

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

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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



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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.

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

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.

most broad definition includes four stages of PFM, each with associated processes.² These are: (1) budget planning/formulation, with

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

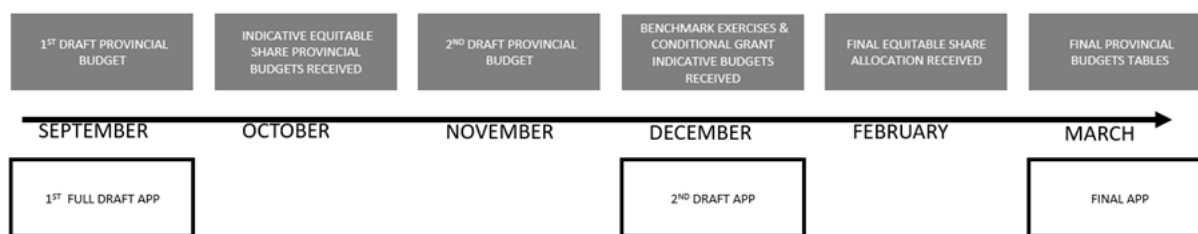


Figure 1 Milestones in the provincial budget and planning cycles. APP, annual performance plan.

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

Centralised control of expenditure (which we described in another companion paper²⁵), 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

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 guide²⁹ 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

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. JW 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].

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

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: <ul style="list-style-type: none"> ▶ Service delivery and finance managers involved. 	Moderate: <ul style="list-style-type: none"> ▶ Confusing reporting lines. ▶ Unclear objectives and divided loyalties. ▶ Informal ways of working established by those involved supported embeddedness. 	Moderate: <ul style="list-style-type: none"> ▶ 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: <ul style="list-style-type: none"> ▶ 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: <ul style="list-style-type: none"> ▶ Finance and service delivery managers attended, but the latter not fully included. 	Weak <ul style="list-style-type: none"> ▶ 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: <ul style="list-style-type: none"> ▶ CEOs felt their inclusion had improved resource allocation decision-making. ▶ Provincial management saw no improvement in PFM, reducing their support. 	Weak: <ul style="list-style-type: none"> ▶ Relationships remained strained between service delivery managers/ CEOs and district finance teams due to poor leadership.
Weekly review meeting	Strong: <ul style="list-style-type: none"> ▶ Only finance managers included because it is a PFM compliance step. 	Moderate: <ul style="list-style-type: none"> ▶ 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: <ul style="list-style-type: none"> ▶ 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: <ul style="list-style-type: none"> ▶ Added to existing tensions and trust deficits because of poor feedback and a lack of collaboration with other strategies.
Weekly touch-base meeting	Strong: <ul style="list-style-type: none"> ▶ All district managers included. 	Strong: <ul style="list-style-type: none"> ▶ District manager as leader. ▶ Roles were clear. 	Strong: <ul style="list-style-type: none"> ▶ Support for the meeting was evident. 	Moderate: <ul style="list-style-type: none"> ▶ 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.

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

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.

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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.

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