

## **Good Governance and Budget Reform in Lesotho Public Hospitals: Performance, Root Causes, and Reality**

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### **Key Messages:**

Public sector budgeting reforms such as performance-based budgeting (PBB) are intended to improve good governance by increasing transparency and accountability for resource allocation decisions, but evidence of effectiveness is limited.

Budget reforms urged by donors and led by the Ministry of Finance need to be adapted to the health sector. Before we can evaluate outcomes of reform, it is essential to monitor implementation progress and, where progress falls short of promise, understand why.

A framework for measuring reform activities in the health sector was developed and tested in four Lesotho hospitals, and found little progress in budget reform. The reform's failure is attributed to a complex design which was not adapted to institutional constraints and lack of capacity in the sector, as well as weak leadership and professional boundaries between clinical and accounts staff.

The complexity and labor intensity of public sector budgeting reforms such as PBB suggest that policymakers and advisors may not fully appreciate the human resource realities of many developing countries. Simpler, more adapted reform strategies may be needed.

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## **Abstract**

Lesotho has been implementing financial management reforms, including performance-based budgeting (PBB) since 2005 in an effort to increase accountability, transparency, and effectiveness in governance, yet little is known about how these efforts are affecting the health sector. Supported by several development partners and \$24 million in external resources, the PBB reform is intended to strengthen government capacity to manage aid funds directly and to target assistance to pressing social priorities. This study designed and tested a methodology for measuring implementation progress for PBB reform in the hospital sector in Lesotho. We found that despite some efforts on the national level to promote and support reform implementation, staff at the hospital level were largely unaware of the purpose of the reform and had made almost no progress in transforming institutions and systems to fully realize reform goals. Problems can be traced to a complex reform design, inadequate personnel and capacity to implement, professional boundaries between financial and clinical personnel, and weak leadership. The Lesotho reform experience suggests that less complex designs for budget reform, better adapted to the context and realities of health sectors in developing countries, may be needed to improve governance. It also highlights the importance of measuring reform implementation at the sectoral level.

## 1. Introduction

The purpose of governance is to protect and promote the well-being of citizens. Political authorities work together with non-state actors to steer the rules for exercise of power, and to guide the interactions between the state and citizens, civil society, and the private sector (Kjaer 2004; Kaufmann and Kraay 2007; Brinkerhoff and Bossert 2008). When governance works well, citizens are better able to achieve individual and common purposes. But when governance is poor, even if a country has financial resources and technical assistance, it may fail to achieve development goals. For governance to work, public organizations must have sufficient institutional capacity to design and implement policies in ways that are “effective, transparent, impartial, and accountable” (World Bank 2001). A main channel to accomplish this is through reform of the budgeting system.

Public financial management (PFM) institutions are integral to governance (Andrews 2010). Within the public budgeting process, policymakers decide priorities, set goals, and allocate resources. While institutions and decision-making structures may vary, governance experts generally believe that budgeting systems function better when they are transparent, provide opportunities for stakeholder participation, exercise control on discretion of agents, and assure accountability for performance (Diamond 2003; Deininger and Mpuga 2005; Ebdon and Franklin 2006; Gilmour and Lewis 2006). Yet, public budgeting institutions in many countries do not yet meet these criteria: they are often based on line-items or objects of expenditure—for example, salaries, medicines, and equipment—and amounts are determined by making incremental changes to past patterns of resource expenditure. This type of budgeting is generally seen as less effective because it is not focused on results: incremental, line-item budgeting makes it difficult to trace expenditures to policy objectives, and to hold government accountable.

Reforms to make budgeting more transparent and accountable try to relate expenditures to objectives, seeking to make budgeting more rational (Lewis 1952; Wildavsky 1978). Recent public finance reforms such as the Medium Term Expenditure Framework (MTEF), and performance-based budgeting (PBB) fall within the paradigm of rational budgeting (Radin 1998; Schiavo-Campo and Tommasi 1999), and are currently being implemented in dozens of countries (Schiavo-Campo 2008). The success of public budgeting reforms also has implications for health systems strengthening (World Health Organization 2007). If successful, budget reform could help improve health sector governance, strengthening the capacity of governments to implement health policies efficiently and fairly and achieve better outcomes (Veenstra and Lomas 1999; Siddiqi, Masud et al. 2009). Therefore, the study of how public budget reforms actually work in the health sector is of critical importance.

This article presents evidence from a study in the hospital sector in Lesotho, a small, land-locked country in Southern Africa which has been implementing public finance and budgeting reforms since 2005 in an effort to create more realistic budgets and provide incentives for efficient and effective management of government services (Central Bank of Lesotho 2007). The study encompassed three principle objectives: to design methods to measure budget reform progress in the health sector; to apply this framework to

describe reform progress in Lesotho's health sector; and to explore factors affecting reform progress. The main purpose of this article is to report the empirical findings on reform implementation progress. The results show that budget reform in Lesotho has not changed institutions or decision-making practices in the health sector, and reform goals were not achieved. After presenting these findings, the study begins to explore some of the possible reasons for failure.

## **2. Background on reforms**

### *Definitions of MTEF and PBB*

MTEF is a central component of many public expenditure management reform programs (World Bank 1998; Le Houerou and Taliencio 2002). While the exact structure of an MTEF may vary, the framework generally includes three components: more realistic medium-term estimation of available resources, early identification and agreement on strategic priorities, and performance-based estimation of resource needs. First, MTEF introduces advanced modeling procedures which are intended to provide better estimates of the total resource envelope available. Secondly, the MTEF process is meant to help countries identify competing priorities for funding which can then be debated and decided during the budget formulation process, rather than during budget execution (Schiavo-Campo and Tommasi 2004). Finally, MTEF is intended to change the orientation of budget preparation within each Ministry from a "line-item" focus toward "performance budgeting" based on defined objectives and activities. Rolling three-year budgets are created and new budget classifications may be introduced to allow monitoring of expenditure in relation to program activities and performance indicators. This is intended to increase accountability. Figure 1 illustrates the steps in a general MTEF framework.

PBB is the "bottom up" component of MTEF. PBB has been defined as procedures intended to "strengthen links between the funds provided to public sector entities and their outcomes and/or outputs through the use of formal performance information in resource allocation decision-making" (Robinson and Brumby 2005). It is an explicit effort to expand the domain of budgeting to include more emphasis on productivity in relation to planned targets, and to strengthen the correspondence between public spending and results.

### *International Experience with PBB Implementation*

To date, PBB has not proven easy to implement. Problems have included lack of basic financial control and performance data systems; inconsistent political will; lack of appropriate incentives; and gaps in alignment and integration within and across government institutions and agencies (Montes and Andrews 2005; Roberts and Andrews 2005; Ronsholt and Andrews 2005). Implementing agencies have had trouble agreeing on performance indicators, integrating costing systems with performance information, and deciding how reforms should be adapted in the context of decentralization (Grizzle and Pettijohn 2002; Kong 2005; Radin 2006). Moreover, although reforms have been

implemented in many countries in Africa, Southeast Asia, Latin America, and Eastern Europe/Central Asia (Le Houerou and Taliercio 2002; Overseas Development Institute 2005; Andrews 2006; Dorotinsky 2007), evaluations have so far found little evidence to show that MTEF and PBB reforms have altered budget allocations (Robinson and Brumby 2005; Schiavo-Campo 2008), possibly because it is too early to see effects and possibly because the content of reforms is not adapted to country context.

Andrews (2004) suggests that the failures in reform implementation described above are due in part to reformers focusing too much on technical aspects—trying to “copy whatever is ‘best practice’ in performance-based reforms” and to reproduce initiatives from other settings—a strategy which he feels is “almost guaranteed to fail.” Andrews believes that the adaptation of reforms to context is essential: reformers must focus on expanding reform space by increasing appropriate authority to collect and use performance information, increasing acceptance of reform goals by political officials and managers (including alignment of incentives for reform adoption), and increasing organizational capacity or ability to complete PBB reforms such as the development of personnel, data and accounting systems, and other structural supports (Andrews 2004).

### *History of PBB Reform in Lesotho*

Reform in Lesotho began in 2005 with planning for the PFM reform agenda. External funding totaled \$24.1 million, with 35% from the U.K. Department for International Development (DFID), 14% from Irish Aid, and 51% from the European Union (EU) (Vian 2010). In addition to MTEF and PBB, the PFM agenda also included plans to strengthen systems to support the integration of performance output data, and to overhaul public audit and procurement (Ministry of Finance and Development Planning and Department for International Development 2005). The government created an Improvement and Reform Steering Committee to guide policy decisions, while a Reform Coordinating Unit (RCU) served as the secretariat. Two external advisors helped to staff the RCU, and four Task Forces were charged with the major components of the agenda: 1) planning and budgeting (MTEF and PBB reforms), 2) accounting and reporting (the Integrated Financial Management Information System (IFMIS) and procurement reforms), 3) audit and oversight, and 4) administration (pension reform).

The reform was introduced in six pilot ministries, including the Ministry of Health. Pilot ministries were asked to prepare a Budget Framework Paper (BFP) by August each year describing policy objectives, performance achieved in past year, anticipated policy changes, and a rolling budget for resources over the next three years. By the time of this study in June 2009, three national BFPs and MTEFs consolidating PBB data from pilot Ministries had been completed.

After the line Ministries submitted their BFPs, the Ministry of Finance and Development Planning (MOFDP) was to hold hearings so that Ministries could defend their proposals. The MOFDP would then prepare final sectoral budget ceilings (Step 3 in Figure 1). These would be submitted to Cabinet for approval, after which budget instructions would be distributed (Step 4). With this information, the line Ministries could prepare their rolling

budgets with detailed expenditure estimates for the first year and rougher estimates for future years.

Similar to experiences in Malawi and Ghana (Anipa, Kaluma et al. 1999), the difficulty with this process is that Finance Ministry in Lesotho did not have adequate time to review all the BFPs, finish the hearings, and get Cabinet approval for recommended sectoral ceilings by October. In order to keep to schedule, the Ministries need to start preparing their budgets before the ceilings are set. Therefore, the MOFDP asks the Ministries to please start building their budgets based on an interim ceiling. The real ceilings are set in December, after which the line Ministries must cut their budgets to fit the finalized ceilings.

The Lesotho budget reform introduced a type of program or output-based budgeting. Individual hospitals began the process by developing plans organized by objectives set out by the Ministry (i.e. increase access to services, etc.). Each plan was to specify those activities needed to achieve objectives, and to identify indicators to measure accomplishments. Hospital staff would then create a performance-based budget organized by program (e.g. general administration, curative services, etc.). Using a set of worksheet forms, hospital staff would map activities to specific programs and outputs. They would then estimate the frequency and total cost of inputs for each activity, and roll up this information to determine total program costs. MOHSW staff would review and amend budget submissions in light of budget ceilings. The reform did not include any change in budgetary authority or power of program managers to make budgetary decisions. Managers could request line-item changes before the reform, and the reform did not alter this provision. Specific planning and budgeting steps are discussed in more detail in later sections.

### **3. Study Methods**

The study took place from March-June 2009 using four case studies each centered on a single hospital's implementation of PBB. The cases were considered to be individual experiments, not a "sample" which is intended to represent the total population of hospitals in Lesotho. The narrative of each case provides descriptive information about processes or factors underlying behaviors as well as the context of the case study, information which is used to develop hypotheses of how factors affect behavior, and under what circumstances these effects are likely to occur (Hartley 1994). If two or more cases support the theory, we can claim analytic replication and there is an argument for inferences to be made (Yin 1994). Hospitals were selected to represent diversity in type, size, geographic location, and performance indicators such as patient satisfaction and accreditation score (Table 1).

The case studies rely on two main sources of data: review of archival documents (budget submissions, financial and performance reports, and plans) and 52 semi-structured interviews with key informants (8-12 people in each hospital, and 11 people at the national level). Unit heads at each hospital were interviewed, including the District Medical Officer (DMO), Matron, Administrator, Accountant, and chiefs of Pharmacy,

Laboratory and Radiology. At the national level, interviews included MOHSW and MOFDP staff and consultants responsible for engaging on reform implementation. Interviews were conducted in English; a research assistant took notes which were later turned into transcripts similar to methods used in other studies (Andrews and Hill 2003; Roberts and Andrews 2005; VanLandingham, Wellman et al. 2005). The interview guide included questions about the informant's role and professional background, general knowledge of the budget reform; planning and budgeting processes; implementation experience and factors affecting reform; and perceived results of reform. Questions were designed to deepen understanding and provide additional evidence of how the planning and budgeting systems were operating, and to elicit perceived changes over time. An important element of the research strategy was to begin building theory to interpret the data. Toward this end, the study used the constructs of the theory of Transformational Change (TC) in health care organizations to guided data collection and analysis (VanDeusen Lukas, Holmes et al. 2007). TC model constructs include impetus to change, leadership, experience with smaller change initiatives, alignment, and integration. These concepts guided the inquiry, although data collection questions were refined in light of initial findings, maintaining an active research approach (Charmaz 2006). The relevance of TC model constructs for budget reform progress in Lesotho is discussed elsewhere and is not the focus of this article (Vian 2010).

The outcome of interest analyzed in this research study was PBB reform progress. Similar to Matthew Andrews's analysis (Andrews 2006), this study captured four dimensions of progress: 1) existence of performance-based plans, 2) existence of performance-informed budgets, 3) evidence of performance monitoring and reporting, and 4) evidence that performance information is used to make allocation and managerial decisions and for budgetary oversight. Expanding on Andrews's work, we developed 21 sub-criteria to delineate evidence of progress. For example, evidence of a performance-based plan was assessed by availability/organization of plan, accountability structure, definition of activities and outputs, participation in the planning process, institutionalization, and acceptance. Each sub-criterion was evaluated as High, Modest, or Low (Table 2).

Case study method allowed researchers to explore not just whether or not progress has occurred, but how and why. In the end, however, there was not much variation between cases in terms of understanding of reform goals, implementation progress, and factors associated with reform. Although the analysis which follows presents data on individual hospital performance against indicators of reform progress, the main focus is on pulling out patterns in the full set of data.

#### **4. Results**

Overall, the hospital staff interviewed—mainly unit heads and people in positions of authority—showed little awareness of the MTEF reform and performance-based budgeting. Some people had heard of the reform through budgeting workshops, but they struggled to describe the main components or characteristics of the reform. Similarly, the Finance personnel were not always well informed. A key informant from the MOFDP

stated, “MTEF as a concept has been introduced, but we still can’t say that people understand it... [MOFDP-sponsored trainings] worked at the beginning, but like anything in government, the sustainability is questionable...over time, the facilitators disappeared. There were three from my department, but now we are left with only one.” Responding to open-ended questions in the interviews, few people could remember what they had learned or thought they could explain the reform to others.

Table 3 presents the ratings of reform implementation. The data show that there has been little progress in implementing reform in any of the hospitals. Of the four dimensions measured, the most progress has been made in performance-based planning, and the least progress in monitoring and use of information.

### **Evidence that performance plans exist**

Progress on this dimension ranged from modest to none. While all hospitals had plans, the documents were hard to locate and department heads often had never seen them. Plans were organized around a department structure with an identified person in charge of each activity. However, planning and budgeting reports used different structures, which meant that plans could not easily map to budgets, a critical component of the MTEF reform (Table 4). The misalignment between the accountability structure in the plans and the program structure in the budgets makes it much harder to monitor performance.

Another weakness in the plans was excessive detail which obscured the connection between resources and outputs, a problem also observed in an earlier evaluation (Strachan 2007). An individual hospital could have over 100 planned activities, each of which needed cost estimates. In addition, staff seemed to misunderstand the concept of output-based budgeting: for example, many plans considered the purchase of items to be an activity (as in “Purchase chairs”) and the purchased item an output (“Number of chairs procured”). On average only 26% of hospital activities were related to the provision of services to patients (i.e. patient care outputs), while 61% of activities were related to inputs to the health care process, such as procuring equipment or training staff. Table 5 presents qualitative data on the input-orientation of hospital planning and budgeting.

One reason for the focus on inputs is that baseline output data are lacking due to well-documented weaknesses in the Health Management Information Systems (HMIS) (Bicknell, Berman et al. 2009). According to one laboratory manager, “When I came, I found that the people weren’t doing the statistics. They would keep them for some months, but not others. [But] when you do the budgeting you need to base yourself on the statistics.” People were not trained in how to make projections, and most department heads did not use formal projection techniques. “Maybe we ordered so much last year, so I increase it a little bit,” said one informant. The concept of medium-term projections of resources needed to achieve objectives was interpreted in a manner focused on inputs, as shown in the quotes in Table 5.

Hospitals lacked costing systems which would allow them to show the costs linked to patient care outputs. In addition, plans lacked measures of efficiency or productivity, such as occupancy rate, cost per bed, or tests per lab staff member.

Regarding participation, institutionalization, and acceptance, hospital personnel stated that the planning process was rushed and not very participatory. The MOHSW had not created documentation for the planning process or developed mechanisms for coordinating tasks. Instead, pressed for time and lacking personnel, the Ministry used workshops to communicate information and coordinate reform activities. The root of these problems may be staff shortages at both the hospital level and at the central MOHSW office, coupled with too many new initiatives promoted by the government and donors. One DMO explained the impact of “too many workshops”:

Normally we would have had our own plan, before the Ministry workshop. We couldn't come together as a team, though, because there were so many other workshops. When the department heads were informed that they needed to prepare the budget, I wasn't there. I was at another workshop.

Workshop-based planning is episodic and doesn't promote the idea that planning and budgeting are continuous management processes. A key informant at the national level explained that people see the budget as “an event, a one-time thing that they work on when it is time, but then they forget about it.”

### **Evidence that performance-based budgets exist**

Progress on this second dimension of reform progress ranged from little to none. Most hospitals could produce some budget worksheets, but none had summarized those worksheets into a report showing totals by activity or program. In one hospital the Human Resources director had the personnel budget on his laptop, while the rest of the budget worksheets were on a different computer.

Problems in costing included calculation errors, poor medium-term expenditure estimates, and excess complexity. The study found frequent data inaccuracies, incorrectly entered formulas, and lack of instructions for filling out the worksheets. The lack of data entry audit procedures cast doubt on the reliability of budget figures. Estimates for years 2 and 3 were generally not related to strategic goals or objectives and did not consider the impact of major policy changes such as abolishing user fees (a policy implemented in 2008). Hospital personnel lacked the capacity to make out-year projections, while central level staff lacked the time, knowledge, and direction to perform this function. The result is that estimates for hospital expenditures are not reliable.

Finally, the complexity of the MTEF worksheets made it difficult to see how activities mapped to programs or to track the total cost of an output. As shown in Figure 2, in-depth analysis of several worksheets was needed to discover that the total cost of training 2 technicians for 6 months was 234,000 Maloti (about \$30,000), an expensive strategy for

increasing quality of radiology services which might have been rejected had anyone realized this was the true cost.

Institutionalization of performance-based budgeting is weak and acceptance of the budgeting process is low. The lack of transparency about the mechanisms of the budgeting process fosters suspicions about how resource allocation decisions are made both within the hospital and by the MOHSW. At the hospital level, some members of the management team have more discretion than others in setting budget priorities and determining how the budget is shaped for submission to the MOHSW; yet there is little oversight or control on how this discretion is exercised. Clinical managers described antagonistic relationships with Accounts office staff and reported problems getting access to budget information. One lab manager explained, “I went to the Accounts office after the initial budgeting meeting and asked which items had made it into the final budget submission. They didn’t know. We weren’t told what was cut and what wasn’t.” Clinical staff also felt unqualified to question decisions made by accountants, as in this quote from a nurse describing her discomfort in a budget meeting, “If you don’t know anything about anything, you won’t say anything. You think, ‘they have technical knowledge on how to do things,’ so you don’t say anything.”

At the level of the MOHSW, the process is equally opaque. When the hospital receives the approved budget there is no explanation about how it deviates from the original submission, so hospital managers cannot tell how or why the budget was cut. Hospitals are not required to re-program their operational plan based on the final budget received, making it difficult to hold managers accountable for results. Any deviation between planned and actual performance can always be blamed on budget cuts rather than inefficiencies or other performance problems.

### **Evidence of performance monitoring and reporting**

The third dimension of budget reform is evidence that hospitals are monitoring and reporting on the use of budgeted resources to achieve targeted results. Hospitals showed little or no progress on this dimension. Most hospitals could not provide baseline data on indicators related to plan objectives due to the weak HMIS, and service statistics were generally not seen as related to budget performance in any case. Because the new government accounting system was not installed at the time of the study, hospitals were unable to compare budgeted and actual expenditures by activity, and budget monitoring was limited to line item comparisons. In three out of the four hospitals studied, managers said they do not receive regular reports from the Accounts department, even when requested, and few managers knew how to read financial reports.

The lack of performance monitoring seemed to be associated with frequent turnover of staff, infrequent management meetings, and unclear relationships between organizational units such as the District Health Management Team (DHMT) and the hospital. Frequent turnover of staff makes it difficult to have consistent performance monitoring. New staff often stated they were not given a copy of the plan produced by their predecessor. In addition, infrequent management meetings do not allow opportunities to discuss implementation progress. Monitoring tasks are fragmented between the DHMT and the

hospital: for example, the hospital collects health indicators while the DHMT is charged with performance monitoring. This requires extra coordination which is challenging given the already weak management systems and lack of staff. In one hospital, the health information officer position had been vacant for 6 months, and no reports had been created since the last officer left.

### **Evidence that performance information is used**

The fourth dimension of reform progress is evidence that performance information is used for decisions. Key informants at the central level were asked whether the budget reforms had made any difference in allocation of resources among MOHSW programs. For example, were higher performing hospitals or programs within hospitals likely to receive more funding? One key informant said that allocation decisions within the MOHSW had been influenced by performance information, giving as an example the fact that “bigger hospitals get more”. Informants at the hospital level had no perception that budget allocations were affected by performance information.

Hospital managers were asked if they had used performance information to make internal decisions, including making or changing work plans or strategies for service delivery, monitoring efficiency and effectiveness of services, communicating to MOHSW or MOFDP officials about policy, strategic, or operational issues, or in communications with the public. In a few cases, budget and performance information appeared to influence minor decisions. For example, one hospital said they noticed that they were not going to reach their target for school visits because of staff shortages, so they re-programmed the funds mid-year to host a different outreach event. In two hospitals, department heads had plans to improve record-keeping so that statistics could be used to make budget projections in the future.

Factors affecting the use of information included people not being stable in their jobs, and not having enough time to review information before having to make planning and budgeting decisions. In addition, communication between the hospitals and the MOHSW was weak: “We don’t get positive feedback, even when we give them data,” said one hospital informant. No informants could give examples of discussions between the hospital, MOHSW or DHMT about how to improve performance based on MTEF or HMIS data, and hospital managers reported that they lacked permission to form hospital boards or communicate with the public regarding resource allocation decisions.

## **5. Discussion**

This study had several limitations. As the reform had been ongoing for more than 4 years, it was not possible to collect data at baseline to compare to the post-reform situation. In addition, Dimensions 1, 3 and 4 in Table 2 are features of health sector management that are often driven by other sector strategies and reform processes. In the absence of controls, there is no way to distinguish the impact of PBB from that of other sectoral initiatives which may have influenced performance.

At the same time, the results of this study suggest that despite large investments, budget reform in Lesotho is not well understood in the health sector and hospitals have made little progress in implementation. The small changes which have been made in planning and budgeting activities do not seem to have had any impact on strategic planning, resource allocation, or operational decision-making, either within hospitals or at higher levels in the government health system. In other words, the budget reform has failed to achieve its goals in the health sector. This failure is due to problems in both the initial conceptualization of the reform, and its implementation.

The research documented many factors which impeded reform progress, including inadequate capacity to implement (especially the lack of costing and performance measurement systems and insufficient numbers of personnel), professional barriers between clinical and accounts staff who must work together for effective budgeting, and a lack of leadership. Weak leadership prevented hospital management teams from developing a shared understanding of the reform and the motivation to see it succeed, while the health sector's hierarchical authority structure inhibited the type of creative problem-solving and adaptation of systems that PBB requires (Guess 2001; Miller, Hildreth et al. 2001; Melkers and Willoughby 2005). Professional boundaries and mistrust between clinicians and accounts staff made it hard for the two groups to share or use information that might benefit the hospital as a whole. Budget reform in Ghana was similarly impeded by the failure to overcome professional "silos" separating staff with different functions and training (Roberts and Andrews 2005).

The notable failure of this reform to change governance in the health sector raises questions of how it came about, and where the demand for this reform originated. The purpose of this study was not to document the process by which Lesotho created its vision of what good governance would mean for the country, and how involved government officials were in determining the actual content of the PFM reforms to bring the country closer to that vision. But the evidence suggests that the vision for reform was too complex for the health sector, and possibly for the country as a whole. It appears that donors and reform-minded officials promoted initiatives that were beyond Lesotho's capacity, and did not adequately assess or attempt to modify the goals or reform activities to account for the institutional preconditions which were missing at the level of line ministries. The reasons for this are not clear, and beyond the scope of this study.

Merilee Grindle suggests that rather than promoting a long list of institutions, policies, and practices essential for good governance, organizations like the World Bank and DFID should focus on "good enough governance": reforms that are practicable and important given the distinct context and unique experience of the country (Grindle 2007). Similarly, Andrews contends that international frameworks for PFM reform (such as the Public Expenditure and Financial Accountability Program, [www.pefa.org](http://www.pefa.org)) and standard sets of good governance indicators (such as the Worldwide Governance Indicators project) have created "strong isomorphic influences on thinking about what effective government is", leading countries to believe there is only one best model of governance (Andrews 2010).

In the end, despite high-level support within the Ministry of Finance for the reform, few government bureaucrats in Lesotho really understood the substance of the reforms or could provide technical guidance in adapting them to local circumstances. In a setting like Lesotho, where 23% of adults are HIV positive and there is a crisis-level shortage of human resources for health, adopting “best practices” without modification was doomed to failure.

What implications does the Lesotho experience have for implementation of PBB reform in other countries? Although the data from Lesotho do not allow us to draw definitive conclusions, the results suggest that reformers in other countries should temper enthusiasm for a specific technical approach to budget reform—whether it is PBB or any other—with more realistic assessment of feasibility. It is critically important to evaluate the organizational capacity, staff, systems, skills and knowledge that are available and needed to implement governance initiatives not just in general, but in specific sectors such as health. Based on this assessment, reform goals and strategies should be modified and additional supports put in place to adapt or expand reform space. For example, given the scarce human resources in Lesotho’s health sector, reformers might have considered comparing total hospital budget to the expected number of inpatient days and outpatient visits (patient-day equivalents), a single gross measure of efficiency that would nonetheless be a starting point for accountability in resource use. To achieve greater transparency, reformers might have considered the more modest goal of increasing hospital managers’ understanding of line-item budget variance reports, rather than trying to move directly to much more complex program budgeting. Reformers might have considered strategies such as those adopted in Malawi, Tanzania, and South Africa, which involved civic organizations in analysis of budgets to improve transparency and accountability (Ramkumar 2008). Such strategies might achieve better results at a lower cost than the extensive administrative reforms attempted in Lesotho.

Finally, the study findings underscore the importance of monitoring budget reform implementation in line ministries. Progress reports on reform implementation in Lesotho compiled at the national level have been positive, but few looked specifically at implementation in line ministries and perceptions of staff. Similarly, international studies reviewing the progress of budget reform generally have been limited to the central level, a surprising fact given that the reforms require transformation in how work is organized and executed at the line ministry level. The possibility of bias should be considered when evaluations are funded by the same development partners who supported budget reform design and implementation.

## **6. Conclusion**

This study is one of the first attempts to measure PBB reform progress in hospitals in a developing country. The evaluation framework used for the research provides a useful tool and guide for policy-makers seeking to evaluate reform progress in the health sector in other countries. In the case of Lesotho, application of this tool suggests that PBB is not working, and hospitals do not yet have the capacity to link resource allocation decisions to results. Government and development partners interested in promoting good governance should critically evaluate whether to continue investments in this reform, or

to pursue other avenues to promote accountability and transparency in governance.

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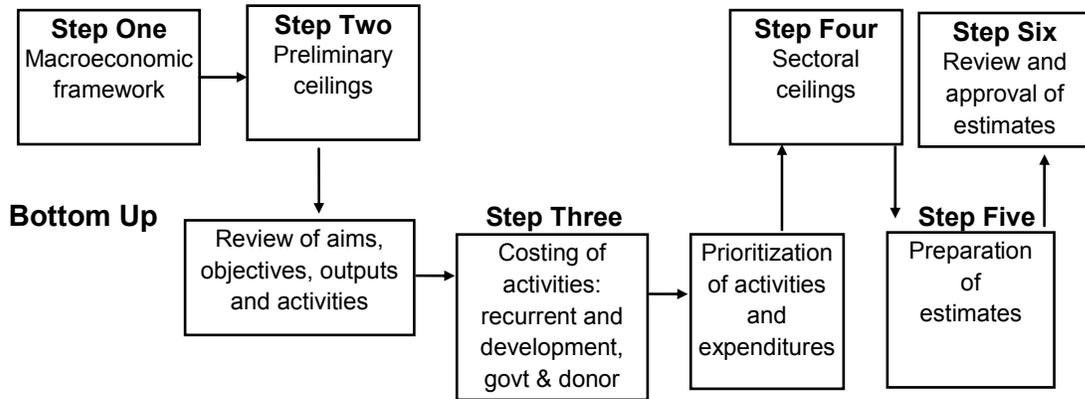
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Figure 1: MTEF Steps

**Top Down**



Source: Anipa, Kaluma, et al. 1999, p. 8

*Note:* The two viewpoints on the MTEF process are “Top Down”, i.e. steps mainly executed from the central level Ministry of Finance, and “Bottom Up”, i.e. steps executed by the staff of the ministries who are responsible for implementing plans and achieving objectives.

**Table 1: Characteristics of Case Study Hospitals**

Characteristic	Hospital A	Hospital B	Hospital C	Hospital D
Level of Facility	Local	District	Regional	Regional
Bed Size	107	108	207	117
Patient satisfaction (2007)	73%	82%	9%	42%
Accreditation results: # of domains rated as satisfactory (out of 11 possible)	2	0	0	1
Development partners: # providing assistance	5	3	4	1
Inpatient Days (FY08)	13,370	30,527	29,067	12,762
Admissions (FY08)	3,254	4,394	5,446	2,613
General OPD Visits (see note)	36,409	28,153	20,014	17,741
Bed Occupancy Rate (BOR)	34%	77%	38%	30%
Average Daily Census (ADC)	37	84	80	35
Average Length of Stay (ALOS)	4.1	6.9	5.3	4.9
Staffing				
Doctors	3	4	7	4
Nurses	29	35	36	27
Nurse Assistants	20	25	36	35
Technical (lab, pharm)	7	6	14	4
Doctors per occupied bed	0.08	0.05	0.09	0.11
Nurse/Nurse Asst/occ.bed	1.32	0.71	0.90	1.77

**NOTES:** Sources: MOHSW, 2008. Annual Joint Review Report 2007/2008; Puglisi, R. J. (2007) Strengthening District Hospitals and Health Centers Step-Down Cost Analysis (Maseru: Boston University). Accreditation Performance Data from W. Chase and C. Schwabe. "GOL-CHAL Hospital and Health Centre Certification and Accreditation Summary Report." Silver Spring, MD: MCDI. November 2007. (Accreditation visits were held again in 2009, but results were not available at time of this study.) Other data from IFC Study 2009. General OPD visits excludes clinics (e.g. MCH, ART). Data are from FY08 except Hospital C, which is FY06 as later data were unavailable. Statistics are calculated as follows: BOR = Inpatient days / beds / 365; ADC = Inpatient Days / beds; ALOS = Inpatient days / Admissions; docs/occupied bed = # doctors/ADC; Nurse/nurse asst/occupied bed = (nurses + nurse assistants) / ADC

**Table 2: Assessing Dimensions of Performance-Based Budget Reform Progress**

Dimension	Criteria for Rating a Hospital as Having Made Strong, Modest, or Little to No Progress
<b>Dimension 1: Evidence that Performance Plans Exist</b>	
Availability of plan	Strong: Operational plan exists and is available in most departments
	Modest: Plan is easily available from at least 1 management team member
	Little/no: Plan not available, difficult to find, or incomplete
Organization of plan	Strong: Clear plan organized by Ministry priority objectives and programs
	Modest: Organized by either objectives or programs
	Little/no: Not organized clearly
Accountability structure	Strong: Assigned person in charge of achieving results for programs
	Modest: Responsible persons specified but incorrect or lack authority
	Little/no: Responsible persons frequently missing or incorrect
Definition of Activities and Outputs	Strong: Activities clear, outputs service-focused (services for the public)
	Modest: Activities/outputs mostly appropriate, some not service-focused
	Little/no: Activities/outputs unclear, unmeasurable, or focused on inputs
Participation in process	Strong: Activities and outputs were chosen in participatory process involving hospital staff, MOHSW, and the public
	Modest: Activities/outputs chosen with limited participation
	Little/no: Process was generally not participatory
Baseline data	Strong: Baseline data were used to set output targets
	Modest: Some output targets set using baseline data, but many were not
	Little or no: Baseline data were generally not used to set targets
Institutionalization	Strong: Written rules and procedures, job descriptions, documentation.
	Modest: Some documentation exists and is used in planning
	Little/no: Little or no documentation
Acceptance	Strong: Hospital managers understand PB planning and find it helpful
	Modest: Some people understand process and find it helpful, but not all
	Little/No: Few people understand the process or find it helpful
<b>Dimension 2: Evidence that Performance-based Budgets Exist</b>	
Availability of Budget	Strong: Complete copy of PBB budget, plus supporting worksheets
	Modest: Hospital has supporting worksheets but not final budget
	Little/no: Hospital does not have worksheets or budget
Organization of budget	Strong: Budget matches activities to MOHSW objectives and programs
	Modest: Activity-program map generally good but some inconsistencies
	Little/no: No map of activities to programs, or map is incorrect/illogical
Use of output and activity costing	Strong: Budgeting by service-focused output targets & activities needed to accomplish them
	Modest: Budget uses activity-based costing, but some problems exist
	Little/no: Costing still largely driven by inputs
Institutionalization	Strong: Written rules and procedures, job descriptions, documentation
	Modest: Some documentation exists and is used
	Little/no: Little or no documentation
Acceptance	Strong: Most people understand PBB and find it helpful
	Modest: Some people understand PBB and find it helpful
	Little/no: Few people understand PBB or find it helpful

<b>Dimension 3: Evidence of Performance Monitoring &amp; Reporting</b>	
Data systems oriented to PBB	Strong: Data systems are oriented to measuring performance against output targets from plan
	Modest: Some evidence that data systems are used to monitor performance against the PBB
	Little/no: Little or no evidence that performance data is available
Performance reporting	Strong: Hospitals produce quarterly reports showing performance against target for output indicators
	Modest: Hospitals produce reports showing performance against target, but the quality may be questionable or timing is irregular
	Little/no: Performance reports are not produced
Financial reporting	Strong: Accurate and reliable activity-based budget versus actual reports produced quarterly and reviewed by management
	Modest: Activity-based reports produced, but quality may be questionable or timing is irregular
	Little/no: Activity-based reports are not produced
<b>Dimension 4: Evidence that Performance Information is Used</b>	
...To make or change work plans	Strong: Several good examples of use of performance information to change work plans or identify bottlenecks in service delivery
	Modest: Fewer examples than above, but suggestive of impact
	Little/no: No examples
...To develop budgets	Strong: Several good examples of use of performance information to estimate resources needed to achieve objectives
	Modest: Fewer examples than above, but suggestive of impact
	Little/no: No examples
...To monitor efficiency and effectiveness	Strong: Several good examples of use of info to evaluate efficiency or effectiveness of current strategies
	Modest: Fewer examples than above, but suggestive of impact
	Little/no: No examples
...To communicate within hierarchy (internal accountability)	Regularly discuss performance information with District Health team and central level in dialogue to improve performance
	Modest: Less discussion, fewer examples, but suggestive of impact
	Little/no: No discussion or examples
...To communicate to the public (external accountability)	Strong: Regularly discuss performance information with hospital board, patient groups or other representatives of the public interest
	Modest: Less discussion or fewer examples, but suggestive of impact
	Little/no: No discussion or examples

**Table 3: Reform Implementation Progress, Case Study Hospitals**

Dimension/ Measure	Hospital				Average
	A	B	C	D	
<b><i>Dimension 1: Evidence that Performance Plans Exist</i></b>					
Availability of plan	●●	●●	●●	●●	Modest
Organization of plan	●	●●	●●	●●	Modest
Accountability structure	●●●	●●	●●	●●	Modest
Defined activities/outputs	●	●●	●●	●	Modest to little
Participation	●●	●	●●	●	Modest to little
Baseline data	○	○	○	○	None
Institutionalization	○	○	○	○	None
Acceptance	●	○	●	○	Little to none
<b><i>Dimension 2: Evidence that Performance-based Budgets Exist</i></b>					
Availability of budget	●●	●	●●	●●	Modest
Organization of budget	●	●●	●●	●●	Modest
Output/activity costing	○	●	●	○	Little to none
Institutionalization	○	○	○	○	None
Acceptance	○	○	○	○	None
<b><i>Dimension 3: Evidence of Performance Monitoring &amp; Reporting</i></b>					
Data systems oriented to PBB	●	●	○	●	Little
Performance reporting	●●	○	○	●	Little
Financial reporting	○	○	○	○	None
<b><i>Dimension 4: Evidence that Performance Information is Used</i></b>					
...To make or change work plans	●	○	○	●	Little to none
...To develop budgets	●	○	○	○	Little to none
...To monitor efficiency and effectiveness	○	○	○	○	None
...To communicate within hierarchy (internal accountability)	○	○	○	○	None
...To communicate to the public (external accountability)	○	○	○	○	None

Key: ○ = no progress; ● = little progress; ●● = modest progress; ●●● = strong progress. Refer to Table 5 for criteria used to evaluate.

**Table 4: Functional Structure Compared to MTEF Program Structure for GOL Hospitals**

<b>Hospital Functional Structure</b>	<b>MTEF Program Structure</b>
DMO Office	General Admin & Management
Administration (incl. maintenance, minor works, drivers & admin staff, manage service contracts, e.g. food for patients)	Administration Infrastructure Development & Maint. Maintenance of Equipment
Accounts	Financial Management
Human Resources	Short-term Training
Nursing	Curative
Outpatient Department	Inpatient Services
MCH	Outpatient Services
Wards	Pharmaceutical Services
Operating Theatre	Laboratory Services
Mental Health Observation Unit	Radiology Services
Pharmacy	Disability
Radiology	Physiotherapy
Laboratory	
ART Clinic	

\* Source: Hospital Functional Structure reflects how personnel report in Hospital A, and is similar in other case study hospitals. MTEF Program Structure is from MOHSW Budget Framework Paper, 2009/10 to 2011/12, August 11, 2008.

**Table 5: Quotes Illustrating Input- versus Activity-oriented Budgeting Process**

<p><b>Mainly input-oriented process</b></p> <ul style="list-style-type: none"><li>• In [the MTEF] method, the things you budgeted for last year, you shouldn't budget for again. If last year you had a printer, then this year you may need a chair. (Pharmacist)</li><li>• We look at what we have achieved, in terms of what we got last time. We base ourselves on inputs, like how many computers. We do the subtraction—we asked for 5 computers last year and only got 3, so we still need 2. (Accountant)</li><li>• You look at what you planned, and then you look at what you have done. You go back to the previous budget to use it as a guide for the new budget. For example, the nursing uniforms. You see how many you need, and how many you have already bought. Then you know what you have to do, how many you still need. (District Medical Officer)</li><li>• We plan on what we need, on the activities, if we want to buy something. Maybe we want some desks, or drugs, or anything. (Pharmacist)</li></ul>
<p><b>Input-oriented with activity-based considerations</b></p> <ul style="list-style-type: none"><li>• You submit the budget by type of reagent needed. Last year we used x quantity, etc. Also you need to budget for new tests. For example, for cytology we had to estimate how many slides we would do and the cost per slide. We also put in training for nurses on how to do pap smears, and a campaign for the public to let them know. Plus some equipment. (Lab Manager)</li><li>• The Administrator or the Matron will ask me to look back in the last year, to say how many patients received x-rays, and all the things I did. Right now, I am desperately in need of a mobile x-ray machine. I also asked for other equipment. (Radiology Head)</li></ul>

**Figure 2: Example of Budgeting for Radiology Training**

