').[15] The second focus area aligns closely with systems software theory in its acknowledgment of how important these 'soft skills' are for improving health system performance.[13] The soft skills part of the training aimed to provide managers with practical skills related to management styles, building trust, and forming positive relationships.[15] The training programme was particularly successful in helping managers to express their own power, empowering them to see themselves as 'change agents' in their health system.[15] The findings from Paper 3 also support the value of soft skill training in health systems and suggests that this training is opened up to finance managers as well, as key health systems actors with substantial power.[209]

Currently, South Africa enforces that everyone in a senior management post in the public service undergo a management training course[xvi] run by South Africa's National School of Government Department. Therefore, there is already precedent for some training prior to entry and an opportunity exists to amend this training (perhaps even with an additional module specific to the sector the senior manager is entering) to account for the soft skills training mentioned above.

9.2.4 Collaboration: "It brings us together as a team."[xvii]

Collaboration, as defined by Gray (1989) centres on two or more people working together to solve a problem they would not/could not solve on their own.[212] This PhD has focused on the somewhat intractable problem of better aligning PFM to service delivery needs, while still safeguarding public funds. Paper 3 allowed for an analysis of what collaboration enables and further provides evidence that a collaborative approach is possible in public sector organisations.[209] This paper also showed how centralisation of financial management does not necessarily mean that there can be no collaboration. There was clearly interest in finding ways to work better together and this was the springboard for some of the strategies analysed in the paper. This means that efforts to improve collaboration do not have to wait for decentralisation of financial management to take place.

Tănase (2013) suggests that participatory budgeting methods, that bring in managers from outside the finance domain, tend to yield more realistic, achievable and appropriate budgets for organisations.[213] Others, like Hofstede (1968) have gone so far as to suggest that collaborative approaches to budgeting can improve the performance of organisations, making a strong case for a more collaborative organisational culture in health systems to support this.[214] During 2019 and 2020, the Nigerian government attempted to improve collaborative budgeting in its ministry of health. The findings from this intervention highlighted the role of leadership and management in facilitating a collaborative environment and showed real financial improvements in health spending when a more collaborative approach was used.[215] Despite the available research and empirical evidence from some contexts, progress

[xvi] https://www.thensg.gov.za/training-course/sms-pre-entry-programme/

[xvii] Verbatim quote from participant: iD13

on participatory budgeting inside health systems remains stunted, and siloed, and finance-driven budgeting in health systems is still the norm in most countries.[101,216]

Notably, trust is viewed as one of the facilitators of collaboration and this research was also able to assess what the impact of a trust deficit was on managers' ability and willingness to work together. This PhD's findings align to the CPM framework in finding trust to be a key facilitator for collaboration and supports similar findings in the HPSR literature on the role of trust as a factor in successful policy implementation.[217] Organisational siloes have also been shown to be detrimental to fostering a collaborative environment and one of the suggested remedies is inter-disciplinary units that can break down these siloes by bringing different managers together more regularly to support better communication and sight of one another's contribution to the organisation.[86] This is referred to as 'cross-functional' teams by Dean (2010).[86] This aligns to the findings in Papers 2 and 3 that suggest ways to bring managers more regularly into one another's physical space.

Mash et al (2013) found a relationship between organisational culture and health system performance.[218] The authors investigated the relationship between organisational culture, values, and performance in five community primary healthcare (PHC) centres in one province of South Africa. In the PHC centres studied, the authors found that the hierarchical and centrally-controlled decision-making culture (measured through a quantitative tool) was hindering performance.[218] They suggest that management mediate their leadership style to rather foster internal collaboration (through open information channels) and shared decision-making. The authors also link the organisation's culture strongly to the leadership style of its senior managers and recommend leadership and management development programmes to support a shift in the organisation's culture to one that is more collaborative.[218]

The institutional separation of the purchaser-provider split under the envisioned NHI presents a challenge for the health system. If poorly managed, it could remove any opportunity for collaboration between local-level service delivery managers and the centralised NHI Fund. Although CuPs are described as a bridge between the NHI Fund and the local provider units, there is currently not enough detail in the NHI-related policy and supporting documentation on how the Fund will interact on a day

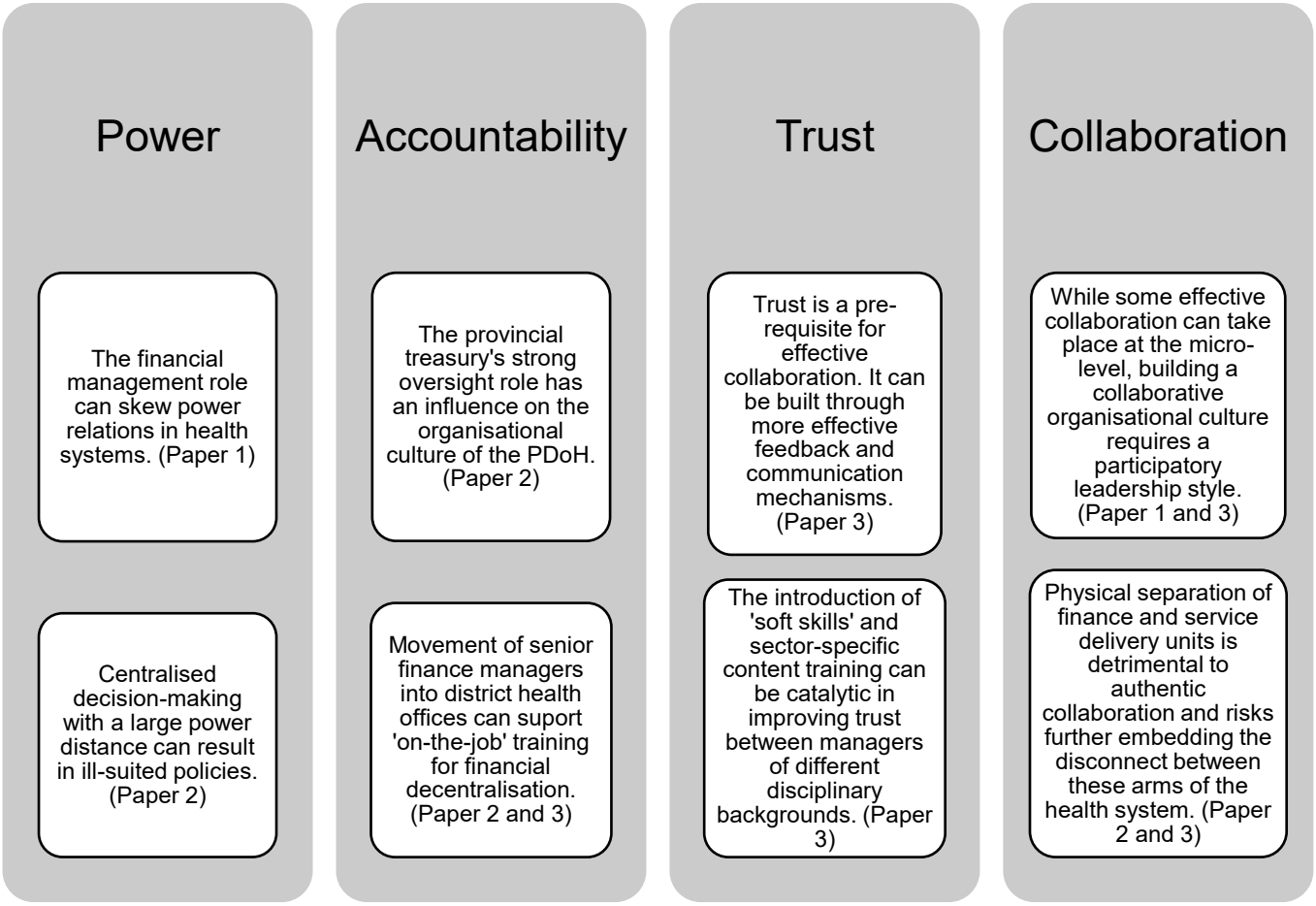
to day basis with the service delivery platform. A single purchaser has some efficiency benefits with regards to a larger risk pool and centralised procurement of some key goods and services. However, large scale centralisation is out of sync both with best practice in other countries with similar systems and with the findings from this PhD research that physical separation has a negative impact on authentic collaboration. The CuPs need to be given sufficient authority and decision-making power rather than just become an extension of the NHI Fund.

9.3 Implications of the findings

Power, trust, accountability, and collaboration show interdependencies in this research. This PhD provides evidence for how a collaborative management approach can transform relationships and support a PFM environment that is an enabler for service delivery.

Figure 11 shows the key findings per theme, as discussed in this section.

Figure 11: Summary of integrating narrative



The integrating narrative has described why there is tension between finance and service delivery managers in health systems. This is largely related to the bureaucratic and highly regulated PFM environment which makes finance managers reluctant to release control, alongside service delivery managers' unwillingness to grapple with the financial management regulations and requirements. This tension is thwarting health system functioning, and future UHC reform, as the organisational context and culture is preventing open communication and participatory decision-making. As a result, the health system is unable to cope with everyday challenges (like resource constraints) and acute crises (like the negligence claims context) effectively.

This lack of resilience has resulted in the department being unable to easily adapt or respond to adverse events and challenges- with finance managers unwilling to apply more flexible finance structures and service delivery managers unable to meaningfully improve healthcare quality despite available clinical governance expertise. This furthered the trust deficit between finance and service delivery managers, which further shut down communication.

A health system with a skewed power imbalance and a lack of trust was also shown to be less effective at designing appropriate policies and strategies, showing the practical value of organisations working on their culture- system 'software' is not just a 'nice to have' but a crucial enabler of functioning. This research highlights the need for leadership training for all senior managers as well content-specific training such that finance and service delivery managers are better able to engage with each other's disciplines. This finding adds to the very recent evidence being generated on the potential of 'soft skill' training for health managers of all disciplines. Another less costly and time-intensive method to support inter-disciplinary learning is by bringing managers into the same physical space more often, or by creating posts for finance managers inside the service delivery platform. This research is one of the first to showcase the value of this physical proximity and to suggest ways of restructuring the system to facilitate collaboration.

9.4 Recommendations

This section highlights the overarching recommendations from this PhD, pulling together key cross-cutting recommendations over and above those outlined in each

of the research papers. This research focuses particularly on the way PFM intersects with service delivery and provides useful lessons for South Africa while we design our approach to UHC, and, in particular, how the purchaser and provider arms of the health system should work together once they are split (as it is currently envisioned). I have used this lens to decide which recommendations to include in this thesis and I have also tried to be mindful of the lessons that may be most valuable for the development of South Africa's National Health Insurance and the associated UHC it should facilitate. My hope is that the findings from this research might be used by others in the field as we embark on this ambitious set of health system reforms.

The first set of recommendations are specific to the PDoH studied. The second set are relevant for the broader South African context. Qualitative research is not generalisable in the same way that quantitative research is, however, there are lessons from this PhD which are meaningful for other settings in the country. The final set of recommendations relate to the global health systems and policy research environment.

9.4.1 Recommendations specific to the provincial department of health studied

1. Rotate the chair of the centralisation committee between finance and service delivery managers, to dilute power concentration and support collaborative management.
2. Invite district level staff to attend the centralisation committee meeting, on a voluntary basis, so they can better understand how decisions are made. If they are unable to physically travel, they could be accommodated through a virtual meeting invitation.
3. Improved documentation of claims from lodgement, settlement and payment is important to protect the department from unnecessary expenditure.
4. Delegate a discrete list of responsibilities to the lower levels of the health system to provide opportunities for capacity building and promote accountability.

9.4.2 Recommendations specific to the South African health system

1. Use the multidisciplinary monthly district-level budget advisory committee meeting (referred to as the monthly finance meeting in Paper 3) as a space to prioritise activities in relation to the available budget. This requires a neutral facilitator and space for service delivery managers to engage with the materials and participate fully in the meeting and associated decisions.
2. Move some provincial-level finance managers into service delivery units (or facilities) to support relational accountability and improve finance managers understanding of the service delivery context. This will also help the finance managers to feel safer when delegating financial responsibility to lower levels of the health system.
3. Where financial management centralisation is in place, expenditure review committees should rotate their leadership to avoid an over concentration of power within the financial management team.
4. Presently in South Africa, all senior managers in the public sector are required to complete training in order to take up their post. This training should be expanded to include leadership, management and other 'soft' skills which would help to shift the culture of PDoHs, over time. For existing management, this training could be run by government training centres and managers could be given a 3-5 year period in which to complete the training.

9.4.3 Recommendations for global health systems and policy research environment

1. Building trust between finance and service delivery managers is key to improving organisational culture which, in turn, will have a positive impact on a health system's ability to render services.
2. Health systems should be mindful of the power associated with the financial management role and actively find ways to share power and support more collaborative management strategies.
3. Relational accountability is predicated on trust and has been shown to improve accountability more so than bureaucratic accountability mechanisms. Efforts to support relational accountability, like creating multidisciplinary units within the health system, can strengthen PFM and service delivery alike.

9.5 Contribution of this PhD

This PhD has contributed in several ways to the body of knowledge on health systems in lower- and middle-income countries. This research question was designed, developed, and analysed from a South African perspective. This has enriched the findings, ensuring our local context is taken into account when analysing and framing the findings and recommendations.

Firstly, this PhD's interdisciplinarity provides a strong basis on which to understand managers' experiences of PFM and the way PFM policies influence organisational culture and relationships.

Secondly, exploring trust and organisational culture at the managerial level is an under-represented area of research for health systems. In particularly, investigating how finance managers influence and shape the culture is novel and important, especially as countries talk about moving towards purchaser provider splits which could further fragment these two arms of the system.

Thirdly, this research adds to the growing body of literature showcasing the importance of using a power lens in health systems research.

Lastly, this research has contributed to HPSR praxis for lower- and middle-income countries, widening the available empirical evidence for LMICs.

9.6 Strengths and limitations

The limitation of not living in the province studied, for ethnographic research in particular, is described in each research article. This limitation was mitigated by a longer data collection period (a full year) and more frequent data collection visits (6 visits). Prolonged engagement is a widely accepted strategy to ensure richness in qualitative research.[219] Some of the visits were also scheduled around important points in the budget cycle (such as the preparation period for the MTEC hearings) ensuring the data analysed was representative of a full financial year cycle. Another limitation was that I was unable to secure interviews with the PDoH Head of Department and the State Attorney. While the interviews I did conduct were rich and valuable, these two actors could have provided further nuance into the centralisation policy and the medical negligence claims environment in the province.

A further limitation pertains to the study taking place in only one province. Although this allowed for much deeper immersion and a thick description, it would have added insight and the ability to draw comparisons across two quite different study sites if more than one province was studied. However, the presentation of the research findings at local conferences and to national stakeholders was helpful in drawing out the recommendations that are applicable to other PDoHs in the country. Given my experience through my role at the NDoH, I also had substantial knowledge of the other PDoHs that allowed me to note the areas that may be useful and pertinent for other South African PDoHs.

The findings of this PhD were presented to the National Treasury and the two stakeholders present stated that the findings aligned with their experience of the South African public health system. This lends credence to the findings of this study (and its trustworthiness). The member-checking process also strengthened this research. Participants were able to contribute to the recommendations from the findings and were in support of the overarching findings and key themes that emanated from the data.

Another strength of this research was the level of trust I was able to establish with participants and the top leadership. This was supported by my previous work in the province. The research topic had the potential to bring tensions and conflict to the surface, therefore I needed to be able to garner trust across the disciplines, hierarchies, and levels of the health system to generate meaningful data.

There was only one interview where it was clear that the person did not trust me, nor the purpose of the research. I was an observer in a site-visit where the finance team from the NDoH came to discuss the hospital's finances, with the provincial finance team. I conducted the interview directly after the site visit and it enabled me to recognise that there was a disconnect between the CEO's demeanour and responses from what she had displayed in the meeting. The data from the interview were a clear outlier from the rest and were not used in any of the articles.

9.7 Areas for further research

Research on the following areas would further strengthen and expand on the findings from this research:

- A similar study could be conducted in a different province to areas of thematic overlap and differences as a result of contextual differences between provinces in South Africa
- A political economy analysis of the province would be invaluable in further drawing out the power dynamics at play inside and external to the department of health
- Further research on the relationship between funding and quality of care would be valuable in providing more evidence on the contribution of system software factors as compared to the impact of resources on quality. This may provide some non-financial mechanisms for improvement for the country to consider.

CHAPTER 10. CONCLUSION

This PhD aimed to understand managers' experiences of public financial management policies and reforms. Managers experienced the centralisation reform, and its implementers, as detrimental to their ability to render services. Managers perceived there to be a power imbalance in the health system, favouring the finance team and this was seen to be inappropriate. The organisational culture of the PDoH was also affected, with managers experiencing the management style as authoritarian and the system as having poor feedback and communication mechanisms. This further concentrated power centrally and limited opportunities for collaboration across disciplinary siloes. The research showed a large trust deficit in the PDoH and this impeded on opportunities for authentic collaboration. Ultimately, the research found interdependencies between power, accountability, trust, and collaboration and how these influence health system functioning.

This research provides empirical evidence for how a collaborative management approach can transform relationships and support the development of a PFM environment that is an enabler for service delivery. Changing this dynamic in health systems would support improved service delivery and, ultimately, health outcomes. The findings from this PhD could, therefore, support South Africa in its design phase of the NHI.

REFERENCES

1. Veneklasen L, Miller V. Power and Empowerment. In: Budlender D, Clark C, editors. A New Weave of Power, People & Politics: The Action Guide for Advocacy and Citizen Participation [Internet]. Oklahoma City: World Neighbours; 2002 [cited 2020 Sep 7]. p. 39–58. Available from: www.wn.org
2. Mbau R, Gilson L. Influence of organisational culture on the implementation of health sector reforms in low- and middle-income countries: a qualitative interpretive review. Glob Health Action. 2018;11(1).
3. Agranoff R, Mcguire M. Big questions in public network management research. J Public Adm Res Theory. 2001;11(3):295–326.
4. Piatti-Fünfkirchen M, Schneider P. From stumbling block to enabler: The role of public financial management in health service delivery in Tanzania and Zambia. Heal Syst Reform. 2018;4(4):336–45.
5. Welham B, Hart T, Mustapha S, Hadley S. Public financial management and health service delivery: Necessary, but not sufficient? 2017.
6. Le Houerou P, Taliercio R. Medium Term Expenditure Frameworks: From Concept to Practice. Prelimanary Lessons from Africa. 2002.
7. Oxford Policy Management Review. Medium Term Expenditure Frameworks – Panacea or Dangerous Distraction? Supporting Strategies for Economic and Social Reform: Paper 2. 2000;(August 1999):1–4.
8. De Renzio P, Smith S. Linking Policies and Budgets: Implementing Medium Term Expenditure Frameworks in a PRSP Context. ODI Briefing Paper. 2005.
9. Andrews M. How Far Have Public Financial Management Reforms Come in Africa? HKS Fac Res Work Pap Ser. 2010;RWP10-018.
10. World Health Organization. The global push for universal health coverage [Internet]. 2014 [cited 2018 Jul 20]. Available from: http://www.who.int/health_financing/GlobalPushforUHC_final_11Jul14-1.pdf?ua=1
11. Blecher M, Daven J, Kollipara A, Maharaj Y, Mansvelder A, Gaarekwe O.

Health spending at a time of low economic growth and fiscal constraint. In: Padarath A, Barron P, editors. South African Health Review 2017. 2017. p. 25–40.

12. Blaauw D, Gilson L, Penn-Kekana L, Schneider H. Organisational relationships and the “software” of health sector reform. Johannesburg; 2003 Oct.

13. Sheikh K, Gilson L, Agyepong IA, Hanson K, Bennett S. Building the field of health policy and systems research: framing the question. PLoS Med. 2011;8(8):1–6.

14. Nyikuri MM, Tsofa B, Okoth P, Barasa EW, Molyneux S. “We are toothless and hanging, but optimistic”: sub county managers’ experiences of rapid devolution in coastal Kenya. Int J Equity Health. 2017;16(113).

15. Nzinga J, Boga M, Kagwanja N, Waithaka D, Barasa E, Tsofa B, et al. An innovative leadership development initiative to support building everyday resilience in health systems. Health Policy Plan. 2021;0(0).

16. Topp SM, Chipukuma JM. A qualitative study of the role of workplace and interpersonal trust in shaping service quality and responsiveness in Zambian primary health centres. Health Policy Plan. 2016;31(2):192–204.

17. Gilson L. Trust in health care: Theoretical perspectives and research needs. J Heal Organ Manag. 2006;20(5):359–75.

18. Ostergaard LR. Trust matters: A narrative literature review of the role of trust in health. Glob Public Health. 2015;10(9):1046–59.

19. Sriram V, Topp SM, Schaaf M, Mishra A, Flores W, Rajasulochana SR, et al. 10 Best Resources on Power in Health Policy and Systems in Low- and Middle-Income Countries. Health Policy Plan. 2018;33(4):611–21.

20. Erasmus E, Gilson L, Govender V, Nkosi M. Organisational culture and trust as influences over the implementation of equity-oriented policy in two South African case study hospitals. Int J Equity Health. 2017;16(1):1–14.

21. Whyle E, Olivier J. Social values and health systems in health policy and systems research: a mixed-method systematic review and evidence map.

Health Policy Plan. 2020 May 6;35:735–51.

22. Barasa E, Mbau R, Gilson L. What Is Resilience and How Can It Be Nurtured? A Systematic Review of Empirical Literature on Organizational Resilience. Int J Heal Policy Manag. 2018;7(6):491–503.

23. Gilson L, Barasa E, Nxumalo N, Cleary S, Goudge J, Molyneux S, et al. Everyday resilience in district health systems: Emerging insights from the front lines in Kenya and South Africa. BMJ Glob Heal. 2017;2(2):e000224.

24. Barasa EW, Cloete K, Gilson L. From bouncing back, to nurturing emergence: reframing the concept of resilience in health systems strengthening. Health Policy Plan. 2017;32:iii91–4.

25. Topp SM. Power and politics: the case for linking resilience to health system governance. BMJ Glob Heal. 2020;5.

26. Erasmus E, Gilson L. How to start thinking about investigating power in the organizational settings of policy implementation. Health Policy Plan. 2008;23(5):361–8.

27. Gore R, Parker R. Analysing power and politics in health policies and systems. Glob Public Health. 2019;14(4):481–8.

28. Akram S, Emereson G, Marsh D. (Re) Conceptualising the third face of power: insights from Bourdieu and Foucault. J Polit Power. 2015 Nov 12;8(3):345–62.

29. Ailon G. What B would otherwise do: A critique of conceptualizations of “power” in organizational theory. Organization. 2006;13(6):771–800.

30. Bachrach P, Baratz MS. Two Faces of Power. Am Polit Sci Rev. 1962;56(4):947–52.

31. Gaventa J. Power after Lukes: An overview of theories of power since Lukes and their application to development. 2003.

32. Institute of Development Studies. The powercube: Understanding power for social change [Internet]. powercube.net. 2011 [cited 2021 Aug 23]. Available from: https://www.powercube.net/other-forms-of-power/the-power-in-the-powercube/

33. Gramsci A. Selections from the Prison Notebook. Smith QH, Nowell G, editors. New York; 1971.

34. Lukes S. Three-Dimensional Power. In: Power: A Radical View. 2nd ed. New York: Palgrave, Macmillan; 2005. p. 108–51.

35. Gaventa J. Reflections on the Uses of the “Power Cube” Approach for Analyzing the Spaces, Places and Dynamics of Civil Society Participation and Engagement [Internet]. 2005 [cited 2021 Jul 4]. Available from: www.hivos.nl

36. Bevir M. Foucault, power, and institutions. Polit Stud [Internet]. 1999 [cited 2021 Oct 13];XLVII:345. Available from: https://web.b.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=4&sid=99ed2d86-8a57-4e66-bf75-94adcced1a45%40sessionmgr103

37. Battilana J. Agency and Institutions: The Enabling Role of Individuals’ Social Position. Organization. 2006;13(5):653–76.

38. Navarro Z. In Search of a Cultural Interpretation of Power: The Contribution of Pierre Bourdieu. IDS Bull [Internet]. 2006 Nov [cited 2021 Oct 16];37(6):11–22. Available from: https://opendocs.ids.ac.uk/opendocs/handle/20.500.12413/8355

39. Mendoza-Botelho. Social Capital and Institutional Trust, are these concepts related? Evidence from Bolivia’s decentralisation. Behaviour. 2013;1(504):1219–37.

40. Hill MJ, Hupe P. Implementing Public Policy: An Introduction to the Study of Operational Governance. Second. Los Angeles: Sage; 2009. 1–232 p.

41. Lehmann U, Gilson L. Actor interfaces and practices of power in a community health worker programme: a South African study of unintended policy outcomes. Health Policy Plan. 2013;28(4):358–66.

42. Gilson L, Elloker S, Olckers P, Lehmann U. Advancing the application of systems thinking in health: South African examples of a leadership of sensemaking for primary health care. Heal Res policy Syst. 2014;12(30).

43. Erasmus, Orgill, Schneider, Gilson. Mapping the existing body of health policy

implementation research in lower income settings: what is covered and what are the gaps? Heal policy Plan. 2014;29(iii):35–50.

44. Parashar R, Gawde N, Gilson L. Application of “Actor Interface Analysis” to Examine Practices of Power in Health Policy Implementation: An Interpretive Synthesis and Guiding Steps Systematic Review. Int J Heal Policy Manag. 2021;10(7):430–42.

45. Long N. The multiple optic of interface analysis. UNESCO. Netherlands; 1999.

46. Gilson L, Schneider H, Orgill M. Practice and power: a review and interpretive synthesis focused on the exercise of discretionary power in policy implementation by front-line providers and managers. Health Policy Plan. 2014;29(suppl_3):iii51–69.

47. Rwafa-Ponela T, Eyles J, Christofides N, Goudge J. Implementing without guidelines, learning at the coalface: a case study of health promoters in an era of community health workers in South Africa. Heal Res Policy Syst. 2020;18(46).

48. Parashar R, Gawde N, Gupt A, Gilson L. Unpacking the implementation blackbox using “actor interface analysis”: how did actor relations and practices of power influence delivery of a free entitlement health policy in India? Health Policy Plan. 2020;35(Supplement_2):ii74–83.

49. McCollum R, Taegtmeyer M, Otiso L, Muturi N, Barasa E, Molyneux S, et al. “Sometimes it is difficult for us to stand up and change this”: an analysis of power within priority-setting for health following devolution in Kenya. BMC Health Serv Res. 2018;18(906).

50. Kokko T, Auvinen T. Shortcomings of New Public Management Ideology From the Power Perspective: Exploration of Power Relations in a Finnish Municipal Organization. Manag Res Pract. 2018;10(2):5–26.

51. Fleming P, Spicer A. Power in Management and Organization Science. Acad Manag Ann. 2014;8(1):237–98.

52. Amis J, Slack T, Hinings CR. Strategic change and the role of interests, power, and organizational capacity. Vol. 18, Journal of Sport Management. 2004. p.

158–98.

53. Barasa EW, Cleary S, English M, Molyneux S. The influence of power and actor relations on priority setting and resource allocation practices at the hospital level in Kenya: a case study. BMC Health Serv Res. 2016;16(1):1–13.

54. Nilsson W. Positive Institutional Work: Exploring Institutional Work Through the Lens of Positive Organizational Scholarship. Acad Manag Rev. 2015;40(3):370–98.

55. Cloutier C, Denis JL, Langley A, Lamothe L. Agency at the managerial interface: public sector reform as institutional work. J Public Adm Res Theory. 2016;26(2):259–76.

56. Topal C. A relational perspective of institutional work. J Manag Organ. 2015;21(4):495–514.

57. Currie G, Lockett A, Finn R, Martin G, Waring J. Institutional Work to Maintain Professional Power: Recreating the Model of Medical Professionalism: Organ Stud. 2012;33(7):937–62.

58. Erasmus E. The use of street-level bureaucracy theory in health policy analysis in low- and middle-income countries: a meta-ethnographic synthesis. Heal policy Plan. 2014;29(iii):70–8.

59. Schein E. Organizational Culture and Leadership. Fourth. Jossey-Bass; 2010.

60. Schein EH. Organizational culture and leadership. 1st ed. Jossey-Bass Publishers; 1985.

61. Scahill SL. “The way things are around here”: organisational culture is a concept missing from New Zealand healthcare policy, development, implementation, and research. J New Zeal Med Assoc. 2012;125(1348):8716.

62. Grant S, Guthrie B, Entwistle V, Williams B. A meta-ethnography of organisational culture in primary care medical practice Organisational culture. J Health Organ Manag. 2014;28(1):21–40.

63. Lok P, Rhodes J, Westwood B. The mediating role of organizational subcultures in health care organizations. J Health Organ Manag.

2011;25(5):506–25.

64. Carlström ED, Ekman I. Organisational culture and change: implementing person-centred care. J Health Organ Manag. 2012;26(2):175–91.

65. Dark F, Whiteford H, Ashkanasy NM, Harvey C, Harris M, Crompton D, et al. The impact of organisational change and fiscal restraint on organisational culture. Int J Ment Health Syst. 2017;11(11).

66. Batras D, Duff C, Smith BJ. Organizational change theory: implications for health promotion practice. Health Promot Int. 2016;31(1):231–41.

67. Scalzi C, Evans LK, Barstow A, Hostvedt K. Barriers and enablers to changing organizational culture in nursing homes. Nurs Adm Q. 2006;30(4):368–72.

68. Willis CD, Saul J, Bevan H, Scheirer MA, Best A, Greenhalgh T, et al. Sustaining organizational culture change in health systems. J Health Organ Manag. 2016;30(1):2–30.

69. Scott T, Mannion R, Davies H, Marshall M. The Quantitative Measurement of Organizational Culture in Health Care: A Review of the Available Instruments. Health Serv Res. 2003;38(3):923–45.

70. Vukonjanski J, Nikolic M, Hadžic O, Terek E, Nedeljkovic M. Relationship between GLOBE organizational culture dimensions, job satisfaction and leader-member exchange in Serbian organizations. J East Eur Manag Stud. 2012;03:333–68.

71. House R, Javidan M, Dorfman P. Project GLOBE: An Introduction. Appl Psychol. 2001;50(4):489–505.

72. House RJ, Hanges PJ, Javidan M, Dorfman PW, Gupta V. Culture Leadership and Organizations: The GLOBE study of 62 societies. Thousand Oaks, editor. London: SAGE Publications; 2004. 9–90 p.

73. Yrjö-Koskinen J, Kagoné M, Souares A, Sauerborn R. The Influence of Organizational Culture on Information Use in Decision Making within Government Health Services in Rural Burkina Faso. Nord J African Stud. 2010;19(4):250–73.

74. Melo S, De Waele L, Polzer T. The role of Post-New Public Management in shaping innovation: the case of a public hospital. Int Rev Adm Sci. 2020;0(0).

75. Head BW, Alford J. Wicked Problems: Implications for Public Policy and Management. Adm Soc. 2015;47(6):711–39.

76. Hope KR, Chikulo BC. Decentralization, the New Public Management, and The Changing Role of The Public Sector In Africa. Public Manag An Int J Res Theory. 2000;2(1):25–42.

77. Barasa EW, Manyara AM, Molyneux S, Tsofa B. Recentralization within decentralization: county hospital autonomy under devolution in Kenya. PLoS One. 2017;12(8).

78. Zon H, Pavlova M, Drabo M, Groot W. Municipal health services provision by local governments: a systematic review of experiences in decentralized Sub-Saharan African countries. Health Policy Plan. 2017;32(9):1327–36.

79. Mitchell A, Bossert TJ. Decentralisation, governance and health-system performance: “where you stand depends on where you sit.” Dev Policy Rev. 2010;28(6):669–91.

80. Reiter R, Klenk T. The manifold meanings of ‘post-New Public Management’ – a systematic literature review. Int Rev Adm Sci. 2019;85(1):11–27.

81. Eriksson E, Andersson T, Hellström A, Gadolin C, Lifvergren S. Collaborative public management: coordinated value propositions among public service organizations. Public Manag Rev. 2020;22(6):791–812.

82. Poocharoen O, Ting B. Collaboration, co-production, networks. Public Manag Rev. 2015;17(4):587–614.

83. Mcguire M. Collaborative public management: assessing what we know and how we know it. Public Adm Rev. 2006;(Special issue).

84. Geddes L. In search of collaborative public management. Public Manag Rev. 2012;14(7):947–66.

85. Delany-Moretlwe S, Kelley KF, James S, Scorgie F, Subedar H, Dlamini NR, et al. Human papillomavirus vaccine introduction in South Africa: Implementation

lessons from an evaluation of the national school-based vaccination Campaign. Glob Heal Sci Pract. 2018;6(3):428–38.

86. Dean KS. Strategies and Benefits of Fostering Intra-Organizational Collaboration [Internet]. 2010 [cited 2021 Aug 27]. (College of Professional Studies Professional Projects: Paper 15). Available from: http://epublications.marquette.edu/cps_professional

87. Kähkönen A-K. The influence of power position on the depth of collaboration. Supply Chain Manag An Int J. 2014;19(1):17–30.

88. Üyesi Ö. A review on intra-organizational relations. J Econ Adm Sci. 2018;19(2).

89. Downe S, Finlayson K, Fleming A. Creating a collaborative culture in maternity care. J Midwifery Women's Heal. 2010 May;55(3):250–4.

90. Rycroft-Malone J, Burton CR, Bucknall T, Graham ID, Hutchinson AM. Collaboration and Co-Production of Knowledge in Healthcare: Opportunities and Challenges. Int J Heal Policy Manag. 2016;5(4):221–3.

91. Adelman HS, Taylor L. Commentary: Advancing mental health science and practice through authentic collaboration. School Psych Rev. 2003;32(1):53–6.

92. Hansen M. Collaboration: How Leaders Avoid the Traps, Create Unity, and Reap Big Results [Internet]. Boston: Harvard Business Press; 2009 [cited 2021 Aug 27]. Available from: https://store.hbr.org/product/collaboration-how-leaders-avoid-the-traps-create-unity-and-reap-big-results/1515

93. Tjosvold DW, Poon M. Dealing with scarce resources: open-minded interaction for resolving budget conflicts. Gr Organ Manag. 1998;23(3):237–55.

94. Martins EC, Terblanche F. Building Organisational Culture that Stimulates Creativity and Innovation. Eur J Innov Manag. 2003;6(1):64–74.

95. Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. Lancet Glob Heal. 2018;6(11 The Lancet Global Health Commission on high quality health systems in the SDG era):e1196–252.

96. Cashin C, Bloom D, Sparkes S, Barroy H, Kutzin J, O'Dougherty S. Aligning public financial management and health financing: sustaining progress toward universal health coverage. Health Financing Working Paper 17.4. Geneva; 2017.

97. Andrews M, Cangiano M, Cole N, De Renzio P, Krause P, Seligmann R. This is PFM [Internet]. HKS Faculty Research Working Paper Series No.285. Cambridge (MA); 2014. Available from: https://bsc.cid.harvard.edu/files/bsc/files/285_andrews_this_is_pfm.pdf

98. World Health Organization. Fiscal space, public financial management and health financing: Sustaining progress towards UHC. Montreux, Switzerland; 2016. (Health Financing Working Paper No. 2).

99. Barroy H, Piatti-Fünfkirchen M, Sergent F, Dale E, O'Dougherty S, Mtei G, et al. Let managers manage: a health service provider's perspective on public financial management [Internet]. World Bank Blogs. 2019 [cited 2020 Apr 2]. Available from: https://blogs.worldbank.org/health/let-managers-manage-health-service-providers-perspective-public-financial-management

100. Kutzin J. Why public finance for UHC? Overview of the issues and of the meeting. In: Public Financing for UHC: Towards Implementation. 2017.

101. Rajan D, Barroy H, Stenberg K. Budgeting for health. In: Schmets G, Rajan D, Kadandale S, editors. Strategizing national health in the 21st century: a handbook. World Health Organization; 2016.

102. Lewis M. We need to measure and address corruption and poor governance in health systems. Int J Heal Policy Manag. 2019;8(10):616–9.

103. Naher N, Hoque R, Hassan MS, Balabanova D, Adams AM, Ahmed SM. The influence of corruption and governance in the delivery of frontline health care services in the public sector: A scoping review of current and future prospects in low and middle-income countries of south and south-east Asia. BMC Public Health. 2020;20(880).

104. Rispel L, De Jager P, Fonn S. Exploring corruption in the South African health sector. Health Policy Plan. 2015;0(0).

105. Piatti-Fünfkirchen Ali Hashim Khuram Farooq M. Balancing Control and Flexibility in Public Expenditure Management. 2019. (Policy research working paper No. 9029).

106. Barroy H, Dale E, Sparkes S, Kutzin J. Budget matters for universal health coverage: key formulation and classification issues. Health Financing Policy Brief No. 4. Geneva; 2018.

107. CABRI. Value for Money in the Health Sector: Policy and Budget Planning. Nairobi; 2011.

108. Health Council of Canada. Value for Money: Making Canadian Health Care Stronger [Internet]. 2009. Available from: www.healthcouncilcanada.ca.

109. Mohammed J, Ashton T, North N. Wave Upon Wave: Fiji's Experiments in Decentralizing Its Health Care System. Asia Pacific J Public Heal. 2016;28(3):232–43.

110. Kimathi L. Challenges of the devolved health sector in Kenya: Teething problems or systemic contradictions? Africa Dev. 2017;42(1).

111. Dwicaksono A, Fox AM. Does decentralization improve health system performance and outcomes in low- and middle-income countries? A systematic review of evidence from quantitative studies. Milbank Q. 2018;96(2):323–68.

112. Abimbola S, Baatiema L, Bigdeli M. The impacts of decentralization on health system equity, efficiency and resilience: A realist synthesis of the evidence. Health Policy Plan. 2019;34(8):605–17.

113. Liwanag HJ, Wyss K. What conditions enable decentralization to improve the health system? Qualitative analysis of perspectives on decision space after 25 years of devolution in the Philippines. PLoS One. 2018;13(11).

114. Miller M, Hart T, Hadley S. Public finance and service delivery: What's new, what's missing, what's next? [Internet]. 2021 [cited 2021 May 30]. Available from: https://odi.org/en/publications/public-finance-and-service-delivery-whats-new-whats-missing-whats-next/

115. Kwenda P, Ntuli M, Mudiriza G. Former Homeland Areas and Unemployment

in South Africa: A Decomposition Approach. 2020 [cited 2021 Jul 17]; Available from: www.iza.org

116. Chipkin I, Meny-Gibert S. Why the past matters: studying public administration in South Africa. J Public Adm. 2012;47(1).

117. National Planning Commission. National Development Plan: 2030 [Internet]. 2011. 489 p. Available from: http://www.nationalplanningcommission.org.za/Pages/NDP.aspx

118. Burger R, Christian C. Access to health care in post-apartheid South Africa: availability, affordability, acceptability. Heal Econ Policy Law. 2018;

119. Rispel L, Moorman J. Federalism, interdependence, and the health care system in South Africa. In: Marchildon GP, Bossert TJ, editors. Federalism and decentralization in health care: A decision space approach. University of Toronto Press; 2018. p. 117–48.

120. World Health Organization. Primary Health Care systems (PRIMASYS): a case study from South Africa. Geneva; 2017.

121. Department of Health. Transformation of the Health System White Paper. Pretoria; 1997.

122. Rispel L. Analysing the progress and fault lines of health sector transformation in South Africa. In: Padarath A, King J, Mackie E, Casciola J, editors. South African Health Review 2016. Health Systems Trust; 2016. p. 17–24.

123. South African Government. National Health Act: No 61 of 2003. Pretoria: South African Government; 2004.

124. South African National Department of Health. White paper for the transformation of the health system in South Africa. 1997.

125. South African National Department of Health. National Health Insurance: Green Paper. Gov Gaz. 2011;34523(3).

126. South African National Department of Health. National Health Insurance for South Africa: White Paper. 2017.

127. Rispel LC, Shisana O, Dhai A, Dudley L, English R, Grobler GP, et al.

Achieving high-quality and accountable universal health coverage in South Africa: A synopsis of the Lancet National Commission Report. In: Moeti T, Padarath A, editors. South African Health Review. Durban: Health System Trust; 2019.

128. South African National Department of Health. Draft NHI Bill. 2018 p. 16–60.

129. South African National Department of Health. National Health Insurance for South Africa: White Paper. Government Gazette 2015.

130. South African National Department of Health. National Health Insurance Bill. 2019.

131. Genesis Analytics, Price Waterhouse and Coopers. Evaluation of the Phase 1 Implementation of the Interventions in the National Health Insurance Pilot Districts in South Africa. Pretoria, South Africa; 2019.

132. Van den Heever A. National Health Insurance Policy Bill Review. 2019.

133. Goudge J, Kawonga M, Mosam A, Wishnia J. Comments on the NHI Bill. 2019.

134. Makinana A. Over 100,000 written submissions on NHI Bill received by parliament [Internet]. Dispatch Live. 2019 [cited 2021 May 5]. Available from: https://www.dispatchlive.co.za/news/2019-10-23-over-100000-written-submissions-on-nhi-bill-received-by-parliament/

135. Statistics South Africa. Breakdown of provincial government revenue for [Internet]. Financial statistics of provincial government. 2017 [cited 2021 Jul 2]. Available from: http://www.statssa.gov.za/?p=11583

136. Wishnia J. Understanding Public Health: Public Health Budget and Expenditure Trends [Internet]. 2017 [cited 2021 Jul 2]. Available from: https://www.insight.co.za/2017/05/17/understanding-public-health-exploratory-notes/

137. South African National Treasury. Medium term expenditure framework: technical guidelines. Pretoria; 2015. p. 1–31.

138. Davén J, Day C, Blecher M, Kollipara A, Wishnia J. Finance. In: District Health

Barometer 2016/17 [Internet]. 2017 [cited 2018 Dec 11]. Available from: http://www.phcperformanceinitiative.org/blog/2015/12/01/primary-health-care-and-sustainable-development-goals.

139. Oboirien KO, Harris B, Eyles J, Goudge J, Orgill M, Mcintyre D, et al. Understanding roles, enablers and challenges of District Clinical Specialist Teams in strengthening primary health care in South Africa. South African Heal Rev 2014/15 [Internet]. 2015 [cited 2019 Apr 23]; Available from: https://journals.co.za/docserver/fulltext/healthr/2014/1/healthr_2014_2015_a6.pdf?expires=1556023344&id=id&accname=guest&checksum=28F975FAF88CFC797842633AF6D9F294

140. World Health Organization. Building strong public financial management systems towards universal health coverage: key bottlenecks an lessons learnt from country reforms in Africa. In: Public financial management for sustainable financing for health in Africa. 2018.

141. Penn-Kekana L, Blaauw D, Schneider H. “It makes me want to run away to Saudi Arabia”: Management and implementation challenges for public financing reforms from a maternity ward perspective. Health Policy Plan. 2004;19(Suppl. 1).

142. South African National Treasury. Principles of Public Administration and Financial Management Delegations. Pretoria; 2013.

143. Wishnia J, Goudge J. Impact of financial management centralisation in a health system under austerity: A qualitative study from South Africa. BMJ Glob Heal. 2020;5(10):1–9.

144. Chakraborti C. Systemic Negligence: Why it is morally important for developing world bioethics. Dev World Bioeth. 2015 Dec 1;15(3):208–13.

145. Lerm H. Medical malpractice litigation: do we need a paradigm shift in our approach to handling medical negligence disputes? Obiter. 2017;38(2):324–41.

146. World Bank. Medical Malpractice Systems around the Globe: Examples from the US-tort liability system and the Sweden-no fault system [Internet]. 2013

[cited 2019 May 16]. Available from: http://siteresources.worldbank.org/IntRussianFederation/Resources/Malpractice_Systems_eng.pdf

147. Rai S, Devaiah VH. The need for healthcare reforms: is no-fault liability the solution to medical malpractice? Asian Bioeth Rev. 2019;11(1):81–93.

148. Bismark M, Paterson R. No-Fault compensation in New Zealand: Harmonizing injury compensation, provider Accountability, and patient safety. Health Aff. 2006;25(1):278–83.

149. Castles M, Richards B. Medico legal mediation: Developing an interdisciplinary roleplay. Aust J Clin Educ. 2018;4.

150. Douglas T. Medical injury compensation: Beyond “no fault.” Med Law Rev. 2009;17(Spring):30–51.

151. South African Law Reform Commission. Project 141: Medico-legal claims [Internet]. 2017 [cited 2018 Nov 16]. Report No.: 33. Available from: http://salawreform.justice.gov.za

152. Whittaker G. Medical Malpractice in the South African Public Sector. 2021.

153. Health Policy Project. Health Financing Profile - South Africa. Heal Policy Proj [Internet]. 2016;(May):2. Available from: http://www.healthpolicyproject.com/pubs/7887/Botswana_HFP.pdf

154. Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D. The health and health system of South Africa: historical roots of current public health challenges. Lancet. 2009;374(9692):817–34.

155. Naledi T, Barron P, Schneider H. Primary Health Care in SA since 1994 and implications of the new vision for PHC Re-engineering. In: Padarath A, English R, editors. South African Health Review. Health System Trust; 2011. p. 17–28.

156. Wishnia J, Smith A, Ranchod S, Chigwanda R. Human resources for health. In: District Health Barometer. Health Systems Trust; 2020. p. 182–98.

157. National Treasury. Provincial budget documentation [Internet]. Pretoria; 2019 [cited 2021 May 5]. Available from:

http://www.treasury.gov.za/documents/provincial budget/default.aspx

158. Bhorat H, Buthelezi M, Chipkin I, Duma S, Mondi L, Peter C, et al. Betrayal of the promise: how South Africa is being stolen. 2017.

159. Faure F. South Africa: what's behind the growth slowdown? Conjoncture. 2017;10–7.

160. Thwala SBP, Blaauw D, Ssengooba F. 'It needs a complete overhaul…': district manager perspectives on the capacity of the health system to support the delivery of emergency obstetric care in an urban South African district. Glob Health Action. 2019;12(1642644).

161. Hlafa B, Sibanda K, Hompashe DM. The Impact of Public Health Expenditure on Health Outcomes in South Africa. Int J Environ Res Public Health. 2019;16(2993).

162. Reich MR. Political economy analysis for health. Bull World Health Organ [Internet]. 2019 Aug 1 [cited 2022 Apr 27];97(8):514. Available from: /pmc/articles/PMC6653823/

163. Shezi S, Chiwire P, Ndlovu N. Factsheet on the Non-Negotiable Budget Items in the Provision of Public Health and HIV/AIDS Services in South Africa [Internet]. 2014 [cited 2021 May 24]. Available from: www.cegaa.org

164. UNICEF. Health Budget Brief: 2018/19 [Internet]. 2019. Available from: https://www.unicef.org/esa/sites/unicef.org.esa/files/2019-03/UNICEF-South-Africa-2018-Health-Budget-Brief.pdf

165. Venter WDF, Kaiser B, Pillay Y, Conradie F, Gomez GB, Clayden P, et al. Cutting the cost of South African antiretroviral therapy using newer, safer drugs. South African Med J. 2017;107(1):28–30.

166. McLaren D, Baduza M, Stevenson S, Chaskalson J. Health budget slashed despite vaccine commitments [Internet]. Spotlight. 2021 [cited 2021 Sep 4]. Available from: https://www.dailymaverick.co.za/article/2021-02-26-health-budget-slashed-despite-vaccine-commitments/

167. National Department of Health. National Health Insurance Bill [Internet].

Pretoria: Government Gazette; 2019. Available from: https://www.gov.za/sites/default/files/gcis_document/201908/national-health-insurance-bill-b-11-2019.pdf

168. Guest G, Namey EE, Mitchell ML. Qualitative Research: Defining and Designing. In: Collecting Qualitative Data: A Field Manual for Applied Research. SAGE Publications, Inc; 2013. p. 1–37.

169. Maxwell JA. A Model for Qualitative Research Design. In: Qualitative Research Design: An Interactive Approach. 2013. p. 1–21.

170. Yin RK. Case Study Research Design and Methods. 5th ed. Thousand Oaks, CA: Sage; 2014.

171. Golafshani N. Understanding Reliability and Validity in Qualitative Research. Qual Rep. 2003;8(4):597–606.

172. Creswell JW. Qualitative Inquiry and Research Design: Choosing among Five Approaches. 2nd ed. SAGE Publications; 2007. 393 p.

173. Creswell JW. The Use of Theory. In: Research Design: Qualitative, Quantitative, and Mixed Methods Approaches. 2009. p. 49–71.

174. Tie YC, Birks M, Francis K. Grounded theory research: A design framework for novice researchers. SAGE Open Med. 2019;7.

175. Timonen V, Foley G, Conlon C. Challenges When Using Grounded Theory: A Pragmatic Introduction to Doing GT Research. Int J Qual Methods. 2018;17.

176. Neubauer BE, Witkop CT, Varpio L. How phenomenology can help us learn from the experiences of others. Perspect Med Educ. 2019;8(2):90–7.

177. Yin RK. Case Study Research: Design and Methods. Fifth. Applied Social Research Methods Series: Volume 5. London: SAGE Publications, Inc; 2013. 1–53 p.

178. Crowe S, Cresswell K, Robertson A, Huby G, Avery A, Sheikh A. The Case Study Approach. BMC Med Res Methodol. 2011;11(100):2–9.

179. Hammersley M, Atkinson P. What is Ethnography? In: Ethnography: Principles in Practice. Third. Routledge; 2007. p. 15–48.

180. World Health Organization. Health Policy and Systems Research: A Methodology Reader. Gilson L, editor. 2012. 0–472 p.

181. Kielmann K, Hutchinson E, MacGregor H. Health systems performance or performing health systems? Anthropological engagement with health systems research. Soc Sci Med. 2022 Feb 18;114838.

182. Huby G, Hart E, McKevitt C, Sobo E. Addressing the complexity of health care: the practical potential of ethnography. J Health Serv Res Policy. 2007;12(4):193–4.

183. Kielmann K. The Ethnographic Lens. In: Health Policy and Systems Research: A Methodology Reader. 2012. p. 235–8.

184. Noble M, Wright G, Noble M, Wright ÁG, Wright G. Using Indicators of Multiple Deprivation to Demonstrate the Spatial Legacy of Apartheid in South Africa. Soc Indic Res. 2013;112:187–201.

185. Noble M, Zembe W, Wright G. Poverty may have declined, but deprivation and poverty are still worst in the former homelands [Internet]. 2014 [cited 2021 Sep 6]. Available from: www.econ3x3.org

186. Salti N. Relative deprivation and mortality in South Africa. Soc Sci Med. 2010;70(5):720–8.

187. Wolmarans A, Tucker J-M, Wishnia J, Phiri J, Abel J, Wood M. Status of NHI Pilot districts: 12 Month progress report. 2016.

188. Hunter J, Thoovakkunon M, Asmall S, Tucker JM, Ravhengani N, Mokgalagadi Y. The Ideal Clinic in South Africa: progress and challenges in implementation. In: Padarath A, Barron P, editors. South African Health Review 2017. 2017.

189. DeJonckheere M, Vaughn LM. Semistructured interviewing in primary care research: A balance of relationship and rigour. Fam Med Community Heal. 2019 Mar 1;7(2).

190. Hammersley M, Atkinson P. Oral Accounts and the Role of Interviewing. In: Ethnography: Principles in Practice. Third. 2007. p. 190–235.

191. Hammersley M, Atkinson P. Research design, problems, cases and samples.

In: Ethnography: Principles in Practice. Third. 2007. p. 49–86.

192. Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. Qual Quant [Internet]. 2018 Jul 1 [cited 2022 Apr 19];52(4):1893. Available from: /pmc/articles/PMC5993836/

193. Nowell LS, Norris JM, White DE, Moules NJ. Thematic analysis: striving to meet the trustworthiness criteria. Int J Qual Methods. 2017;16.

194. Shenton AK. Strategies for ensuring trustworthiness in qualitative research projects. Educ Inf. 2004;22(2):63–75.

195. Lincoln YS, Guba EG. Establishing trustworthiness. In: Naturalistic Inquiry. 1985. p. 289–331.

196. Dowling M. Approaches to reflexivity in qualitative research. Nurse Res. 2006;13(3):7–21.

197. Lawrence TB, Suddaby R. Institutions and Institutional Work. In: Sage Handbook of Organization Studies. 2nd ed. 2006. p. 215–54.

198. World Health Organization. Open mindsets: Participatory Leadership for Health [Internet]. Geneva; 2016 [cited 2022 Apr 27]. Available from: http://www.who.int

199. Gilson L, Agyepong IA. Strengthening health system leadership for better governance: what does it take? Health Policy Plan [Internet]. 2018 Jul 1 [cited 2022 Apr 27];33(suppl_2):ii1–4. Available from: https://academic.oup.com/heapol/article/33/suppl_2/ii1/5050013

200. Doherty J, Gilson L, Shung-King M. Achievements and challenges in developing health leadership in South Africa: the experience of the Oliver Tambo Fellowship Programme 2008–2014. Health Policy Plan [Internet]. 2018 Jul 1 [cited 2022 Apr 27];33(suppl_2):ii50–64. Available from: https://academic.oup.com/heapol/article/33/suppl_2/ii50/5050015

201. Inclusive Society Institute. Universal health coverage pathways for South Africa. 2020.

202. Nxumalo N, Gilson L, Goudge J, Tsofa B, Cleary S, Barasa E, et al. Accountability mechanisms and the value of relationships: experiences of front-line managers at subnational level in Kenya and South Africa. BMJ Glob Heal. 2018;3(4).

203. Leli H, Addulahi O, Tsofa B. Public hospitals' finance management systems, and accountability mechanisms in the context of decentralized health systems in low- and middle-income countries – A thematic review: Under Peer Review. AAS Open Res. 2019;2:18.

204. Bossert T. Analyzing the decentralization of health systems in developing countries: Decision space, innovation and performance. Soc Sci Med. 1998 Nov;47(10):1513–27.

205. Liwanag HJ, Wyss K. Optimising decentralisation for the health sector by exploring the synergy of decision space, capacity and accountability: Insights from the Philippines. Heal Res Policy Syst. 2019;17(1).

206. Choonara S, Goudge J, Nxumalo N, Eyles J. Significance of informal (on-the-job) learning and leadership development in health systems: lessons from a district finance team in South Africa. BMJ Glob Heal. 2017;2(1):e000138.

207. Gumede W. Combating Corruption in South Africa [Internet]. 2017 [cited 2021 Nov 19]. Report No.: Policy Brief 14. Available from: https://democracyworks.org.za/policy-brief-12-combating-corruption-in-south-africa/

208. South African Government. National Health Insurance Bill. 2019 p. B11-2019.

209. Wishnia J, Goudge J. Strengthening public financial management in the health sector: a qualitative case study from South Africa. BMJ Glob Heal. 2021;6(e006911).

210. Kodish S. Communicating organizational trust: An exploration of the link between discourse and action. Int J Bus Commun. 2017;54(4):347–68.

211. Fana T, Goudge J. Austerity, resilience and the management of actors in public hospitals: A qualitative study from South Africa. BMJ Glob Heal. 2021;6(2).

212. Gray B. Collaborating: Finding Common Ground for Multi-party Problems. San Francisco, CA: Jossey-Bass; 1989.

213. Tănase GL. An Overall Analysis of Participatory Budgeting Advantages and Essential Factors for an Effective Implementation in Economic Entities. J East Eur Res Bus Econ. 2013;2013(201920).

214. Hofstede G. Budgets in motivation theory: the game spirit. In: Tavistock, Assen, Van Gorcum, editors. The game of budget control. 1st ed. London: Tavistock Publications Limited; 1968.

215. Agbola O, Olayinka Lawal, Simbiat Abrahams Obi, Felix Uweja H. Forming a collaborative mechanism for budget reforms in Nigeria [Internet]. Results for Development blog series. 2021 [cited 2021 Sep 23]. Available from: https://r4d.org/blog/forming-a-collaborative-mechanism-for-budget-reforms-in-nigeria-part-2-of-2/

216. Tsofa B, Molyneux S, Goodman C. Health sector operational planning and budgeting processes in Kenya- “never the twain shall meet.” Int J Health Plann Manage. 2015;10(1002).

217. Scott V, Mathews V, Gilson L. Constraints to implementing an equity-promoting staff allocation policy: understanding mid-level managers’ and nurses’ perspectives affecting implementation in South Africa. Health Policy Plan. 2012;27(2):138–46.

218. Mash RJ, Govender S, Isaacs AA, De Sa A, Schlemmer A. An assessment of organisational values, culture and performance in Cape Town’s primary healthcare services. South African Fam Pract. 2013;55(5):459–66.

219. Barusch A, Gringeri C, George M. Strategies Used in Published Articles Rigor in Qualitative Social Work Research: A Review of Strategies Used in Published Articles. Soc Work Res. 2011;35(1):11–9.

220. Fox N. Trent focus for research and development in primary health care: how to use observations in a research project. Sheffield; 1998.

Appendix 1: Senate Plagiarism Policy

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

FACULTY OF HEALTH SCIENCES

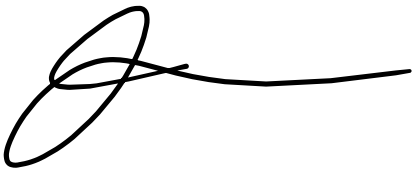
PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

I Jodi Wishnia (Student number: 1493762) am a student registered for the degree of Doctor of Philosophy in the academic year 2021.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.

Signature:



Date: 6 May 2022

Appendix 2: Permission for reproducing published articles in this thesis

Creative commons licence agreement

This page is available in the following languages:

Creative Commons License Deed

Attribution-NonCommercial 4.0 International (CC BY-NC 4.0)

This is a human-readable summary of (and not a substitute for) the license.

You are free to:

Share — copy and redistribute the material in any medium or format

Adapt — remix, transform, and build upon the material

The licensor cannot revoke these freedoms as long as you follow the license terms.

Under the following terms:

Attribution — You must give appropriate credit, provide a link to the license, and indicate if changes were made. You may do so in any reasonable manner, but not in any way that suggests the licensor endorses you or your use.

NonCommercial — You may not use the material for commercial purposes.

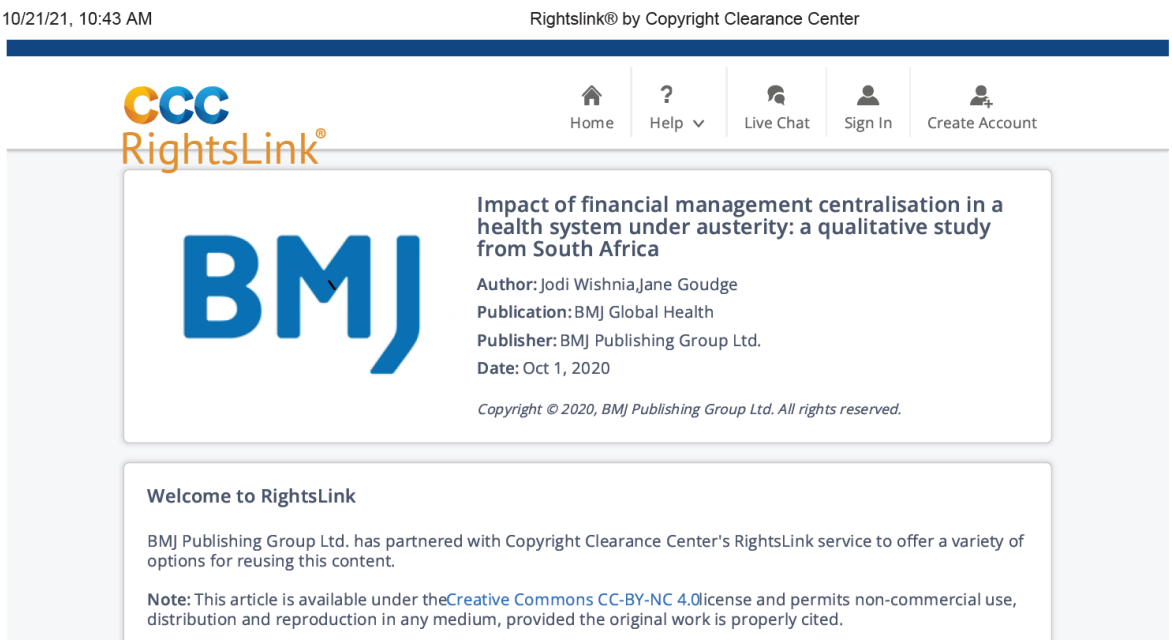
No additional restrictions — You may not apply legal terms or technological measures that legally restrict others from doing anything the license permits.

Notices:

You do not have to comply with the license for elements of the material in the public domain or where your use is permitted by an applicable exception or limitation.

No warranties are given. The license may not give you all of the permissions necessary for your intended use. For example, other rights such as publicity, privacy, or moral rights may limit how you use the material.

Proof of Paper 2 and 3 being published under the Creative Commons licence



10/21/21, 10:43 AM Rightslink® by Copyright Clearance Center

CCC RightsLink®

Home | Help | Live Chat | Sign In | Create Account

BMJ

Impact of financial management centralisation in a health system under austerity: a qualitative study from South Africa

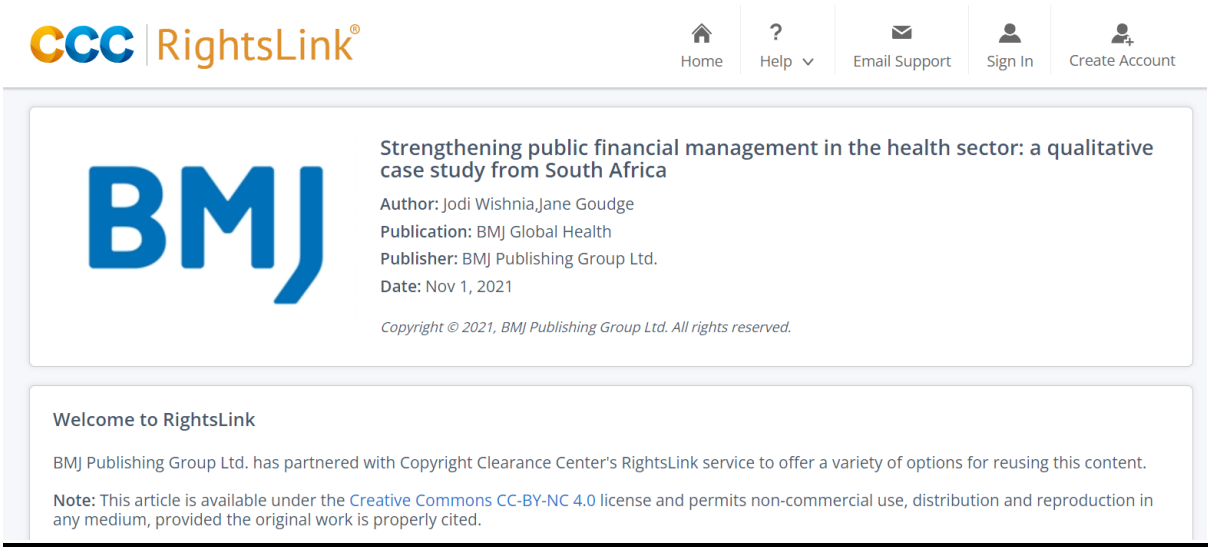
Author: Jodi Wishnia,Jane Goudge
Publication: BMJ Global Health
Publisher: BMJ Publishing Group Ltd.
Date: Oct 1, 2020

Copyright © 2020, BMJ Publishing Group Ltd. All rights reserved.

Welcome to RightsLink

BMJ Publishing Group Ltd. has partnered with Copyright Clearance Center's RightsLink service to offer a variety of options for reusing this content.

Note: This article is available under theCreative Commons CC-BY-NC 4.0license and permits non-commercial use, distribution and reproduction in any medium, provided the original work is properly cited.



CCC RightsLink®

Home | Help | Email Support | Sign In | Create Account

BMJ

Strengthening public financial management in the health sector: a qualitative case study from South Africa

Author: Jodi Wishnia,Jane Goudge
Publication: BMJ Global Health
Publisher: BMJ Publishing Group Ltd.
Date: Nov 1, 2021

Copyright © 2021, BMJ Publishing Group Ltd. All rights reserved.

Welcome to RightsLink

BMJ Publishing Group Ltd. has partnered with Copyright Clearance Center's RightsLink service to offer a variety of options for reusing this content.

Note: This article is available under the Creative Commons CC-BY-NC 4.0 license and permits non-commercial use, distribution and reproduction in any medium, provided the original work is properly cited.

Appendix 3: University of Witwatersrand Human Research Ethics Committee (Medical) Approval

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

R49 Ms J Wishnia

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M170346

NAME: (Principal Investigator)	Ms J Wishnia
DEPARTMENT:	School of Public Health Centre for Health Policy Medical School University
PROJECT TITLE:	*Understanding managers' experiences of public financial management policies and reform: a qualitative study from a South African provincial department of health* *"They couldn't make stones into bread"* ***Change of study title noted on 29/09/2021***
DATE CONSIDERED:	31/03/2017
DECISION:	Approved unconditionally
CONDITIONS:	
NOTE:	If contact information regarding student study participants is required, please contact the Registrar's office - <Nicoleen.Potgieter@wits.ac.za>
SUPERVISOR:	Professors J Goudge and J Eyles
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	19/07/2017

This Clearance Certificate is valid for 5 years from the date of approval. An extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office secretariat on the 3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research protocol as approved, I/we undertake to submit details to the Committee. **I agree to submit a yearly progress report**. When a funder requires annual re-certification, the application date will be one year after the date when the study was initially reviewed. In this case, the study was initially reviewed in March and therefore reports and re-certification will be due in the month of **March** each year. Unreported changes to the study may invalidate the clearance given by the HREC (Medical).

Signature of Principal Investigator — Date: 29/09/2021

Appendix 4: Provincial Ethics Approval (De-Identified)

[redacted] Department of Health

Enquiries: [redacted]
Tel No: [redacted] 608 0856
Date: 13 June 2017
Fax No: [redacted] 642 1409
e-mail address: [redacted]

Dear Ms. J. Wishnia

Re: The Impact Of Institutional Work On Policy Implementation In South African Departments Of Health, With A Focus On Financial Management, Planning And Service Delivery Units In [redacted] 2017RP45_623)

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the [redacted]. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on th[redacted] will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

SECRETARIAT: [redacted] HEALTH RESEARCH COMMITTEE

[redacted]

Appendix 5: Informed consent leaflets

Unique Number:

Participant Observation

Research Title: The impact of institutional work on policy implementation in South African Departments of Health, with a focus on financial management, planning and service delivery units

Principal Investigator: Jodi Wishnia

Date: XX XX

Dear Colleague,

Introduction

I am doing my PhD in Public Health, through the University of the Witwatersrand's Centre for Health Policy. My research aims to better understand how people and organisational contexts affect the quality of policy implementation in the South African public health sector. Through my work with the National Department of Health, I have been able to learn about how the system functions and where potential areas for concern lie. I hope that this research could give departments valuable insight into possible strategies to improve financial management, based on the experiences and knowledge of the many potential participants in this study.

Invitation to participate

I would like to invite you to participate in this research study given your position within the public health system.

What is involved in the study?

I will be observing and writing down thoughts and reflections during key meetings in which you may be a part of. My aim is not to influence the meeting in any way but rather to observe the way things currently function and use this to understand the existing practices and processes in your department. The study will observe approximately 50 people per department, depending on who agrees to participate.

All participants will be employees or consultants in the department of health. There is nothing you will need to actively do to participate, as I would like to observe you during your everyday work life.

Risks

There are no risks to participating in this research. All data will be anonymised so that any observations made will not be traceable to the individual concerned.

Benefits

There are no financial or other benefits to participating in this research. The findings of the study will be shared with all departments and all participants in the hope that the findings may help improve policy implementation.

May you withdraw from the study?

Certainly, you may do this at any time without having to give a reason. Participating in this research is completely voluntary. Not taking part in it, or withdrawing from it, carries no negative consequence of any sort.

Reimbursements

Should there be any cost to the participant, the researcher will reimburse him/her, however this is unlikely given that the research will be conducted during work hours in the participant's work environment.

Confidentiality

The researcher will anonymise all information so that it is not possible to trace who the individual participants or departments were that took part in the study. The data will be kept in password protected files on the researcher's computer.

Who to call for more information?

You are welcome to call me on 076 862 3221 or email on jodiwishnia@gmail.com

You are also welcome to call the Research Ethics Committee administrator and chair Ms Zanele Ndlovu on 011 717 1252/2700/1234/2656 or email on zanele.ndlovu@wits.ac.za to report any complaints / problems.

Informed Consent

Please circle your choice

I hereby **consent/do not consent** to the researcher observing me and taking notes during meetings that I am in:

Name and Surname	
Department and rank	
Date	
Signature	

Interviews

Unique Number:

Research Title: The impact of institutional work on policy implementation in South African Departments of Health, with a focus on financial management, planning and service delivery units

Principal Investigator: Jodi Wishnia

Date: XX XX

Dear Colleague,

Introduction

I am doing my PhD in Public Health, through the University of the Witwatersrand's Centre for Health Policy. My research aims to better understand how people and organisational contexts affect the quality of policy implementation in the South African public health sector. Through my work with the National Department of Health, I have been able to learn about how the system functions and where potential areas for concern lie. I hope that this research could give departments valuable insight into possible strategies to improve financial management, based on the experiences and knowledge of the many potential participants in this study.

Invitation to participate

I would like to invite you to participate in this research study given your position within the public health system.

What is involved in the study?

I would like to interview you to gain a greater understanding of your experience of working in the public health sector. The interview will not have set questions. I will explain what I would like to try and understand and then allow you to speak freely on the topic. It is therefore not possible to give you the questions that will be asked beforehand, however you will be able to speak only about issues you feel comfortable sharing. If possible, I would like to audio record the interviews so that I can ensure all the information is captured but this is not compulsory and can be

agreed upon when scheduling the interview. A separate consent form will be made available should you agree to be audio-recorded.

Risks

There are no risks to participating in this research. All data will be anonymised so that any observations made will not be traceable to the individual concerned.

Benefits

There are no financial or other benefits to participating in this research. The findings of the study will be shared with all departments and all participants in the hope that the findings may help improve policy implementation.

May you withdraw from the study?

Certainly, you may do this at any time without having to give a reason. Participating in this research is completely voluntary. Not taking part in it, or withdrawing from it, carries no negative consequence of any sort.

Reimbursements

Should there be any cost to the participant, the researcher will reimburse him/her, however this is unlikely given that the research will be conducted during work hours in the participant's work environment.

Confidentiality

The researcher will anonymise all information so that it is not possible to trace who the individual participants or departments were that took part in the study. The data will be kept in password protected files on the researcher's computer.

Who to call for more information?

You are welcome to call me on 076 862 3221 or email on jodiwishnia@gmail.com

You are also welcome to call the Research Ethics Committee administrator and chair Ms Zanele Ndlovu on 011 717 1252/2700/1234/2656 or email on zanele.ndlovu@wits.ac.za to report any complaints / problems.

Informed Consent

Please circle your choice

I hereby **consent/do not consent** to the researcher interviewing me.

Name and Surname	
Department and rank	
Date	
Signature	

Permission to Audio-Record Interviews

Unique Number:

Research Title: The impact of institutional work on policy implementation in South African Departments of Health, with a focus on financial management, planning and service delivery units

Principal Investigator: Jodi Wishnia

Date: XX XX

Dear Colleague,

Thank you for agreeing to be interviewed for this study.

In order to capture our conversation as accurately as possible, it would be helpful to be able to audio-record our discussion.

Please circle your choice below with regards to being audio-recorded and sign this form.

I hereby **consent/do not consent** to be audio-recorded during my interview with the researcher.

Name and Surname	
Department and rank	
Date	
Signature	

Appendix 6: Faculty approval for change of thesis title

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172076

Reference: Mrs Sandra Benn
E-mail: sandra.benn@wits.ac.za

18 August 2021
Person No: 1493762
TAA

Miss JM Wishnia
1 Browns Park
35 First Avenue
Illovo
2196
South Africa

Dear Miss Jodi Wishnia

Doctor of Philosophy: Change of title of research

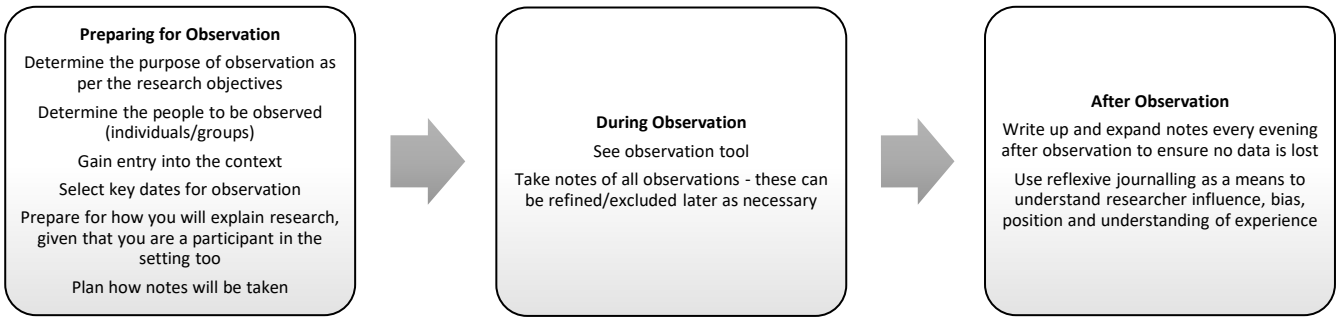
I am pleased to inform you that the following change in the title of your Thesis for the degree of Doctor of Philosophy has been approved:

From:	**The impact of institutional work on policy implementation in South African Departments of Health, with a focus on financial management, planning and service delivery units in** [redacted]
To:	**Understanding managers' experiences of public financial management policies and reform: A qualitative study from a South African provincial department of health "They couldn't make stones into bread."**

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

Appendix 7: Observation guide



Adapted from: Trent Focus for Research and Development in Primary Health Care: How to Use Observations in a Research Project [220]

To fill in prior to observation

Date:	
Department of Health:	
Name of Meeting:	
Stated purpose of Meeting:	
Stated aim of meeting (if any):	
Meeting type: Routine/ Ad hoc/ emergency / special / other (elaborate)	
Name of Chair:	
Occupation/Position of Chair:	

To focus on during observation

Participants

- Units from which the members originate
- Number per unit
- Which unit is 'owner' of the meeting (is it the same unit as chair is from, or different)
- Does one participant/unit dominate

Actions

- Time of arrival versus start time of meeting
- Seating arrangement
    - Do colleagues sit in groups
    - At the table or removed
- Which colleagues participate in the meeting (measured by talking, lack of distractions, body language and non-verbal communication)
    - How many
    - From which unit

Behaviour

- Behaviour of meeting chair
    - Authoritative/engaged/relaxed/disinterested/rushed etc
- Response of attendees to chair
    - Engaged/bored/frustrated
    - On cell phone/laptop/distracted by work or non-work (social media etc)
- Body language during meeting (engaged, busy, frustrated)
- Tone of voice during participation

Content of Meeting

- Did the meeting achieve its aim?
- What are the resolutions?
- How is consensus reached?
    - Chair decides
    - Members vote
    - Imposed/dictated
    - No consensus
- How do members respond to resolution decisions?
    - Indifference, frustration, anger
    - Satisfied/pleased/invested
- Who/which unit is responsible for the next steps?
- Are their dates associated to assigned tasks?
- Who will follow up?

- Are there consequences to non-performance? (Can be observed in the next meeting as well)

Appendix 8: Grand Tour Interviews

Target audience: Provincial Managers

My research is focusing on the experience of working within the department of health. I am particularly interested in your day-to-day life and how you cope with challenges of working within this organisation. I would like to hear your experience of working in your current role. I am particularly interested to hear how and when you interact with other managers from different units within the head office as well as the district health offices or facility managers.

I have a few standard questions I will ask throughout the interview, but please also feel free to tell me anything else that seems relevant.

a) Can you take me through your average day/week- what are your daily tasks and how do you manage them?
b) How do you see your role? What are your core functions both in the head office and in the greater health system of the province?
c) Say you need to change the way something is currently being done, how would you go about doing that? Who are the people you would talk to and what actions would you take to make the change happen?
d) How often do you interact with other managers from different units within the head office and what are some of the main reasons you hear from them?
e) If you are told of a new policy initiative, what is the usual process for designing the policy for your province? Take me through the process from the moment you hear about the policy, to how you plan for it (who you talk to, what you prepare etc.) and how you communicate the policy down the health system
f) Can you tell me a story of when you were trying to do your job, and something stopped you from being able to do it to your best ability?
g) What do you think is the reason for the high numbers of medicolegal cases in the province?
    i. If you could design a medicolegal strategy to improve the high number of claims in the province, what would be your first actions?

Target audience: District Managers

My research is focusing on the experience of working within the department of health. I am particularly interested in your day-to-day life and how you cope with challenges of working within this organisation. The district office can be viewed as the implementing arm of head office and I would like to hear your experience of this role. I am particularly interested to hear how and when you interact with head office and whether this support is valuable to you. I am also interested in how you have approached your role as district manager and what processes you have in place to manage the district office.

I have a few standard questions I will ask throughout the interview, but please also feel free to tell me anything else that seems relevant.

h) Can you take me through your average day/week- what are your daily tasks and how do you manage them?
i) How do you see your role as district manager? What are your core functions both in the district and in the greater health system of the province?
j) Say you need to change the way something is currently being done, how would you go about doing that? Who are the people you would talk to and what actions would you take to make the change happen?
k) How often do you interact with head office and what are some of the main reasons you hear from them?
    i. Do you ever initiate contact with the head office and what are some of the main reasons for doing so?
l) If you are told of a new policy initiative, how do you go about implementing it? Take me through the process from the moment you hear about the policy, to how you plan and implement it (who you talk to, what you prepare etc.)
m) Can you tell me a story of when you were trying to do your job, and something stopped you from being able to do it to your best ability?
n) What do you think is the reason for the high numbers of medicolegal cases in the province?
    i. Do you think the district office plays a role in any way?
    ii. If you could design the strategy to improve it, what would be your first actions?

Target audience: District level staff

My research is focusing on the experience of working within the department of health. I am particularly interested in your day-to-day life and how you cope with challenges of working within this organisation. The district office can be viewed as the implementing arm of head office and I would like to hear your experience of this role. I am particularly interested to hear how and when you interact with head office and whether this support is valuable to you.

I have a few standard questions I will ask throughout the interview, but please also feel free to tell me anything else that seems relevant.

a) What is your role in the district?
b) Can you take me through your average day/week- what are your daily tasks and how do you manage them?
    i. What are your core functions in the district?
    ii. Is your work mostly routine or mostly unplanned (why?)
c) How often do you interact with head office and what are some of the main reasons you hear from them?
    i. Do you ever initiate contact with the head office and what are some of the main reasons for doing so?
d) Can you tell me a story of when you were trying to do your job, and something stopped you from being able to do it to your best ability?
e) Now, think about when something happened, or someone did something, that helped you to perform your job better. Can you tell me more about it?
f) If you are told of a new policy initiative, how do you go about implementing it? Take me through the process from the moment you hear about the policy, to how you plan and implement it (who you talk to, what you prepare etc.)
g) How do you experience the way resources (financial and technical) are allocated in the province?
    i. Can you think of any examples to help me understand your experiences?

Target audience: Hospital CEO

My research is focusing on the experience of working within the department of health. I am particularly interested in your day-to-day life and how you cope with challenges of working within this organisation. Hospital CEOs are expected to be managers who have clinical, financial, HR and many other skills. Therefore, it will be valuable to understand how you manage your role and how you experience both the support you get from the district or head office and how you give support to the clinics and CHCs underneath you. Please also take me through the process of planning and budgeting for your facility and how this may need to adapt in-year.

I have a few standard questions I will ask throughout the interview, but please also feel free to tell me anything else that seems relevant.

a) Can you take me through your average day/week- what are your daily tasks and how do you manage them?
b) How do you see your role as CEO? What are your core functions both in the hospital and in the greater health system of the province?
c) Say you need to change the way something is currently being done, how would you go about doing that? Who are the people you would talk to and what actions would you take to make the change happen?
d) Can you tell me a story of when you were trying to do your job, and something stopped you from being able to do it to your best ability?
e) Can you tell me the story of a time when you interacted with PDoH managers/colleagues and how that affected your ability to do your job?
f) Now, think about when something happened, or someone did something, that helped you to perform your job better. Can you tell me more about it?
g) If you are told of a new policy initiative, how do you go about implementing it? Take me through the process from the moment you hear about the policy, to how you plan and implement it (who you talk to, what you prepare etc.)
h) Do you have delegations (financial or HR)
    i. if yes, how have you experienced managing these
    ii. if no, how does this effect your ability to manage, what are some of the practical effects of not having delegations as a hospital manager
i) Has your hospital experience medicolegal claims in the last 5 years?

i. If yes, why do you think these happened? What do you think is the root cause and how could you/the PDoH improve these?
ii. If no, why do you think this is the case? Do you think your hospital is managing differently from others to achieve this positive result?

Target audience: District Clinical Specialist Team member

My research is focusing on the experience of working within the department of health. I am particularly interested in your day-to-day life and how you cope with challenges of working within this organisation. As one of the new NHI policy initiatives, I would like to hear some of your stories and experiences of being part of the DCST and what has made building the programme easy or more difficult. I also would like to hear how you interact with the district health office and the provincial department of health and whether the current engagement is optimal.

I have a few standard questions I will ask throughout the interview, but please also feel free to tell me anything else that seems relevant.

a. Please describe your role and responsibilities in the team
b. Can you take me through your average day/week- what are your daily tasks and how do you manage them?
c. Say you need to change the way something is currently being done, how would you go about doing that? Who are the people you would talk to and what actions would you take to make the change happen?
d. Can you tell me a story of when you were trying to do your job, and something stopped you from being able to do it to your best ability?
e. In your role as a DCST member, you probably sometimes have to give advice to facility to district staff. How would you do this (practical steps)? What approach would you take?
f. Can you tell me the story of a time when you interacted with PDoH managers/colleagues and how that affected your ability to do your job?
g. Now, think about when something happened, or someone did something (within provincial, district office or in the facilities), that helped you to perform your job better. Can you tell me more about it?

h. From your perspective, what do you see as some of the major challenges of the department at the moment?
i. How do you see your role in relation to the medico-legal strategy in the PDoH? Is the DCST being used to improve medico-legal cases at all?

Appendix 9: Turnitin report

1493762:JWishnia_PHD_Thesis_20211204.pdf

ORIGINALITY REPORT

9%	8%	5%	2%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	Jodi Wishnia, Jane Goudge. "Strengthening public financial management in the health sector: a qualitative case study from South Africa", BMJ Global Health, 2021 Publication	1%
2	Submitted to City University Student Paper	1%
3	Submitted to University of Witwatersrand Student Paper	1%
4	wiredspace.wits.ac.za Internet Source	1%
5	www.researchgate.net Internet Source	<1%
6	gh.bmj.com Internet Source	<1%
7	hdl.handle.net Internet Source	<1%
8	www.hst.org.za Internet Source	<1%