PN-AAL-132

Project 936-5000
Contract AID/DSPE-C-0002

AMERICAN PUBLIC HEALTH ASSOCIATION
International Health Programs
1015 Fifteenth Street, N.W.
Washington, D.C. 20005

ISN 13080
PN-AAL-138

A REPORT ON MANAGEMENT ASSISTANCE TO THE MINISTRY OF HEALTH OF THE HASHEMITE KINGDOM OF JORDAN

A Report Prepared By:
MICHAEL H. BERNHART, PH.D.
OLGA L. QUINTANA, D.B.A.

During The Period:
DECEMBER 4-17, 1981

Supported By The:
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT
(ADSS) AID/DSPE-C-0053

AUTHORIZATION:
Ltr. AID/DS/HEA: 5/11/82
Assgn. No. 583087

PREFACE

The consultancy described in this report was performed by Michael H. Bernhart, Ph.D., Associate Professor, and Olga L. Quintana, D.B.A., Assistant Professor. Special thanks are due to John Wiles, AID/NE/TECH, and Barry Karlin, American Public Health Association (APHA), who processed the paperwork for this assignment in two and one-half working days. No doubt, they were aided by others whom the consultants did not contact; thanks are extended to these people as well. Equally adroit was the handling of the request in Amman by Scott Edmonds, USAID/OTP/Amman. The smooth, professional (and uncomplaining) manner in which the consultancy was arranged on short notice poses the danger of giving the "bureaucracy" a good name.

The man who made the technical assistance both useful and enjoyable for the past 21 months is H.E. Zuhair Malhas, M.D., Minister of Health, Hashemite Kingdom of Jordan. This extraordinary person, aided by his capable co-workers in the Ministry, did more to upgrade the administrative capacity of the organization than most observers would have believed possible two years ago.

The consultants also would like to acknowledge the friendship, trust, and assistance extended by Drs. Bilbeisi, Subeihi, Shahed, Lubani, Mustafa-Issa, and Rashdan, Mr. Al Jadid and Mr. Muneyer, and many others whose names appear in Appendix A.

This visit was a continuation of earlier technical assistance to the Ministry of Health of Jordan that was conducted under the auspices of the Association of University Programs in Health Administration (AUPHA), AID Contract ta-c-1480, Office of Rural Development and Development Administration. A report on the project was prepared by the senior author for AUPHA; the first two chapters of this report are a condensation of that earlier work. Also available from the AUPHA is a collection of training and design exercises developed by the two authors while they were in Jordan.

C O N T E N T S

	Page
PREFACE	i
EXECUTIVE SUMMARY	iv
ABBREVIATIONS	viii
I. INTRODUCTION AND BACKGROUND	1
Purpose of the Assignment	1
Itinerary	2
Organization	2
Background	2
Administration of the MOH in 1980	3
II. REVIEW OF EARLY EFFORTS	4
Strategy for Assistance	4
Objectives	4
A. Functional Management	4
B. Sequential Objectives	7
C. Managerial Orientation	10
Policies	10
A. Externalization of Management Functions	11
B. Minimizing of Costs	14
C. Placement of Permanent Staff in Field	14
D. Continuity of Consultants	14
E. Resources	14
F. Implementation of Activity	14
G. Training Methods and Materials	15
Methods	15
Implementation	16
A. Objective Setting	17
B. Accounting	17
Evaluation of Assistance Through August 1981	18
Mistakes	19

Page

A. Delineation of Artificial Turf 20
B. Coordination with Local Institutions 20
C. Swimming Against the Cultural Current 20

III. REVIEW OF RECENT WORK 21

The Plan of Work 21
Approach 21

A. Accounting 21
B. Supervision 22

IV. RECOMMENDATIONS 23

Budgeting 23
Supervision 23
Information 24
Training 24

APPENDICES

Appendix A: List of Principal Contacts

Appendix B: Summary of MOH Services

Appendix C: Seminar on Budgeting

Appendix D: Seminar on Motivation and Supervision

Appendix E: Performance Recording Forms and Instructions

Appendix F: Recommendations for Supervision and Budgeting

EXECUTIVE SUMMARY

This consultancy to the Ministry of Health (MOH) of the Hashemite Kingdom of Jordan was conducted by Michael H. Bernhart, Ph.D., and Olga L. Quintana, D.B.A. Field work was performed between December 4, 1981, and December 17, 1981. The broad purposes of the assignment were to provide ongoing support to improvements in financial control and field supervision. The two consultants had been working for 21 months in these and other management areas. Specifically, on this visit the consultants were to review the implementation of financial control measures, establish a process for reviewing the budget, assist in the development of performance indicators for operating units, and train supervisors in the use of those indicators.

Recent Work

The consultants reviewed progress in both field supervision and financial control. A major obstacle for the MOH has been the lack of precedents in either area as it has attempted to upgrade its two management systems. Historically, fiscal accountability has applied only to top government officials and has been general only. Operating managers (hospital, district, or program directors) have exercised little discretion in using funds, and they have not been held accountable. A government-wide move to decentralized administration will give more authority to operating managers; fiscal accountability must make parallel increases.

Field supervision also has required attention. When the current Minister of Health was appointed two years ago, program and central office supervisors performed little field supervision; it appeared that they did not perceive it to be one of their functions. What supervision was conducted focused on procedure, and not performance. Decentralization has increased the urgency for improved field supervision.

To assist the MOH in developing and using adequate systems to control budgeting and field supervision, the consultants provided training to educate MOH officials in the principles that govern these activities and to motivate staff to use the systems. The consultants visited field units to obtain proposals from operational personnel on the form and content of the two systems; these proposals were incorporated after discussion with central office staff. Two seminars were then given to the officials responsible for implementing or supervising the two systems. The first seminar, on accounting and budgeting, sought to correct problems of compliance with and interpretation of the nascent decentralized accounting system and to equip officials for rebudgeting, which will take

place during the second quarter. The second seminar, on supervision, stressed the supervision of field units for performance. Indicators of unit performance were presented, discussed, and refined, and a strategy to implement the measures was finalized.

Strategy for General Assistance

This visit was the ninth that the team of management consultants had made to the MOH. The strategy for assistance was unique in several respects and is described, with examples, in Chapter II. The objectives of the strategy were threefold:

1. To improve functional area management. Management functions (accounting, planning, supervision, etc.) were divided into two categories: (a) those that were stable, and hence subject to routinization, and (b) those that were relatively volatile. In the stable functional areas, the emphasis was on design and implementation of procedures and formal systems. In the volatile functional areas (e.g., planning and evaluation), the improvement of diagnostic and analytic skills was stressed.

2. To achieve progress in a functional area by completing a sequence of subobjectives. The subobjectives were to:

   a. Make the organization aware of general management deficiencies (where they exist);

   b. Specify exact management deficiencies;

   c. Develop the ability, within the organization, to design solutions to specific management problems;

   d. Design appropriate solutions;

   e. Develop, within the organization, the capability to implement solutions; and

   f. Implement solutions.

   Two benefits are obtained from this approach. One, the basis for continued work is always assured; a strategy that aims directly at providing solutions, to cite a bad example, may encounter a skeptical organization, ill-prepared to support implementation of the solution. Two, consultants may withdraw from a functional area upon completion of any subobjective, knowing that nothing that has been accomplished will be lost.

In fact, the consultants did just that, turning work in one area over to another contractor, and retiring from another area when it was clear that the MOH was going to proceed quickly through the sequence unassisted.

3. To promote a managerial orientation among MOH officials. Beyond functional competence, the consultants wanted to raise the level of interest of all MOH officials with program results.

Complementing the objectives of the strategy were the following policies:

1. Assistance should not foster the externalization of management functions. The consultants' activities should not diminish the extent of the manager's role.

2. Costs should be minimized. Total direct costs of the project, spread over 21 months, 24 consultant visits, and 1 person-year on-site, were approximately $80,000.

3. No permanent staff should be placed in the field. Placement of permanent staff in the field raises costs, reduces flexibility, and invites externalization of management functions.

4. Continuity should be maintained by using only a few consultants, even if they sometimes must work out of their area of specialization.

5. No recommendations should be made to the MOH that require additional resources. Ruled out were the creation of new units, addition of staff, etc.

6. Work should begin in areas identified by the organization.

7. Local examples and data should be used in all training materials.

8. Novel didactic methods should be used in seminars and workshops.

9. Training materials should be sufficiently general to be useful to health management programs in universities.

10. Threat to participating officials should be minimized by:

    a. Avoiding exercises that reveal poor individual performance;

    b. Having a clear--and foreseeable--termination point for all exercises; and

c. Creating exercises that are within the capabilities and knowledge of participating officials.

Recommendations

The following recommendations on budgeting, supervision, information, and training were made:

1. Budgeting: Revise the current budget by June, at the latest. Technical assistance would be useful for this process, as well as for the budgeting process for 1983, which begins in June.

2. Supervision: Continue to monitor, and modify as necessary, the performance-recording system. External assistance might be requested, if an early evaluation is desired or problems appear in the system. (A summary of implementing recommendations to the MOH is found in Appendix F.)

3. Information: Resume development of an integrated management information system (MIS). Work here was interrupted at the request of a contract consultant who is no longer present in Jordan. At this time, there is a pilot project in primary health care service statistics; no complementary work to improve the information system in program management or institutional care exists.

4. Training in Health Program Management: The consultants endorse the Minister's proposal that Ministry officials receive an in-country training course in public health program management.

ABBREVIATIONS

AID	Agency for International Development
APHA	American Public Health Association
AUPHA	Association of University Programs in Health Administration
IUD	Intrauterine Device
JD	Dinar, Monetary Unit of Jordan
MCH	Maternal and Child Health
MIS	Management Information System
MOH	Ministry of Health
USAID	United States Agency for International Development

I. INTRODUCTION AND BACKGROUND

I. INTRODUCTION AND BACKGROUND

Introduction

This report describes management development assistance provided to the Ministry of Health (MOH) of Jordan. This assistance, provided by the same group of consultants, dates back to March 1980. In addition to a description of the most recent visit, the report contains a summary of experience acquired to date. The Ministry made remarkable advances in improving its overall management during the collaboration; thus, special attention is given to the external assistance that was provided to determine whether any lessons may be gleaned that might transfer to other situations. Success stories of management development in health programs are too rare not to be examined.

Purpose of the Assignment

The most recent consultancy to the MOH, the ninth since the collaboration began, was requested to undertake the following specific tasks:

> Review the implementation of financial control measures at the regional and hospital levels. Ensure that primary health care expenditures can be separated from those incurred by hospitals. Review compliance with the new decentralized accounting system and difficulties that might be traced to design problems or the lack of necessary skills. Propose design remedies or provide training, as appropriate.
>
> Establish a process for a first-quarter review of budget performance and revision. Train officials in that process.
>
> Review the performance indicators proposed by working groups of MOH officials and assist in the preparation of additional lists of performance indicators for clinics, centers, mobile units, and district hospitals.
>
> Assist in the preparation of graphs, forms, and data collection instruments relevant to the performance indicators.
>
> Train field supervisors to implement the performance measures.

- Accompany selected field supervisors on implementation visits to primary care units.

Itinerary

Mr. Michael Bernhart arrived in Jordan on December 4, 1981; Ms. Olga Quintana arrived the following day; both departed on December 17. Ms. Quintana visited all the regional offices (Irbid, Karak, Ma'an, Salt, and Amman), and also worked in the central office. Mr. Bernhart visited hospitals, health centers, maternal and child health (MCH) centers, and health clinics in four of the five regions (Amman, Irbid, Salt, and Yarqa; Suweileh and Ma'an). Both consultants visited health facilities in Aqaba and Wadi Rum.

Organization

The second chapter of this report contains a review of the history of collaboration with the MOH to the most recent visit. The strategy for assistance which the consultants used is discussed, and short examples are given to show how the strategy was implemented in the field. An attempt is made to evaluate the results of the first 20 months of the collaboration. The third chapter of the report focuses exclusively on the most recent visit, which was supported by the American Public Health Association (APHA). The status of work in each area is reviewed, and priorities for addressing unresolved issues are discussed. The activities and accomplishments of the visit are then described. The fourth and final chapter presents recommendations for future action.

Background

In March 1980, the MOH requested that consultants from the Association of University Programs in Health Administration (AUPHA) examine the administrative problems and needs of the Ministry. In response, Mr. Robert Emrey and Mr. Michael Bernhart spent two weeks in Jordan and produced a document which detailed the most pressing difficulties which they detected; those problems are summarized below.

This evaluation was requested by the recently appointed Minister of Health, Dr. Zuhair Malhas. Before his appointment, Dr. Malhas had little experience with the public sector or large organizations and sought the advice of experts in health organization management in the early weeks of his tenure. The findings of the consultants coincided with Dr. Malhas' own assessment, and the MOH, the United States Agency for International

Development (USAID), and the AUPHA agreed that a team of AUPHA consultants would make a series of visits spaced over a year's time. In September 1981, this agreement was extended through the end of the AUPHA's centrally-funded contract with AID.

Administration of the MOH in 1980

In their initial report, the consultants stated that the new Minister had inherited a legacy of administrative problems.* These included:

- Extreme centralization of authority. For example, the Minister had to approve and sign requests for leave for all 6,000 employees of the MOH.
- An accounting system that offered no opportunities for management control and few for financial control.
- A very broad span of control under the Minister and the Undersecretary.
- Some combinations of functions within the structure that were no longer logical (e.g., planning and foreign relations).
- An incentive system (largely prescribed by law) that fostered high turnover of personnel.
- Supervision of operating units that was infrequent and without a clear purpose.
- Weak mechanisms for communicating the MOH's goals and policies to operating personnel.
- Divergence between the Ministry's objectives and its budget.
- Underutilization of data. The information system was laden with forms and reports that had been accumulating for decades.
- Most important, lack of congruence between the health needs of the population (primary care, maternal and child care, and prevention) and the organization of services of the MOH (predominantly institutional care and curative medicine).

* Robert Emrey and Michael Bernhart, "Findings and Proposals from Preliminary Management Review of Ministry of Health, Hashemite Kingdom of Jordan," Washington, D.C.: AUPHA, March 23, 1980.

This list of problems could be augmented, as for any program, but only at the risk of painting too bleak a picture.

The consultants felt that the MOH was doing a much better than average job in tracking and controlling infectious diseases, immunizing the population, supplying medicines to units, maintaining personnel records, and particularly in addressing itself to the correction of its own problems. Many Ministry officials may have felt frustrated in trying to improve their agency's services and administration; none was complacent. The general impression of the consultants was that the organization had high potential for change and improvement, and that that was attributable to the quality of the staff, from the Minister on down. That the MOH could retain so many excellent people defies easy explanation, given the attractive salaries in the private sector and the exorbitant salaries available in the Gulf States.

Information on the operations and resources of the MOH may be found in Appendix B.

II. REVIEW OF EARLY EFFORTS

II. REVIEW OF EARLY EFFORTS

The Minister and his top officials were genuinely dedicated to improving the performance of the Ministry of Health, and they had some legitimate obstacles to overcome to improve performance. They also were receptive to external assistance, which, in management improvement, came primarily from consultants provided by the AUPHA. This chapter contains a description of the strategy of the consultants and how it was implemented. This work was only a small part of the range of activities undertaken by the Ministry over the past two years to upgrade management performance.

Strategy for Assistance

The word "strategy" is used here to mean a set of objectives and policies which guide action; the methods that were ultimately employed were derivatives of the strategy. Certain objectives and policies were pursued consciously.

Objectives

The ultimate goal of management development assistance in public health is to achieve a better fit between the health needs of the client population and the services offered by the organization. In addition, one hopes that services will be provided with increasing efficiency. This goal is so distant, however, that it is useful to have more immediate, or operational, objectives. The operational objectives for the assistance to the MOH of Jordan were threefold: to work in the functional areas of management (functions of management such as personnel, logistics, accounting, supervision, and evaluation); to orient top-level managers in the organization to problems and solutions; and to identify progress in each functional area. These operational objectives are discussed below.

A. Functional Management

In management development, immediate objectives often follow one of two schools of thought: process or systems.

Those who adhere to "process" contend that the key to long-term organizational success is the organization's ability to adapt and change. Technical assistants who take this view cite the rate of change in the environment and argue that people who do not understand their own

administrative systems cannot effectively operate them. The foci of external assistance, according to this school, are people and process.

The "system" school argues that administrative reform must pay major attention to formal systems. It is argued that, because turnover in the public sector is high and administrative skills often are weak, the burden falls on formal systems to guide behavior. A rigid and comprehensive formal system, the argument goes, permits individuals, each with only a narrow range of skills, to make effective contributions and enables the entire organization to run smoothly. Technical assistants who hold this view focus primarily on procedures and the design of management systems.

The approach taken by the consultants to the MOH was that the school or path chosen depends largely on the functional area of management that one wishes to improve. For example, logistics may require a systems approach, and planning, a process approach. The key variable in determining whether people or procedures are more important is the relative stability of the system. If circumstances make varying and unpredictable demands on an administrative system, then routines and procedures are only a hindrance. If the functional area is in a state of flux, relative emphasis should be placed on opportunities for operators to acquire broad skills and understanding; revisions will have to be made continually to meet changing demands. Conversely, where the work of a functional area varies little, as on an assembly line, the procedures can, and should, be carefully specified; the operators of the system do not need to be able to redesign the entire system, only to perform their prescribed duties.

As examples, the following three functional areas do not lend themselves to stable systems:

- Evaluation: This is, or perhaps should be, a flexible system to accommodate variety among projects, users of data, reporting requirements, and time horizons.

- Supervision: Closely allied to evaluation, this function is also subject to shifting demands. Although schedules of supervisory visits and inspection checklists are useful, they are not the end of the supervisory system. The diverse roles of supervision are easily distorted when the principles are not well understood by all supervisors.

- Planning: The quick isolation of formal planning units in an organization is too well known to belabor here. Most planning is probably replanning, usually with partial data, under tight schedules, and amidst vast uncertainty.

The three preceding management functions exemplify the volatility that makes emphasis on procedures and systems relatively ineffective. One would hope that the persons with primary responsibility for these functions possess a clear understanding of the objectives, purposes, and contribution of their areas and that they are aware of a broad range of techniques that can be applied as conditions demand.

In contrast are those management functions that permit a high degree of systematization or routinization. Accounting and logistics might be listed in this category.

> Accounting: Stability and standardization are hallmarks of good accounting systems. No one should be given a license to tinker endlessly with an accounting system.
>
> Logistics: Logistics is somewhat the same as accounting; in addition, the design options are few.

Poor accounting and logistics systems do exist that should be revised. The point is that revisions should be rare, and routinization the rule. The relative emphasis is on the system.

Summarizing this information, the first set of objectives would be:

1. *Improve functional area management.*

   a. *Improve, as needed, the formal procedures and routines in stable functional areas.*

   b. *Add, as needed, to the diagnostic skills and general understanding of individuals working in more volatile functional areas.*

B. Sequential Objectives

The second set of objectives deals with how far one wishes to go in each functional area. It is not necessary to always think of the total overhaul of a functional area as the only legitimate goal, at least not so far as the participation of external consultants is concerned. Change projects embody many discrete steps, and the kind of technical assistance that is appropriate is different at each step. The steps may be stated as objectives and arranged in the sequence normally encountered in management assistance. This sequence would be:

1. Awareness of Problem: The client organization is aware of the general magnitude and location of management problems (this usually precedes the request to provide assistance).

2. Specification of Problem: A close analysis permits the client to specify the areas where changes need to be made. In effect, the client could take control of the change process at this point.

3. Ability to Design Solutions: Through training or recruitment of management specialists, the organization develops some ability to design solutions to current problems.

4. Design of Solutions: Appropriate solutions are actually designed.

5. Knowledge of Implementation Practices: Designs do not implement themselves; someone has to think through the training needs, incentives, detailed procedures, etc., that are required to move from design to practice.

6. Implementation of the Design.

7. Evaluation of the New System.

8. Repetition of Steps 1-7.

In turn, each of the above steps could become an objective.

Recalling the earlier discussion on directive and product-oriented interventions, as opposed to non-directive and process interventions, the distinction bears primarily on Objective Level Three, ability to design solutions, and Objective Level Five, ability to implement solutions. Summarizing that earlier discussion, the key variable was whether a system required frequent revision or could be routinized. In functional areas where there is no need to make constant changes, the requirement to equip managers with design and implementation skills becomes less compelling. Hence, in accounting or logistics, one might pass lightly over the third and fifth objectives. In contrast, these become very important objectives for planning, supervision, and goal-setting.

One might ask whether or not every management assistance project follows the above sequence. The answer is, no. There are many shortcuts. If one aims from the outset to implement a system, say, planning, it is tempting to recruit a few counterpart officials and give them inservice training in the mechanics of the system. The basic disadvantage of this approach is that, if something goes wrong, virtually nothing is left to the client organization. If sequential objective levels are targeted,

it is possible to withdraw technical assistance at any point without endangering work that has gone on before. For example, if work has proceeded through Objective Level Four, the design of solutions, and the technical assistance stops (because of loss of funding, political pressure, rotation of personnel, etc.), the organization would retain all the necessary elements to continue the process on its own or to resume it at a later date, when conditions improve.

The decision to establish as an objective the completion of the next level in the sequence depends on ability to meet the following conditions:

- Have the tasks in the preceding level been completed satisfactorily?
- Is the organization likely to benefit from external assistance?
- Do conditions remain favorable for continued change?
- Are resources available to support the assistance?

If a positive answer can be given to all four questions, then the technical assistants and the organization can address the next objective level.

It is possible to work on different objectives for different functional areas; however, this can lead to minor problems, because the kind of assistance differs for each objective. For example, design of solutions requires the encouragement of bold thinking--a relaxed, non-evaluative attitude by the technical assistant may be the most appropriate. In contrast, implementation calls for monitoring (policing), which ushers in a climate that is just the opposite of that created in a relaxed atmosphere. If the technical assistant is working with the same counterparts at both levels, confusion is likely.

Summarizing the sequential approach to objectives, the approach, stated as an objective of the project, would be:

2. *Set sequential objectives for the development of each functional area to be worked on following this progression:*

   a. *Organization is aware of general problem;*

   b. *Organization defines specific problems;*

   c. *Organization is capable of designing solutions;*

   d. *Solutions to identified problems are designed;*

e. Organization is capable of implementing solutions; and

f. Appropriate solutions are implemented.

C. Managerial Orientation

The objectives described above all deal with improving management functions. The whole of management, however, is greater than the sum of the functional parts. Also needed are leadership, objectives, policies, and motivation, to name only a few items, to achieve organizational success. For want of a commonly accepted word or phrase to describe these less tangible qualities that distinguish the successful organization, the consultants used the terms "managerial orientation" and "results orientation." Where "results" or "managerial" orientation is adopted, a health program manager performs the following tasks:

--checks the goals of the program against the health needs of the population;

--confirms that each activity contributes to the program's goals;

--anticipates emerging needs; and

--redirects program resources when activities, goals, and needs no longer match up.

The objective in this area may be stated thus:

3. Promote, via training, consultation, and system design, a managerial orientation among MOH officials.

This is, admittedly, a "soft" objective and virtually impossible to evaluate. Nevertheless, to ignore this dimension of management would be inadmissible.

Policies

The second component of a strategy, in addition to objectives, is the set of policies employed. When the policies and objectives are logically related, the activities to be undertaken should fall out naturally.

The adopted policy represents a conscious choice among alternatives. Readers will recognize that for many of the policies listed above, there are defensible alternatives.

A. Externalization of Management Functions

A management function becomes externalized when it is no longer seen as the responsibility of the managers in the organization. Small businesses deliberately contract out functions such as bookkeeping and marketing to experts in those fields. The process is pernicious when it is unintentional, with managers relinquishing responsibility for a function that they should continue to perform. Technical assistance and donor policies can lead to unintended externalization of management responsibilities. Evaluation is a case in point. Donor agencies and their technical emissaries may be active in specifying criteria and methodology, training investigators, and analyzing the data. In fact, a donor may conduct the evaluation entirely with its own resources. The public sector manager, particularly one with limited management experience, who witnesses this may come to view evaluation as outside his or her role--because donors do it. The same process can occur in planning, information systems, and accounting (where the system may become biased toward auditing and away from management control).

As an extended example of how policies and objectives combine to generate methods for providing assistance, the reader might consider how this policy, avoiding externalization of functions, combines with the distinction in the first objective between stable and volatile functional areas.

In the four-cell table illustrated in Exhibit II-A, management functions are categorized according to two dimensions: degree of routinization desired in the system (stable functions lend themselves to high routinization, and volatile functional areas to low routinization) and susceptibility of the function to externalization. The assignments in the table were made in accordance with the way each function was performed in the Ministry. For example, "Personnel" was largely a clerical function in the MOH. The policy-making aspects of this component were greatly constrained by law; hence, the personnel function was assigned to the stable, or "High Routine," part of the table.

This categorization has the following implications for the methods used to provide assistance:

> If an administrative function falls into the "High Routine-Often Externalized" quadrant, the task is to develop a system with the host organization <u>and</u> to motivate the organization to use that system. This normally means that the organization's top managers

Exhibit II-A

SUSCEPTIBILITY TO EXTERNALIZATION

Level of Routinization Desired	Often Externalized	Rarely Externalized
High	Management Information System Service Statistics Auditing I	Financial Control Purchasing Personnel Distribution II
Low	Planning Evaluation Training III	Supervision Budget Preparation Programming Motivating IV

see the system as responsive to their administrative needs. It is emphatically not enough that they participate in the design process; this merely creates transitory interest. The managers must perceive the utility of the system in discharging their own responsibilities.

Functions that lie within the "High Routine-Rarely Externalized" quadrant are the simplest to understand. The technical assistant need only sell the superiority of his or her proposed system. It is possible to be quite directive when working in these functional areas.

The "Low Routine-Often Externalized" functions make for slow going. The personnel in those areas must possess a broad knowledge of purposes and techniques, and managers must actively manage and exploit the functions. The common state of isolation in which planning, training, and evaluation are found testifies to the difficulty of successfully integrating these components into program management. The problem is exacerbated when the functions are approached as distinct and separable from management. The approach taken by the consultants, who recognized that they had neither the resources nor the mandate to work extensively in these areas, was to focus on the problems of management utilization. The objective of the exercises was to get line managers to specify training needs or planning requirements. Although much of the assistance involved exercises in planning and evaluation, in general, the consultants avoided any approach to these functions as systems per se, which, it was feared, would only contribute to the perception that the functions were the purview of foreign consultants.

"Low Routine-Rarely Externalized" functions usually require that personnel increase their knowledge. Because there is little danger that the function will become externalized, it is possible for the technical assistant to spend less time on issues of utilization. Thus, the relative emphasis, when addressing functions in this quadrant, is on raising the skill level of persons responsible for conducting the activity.

The table in Exhibit II-A contains a priori assignments and a point of departure. Circumstances can, and in Jordan did, modify the approach so that it differs from that indicated in the table. Most notably, it was found that the financial control function received little emphasis in the Government of Jordan. Consequently, not only was system design indicated (the second quadrant), but also organization managers had to be motivated to use the system; the approach that was needed was closer to that of the first quadrant.

B. Minimizing of Costs

The second policy was to minimize costs. The decision to give priority to this policy was largely a reaction to the high costs of management development efforts elsewhere; often, these were more than $1 million. Management development produces intangible or long-term results in program performance; the benefits are difficult to identify, and this makes justification of the high costs difficult as well. Effective assistance that is low in cost is feasible. After nearly two years of work, 24 consultant visits, and 1 person-year on-site, the total direct costs of the assistance provided to the MOH were approximately $80,000.

C. Placement of Permanent Staff in Field

Consistent with the policy to minimize cost was the decision not to place permanent staff in the field. It was decided that the counterpart officials could devote only limited time to management improvement. Full-time, on-site technical assistants run the risk of either taking over functions (externalization) or garnering a single counterpart with whom to work (isolation). Development may also require time to mature. If periodic visits are made, initiatives can be launched which may require several months of gestation; the adviser's scheduled return exerts subtle pressure to complete work, and his or her reappearance offers an opportunity to renew lagging momentum.

D. Continuity of Consultants

The same three persons conducted nearly all the technical assistance activities. The preference was for continuity and rapport rather than specialized expertise.

E. Resources

All recommendations were to be feasible, given current resources. No solutions were suggested that required additional manpower or money.

F. Implementation of Activity

Work was to begin in areas identified by the organization; the agenda for those areas was to receive priority.

G. Training Methods and Materials

Four policies dealt specifically with training methods and materials. It was decided that:

- Training materials would rely on local examples and data.
- Instruction was to rely on novel didactic methods (in-basket exercises, role plays, teaching cases, etc.).
- Training materials were to be written in sufficiently general form that they could be disseminated to health management training programs in universities.
- Exercises were to seek to minimize three sources of threat. They were to:

  a. Reveal poor individual performance. All exercises were to be design exercises; they were to guide officials through the steps for the redesign of a system. The exercises were not to be problem-finding expeditions.

  b. Minimize the possibility of "tar-babies." All design exercises were to have clear termination points. They were not to be open-ended; thus, a participant would not have to fear that he or she would be embracing an endless task--a "tar-baby." Shorter exercises were conducted first to encourage the belief that each led to an immediate, concrete, and useful product.

  c. Reveal ignorance. The exercises were not to require the application of data that were not already available to participants. Implicit in a design exercise is the expectation that a manager will be knowledgeable enough to complete it, particularly when the exercise deals with his or her own area of responsibility. The extent of the officials' knowledge had to be determined before a design exercise could be produced.

Methods

In addition to the standard consulting tools--interviews, training, observation (several person-weeks were spent passively observing patient care in clinics, centers, and hospitals to gain an understanding of and appreciation for operational demands), advising, and reporting--the

consultants relied heavily on design exercises. The policies and objectives described above pointed to the development of these exercises, which covered the following areas:

- Objective Setting
- Information System
- Supervisory System
- Decision Limits Manual
- Job Descriptions
- Resource Inventory
- Programming
- Inventory
- Accounting Flow Charts
- Environmental Assessment
- Incentives System.

For each area, a small group of officials was required to design solutions or systems. It is important to emphasize that these exercises did not seek to identify problems, but to design systems or solutions, as though no system existed at the time. The rationale for this approach was that it might be more acceptable to members of an organization to create a new system than to look for defects in the old. Participants were selected who, as a group, had control over enough factors in a situation that they might, by concerted action, make changes in the area. The group was instructed in the use and purposes of the exercise, either informally or in a training session. It then completed the exercise before the consultant(s) returned.

Implementation

In the best situation, management development proceeds as follows: Organizational objectives are examined and revised in accordance with environmental conditions; the structure is shaped to emphasize new priorities and facilitate goal attainment; operational resources are inventoried and plans are made to adjust or augment those resources; and all supporting systems are realigned as necessary.

This theoretically correct approach was the plan of the Minister of Health. The Minister wanted to move the MOH away from its excessive commitment to secondary and tertiary care and toward primary care and prevention. To support this effort, he asked the consultants to help refine objectives and propose an organizational structure that simplified administration and strengthened the MOH's capacity to pursue the new objectives. Because he envisioned that the new structure would be decentralized, he wanted the control mechanisms for the accounting, information, and supervisory systems to be enhanced. Given so broad and enlightened a mandate, the consultants were eager to comply.

The general approach followed the steps described earlier. It began with problem awareness, moved on to problem specification, and proceeded to complete the remaining steps for each objective level. These levels are used as a framework for the discussion that follows. In this report, work in only two areas, objective setting and accounting, is examined, to avoid a repetitious presentation.

A. Objective Setting

The Minister recognized that 83 percent of the budget was too high for curative services (mainly hospitals). Recent studies had confirmed that the mortality rates for women and children were disproportionately high and that the principal causes of death and disease were water-borne vectors or preventable infectious diseases. From this information, it was evident that the Ministry had passed through Objective Level 2, problem specification, and was ready to begin designing solutions.

One of the technical assistants created an exercise in which information on the prevalence, severity, and manageability of a disease could be combined to establish priorities among diseases. The exercise combined Objective Levels 3 and 4; it both taught the methodology and produced a solution, in this case, a revised set of objectives for the MOH. The Ministry completed the process on its own, adopting and promulgating the objectives.

B. Accounting

The MOH had little awareness that accounting required attention; indeed, one needed to be familiar with sophisticated accounting systems to comprehend the improvements that were possible. In the original report to the MOH, drafted by two of the consultants, neither of whom was an expert in financial management, accounting was cited as deficient and general changes were implied that might be required. The assessment was accepted, after further discussion by the MOH, and for the third visit

of the technical assistants an expert in financial control was recruited. This person conducted an in-depth study with the chief accountant; the study included a questionnaire on the budgeting process that was administered at all hospitals. In the report on this study, many areas were highlighted where financing was under-controlled and inefficiencies in the system existed. The report was digested quickly, completing attainment of the second-level objective.

The third-level objective is the ability to design solutions. Activity during this phase was protracted, because too few people in the MOH had any formal training in financial management. A seminar was held for 60 accountants, and an "experiment" was launched in one region to determine whether and how cost data could be captured. The steps in the central accounting process were flow-charted by the operators of the system, who earlier had functioned as mindless cogs, ignorant of the total process. By the end of March 1981, there was a cadre of persons in the MOH who could make useful improvements in the accounting system. (Jordanian law and practice provide little incentive to tighten financial control; it is the most permissive system known to the consultants--and perhaps testimony to the basic honesty of Jordanian public officials.) The third-level objective was thus achieved.

Conditions appearing to be suitable, work began on the fourth-level objective, design of an improved system. The findings of the "experiment" were consolidated, new ledgers were printed and distributed, and each district accountant spent two weeks in inservice training in the central office to learn the procedures.

The fifth-level objective is to impart implementation skills to the client. A detailed program was presented to the Ministry for implementation that included training by Jordanian agencies. The training programs did not come off, and the Ministry asked that the consultants get on with implementation. Here, the consultants combined the fifth and sixth objective levels. The fifth level is learning to implement, an expendable step in a stable functional area. Implementation activities, the sixth objective, were undertaken in June and August, 1981. Two seminars were held to instruct and motivate MOH directors in the use of financial data. The level of compliance with the recording requirements was checked. Training was also provided for regional accountants.

Evaluation of the Assistance Through August 1981

There is common agreement, within and outside the Ministry, that the Ministry has made unprecedented progress in the past two years. Objectives are now more responsive to health needs, the organizational structure has been changed to reflect priorities and to improve internal efficiency, and the major functional areas have been strengthened. The technical

assistants accomplished none of these outcomes, although they had the good fortune to be present during their achievement. It is virtually impossible to determine what the technical assistance contributed to this project without running the entire experiment again without the external consultants. If the experiment were redone, the consultants' subjective conclusion would be that the MOH would have achieved essentially the same results without the consultants, but perhaps more slowly.

It is somewhat easier to evaluate the assistance on its own terms: Did the strategy provide a useful and comfortable guide to action? The answer is, yes. Rarely was there indecision about what to do next, and the individual interventions (training, exercises, etc.) usually hit a responsive chord. Specifically, the following elements might be commended to others:

- Sequential Objectives: It was possible to turn work over in one functional area to another contractor, with only minor disruption, and to withdraw entirely from an area when it was obvious that MOH officials would complete the process. A minor problem with sequential objectives is that some donors may find it cumbersome to fund the series of "Go-No Go" points.

- Functional Areas: The distinctions that were made--stable versus volatile and externalizable versus non-externalizable--were extremely useful in framing an approach. In addition, because an objective for managerial orientation was established, this aspect of management was not neglected during work on the functional areas (seminars specifically devoted to this topic were offered.)

- Team Continuity: When a fourth consultant was brought into the project for short-term (one visit) assistance, the advantages of established rapport and knowledge of the situation, which the other three consultants enjoyed, became apparent immediately.

- Design Exercises: The exercises achieved their intended purposes with consistency. Apparently, they did not raise the level of threat.

Mistakes

Overall, the project was a success, and this success makes it easy to look for mistakes.

A. Delineation of Artificial Turf

The consultants foreswore work in planning to leave that field open to another contractor who was to arrive later. Unfortunately, planning is such an important part of management that it is difficult to ignore altogether when one has taken all of management (excluding planning) as the field of action. The thin disguise of "operational programming" was employed when it was felt that this function could no longer be ignored. Technical areas with well-defined boundaries may lend themselves to neat parceling; management appears not to.

B. Coordination with Local Institutions

One would like to think that local institutions could become involved and either supplement the efforts of external consultants or supplant them altogether. Efforts to collaborate with two local institutions failed. The conclusion was that the consultants could not provide the incentives for local institutions to become enthusiastically involved nor, in the absence of a permanent presence, to integrate them effectively into the project.

C. Swimming Against the Cultural Current

Participation in one design exercise, the development of a manual on approval limits, was only passive. In the face of this limited success, the examination of organizational decisionmaking revealed that the proposed design lacked antecedents in both the organization and society. A substitute approach was immediately offered. The incident, which was insignificant in practice, did point up the fact that, even with meticulous research, it is possible to assume the presence of something that does not exist.

III. REVIEW OF RECENT WORK

III. REVIEW OF RECENT WORK

The Plan of Work

The work plan for the December, 1981, visit called for attention to two areas, accounting and supervision. The status of both prior to the visit is described below.

Considerable effort had gone into the development of a simple decentralized accounting system. The effort posed two problems peculiar to Jordan. One, there was a lack of trained accountants to operate the system. Two, there was neither precedent nor pressure for directors to manage the accounting function. Training did address the two problems, often in sessions involving both accountants and directors.

The regions had been maintaining accounting ledgers since September 1981, with varying degrees of enthusiasm and accuracy. The decentralized system of budgets and accounts was scheduled for introduction on January 1, 1982.

Two years ago, few persons conducted field supervision. The quantity of supervision rose markedly during Dr. Malhas' first year as Minister, but many supervisors appeared to be uncertain about the purposes of the supervisors' visits to the field. To correct this situation, training was conducted and small groups of officials worked on checklists and training guides for supervisors.

Still lacking was a mechanism to encourage supervisors to focus more on the results that operating units obtained. A group of district directors had attempted to develop sets of goals for operational units; the goals themselves needed to be field-tested, refined, and implemented.

Approach

A. Accounting

The overriding concern of the consultants was that the fledgling, decentralized budgeting and accounting system would founder. In the past, directors, other than the Minister and Undersecretary, had not been accountable for the use of financial resources. This protected them from a burden, but it also reduced managerial discretion. The question for the consultants was: Would the directors be more attracted by the advantages

of a financial control system than repelled by the additional work and responsibility that such a system entails?

In conducting their seminars, the consultants attempted to generate enthusiasm for a system, but it was recognized that the system would have to demonstrate its utility in practice. There was--and is--danger that the accounting and budgeting system would not be perceived by the directors as useful, because of inadequacies in the budget. Regional budgets, for example, were prepared with limited and suspect data, and thus sometimes corresponded poorly to actual resource requirements.

In these circumstances, regional directors can quickly become disenchanted with a system that measures their performance against an unreasonable standard. The solution is to correct the regional budgets as early in the year as possible. If credible budgets can, through revision, be established, the entire process stands a good chance of both surviving and being used by the directors.

The consultants visited all five regional headquarters to determine the level of reporting compliance and to solve individual problems. They then worked with central office staff to develop a system and criteria for budget review and revision. With the central office staff, the consultants gave a half-day seminar (see Appendix C) to motivate use of the system and to prepare the directors to participate in the budget review process.

B. Supervision

As in many organizations, MOH supervisors are responsible for transmitting goals and policies to operating personnel. Clear, measurable goals facilitate this process. The consultants asked groups of district directors (a district is a subunit of a region) to develop such goals for health facilities. The consultants took the lists to hospitals, health centers, MCH centers, and village clinics in all five regions, and asked the staff at these facilities to comment on the clarity and relevance of the goals. Some changes were made as a result. The revised lists were then presented to the district directors at a group meeting, where the format for presentation was revised once again. Another half-day seminar was given by the consultants for the district directors to explain and motivate use of the goals and forms. (See Appendix D for information on this seminar; see Appendix E for copies of the instructions and the forms for recording goal attainment in health facilities.)

IV. RECOMMENDATIONS

IV. RECOMMENDATIONS

There appears to be an urgent need for follow-up in three functional areas and general management training to support the initiatives now under way. Specific written recommendations to the MOH were presented to the Minister and Undersecretary before the departure of the consultants (see Appendix F). The following recommendations deal exclusively with external assistance.

Budgeting

There is concern that the success of the new financial control system depends on the realism of the regional budgets. The current budget will have to be revised in June, at the latest. June is a convenient month for budget work, because it signals the start of the next cycle for budget preparation. A technical assistant could perform three tasks:

--assist in analyzing budget performance to date and introducing appropriate analytical procedures;

--help to establish criteria for future budgetary allocations and reallocations; and

--encourage staff to tackle these difficult chores.

Supervision

During the last trip, agreement was reached on the goals that will orient supervisory visits. The consultants have only limited field experience with this approach, however. Because the approach is a major departure for both supervisors and operating personnel, it would be reasonable to anticipate initial difficulties and perhaps the need for modifications. Technical assistance could be useful in several respects. One, as with budgeting, the presence of a technical assistant would be an incentive to focus attention on the new supervision system and start-up problems. Two, an early evaluation of the system would be useful, particularly if it addressed the extent of implementation, the accuracy and consistency of implementation, and relevance to operational needs. Three, where problems are found, training and redesign efforts could be undertaken as necessary.

Information

The consultants began work on the information system early in the project and worked through Objective Level Three, capacity to design solutions. At that juncture, another contractor, with responsibility for developing a planning unit within the MOH, asked for a larger role in the effort to design the information system. Project consultants suspended work in the area, but the individual who had requested the transfer of responsibility was replaced. His replacement takes the view (somewhat better balanced, in the consultants' opinion) that management information is not the exclusive purview of the planning unit.

The events described above have interrupted work in this important area. Several tasks which follow the objective levels remain to be done. These are:

1. Design a system.
2. Field-test and revise the system.
3. Implement the system.
4. Evaluate the system.

It is important to note that there is a primary health service statistics system under development; there is, however, no complementary effort to upgrade monitoring of institutional care. Nor is an effort being made to integrate the former system into the management information system. The potential roles of technical assistants are self-evident.

Training

A continuing concern of the project has been the "managerial orientation" of the directors. Training for many of these persons (medical directors) and the structure within which they work do not always encourage the broad orientation to results which one would hope for in public health. To address this concern, and to reinforce progress to date, the Minister has proposed that a training course, lasting one month or longer, be offered for directors and supervisors in the MOH. The training would be conducted in half-day sessions to minimize disruptions of Ministry operations, and it would cover the standard topics in public health management. The consultants endorse this proposal and are preparing a training syllabus for the Minister's consideration.

APPENDICES

2

Appendix A

LIST OF PRINCIPAL CONTACTS

Appendix A

LIST OF PRINCIPAL CONTACTS

Ministry of Health

Dr. Zuhair Malhas, Minister

Dr. Suleiman Subeihi, Undersecretary

Dr. Mahmoud Shahed, Director of Planning

Dr. Yousef Mustafa-Issa, Director of Medical Care

Dr. Anwar Bilbeisi, Director, Amman Region

Dr. Tawfiq Lubani, Head, Planning

Dr. Nofan, Director, Irbid

Dr. Anani, Director, Salt

Dr. Mohammad Hodar, Director, Ma'an

Dr. M. Sabha, Acting Regional Director, Karak

Mr. Amin Muneyer, Chief Accountant

Mr. Mahmoud Alkan, Chief Accountant, Salt

Mr. Abid Al Fath, Chief Clerk, Salt

Mr. Sami Baduan, Chief Accountant, Irbid

Mr. Awad Yehya Yasser, Chief Accountant, Ma'an

Mr. Fahed Masarweh, Assistant Administrator, Karak

Mr. Ali El Houari, Chief Accountant, Karak

Mr. Methgal Saraireh, Accountant Trainee, Karak

Mr. Ali Abul Aljawad, Chief Accountant, Amman

Dr. Aram Yaghlian, Director, Supplies

Dr. Sowan, Research

Dr. Abdul Hafeez Momoni, Director, Irbid Hospital

Mr. Hasan Sa'adi, Administrative Assistant, Irbid Hospital

Mr. Abdul Amdan, Nurse, Wadi Rum Clinic

Dr. Sa'ad Kharabsheh, District Director, Salt

Dr. Usami Unis, Physician, Salt

Dr. Osayama Abdulramah, Hospital Director, Ma'an

Eng. Mohammad Dajani, Director, Sanitation

Dr. Atef Ali El Farran, Center Director, Agaba

Mrs. Hint Madani, Nurse, MCH Center, Agaba

Dr. Hosni Momoni, District Director, Mafraq

Dr. A. Qudah, District Director, Ajloun

Dr. Mahmoud El Zurbi, Assistant Director, Irbid

Dr. F. Halasa, District Director, Madaba

Dr. M. Gool, Assistant Director, Irbid

Dr. S. Uleiwah, District Director, Tafileh

Dr. A. Shureideh, District Director, Zarga

Dr. M. Salaymeh, District Director, North Goor

Dr. Zuhair Teif, District Director, Jarash

Dr. Burmawi, Special Assistant to Minister

Mr. Kahlid Al Jadid, Chief, Personnel

Dr. Selma Bitar, Physician, Wadi Hadadi, MCH Center

Dr. Youseff Manzur, Assistant Director, Amman Region

Dr. Mawia Bakri, Physician, MCH Center, Hashmi

Dr. Mohammed Said Borini, Director, Suweileh Health Center

USAID

Mr. Walter Bollinger, Director

Mr. Scott Edmonds, Health Official

6

Appendix B

SUMMARY OF MOH SERVICES

7

Appendix B

SUMMARY OF MOH SERVICES

The Ministry of Health (MOH) of Jordan provides medical care to those segments of Jordan's population of two million (East Bank) who are not served by the private sector or have access to the military's health facilities. Recent data show that slightly less than one-half of the population is cared for by the MOH. Part of this group is government employees and their families who are "insured." In addition, the MOH conducts the standard range of preventive health activities: food supplement programs, vaccinations, school health programs and examinations, health education, and media campaigns. The MOH is also responsible for promoting environmental health, and it monitors food, air, and water quality. It also licenses and examines health facilities and practitioners and tests pharmaceutical products sold in the country.

To accomplish all this, at the time of the initiation of the technical assistance, the MOH had 6,000 employees, 13 hospitals, more than 500 health centers and clinics, and a budget of approximately U.S.$25 million. Seventy-three percent of the budget was assigned to general curative services and 9 percent to preventive medicine; the remainder was distributed among special activities, such as malaria control, laboratory, education, X-rays, and vaccinations. Services were concentrated, as was the population, around the capital city of Amman. Administratively, 11 health districts were organized; however, these districts had only limited administrative functions.

Unless an individual could demonstrate need, charges were assessed for services; the fees bore a rough correspondence to costs incurred in delivering the services; for example, an X-ray cost more than a blood count. Most preventive health services were provided at no cost. At the time technical assistance was initiated, the MOH received little international financial assistance. A few commodities and scholarships came from multilateral donors; bilateral assistance was confined primarily to occasional scholarships and short-term technical consultancies.

Health Needs

Surveys, estimates, and the MOH's service statistics demonstrated repeatedly throughout the 1970s that women and children were underserved in proportion to their ranking among the morbidity statistics. Although cardiovascular diseases dominated the mortality data, gastrointestinal diseases were the primary cause of hospitalization, followed by upper respiratory infections, parasitosis, and accidents. Outpatient data are

sketchy, but they appear to be dominated, again, by gastrointestinal and upper respiratory problems. A high percentage of the total cases seen or admitted can be traced to water-borne vectors, a predictable pattern in a developing and water-short nation.

The health picture was by no means static. Cholera, also a water-borne disease, erupted at nearly annual intervals; when this occurred, the MOH committed the preponderance of its available resources to containing the disease. Furthermore, an estimated 30 percent of migrant workers from Egypt were infested with schistosomiasis upon arrival in Jordan; periodic campaigns were necessary to prevent the spread of the vector. Finally, the health profile of the nation was characteristic of many rapidly advancing countries: The degenerative diseases associated with increasing life spans and modernization were taking their place in the statistics, along with acute infections associated with poverty. Jordan had not yet succeeded in eliminating many of the health problems peculiar to underdevelopment, yet, it already was experiencing those characteristics of wealthy societies.

Organization of Services

The provision of health services was organized into the three familiar levels of care: community care via a nurse-staffed clinic; outpatient care via a physician (often a specialist) who staffed the center; and inpatient care in district hospitals. A fourth level can be added when the central hospital, El Bashir, is considered. El Bashir received not only all the complex cases, but also those cases which many health center doctors referred when they felt tests were necessary; the district hospital was thus bypassed.

Vertically integrated programs were somewhat divorced from the structure described above. Maternal and child health centers (30) were centrally supervised from Amman; there was little contact or coordination with district-level health officials or other nearby facilities. The tuberculosis and malaria programs were both endangered by their success and had become orphans in the organization. The new mission of the tuberculosis program, chest diseases, required closer integration into general services than was consistent with vertical program management. Some programs, such as school health, mobile vaccination teams, and environmental health, operated within a matrix organization; they were accountable to both the central and district levels.

These variants did not change the overriding administrative feature of the MOH: centralization of authority. In early 1980, the Minister of Health was still required to authorize the absence of the lowest employee (recall that there were 6,000 employees) and to pass judgment on most hirings. This degree of centralized control appeared to be common throughout the government.

9

Appendix C

SEMINAR ON BUDGETING
(December 15, 1981)

Appendix C

SEMINAR ON BUDGETING
(December 15, 1981)

TOPICS

I. The Budgeting Process

General Approach
Prerequisites
Discussion

II. The Allocation Process

A Case Study
Sensitivity Testing of Data

III. Re-Budgeting

Identification of Variances
Causes of Variances
Discussion

LIST OF PARTICIPANTS

Dr. Zuhair Malhas, Minister

Dr. Suleiman Subeihi, Undersecretary

Dr. Mahmoud Shahed, Director of Planning

Dr. Yousef-Mustafa Issa, Director of Medical Care

Dr. Anwar Bilbeisi, Director, Amman Region

Dr. Mahmoud el Zurbi, Assistant Director, Irbid

Dr. Anani, Director, Salt

Dr. M. Hodar, Director, Ma'an

Dr. M. Sabha, Acting Regional Director, Karak

Mr. Amin Muneyer, Chief Accountant

Mr. Mahmoud Alkarn, Chief Accountant, Salt

Mr. Sami Baduan, Chief Accountant, Irbid

Mr. Awad Yehya Yasser, Chief Accountant, Ma'an

Mr. Methgal Saraireh, Accountant, Karak

Mr. Ali Abul Aljawad, Chief Accountant, Amman

BUDGETING SEMINAR

Introduction

The budgeting process is part of planning; therefore, the expenditures budget becomes the operating plan for the year. The operating budget requires the following:

--estimate costs; and

--define the relationship between the budget and responsibility centers or regions.

In the Ministry of Health (MOH) in Jordan, there are two current budgets. The first budget is the "request budget." This budget is a request for funds which is presented to the legislature for approval. The second budget is the "actual budget." This budget is prepared after the legislature approves the amounts to be provided to the Ministry. It will be prepared in January and will show the amounts that will be allocated to each region.

The Process

An outline of the process is given below.

A. Guidelines

1. Formulation of guidelines at the central office.

2. Communication of guidelines to the regional directors.

Examples of guidelines are:

1. Do not exceed this year's budget by more than 6 percent.

2. Include data for the current year.

3. Provide formats to be used.

4. Whenever possible, for instance, in a hospital, include quantities and unit cost.

B. Preparation, Review, and Approval (Approximately 6 months)

1. Distribute instructions (guidelines).

   Regional directors could ask hospital directors to develop a budget for their respective hospitals.

2. Prepare initial budget (pro-forma).

3. Review the initial budget at the regional level and then submit it to the central office.

4. Review budget (by budget committee) at the central offices.

5. Approve and submit budget to the legislature.

6. Approve final budget (by legislature).

When the budget is reviewed, the following issues are usually raised:

--reasonableness of the requisitions;

--availability of funds; and

--competition among regions.

C. Budgeting Expenditures

1. Use historical data and start with current level.

2. Make cost estimates.

3. Whenever possible, identify fixed and variable costs.

4. Formulate and quantify objectives.

Prerequisites for Effective Budgeting

The prerequisites for effective budgeting are:

--a sound organizational structure;

--an accounting system capable of generating useful information along the responsibility lines;

--a planning mechanism; and

--good statistical data.

EXERCISES

1. The maintenance budget for your region allowed 1,200 JDs for repairs per month. Actual expenses amounted to 2,000 JDs for May 1982, and 2,000 JDs for June 1982. The budget report appears below.

Month: May 1982

Budget	Actual	Variance	Year to Date
1,200	2,000	(800)	200

Month: June 1982

Budget	Actual	Variance	Year to Date
1,200	2,000	(800)	(600)

Analyze this variance.

2. Knowing that there is going to be a reallocation of resources in June, what records should you maintain to justify additional requests?

3. Assume that 40 percent of the population of Jordan is in Amman, 30 percent in Irbid, 15 percent in Karak, 10 percent in Salt, and 5 percent in Ma'an. The total maintenance budget for the year 1982 is 200,000 JDs. A budget report for the six-month period ended June 30, 1982, appears below.

Budget Report for the Six-Month
Period Ended June 30, 1982

Region	Budget	Actual	Variances
Amman	43,000	45,000	(2,000)
Irbid	32,000	28,000	4,000
Karak	10,000	15,000	(5,000)
Salt	10,000	10,000	- 0 -
Ma'an	5,000	2,000	3,000
TOTAL	100,000	100,000	- 0 -

Comment on these results.

RE-BUDGETING

Very seldom, actual results correspond with expectations. By using performance analysis, it is possible to compare actual and planned performance with the aim of determining the differences, the causes of the variances, and the persons responsible for the performance.

Ways of Making Comparisons

An outline of ways of making comparisons is given below.

1. Determine the differences between actual and budgeted performance.

   Question the Budget.

   Were resources realistically allocated?

   Were there any mathematical errors?

   Were the historical data sound?

   Question the Actual.

   Was the information reliable?

   Did anything unusual or non-recurrent take place?

   Was the region well-managed?

2. Compare between regions.

   Use absolute monetary amounts, adjusting for differences in population and other factors.

   Use relative performance, such as cost per procedure and cost per encounter.

3. Examine other variances.

   Volume (caused by differences in the quantity of services provided).

Price (caused by differences in prices).

Efficiency (not explained by volume or price).

DATE: _____

	Budget	Actual	Variance	Variances To Date
Salaries and Allowances				
Travel				
Rent				
Utilities				
Maintenance				
Supplies				
Total				

DIRECTOR _____

ACCOUNTANT _____

وزارة الصحة

بيانات احصائيه عن محافظة معان

الموضوع	المجموع العام	محافظة معان	النسبه المئويه للمحافظه
السكان	٢٢٣٤٠٥٩	٧٨٢٦٦	٣ر٥ ٪
عدد المستشفيات	١٣	١	٧ر٧ ٪
ادخالات المستشفيات	٨٠٩١٢	٢٩٣٨	٣ر٦ ٪
معدل الاقامه	٤ر٥	٣ر٧	٨٢ر٢٪
تكلفة اقامة اليوم الواحد	١٩ر٧٥٦ دينار		
عدد الاسره	١٤٥٥	٨٦	٥ر٩ ٪
معدل استعمال الاسره المئوي	٦٨ ٪	٣٤ر٦ ٪	٥٠ر٩٪
عدد المراكز الصحيه	٨٨	٧	٨ ٪
عدد مراكز الامومه	١٢	٣	٤ر٨ ٪
العيادات الضروريه	٢٨٣	٣٩	١٣ر٨٪
المراجعون للمراكز والعيادات	٢١٧٣٧٨٢	١٢٧٠٢٢	٥ر٨ ٪
المعالجون للمراكز والعيادات والمستشفيات .	٢٠٦٣٠٧٢	٩١٥٦٦	٤ر٤ ٪
عدد صور الاشعه	٢١٦٣٤٦	٣٤٣٠	١ر٦ ٪
عدد فحوصات المختبر	٧٥٨٨٥٠	٢١٠٥٦	٢ر٨ ٪
الاطباء	٦٢٩	٢٥	٤ ٪
اطباء الاسنان	٦٢	٥	٨ر١ ٪
الصيادله	٣٤	١	٢ر٩ ٪
الممرضون والممرضات القانونيات	٢٢٩	٧	٣ر١ ٪
القابلات القانونيات	١٥١	٦	٤ ٪
الممرضون والممرضات بالتدريب	١٣٣٨	١١٤	٨ر٥ ٪
فنيون	٦١٠	٢٣	٣ر٨ ٪
بقية الوظائف	٣٩٨٦	٩٢	٢ر٣ ٪
الموازنه	١٤٠٦٢٠٠٠		
معدل التضخم	١٠ ٪		

الحالات المرضيه مرتبه حسب وقوعها :-

C-12

1980

	Ma'an	Country
Population	78,266	2,234,059
Number of Hospitals	1	13
Number of Health Centers	7	88
Number of MCH Centers	3	62
Number of Clinics (Rural)	39	283
Number of Physicians	25	629
Number of Staff Nurses	7	229
Number of Auxiliary Nurses	114	1,338
Number of Technicians	23	610
Number of Hospital Admissions	2,938	80,912
Average Length of Stay	3.7	4.5
Number of Outpatient Visits	127,022	2,173,782
Number of X-Rays	91,522	2,063,072
Number of Lab Exams	21,056	758,850
Cost/Hospital Stay/Day		19.756 JD
Number of Hospital Beds	86	1,455
Occupancy Rate	34.6%	68%
Expenditures, 1981		14,075,000 JD
Expected Inflation Rate	----	10%

Appendix D

SEMINAR ON MOTIVATION AND SUPERVISION
(December 16, 1981)

Appendix D

SEMINAR ON MOTIVATION AND SUPERVISION
(December 16, 1981)

TOPICS

I. Assessing Performance

Activities
Results
Impact
Case: A Problem of Low Performance

II. Theories of Motivation

Goals
Supervisor's Role
Role Play

III. Performance and Feedback

Role Play
Meaningful Feedback
Discussion of Performance Charts

LIST OF PARTICIPANTS

Dr. H. Momani, Mafraq

Dr. A. Qudah, Ajloun

Dr. F. Halasa, Madaba

Dr. M. Gool, Irbid

Dr. S. Uleiwah, Tafileh

Dr. A. Shureideh, Zarqa

Dr. M. Salaymeh, North Ghor

Dr. Z. Teif, Jarash

H.E. Dr. Zuhair Malhas, Minister

H.E. Dr. Suleiman Subeihi, Undersecretary

D-3

A PROBLEM OF LOW PERFORMANCE

Dr. Francisco Gutierrez was the director of the Nicaraguan Family Planning Division of the Ministry of Health. Dr. Gutierrez was in trouble with his supervisors because, for the third straight year (1973, 1974, and 1975), the number of women enrolled in the birth control program (women actively using contraceptives given by the government) had not increased but had remained steady--approximately 7 percent of the women of child-bearing age. This enrollment level was unsatisfactory, because it would not reduce Nicaragua's rapid population growth rate (more than 3 percent per year) that was creating overcrowding of schools, unemployment, insufficient housing, and misery for families that could not afford to support more children. Many women entered the program, but few continued for more than one or two months; hence, the low enrollment level.

The program worked as follows: Contraceptives were given to women in clinics and health centers. To receive the contraceptives--pill, IUD, condoms, or foams and jellies--a woman would come to a clinic and wait for a consultation with the doctor. While waiting, she would be interviewed by the social worker, who would collect information on the woman and her family. The woman would then be weighed, her blood pressure would be taken, a pelvic exam would be made, and a papanicolau smear would be taken. These steps would be followed, regardless of the contraceptive method prescribed; if one of the steps could not be followed, the woman was sent away (e.g., there often were no slides for the pap smears). The woman would receive her pills, condoms, etc., or be given an appointment to have an IUD inserted. Most women were put on the pill and told to return monthly for re-supply. All women had to come in every six months for a pap smear to continue in the program. Although none of the contraceptive methods was linked to cervical cancer, it was felt that the program gave women access to cancer screening that they normally would not receive (unfortunately, the Ministry had no facilities to treat cervical cancer). Promotion was carried out on the radio, and home visits were made by social workers.

Dr. Gutierrez noted that, despite efforts, the enrollments remained low. He knew that there was need for contraception; more than one-half of the beds of the maternity hospital were always filled with women who had been injured or infected while undergoing illegal abortions. He assumed that women--and there were thousands--who would risk their lives to obtain an abortion from unskilled "doctors" clearly did not want to have a child and were good candidates for the program. Yet, such women did not stay in the program.

Questions

1. What is the objective of the family planning program in the case?

2. Do all the program's activities promote that objective?

3. What changes would you make to increase the number of women who stay in the program?

Appendix E

PERFORMANCE RECORDING FORMS AND INSTRUCTIONS

Appendix E

PERFORMANCE RECORDING FORMS AND INSTRUCTIONS

INSTRUCTIONS

Form: Chlorine level

Application: Clinics equipped with a simple chloroscope

This form provides a record of water quality available in the community.

The nurse should take as many readings as his or her judgment dictates and record the date and result. It would be a good idea to record unsafe chlorine levels in a bright color to highlight the problem.

This form especially should be displayed in a prominent location so that the community has access to the findings.

E-2

WATER QUALITY

Date of Sample	Result

E-3

INSTRUCTIONS

Form: Environmental Sanitation

Application: Health Center
MCH Center
Clinic

This form provides a record of the general level of sanitation in the community.

At the end of every month the nurse or clerk should enter:

- The number of homes in the community that lack working latrines or sewage disposal facilities;
- The number of open refuse seen on the last working day of the month in the community. To do this, the nurse must make a brief inspection of the community.

E-4

ENVIRONMENTAL SANITATION

NUMBER OF HOMES IN COMMUNITY_____

Month	Homes Without Latrines	Open Refuse Seen
January	_____	_____
February	_____	_____
March	_____	_____
April	_____	_____
May	_____	_____
June	_____	_____
July	_____	_____
August	_____	_____
September	_____	_____
October	_____	_____
November	_____	_____
December	_____	_____

E-5

INSTRUCTIONS

Form: Mother and Child Care

Application: MCH Centers

This form provides a record of the efforts and success of MCH centers in preventive health care. It is different for the morbidity data that are found on another form, which is also used in the MCH centers.

At the end of every month, the clerk or other employee of the center should enter:

- The number of home deliveries attended by midwives of the center during the month;
- The number of well-baby checkups given during the month;
- The number of all prenatal visits given to expectant women during the month. This includes women who have come for pregnancy testing.

E-6

MOTHER AND CHILD CARE

Month	Home Deliveries	Prenatal Check	Well-Baby Check
January	_____	_____	_____
February	_____	_____	_____
March	_____	_____	_____
April	_____	_____	_____
May	_____	_____	_____
June	_____	_____	_____
July	_____	_____	_____
August	_____	_____	_____
September	_____	_____	_____
October	_____	_____	_____
November	_____	_____	_____
December	_____	_____	_____

E-7

INSTRUCTIONS

Form: Cumulative Vaccinations

Applications: Health Center
MCH Center
Clinic

This form provides a cumulative record of vaccinations.

At the end of every month the nurse or clerk should enter:

- The number of third doses of DPT vaccine given in the community, and add that to the previous total;
- The number of third doses of polio vaccine given in the community, and add that to the previous total; and
- The number of measles vaccinations given during the month, and add that to the previous total.

To begin, records must be searched to determine the initial number of children who have received the first course of all three vaccines. The total number of children living in the community should be reviewed at the start of every year.

CUMULATIVE VACCINATIONS

TOTAL CHILDREN UNDER FIVE IN COMMUNITY _____

Month	DPT Third Dose This Month	Cumulative DPT	Polio Third Dose This Month	Cumulative Polio	Measles This Month	Cumulative Measles
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						

E-9

INSTRUCTIONS

Form: Community Morbidity

Application: Health Center, MCH Center, Clinic

This form provides a record of the major disease group. At the end of every month, the nurse or clerk should enter:

- The total number of consultations provided (excluding dental) by the physician and nurse;
- The number of cases diagnosed as a respiratory infection;
- The number of cases of all diarrheas, regardless of specific diagnosis; and
- The number of notifiable infectious diseases diagnosed during the month.

For MCH centers only, the following should be recorded:

- The number of underweight children (as per chart) seen during the month; and
- Repeat visits for the same complaint.

These are not precise epidemiological data, but they are used to gauge <u>changes</u> in the community's health.

E-10

COMMUNITY MORBIDITY

Month	Total Consultations	Respiratory Infections	All Diarrheas	Notifiable Infectious Diseases	Underweight Children
January					
February					
March					
April					
May					
June					
July					
August					
September					
October					
November					
December					
Year Totals					

E-11

INSTRUCTIONS

Form: Primary Causes of Death

Application: Hospitals

This form records the primary causes of death in five general groups. It also presents total deaths and those that were aggravated or precipitated by malnutrition.

At the end of every month, the clerk should enter the total number of deaths for each category. A space should be left at the bottom of the form for the inclusion of another disease category that the hospital director may feel is relevant to his area of the kingdom.

E-12

PRIMARY CAUSES OF DEATH

Month	Total Deaths	Typhoid	Measles	Dysentery	Streptococcal Throat	Respiratory Tract Infection	Malnutrition (Comp./Precip.)
January							
February							
March							
April							
May							
June							
July							
August							
September							
October							
November							
December							
Year Totals							

E-13

INSTRUCTIONS

Form: Surgery

Application: Hospitals

This form records the major vital events surrounding surgical interventions.

At the end of every month, the clerk should record:

- The number of cases that developed septic wounds following surgery. This figure should be expressed as a percentage by multiplying it by 100 and dividing the result by the number of procedures performed.
- The number of individuals who died while awaiting surgery. This number should also be expressed as a percentage by multiplying it by 100 and dividing it by the number of admissions to the surgical ward.
- The number of deaths during surgery. This number is expressed as a percentage by multiplying it by 100 and dividing it by the number of procedures.
- The number of postoperative deaths. Again, this is a percentage of procedures.

If year totals are calculated, the rates cannot be added; the raw data must be totaled and then converted into a percentage.

E-14

SURGERY

Month	Septic Wounds Per 100 Procedures	Preoperative Deaths Per 100 Admissions To Surgery	Operating Room Deaths Per 100 Procedures	Postoperative Deaths Per 100 Procedures
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				
Year Totals				

E-15

INSTRUCTIONS

Form: Infant Care

Application: Hospitals

This form records certain vital events in the nursery.

At the end of each month, the clerk should enter:

- The number of infants who develop sepsis. A rate should be shown by multiplying the number of sepses by 100 and dividing by total births.
- The number of infant deaths, including stillborn, as a percentage of total births.

E-16

INFANT CARE

Month	Sepsis Per 100 Births	Deaths Per 100 Births
January	_____	_____
February	_____	_____
March	_____	_____
April	_____	_____
May	_____	_____
June	_____	_____
July	_____	_____
August	_____	_____
September	_____	_____
October	_____	_____
November	_____	_____
December	_____	_____

E-17

INSTRUCTIONS

Form: Maternal Care

Application: Hospitals

This form records events in the maternity ward and delivery room.

At the end of each month, the clerk should enter:

- The percentage of deliveries that result in perpeural sepsis. Note that many such cases will not be evident prior to initial discharge following delivery but will reappear after a week's time.
- Percentage of admissions to maternity ward that result in deaths. This includes all admissions to the ward, not just deliveries.

E-18

MATERNAL CARE

Month	Sepsis Per 100 Deliveries	Deaths Per 100 Admissions To Maternity Ward
January	_____	_____
February	_____	_____
March	_____	_____
April	_____	_____
May	_____	_____
June	_____	_____
July	_____	_____
August	_____	_____
September	_____	_____
October	_____	_____
November	_____	_____
December	_____	_____

Appendix F

RECOMMENDATIONS FOR SUPERVISION AND BUDGETING

Appendix F

RECOMMENDATIONS FOR SUPERVISION AND BUDGETING

To facilitate supervision of operating units and to improve motivation of operating personnel, the following steps are recommended:

1. Translate the accompanying forms and instructions into Arabic.*

2. Print the forms on heavy stock, because they will be mounted on walls for a year.

3. Distribute a sufficient number of sets of forms and instructions to each district assistant director for each facility in each district.

4. Explain how the forms should be used. Not all district directors were present for the explanation of how to use the forms. Notably, Ramtha, Ma'an, Aqaba, Salt, and Amman were not represented. The Undersecretary should explain the purpose and use of the forms to assistant directors from these districts.

5. Inform the district assistant directors, by memorandum, to immediately implement use of the forms.

6. One month later, have the Undersecretary visit the districts to check for compliance.

7. Ensure that every district director prepares a schedule of supervisory visits and presents it to his regional director.

---

* The following were included as attachments: a list of those who attended the supervision seminar; forms for clinics and centers (5); and forms for hospitals (4).