Chapter-V
CHAPTER-V

FINANCIAL MANAGEMENT OF GOVERNMENT HOSPITALS

There are no two opinions on the issue that without adequate resources hospital development would remain only on the paper. Finance is the fuel of health administration as all activities for the development of hospitals need finances directly or indirectly. It is well known that health is wealth. Health is basic component of socio-economic development and hence the investment in health sector is bring rich dividends.

1. FINANCIAL NEEDS OF GOVERNMENT HOSPITALS

Although health is recognised as a human right to be made available to all the members of the society, however, the fulfillment of this right depends upon the availability of adequate finances. Dr. Brian Abel Smith in his article "Global perspective on Health Service Financing has rightly mentioned the reasons of low priority to health financing to quote him.

The financing of health services is now a subject of major concern to governments all over the world. The causes are not hard to identity. The world economic crisis has lowered rates of economic growth and in a number of countries gross national product per head has been falling or national product has declined in absolute terms. The international debt problems of many developing countries are
now formidable and when help has to be sought from the International Monetary Fund, cuts in public expenditure are often required as part of the price for further loans. Public expenditure on health services is one possible target for finding the savings which are required.

Investment in health is thus of vital significance, especially in the developing countries like India, for enriching the quality of human life which in turn can promote economic development. It has been rightly said that not gold but only men can make a nation great and strong. The deleterious consequences of non-investment or inadequate investment in health are indeed very serious. It is right to say that health is vital for ethic, artistic, material and spiritual development of man.

We have to ensure adequate finances for development of efficient public health services. Any society should consider that a high quality of life, and happiness of the people, which can only be obtained through a sufficient level of health, is not only a basic need to development but should be the lone objective of development.

**Capital and Revenue Expenditure**

i) Expenditure incurred for acquisition of assets for carrying on the activities of the hospital, such as land, buildings, equipment, furniture, etc. is classified as Capital Expenditure.

ii) Expenditure incurred for goods or services for running the hospital, the benefits of which are unlikely to be carried over from one accounting period to another, such as consumable materials, repairs and maintenance, salaries, taxes, interest, etc. is classified
as Revenue (operating) Expenditure. Such an expenditure relating to a period is setoff against the income of earnings of the said period to arrive at the surplus or the deficit resulting from the operation of the hospital.

iii) At times, there would be border-line cases and a doubt arises whether to treat the expenditure as Capital or Revenue. In such cases, generally the criteria is whether the benefit of such an expenditure is likely to be long-run and it accrues over a period of years. If so, the expenditure is treated as Capital and it is added on to assets.

iv) Assets should be recorded at cost. Since these are utilised for the hospital, it is necessary that a 'charge' for utilisation of such services be debited to the operating expenses and this is termed Depreciation.

v) Depreciation is a notional loss suffered by fixed assets on account of wear and tear and ageing. This loss is reflected as an expense.

The value of the fixed asset is reduced to the extent depreciation is charged and the net value is shown in the balance sheet. At the end of every year, cumulative depreciation is deducted from the original value of the asset.

Amount charged as depreciation is generally invested in a sinking fund, so that money is available when the asset is completely depreciated. Since in a rising market the replacement cost is more than the original price of the asset, it might be necessary to charge a little 'extra' in the charges levied to the patients to cover this contingency and this is also invested.
vi) Quite a number of items such as stainless steel trays, basins, baskets, medical and surgical instruments would be required for the use of the hospital. Since they are not of permanent nature like fixed asset, they are classified as Minor Equipments.

- one method is to charge them off at the time the incidence of expenditure takes place and keep only quantity inventory of the items. This method is further modified;

- at the year end, inventory of the available equipment is taken and the cost of the same is credited; and

- another method is to debit the cost to Minor Equipments and treat it as an asset. At the year end, inventory of such items is taken and necessary adjustments made.

vii) Sometimes, payment is made towards expenses such as, Insurance, taxes, etc. covering a period beyond the accounting period. To the extent, it does not relate to current year, it may be treated as Prepaid Expenses and classified as an Asset.

Almost every activity, good or bad, involves finance. Finance lies at the root of most of the problems today and as such, solutions to the problems are guided by the financial compass approved by appropriate authorities. Hospital administration is no exception to this.

In our country health care is assuming greater and greater importance. The services demanded of and available from the Hospitals are increasing in both numbers and complexities. It is, therefore, of utmost importance that there should be efficient financial and cost administration. Through, modern method and control for efficient financial and cost administration of a modern hospital are lacking the reducing feature is that
there has been an awareness now to have these introduced with a view to making the services more and more efficient and making available to a common man at lesser cost. By this, hospital authorities and the doctors have everything to gain and nothing to lose by adoption or adaptation of methods, depending upon the size and complexity of the organisation.

Hospital organization should provide for one such department under the control of a person who has been specialised in financial management as finance is very important area and medical men are generally poor in matters concerned with financial management. Most of the hospital administrators are from medical profession. They do not have systematic and adequate of the basic fundamentals of finance and they do not even understand sometimes, the financial implications of some activities of hospital organization. Therefore, to manage limited finance effectively doctors should take the advantage of the services of the experts of finance in making project planning and budget proposals, in cost accounting and cost analysis of the various activities to find out how the maximum benefit could be achieved at minimum cost.

Management of hospitals has also to think about the sources from which required funds can be acquired. These are known as financing decisions. There may be different sources of financing having different costs and benefits and conditions attached to the same. Management has to select an appropriate source by considering its short as well as long term impact on the efficient working of hospital organisation. Only a qualified person in financial management can perform all these functions appropriately.
Table No. 5.1 - Capital Expenditure on Medical and Public Health and Family Welfare in U.P.

<table>
<thead>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Plan</td>
<td>Non-Plan</td>
<td>Total</td>
<td>Plan</td>
</tr>
<tr>
<td>A.</td>
<td>Medical and Public Health</td>
<td>146,720</td>
<td>1447</td>
<td>148,167</td>
<td>116,778</td>
</tr>
<tr>
<td>B.</td>
<td>Family Welfare</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>C.</td>
<td>Loan &amp; Advances by State Government</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tr>
</tbody>
</table>

Source: Various Budget Documents of Government of Uttar Pradesh.

* B.E. – Budget Estimates
* R.E. – Revised Estimates

It is clear from the table no.5.10 that in the year 2006-07 total capital expenditure was Rs. 148167 lakhs out of which Rs. 146720 lakhs was Plan expenditure and the remaining Non Plan. In the year 2007-08 capital expenditure both plan and non plan declined to Rs. 116893 lakhs and Rs. 1207 lakhs respectively. However in the year 2008-09 the budgeted capital expenditure has increased as compared to the expenditures in the year 2006-07 and 2007-08.
Table No. 5.2 - Revenue Expenditure on Medical and Public Health in U.P.

(Rs. in lacks)

<table>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Plan</td>
<td>Non-Plan</td>
<td>Total</td>
<td>Plan</td>
</tr>
<tr>
<td>A.</td>
<td>Medical and Public Health</td>
<td>51,157</td>
<td>185,654</td>
<td>236,611</td>
<td>55,295</td>
</tr>
<tr>
<td>B.</td>
<td>Family Welfare</td>
<td>33,669</td>
<td>11,535</td>
<td>45,205</td>
<td>38,802</td>
</tr>
</tbody>
</table>

Source: Various Budget Documents of Government of Uttar Pradesh.

* B.E. – Budget Estimates
* R.E. – Revised Estimates

Table no.5.2 shows that the Revenue expenditure has increased every year since 2006-07. It was Rs. 236611 lakhs in the year 2006-07 while it increased to Rs. 293475 lakhs (revised) in 2007-08 and Rs. 325477 lakhs in the year 2008-09. This shows the tendency of government to develop as much services as possible. Family Welfare expenditure has also increased every year during the same period again indicating that the state government is fully aware of its welfare responsibilities.
2. FINANCIAL RESOURCES

The hospitals receive funds and grant from Government as well as from donors. But the acquisition of funds is not the only thing which is important. The most important is its proper allocation and appropriate utilization. Moreover, the financial resources available to a hospital are limited. In many Government hospitals more than 60 percent of the allocated finance is required to be spent on salaries and wages and another 25 to 30 percent on stores and consumables. These expenses are continuously rising. On the other hand, specially in public hospitals, because of inadequate planning or delay in planning and implementation, lot of finance, sanctioned remains unutilised and funds lapse. This shows that efficient management of finance is very significant for hospital organization.

Almost every activity, involves, finance. Finance lies at the root of most of the problems of today and as such solutions to the problems are guided by the financial compass approved by appropriate authorities. Hospital administration is no exception to this.

In our country health care is assuring greater and greater importance. The services demanded of and available from the hospitals are increasing in both numbers and complexities. It is, therefore of almost importance that there should be efficient financial and cost administration. Though, modern method and control for efficient financial and cost administration of a modern hospital are lacking the redeeming feature is that there has been an
awareness now to have these introduced with a view to making the services more and more efficient and making available to a common man at lesser cost. By this hospital authorities and the doctors have everything to gain and nothing to lose by adoption or adaptation of method, depending on the size and the complexity of the organisation.

Finances for hospitals may be guaranteed mainly by the follows sources:

A). Allocation of finance by Union and State Governments.


C). Injecting economy through the curtailment of wasteful expenditure.

**A). Allocation of Finance by Union and State Government**

Financing of health is very difficult task as the resources in India arc limited and the needs are abundant. Programme of health lie at the base of efforts to harness the energies of the people. The Union and State Governments provide health finances under plan and non-plan schemes.

Restructuring of the health care Infrastructure, redeployment and skill development of the manpower, development of referral network, improvement in the health management information system, development of disease surveillance and response at district level are some of the critical steps that have to be taken up by the
State Government. In order to improve the functional status and efficiency of the existing health care infrastructure and manpower in the states.

The centrally sponsored disease control programmes and the family welfare programme provide funds for additional critical manpower and equipment; these have to be appropriately utilised to fill critical gaps, the ongoing and the proposed EAPs are additional resources. Health is one of the priority sector for which funds are provided in the central budget under the head Additional Central Assistance (ACA) for basic minimum services. The States can utilise these funds for meeting essential requirements for operationalising urban and rural health care.

Although states have most of the responsibility for health interventions and spending, the central government is important, too, especially in prevention programs. There is also emphasis on devolving health services delivery to elected local governments, called panchayati raj institutions (PRIs).

The central government accounts for about a quarter of all public spending on health, with most of the remainder from state governments. Central-state proportions vary greatly, this is due to the fact that state government spending percentages are not uniform in all the states.

Although the central government's role in overall health spending is modest, it dominates financing of public health and family welfare activities and centrally sponsored communicable
disease control programs (such as the National Vector-Borne Disease, Leprosy Eradication, TB Control, and AIDS/STD Control Programs).

Most health spending by states is for medical services-between 50 and 75 percent for curative services in hospitals. Some of this spending supports facilities providing primary care, but most goes for urban health care, teaching hospitals, administration, and family planning.

**B. Mobilisation of Resources**

i) Users charges

Most of the developing countries were providing free health services as it was very difficult for the poor to afford payment. It was feared that poor people with infectious diseases can create health problems for the community. However, it is being realised now that people must pay a part of the expenditure incurred in providing services to them. It should not be totally free. The users can pay for diagnostic test, hospital admissions, OPD consultations etc. There is now virtually no country in Western Europe which allows free medical care. Besides supplementing health resources, it promotes people's participation. However, user charges should be kept low keeping in view the per capita income of the people. Referred patients may not be changed to encourage referral system.

Charging fees for services may only slightly affect the demand negatively for health services, because demand for in-patient and
out-patient care is highly inelastic. However, consumers will be more responsive to the quality of care, time costs and the relative prices of alternative types of care givers. Cost sharing will augment resources for the health sector and should, therefore, lead to improvements in supply, both in qualitative and quantitative terms. Sustainability would also be promoted to a large extent because the revenue realised would finance a portion of the operational costs, thereby relieving the budgetary constraint. Cost sharing would result in improvements in the quality of care if the resources generated internally by a hospital are ploughed back for improving the availability of drugs and equipment in that hospital.

Most of the states have delegated the powers to the hospital authorities to make use of the user charges for the promotion of quality health care. Under this system, there is a danger of misuse of funds. The better method would be to collect users charges from all institutions at the state level and then provide amounts out of these funds as contingency grants to hospital authorities. This would encourage transparency accountability and good governance.

ii) Employer’s Liability

Many autonomous institutions provide free medical services to their employees. The central and State Government employees get either fixed medical allowances or free treatment or reimbursement. In industry, there is an ESI scheme, wherein the expenditure on health is shared among employees, employers and government. The Employees State Insurance Scheme is operated under the Employees
State Insurance Act, 1948, according to which, it is the statutory responsibility of state government to provide medical care to the insured persons. The Employees State Insurance Corporation, Government of India shares 7/8th of the total expenditure on such medical care, the state shares 1/8th of total expenditure. In case of opening of new dispensaries in the state, the ESIC pays the full expenditure for the first three years.

**Central Government Health Scheme (CGHS)**

The Centre organises facilities for health care of its employees and pensioners living in the capital and other major cities through Central Government Health Scheme and Public Hospitals. It rushes relief and supplies to areas hit by natural calamities and unforeseen disasters. The Ministry also assists in investigations for Serological and Chemical Examination Services.

The Central Government Health Scheme (CGHS) was started in 1954 with the objective of providing:

(a) Comprehensive medical care facilities to the Central Government Employees and their family members;

(b) To avoid cumbersome system of medical reimbursement.

Besides Central Government Employees, the scheme also provides services to:

- Members or Ex-members of Parliament;
- Judges of Supreme Court and High Courts (sitting and retired);
- Freedom Fighters;
• Central Government Pensioners, employees of Semi Autonomous bodies/Semi-Government Organisations;
• Accredited Journalists;
• Ex-Governors and Ex-Vice Presidents of India.

The following facilities are being provided to the beneficiaries through dispensaries, polyclinics, and Government/recognized hospitals:

• Out patient care facilities in all systems;
• Emergency services in Allopathic system;
• Free supply of necessary drugs;
• Lab and Radiological investigations;
• Domiciliary visits to seriously ill patients;
• Specialist consultation both at the dispensary and hospital level;
• Family Welfare Services;
• Treatment in specialised hospitals-both Government and private recognized reputed hospitals;
• 90% advance for undergoing specialised procedures after admission in hospitals.

iii) Private Sector

Private sector possesses immense potentiality to provide decent health care to the people. We are witnessing the mushroom growth of Nursing homes, complex hospitals like Appolo, Cadila, etc. They are making a good contribution. However, court should be
taken that they not exploit the people. The charges in private
hospitals are so high that only selected people can avail of their
benefits. Even these have become cheating devices of specialists. It
is high time that the Union Government should come out with a
legislation to provide control over these institutions so that they
serve the people and not resort to profit-making and fleecing the
people.

iv) NGO’S (Non Government Organisation) Role

There are many institutions run by voluntary organisations. it
has been seen that most of the NGOs get the money from
Government. Such NGOs should be discouraged and asked to raise
their own resources. Only those NGOs should be encouraged, which
can raise more than 50% to finances themselves. We should
encourage such organisations like Ramakrishna Mission, which has
been providing excellent health services and was awarded by Govt.
of India for its medicated services. The state should award such
individuals to set example of service. There are many other religious
organisations like Khalsa Panth, Sanatan Dharm, Christianity, etc.,
which also provide such service.

v) Philanthropy

Charity is one of the oldest and most common in India.
Individual donors give donations to hospitals and institutions and
business men and industrialists to develop health institutions from
their personal assets.
Many private individuals are providing health facilities purely from their personal resources like Mohan Dai Cancer Hospital, Ludhiana, a premier institution set up by Lala Vidya Sagar Oswal in memory of his wife, who died of cancer. Similarly, many industrialists like Birla, Tata have set up such institutions. Many individuals give funds for additions in existing health institutions like Dr. P.N. Chuttani, who donated huge funds to PGI.

vi) International (Multi-lateral and Bilateral)

World Health Organizatin through its South-East Asia Regional Office provides assistance to a number of projects in priority areas through expertise, equipment and fellowships.

In addition to these, there are many specific programmes assisted by other countries on bilateral basis.

Based on discussion, it was found that most of the funds are not utilized properly. Because of administrative obstacles, the foreign assistance fails to produce the desired impact.

**C. Curtailment of Wasteful Expenditure**

Wasteful expenditure, especially in institutions run by government is very high. A serious problem in this area is of inefficient use of allocated resources and non-utilisation of actual and potential resources judiciously and properly. Huge resources are being wasted because of selection of inappropriate technology, inefficient management and unsatisfactory control mechanisms.
It is necessary that public revenue should be raised in an equitable manner and spent economically so that the tax payers may get full value of their money.

The decline in public investment in health and the absence of any form of social insurance have increased insecurities. The poorest 10% of the population rely on sale of their assets or on borrowings to meet cost of hospitalization, entailing inter-generational consequences on the family's ability to access basic goods and affecting their long term economic prospects. Studies reveal that health expenditure is the second biggest cause for rural indebtedness and hospitalized Indians spend on an average 58% of their total annual expenditure. Over 40% of hospitalized persons borrow heavily or sell assets to cover expenses and 25% Indians fall below the poverty line because of hospital expenses while in Uttar Pradesh this figure is around 34%.
CHART 5.1: STRUCTURE OF HEALTH CARE SYSTEM
A Flow chart of Uttar Pradesh

Sources of Funds

- Central Govt. MOHFW
- State Govt.
- Local Govt.
- ESA
- Private Sector
- Households

Funding Mechanisms

- DoH & FW
- Local Bodies
- NGOS
- ESIC
- Health Insurance
- Out of Pocket Expenses

Providers

- Public Providers
- ESIS Network of Dispens/Hosp.
- NGOS & Charitable Inst.
- Private Providers

Uses

1. Primary Care
   - Curative
   - Preventive
   - Promotive

2. Secondary/Tertiary Care
   - Inpatient care

   - Compensation
   - IEC

Abbreviations:
MOHFW: Ministry of Health & Family Welfare (Union Govt.)
DOHFW: Department of Health & Family Welfare (U.P. State)
ESA: External Support Agencies
NGO: Non Governmental Organizations
ESIC: Employees State Insurance Corporation
Table No. 5.3 Extent of Funding by Union Government*

<table>
<thead>
<tr>
<th>Major/Minor Head of Development</th>
<th>Pattern of Funding</th>
<th>Major/Minor Head of Development</th>
<th>Pattern of Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL &amp; PUBLIC HEALTH</td>
<td></td>
<td>Compl.-ation</td>
<td>Cent percent</td>
</tr>
<tr>
<td>101 Prevention and Control of Diseases</td>
<td></td>
<td>Supply of Surgical equipments</td>
<td>Cent percent</td>
</tr>
<tr>
<td>01 National Malaria Eradication Programme</td>
<td></td>
<td>Sterilisation bed scheme</td>
<td>Cent percent</td>
</tr>
<tr>
<td>(a) Rural</td>
<td>50 percent</td>
<td>Conventional contraceptives</td>
<td>Cent percent</td>
</tr>
<tr>
<td>(b) Urban</td>
<td>50 percent</td>
<td>Postpartum centre</td>
<td>Cent percent</td>
</tr>
<tr>
<td>02 National Filaria. Control</td>
<td>50 percent</td>
<td>Subdivisional Postpartum centre</td>
<td>Cent percent</td>
</tr>
<tr>
<td>03 Control and Eradication of Communicable Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) National Goitre Control Programme</td>
<td>Cent percent</td>
<td>Mass education</td>
<td>Cent percent</td>
</tr>
<tr>
<td>(b) National Leprosy Programme</td>
<td>Cent percent</td>
<td>Oral rehydration therapy</td>
<td>Cent percent</td>
</tr>
<tr>
<td>(c) Prevention of Blindness</td>
<td>Cent percent</td>
<td>Divisonal level vehicles</td>
<td>Cent percent</td>
</tr>
<tr>
<td>04 National T.B. Control Programme</td>
<td>50 percent</td>
<td>Health and Family welfare training centre</td>
<td>Cent percent</td>
</tr>
<tr>
<td>05 Encephalitis</td>
<td>50 percent</td>
<td>Health and Family welfare training centre building</td>
<td>Cent percent</td>
</tr>
<tr>
<td>800 Other Expenditure (Family Welfare</td>
<td></td>
<td>Scheme prophylaxis against nutritional anaemia among mother and children</td>
<td>Cent percent</td>
</tr>
<tr>
<td>State Secretariat cell</td>
<td>Cent percent</td>
<td>Indian population project</td>
<td>Cent percent</td>
</tr>
<tr>
<td>State Family Welfare Bureau</td>
<td>Cent percent</td>
<td>Training of auxiliary nurse/midwife/lady health visitor/dais</td>
<td>Cent percent</td>
</tr>
<tr>
<td>Divisional Lieveal Org.</td>
<td>Cent percent</td>
<td>Maintenance and extension of health guide scheme</td>
<td>Cent percent</td>
</tr>
<tr>
<td>City Family Welfare Bureau</td>
<td>Cent percent</td>
<td>Regional public health nursing school Varanasi</td>
<td>Cent percent</td>
</tr>
<tr>
<td>District Family Welfare Bureau</td>
<td>Cent percent</td>
<td>State M.T.P. cell</td>
<td>Cent percent</td>
</tr>
<tr>
<td>Rural Family Welfare centres/sub centres</td>
<td></td>
<td>Drug and dressing for M.T.P.</td>
<td>Cent percent</td>
</tr>
<tr>
<td>Aids Control Project</td>
<td>Cent percent</td>
<td>Green card schemes</td>
<td>Cent percent</td>
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<tr>
<td>Continuation. of Family Welfare centres/sub centres</td>
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<td>Schemes under P.C.R. Act</td>
<td>Cent percent</td>
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<tr>
<td>Urban Family Welfare centres run by the State govt. including revamping scheme</td>
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<td>Cons. Completion of R.F.W.C. at PHC</td>
<td>Cent percent</td>
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<tr>
<td>Urban Family centres run by the local bodies / voluntary organisations</td>
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<td>Rural F.W. clinic</td>
<td>Cent percent</td>
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<tr>
<td>Immunisation programmes</td>
<td>Cent percent</td>
<td>Renovation of L.U.D. Rooms/O.T</td>
<td>Cent percent</td>
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<tr>
<td>Nutritional programmes for control of blindness among children due to deficiencie</td>
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<td>Training of MO's in M.C.I.</td>
<td>Cent percent</td>
</tr>
<tr>
<td>District Family Welfare vehicles</td>
<td>Cent percent</td>
<td>Procurement of Syringe needle and Boises</td>
<td>Cent percent</td>
</tr>
<tr>
<td>State Family Welfare vehicles</td>
<td>Cent percent</td>
<td>Reconatalization facilities at P.P. centre</td>
<td>Cent percent</td>
</tr>
<tr>
<td>Training Family welfare Training Centres</td>
<td></td>
<td>Specific area Approach paper</td>
<td>Cent percent</td>
</tr>
<tr>
<td>A.N.MA., H.V. School vehicles</td>
<td>Cent percent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procurement of PHC vehicles</td>
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3. BUDGET ALLOCATIONS

Performance Budget

The existing health budgets have been mainly designed to ensure financial and legal accountability to the legislature and within the executive, observance of similar accountability on the part of each subordinate agency. Budgets are generally prepared with an emphasis on the subjects of expenditure constituting the primary units of appropriation such as pay of officers, pay of establishment, allowances and honoraria, etc. It lays more emphasis on the cost aspects without any indication of the results.

It has been mentioned by the report of the ARC Study Team that Performance budgeting as is generally known is essentially a technique of presenting government operations in terms of functions, programmes, activities and projects. Through such a meaningful classification of transactions governmental activities are sought to be identified in the budget in the financial and physical terms so that a proper relationship between inputs and outputs could be established and performance assessed in relation to costs. According to Shri S.S. Visvanathan, Performance budgeting is a comprehensive operational document conceived, presented and implemented in terms of programmes, projects and activities with their financial and physical aspects closely inter-woven. The most important objective of this technique is the precise definition of the work to be accomplished or service to be rendered and a correct estimate of what that work or service will cost in financial terms.
Significance /Purpose of Budget

Performance budgeting facilitates better programming, decision-making, review and control for a more intelligible presentation of governmental activities to the public and the legislature. Broadly speaking, the main purposes sought to be served by performance budgeting are:

- to correlate the physical and financial aspects of every programme/activity,
- to improve budget formulation, review and decision making at all levels of management in the government machinery,
- to facilitate better appreciation and review by the legislature;
- to make possible more effective performance audit,
- to measure progress towards long-term objectives as envisaged in the plan,
- to bring annual budgets and development plans closely together through a common language.

Process of Performance Budgeting

The process of performance budgeting includes the following:

- Establishment of goals, objectives and targets.
- Formulation of functions, programmes and activities of a given function.
- Setting up of norms and standards
- Designing of control and evaluation system.
- Delegation of financial powers.

**Preparation of Budget**

- A satisfactory budget cannot be prepared on imagination, though at times 'imagination' is necessary. It is based on experience as reflected in accounting and other records, modified or extended by future needs and requirements. Knowledge of past performance, constructive examination of what has happened in the past and accurate statistical information for a period of at least five years, will/act as a guide, a compass. Data of past performance are to be correlated; changes with service mix are to be studied; internal and external factors influencing the hospital activities, specially the admissions have to be studied; constraints from within the organisation due to adverse effect of policy decisions; inadequate funds to maintain specialization or other factors, are to be dearly identified; external constraints can be numerous and complex but perceptible changes in other hospitals, population trends and other apparent changes are to be identified since these affect admissions.

- Since the budget is to be used as an instrument of control, and control cannot be exercised by looking only backwards, action necessary to reflect the anticipated effect of the above factors, and to remedy the situation, has to be planned. The essence of control is to set objectives for the future, and then set the course to reach them. Steps are to be introduced to secure that
the plan is being carried out and the objectives attained. Deviations from the course, there are bound to be and these must be measured, allowed for and corrected.

- The first step in the preparation of the budget is that written instructions regarding procedures to be followed, accompanied by illustrative forms and calculations, have to be issued and those should be disseminated to all personnel who will be involved in the actual budget, preparation or in the execution of the budget.

- Each Department will then prepare their budget, forecast their income and expenditure, taking note of the various factors.

- Since Salaries and Wages generally form 40 to 50 per cent of the total expenditure, the budget for this should be as realistic as possible, and it should be accurate.

- Additional staff requirements, if any, have to be specifically grouped separately and justification for the same has to be indicated.

- Other expenses such as food, drugs, supplies and expenses can be projected on the basis of past year's based on per diem expenses.

**Zero-Base Budgeting (Z.B.B)**

Zero-Based Budget requires that health organizations while preparing their budgets should not take earlier years expenditure for granted and therefore should start afresh. In this process, the examination of existing programmes and activities has to be done in
the same manner as would apply to newly proposed ones.

ZBB is an operating planning and budgeting process which requires each manager to justify his entire budget request in detail from a scratch and shifts the burden of proof to each manager to justify why he should spend any money at all.

Zero-base budgeting is thus a rationalization of the regular budgeting process to ensure accountability and maximum utility. It demands a total rejustification of every financial activity from zero.

**Essentials**

- Need of eliminating redundant expenditure, which is not serving the existing purpose.
- To identify and remove duplication or multiplication of expenditure.
- To search for alternative device to save expenditure.
- Optimise expenditure by making it productive and efficient.
- An appropriate administrative structures to ensure fruitful application of new budgetary aspects.
- To design all effective communication system in the organization.
- To design an adequate information system.

**Methodology**

It involves the following major steps:

- Identification of Decision Units.
- Formulation and Development of Decision Packages.
- Evaluating and Ranking Decision Packages in order of priority.
- Preparation of budget by allocating resources to activities or decision packages.
- Follow up and Revision.

**Chart No. 5.2**

**Medical and Health Budget of U.P. for 2007-08**

- A provision of Rs. 4,674 crore made for Medical and Health schemes proposed as per the new demands of Rs. 462 crore.
- District Hospitals would be set up at Sant Kabir Nagar, Shravasti, Sant Ravidas Nagar, Auraiyya and Balrampur. A 100-bed hospital will be set up at Kanpur Nagar.
- As many as 35 Ayurvedic and Unani Hospitals would be set up at urban areas and 125 such hospitals would be set up in rural areas. Besides, 92 new Government Homeopathic Hospitals would also be set up.

- Rs. 276 crore arranged for the construction of the buildings of P.H.Cs.

- An arrangement of Rs. 286 crore made for the construction of State Medical Colleges and for purchasing equipment.

**Medical, Health and Family Welfare**

Action will be taken for construction of buildings for 100 community health centres and 674 Primary Health Centres this year. Scheme for construction of 100 PHCs and 15 CHCs in scheduled castes/tribes dominated areas. Buildings of 4,512 sub-centres will also be constructed.

Encouragement to private sector for setting up of 500-bed hospital for providing VIP medical facility in remote areas.

**Medical Education**

KGDU has been merged in Chhatrapati Shahuji Maharaj Medical University and the former status of dental faculty has been given to it. The construction of Centenary Hospital will be completed soon and it will start running for the treatment of people. Arrangement of Rs. 515 crore for the construction of buildings and equipment has been made in this year.
Medical and Health Budget of U.P. for 2008-09

- A provision of Rs. 383 crore is proposed for construction of PHCs and CHCs in 2008-09, out of which Rs. 55 crore is proposed to be spent in the areas predominantly inhabited by scheduled castes.

- A provision of Rs. 200 crore for construction of sub-centres for the year 2008-09, out of which Rs. 25 crore will be utilized in the SC dominated areas.

- A provision of Rs. 235 crore by way of State's share has been made for promoting health facilities, family welfare and maternal care services in rural areas under the National Rural Health Mission.

- A provision of about Rs. 694 crore has been made for medical colleges being constructed in various districts. Out of this amount, provision of Rs. 624 crore has been made under the special component plan.

Medical, Health and Family Welfare

- A budgetary provision of Rs. 5626 crore for medical and health, showing an increase of 20 per cent over the last year. Besides, an amount of Rs. 1330 crore, to be received from the Central Government under the National Rural Health Mission, will also be available.

- A provision of Rs. 234 crore under the head of drugs and chemicals, which is 37 per cent more than the last year.
• The 100-bed hospitals being constructed in Kaushambi, JP Nagar, Tarwan (Azamgarh) and Sirauli Ghauspur (Barabanki) will be completed in 2008-09.

• A provision of Rs. 383 crore for construction of PHCs and CHCs.

• Sub-health centers will be constructed under a proposed provision of Rs. 200 crore in 2008-09. Out of this amount, Rs. 25 crore is meant for construction of these centers in the areas predominantly inhabited by Scheduled Castes.

• A provision of about Rs. 235 crore is mooted by way of state's share under the National Rural Health Mission

Medical Education

• Decision to develop the Chhatrapati Sahuji Maharaj Medical University, Lucknow as a center of excellence. An expenditure of Rs. 447 crore is estimated under this head in the next five years.

• A proposal of Rs. 453 crore for Government Medical Colleges under construction in Ambedkar Nagar, Saharanpur and Banda.

• The buildings of Medical College under construction in Azamgarh, Orai (Jalaun) and Kannauj and as also of Paramedical College in Jhansi will be completed at the earliest.

• Two new homoeopathic medical colleges are being set up in Gorakhpur and Aligarh.
Medical and Health Budget of U.P. 2009-10

- An amount of Rs. 6,503 crore has been made in the budget for Medical, Health and Family Welfare Schemes, which is 16% more than the last year.

- Budgetary provisions of Rs. 85 crore made for the construction of PHCs and Rs. 290 crore for CHCs buildings in 2009-10.

- An amount of Rs. 266.36 crore earmarked in 2009-10 under the medicine and chemicals head, which is 14% more than the provision of Rs. 233.67 crore made last year.

- Provision for free treatment of Japanese Encephalitis and Acquired Encephalitis Syndrome in all District Hospitals of the State. Out of 34 districts affected from J.E., 2.72 crore children vaccinated in 27 districts. Vaccination in remaining 7 districts would be done in 2009-10.

- A provision of Rs. 1240 crore made in the budget of 2009-10 for Family Welfare Programme, which is 25% more than last year.

- An amount of Rs. 300 crore provided for State's share in the National Rural Health Mission, which is 28% more than last year.

- Janani Suraksha Yojana is being implemented for bringing about decrease in maternity mortality rate through safe delivery.

- An amount of Rs. 1,239 crore provided for Allopathic Medical Colleges, Medical University and super specialty Medical Institutes.
4. FUND UTILISATION

Financial management involves three important decisions:

(i) Investment decisions,
(ii) Financing decisions, and
(iii) Dividend decisions.

Unless the hospitals are organized in a corporate form and on profit basis, the third decision, i.e., dividend decision is not so relevant. But in spite of this if we intend to run our hospitals efficiently we have to allocate the available finance among the required activities in such a way so as to avoid deficit, so far as it is possible and in case, if there is surplus, it must also be managed in the best possible way.

Investment decision, which is an important area of financial management, plays a significant role in hospital management. Investment decisions may be either for long or for short-term. Long-term investment includes the decisions on purchasing of very important instruments such as boyle's apparatus, ventilators, X-Ray machines, auto-analysers, surgical instruments (routine and special) and other necessities of operation theatre such as operation table, troleys, drums, autoclave machines, etc. This involves the large amount of investment for a long period. These are capital budgeting decisions. These refer to long-term assets which remain in operation and yield a return in quantitative terms (where fee is charged) and qualitative terms (where fee is not charged) over a period of time,
usually exceeding one year. These involve current expenditure but are likely to produce benefits over a period of time longer than one year. If hospitals charge fees for its services these decisions are very significant for three reasons:

(i) Potentially significant anticipated benefits,

(ii) Degree of risk as the amount involves a large amount, and

(iii) A relatively long time period between the initial outlay and anticipated benefits during the economic life of an asset (machine).

Here, management has to study anticipated future benefits quantitative and qualitative-against the current initial investment and other expenditure on operation, maintenance, repair, overhauling, etc. While considering benefits, it has also to consider effect on other projects under consideration, indirect expenses, depreciation, working capital requirement throughout their effective life. Sometimes two or three capital budgeting decisions compete for limited available finance. Here, management has to utilize some appraisal techniques, or indulge in capital rationing (If they charge fees for their services). Now the doctors who are specialists in their respective areas may not give full justice to this problem. Hence, they should take the services of professionals in the area of financial management by creating a separate department under the control and guidance of qualified financial manager.
If hospitals do not charge any fee, and run on the funds provided by the Government, Cheritable Trusts or individual donors, then also the problem of efficient utilization of funds remains. Hospital management has to evaluate potential benefits in qualitative terms against the current and subsequent outlay.

Moreover, hospitals also require efficient working capital management. They require drugs, linen, cotton, bed sheets, pillows, syringes, needles, etc. continuously. These are the short, term assets which lose their identity fairly quickly and mostly immediately or within a year or two. In the management of working capital, the time factor is not so crucial but to decide the optimum amount of all these short-term requirements is very important. Here management has to consider average daily census, bad occupancy rate, average length of stay, bed turnover rate, number of average out-patients, number of different kinds of surgical operations, etc. and take an appropriate decisions for required sum in a given period. This also needs expert's knowledge.
Table No. 5.4 - Expenditure on medical and public health and family welfare* in U.P. As ratio to Aggregate Disbursements

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Years</th>
<th>% of Total Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>2000-01</td>
<td>4.0</td>
</tr>
<tr>
<td>2.</td>
<td>2001-02</td>
<td>3.6</td>
</tr>
<tr>
<td>3.</td>
<td>2002-03</td>
<td>3.8</td>
</tr>
<tr>
<td>4.</td>
<td>2003-04</td>
<td>2.7</td>
</tr>
<tr>
<td>5.</td>
<td>2004-05</td>
<td>3.8</td>
</tr>
<tr>
<td>6.</td>
<td>2005-06</td>
<td>5.1</td>
</tr>
<tr>
<td>7.</td>
<td>2006-07</td>
<td>5.7</td>
</tr>
<tr>
<td>8.</td>
<td>2007-08</td>
<td>5.2</td>
</tr>
<tr>
<td>9.</td>
<td>2008-09</td>
<td>5.6</td>
</tr>
</tbody>
</table>

*Includes Capital and Revenue Expenditure

Source: Various Budget Documents of Government of Uttar Pradesh.

It is clear from the table no. 5.4 that expenditure on Medical and Public health in U.P. ratio to aggregate disbursement shows a zig-zag trend up to the year 2004-05. Thereafter it increased in the year 2005-06 and 2006-07 but declined in the year 2007-08. It again went up in the year 2008-09. This is due to the fact that the government could not decide a permanent policy of expenditure on health.
Expenditure on Medical and Public Health and family welfare * in U.P. as ratio to Aggregate Disbursements

<table>
<thead>
<tr>
<th>Year</th>
<th>% of Total Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000-01</td>
<td>4</td>
</tr>
<tr>
<td>2001-02</td>
<td>3.6</td>
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<tr>
<td>2002-03</td>
<td>3.8</td>
</tr>
<tr>
<td>2003-04</td>
<td>2.7</td>
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<tr>
<td>2004-05</td>
<td>3.8</td>
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<tr>
<td>2005-06</td>
<td>5.1</td>
</tr>
<tr>
<td>2006-07</td>
<td>5.7</td>
</tr>
<tr>
<td>2007-08</td>
<td>5.2</td>
</tr>
<tr>
<td>2008-09</td>
<td>5.6</td>
</tr>
</tbody>
</table>

Source: Various Budget Documents of Government of Uttar Pradesh
Table No. 5.5 - Development Expenditure on Medical and Public Health in U.P.

(Rs. in Crore)

<table>
<thead>
<tr>
<th>Item</th>
<th>2006-07</th>
<th>2007-08</th>
<th>2008-09</th>
<th>% Variation</th>
<th>Column 4 over 2</th>
<th>Column 5 over 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 over 2</td>
<td>5 over 4</td>
</tr>
<tr>
<td>A. Revenue Expenditure</td>
<td>22205</td>
<td>27760</td>
<td>32224</td>
<td>25</td>
<td>16.1</td>
<td></td>
</tr>
<tr>
<td>B. Capital Expenditure</td>
<td>3170</td>
<td>3807</td>
<td>4737</td>
<td>20.1</td>
<td>24.4</td>
<td></td>
</tr>
<tr>
<td><strong>Total (A+B)</strong></td>
<td>25375</td>
<td>31567</td>
<td>36961</td>
<td>24.4*</td>
<td>17.1*</td>
<td></td>
</tr>
<tr>
<td>Loan &amp; Advances by</td>
<td>74</td>
<td>187</td>
<td>182</td>
<td>152.7</td>
<td>-2.7</td>
<td></td>
</tr>
<tr>
<td>State Government for</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>development purchase</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Various Budget Documents of Government of Uttar Pradesh.

* Average variation with capital and revenue expenditure.

Table no. 5.5 shows that developmental expenditure both capital and revenue is consistently increasing since 2006-07. This shows that the state government is fully aware of health of need of people of the state.
Development Expenditure on Medical and Public Health in U.P.

Source: Various Budget Documents of Government of Uttar Pradesh
Public Investment in Health

Public Health spending in India has come down to the level of 0.9% of G.D.P. Public Health spending in India is among the lowest in the world and only Burundi, Burma, Pakistan, Sudan and Cambodia spend less than India. India is one of the fifteen countries in the world where households account for more than 80% of total health spending. The budgetary allocation of the State Governments has also declined up to 1999 however recently the trend has reversed. It must be remembered that State Governments spend 85% of total per capita health expenditure and only 15% comes from the Government of India. In Uttar Pradesh, public health spending has increased from 0.91% of GDP in 2002-03 to 0.98%.

The share of resources deployed in U.P. on medical and public health in the First Five Year Plan was 9% which came down to 1% in the Fifth Five Year Plan and then again went up to 4% in the Seventh Plan. It again declined to 2% in the Ninth Plan but again went up to 4.34 in tenth plan. In the first two years of the eleventh Plan, the expenditure on medical and public health was Rs. 1493.6 crores and Rs. 2216.15 crores respectively. While proposed out lay for the third annual plan was Rs. 2275.02 crores. The trend is clearly evident from the figure given below:
Table No. 5.6 - Expenditure on Medical and Public health in U.P. during five years plans

(in lakh Rs.)

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Plans</th>
<th>Expenditure</th>
<th>% of Medical Expenditure to total outlays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>First Plan</td>
<td>1309</td>
<td>8.5</td>
</tr>
<tr>
<td>2</td>
<td>Second Plan</td>
<td>983</td>
<td>4.2</td>
</tr>
<tr>
<td>3</td>
<td>Third Plan</td>
<td>2470</td>
<td>4.4</td>
</tr>
<tr>
<td>4</td>
<td>Fourth Plan</td>
<td>3244</td>
<td>2.8</td>
</tr>
<tr>
<td>5</td>
<td>Fifth Plan</td>
<td>3774</td>
<td>1.3</td>
</tr>
<tr>
<td>6</td>
<td>Sixth Plan</td>
<td>19079</td>
<td>2.9</td>
</tr>
<tr>
<td>7</td>
<td>Seventh Plan</td>
<td>45733</td>
<td>3.8</td>
</tr>
<tr>
<td>8</td>
<td>Eight Plan</td>
<td>56787</td>
<td>2.6</td>
</tr>
<tr>
<td>9</td>
<td>Ninth Plan</td>
<td>65569</td>
<td>2.3</td>
</tr>
<tr>
<td>10</td>
<td>Tenth Plan</td>
<td>394269</td>
<td>4.34</td>
</tr>
<tr>
<td>11</td>
<td>Eleventh Plan (Agreed outlay)</td>
<td>1319405</td>
<td>7.29</td>
</tr>
</tbody>
</table>

Source: Economics & statistics Division state planning institute Uttar Pradesh.
% of Expenditure on Medical and Public Health in U.P. During Five years plans

Source: Economics & Statistics Division state planning institute Uttar Pradesh
Table No. 5.7 - Annual Plan’s outlay for eleventh five year plan (Medical & Public Health)

<table>
<thead>
<tr>
<th>Items</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved outlay</td>
<td>1714.17</td>
<td>2388.01</td>
<td>-</td>
</tr>
<tr>
<td>Actual Expenditure</td>
<td>1493.60</td>
<td>2216.15</td>
<td>-</td>
</tr>
<tr>
<td>Proposed outlay</td>
<td>-</td>
<td>-</td>
<td>2275.02</td>
</tr>
</tbody>
</table>

Source: State finances Budget Documents of Government of Uttar Pradesh.

5. FINANCIAL CONTROL – AUDIT

Objectives of Audit

The audit objectives are as under:

i) Whether programmes and schemes, launched for hospitals are based on reliable data and are systematically implemented;

ii) funds earmarked for the various schemes are adequate and utilized optimally;

iii) various health services provided, have an impact on health indicators;

iv) Whether clinical service quality through skill development, quality assurance and upgraded facilities has proved;
v) public health service quality through strengthened disease surveillance and control systems and waste management system has proved; and

vi) monitoring system at various levels are functioning effectively.

**Audit Criteria**

The performance of rural health sector was assessed based on criteria specified in:

i) Financial Hand Book.

ii) Budget Manual, UP Medical Manual along with Medical Services Rules.

iii) Guidelines of various schemes for rural health sector and Government Orders issued from time to time.

**Scope of audit**

The performance audit covering the period 2002-07 was conducted during March 2007 to October 2007 by test check of records of the offices of DGMH and DGNPME, CMOs of the 16 districts involving expenditure of Rs. 1,116.83 crore, (15 selected by PPSWR method and Lucknow being the capital district) along with the records of 101 CHCs, 762 PHCs and 3,205 SCs of these districts. Besides, joint inspection with a representative of CMO of one CHC and one PHC selected randomly in each district was also carried out and records, e.g., stock register of medicines, indoor and outdoor patient registers and infrastructure for basic health facilities were verified.
Audit objectives/criteria were discussed and agreed upon by PS, MH & FW during an entry conference held in April 2007. The draft review was communicated to the Government (September 2007) and discussed on 16 October 2007 in the exit conference held with PS, MH & FW. Facts and figures were confirmed and recommendations accepted by the Government.

Finance Control

i) Finance is the backbone of every organisation and it furnishes the means to obtain resources necessary for achieving the objectives of the organisation. Hospital, a non-profitable organisation, is very much concerned, particularly over the rising cost of patient care. The role of Financial Controller, Adviser and the financial and cost management in such circumstances is extremely difficult but essential at least to point out areas of economics.

ii) Financing of ongoing activities, expansion of existing services, replacement of out equipment, acquiring of new techniques, equipments and overall manpower financing are the broad areas where funds are required for the operation of a hospital. Apart from this, the physicians are very keen to use the latest techniques and drugs; the surgeons, the latest instruments and equipments, to alleviate and eliminate the sufferings of human beings. All these cost money and hospital authorities have to make efforts to arrange financial resources.

iii) Most of the hospitals in India are being controlled and financed by Central/State Governments and Autonomous Organisations.
but are governed by Act of Parliament. The Government (various ministries) has to get its financial demands voted by an Act of Parliament State Assembly and has to render accounts for the proper utilisation of funds. The accounts are subject to audit by CAG. The procedure prescribed for maintenance of accounts by the Government has, therefore, to be followed, and hospitals are no exceptions to this.

iv) Cost benefit and cost effective analysis are important techniques for the management to assess any projected investment. The management has to consider whether any new sophisticated equipments are a must; whether they could be utilised properly for the benefit of the community at large or whether they are just prestigious equipments, as a show piece.

v) As stated earlier, the goal of financial and cost management in a hospital is to see that the community is provided with the service it needs at an acceptable level of quality and at the least possible cost. A sound and proper financial management is, therefore, essential for efficient and economical operations of a hospital keeping the welfare of the community as its basic objective without sacrificing the concept of propriety of financial and cost management. It has also to aim at proper planning and efficient and effective utilisation of resources.

vi) The Chief of Finance or the Financial Controller /Adviser shall be all eyes and ears. He is a watch dog; not a blood hound. He has a difficult task to perform, and a heavy responsibility to discharge.
vii) The important duties of the finance controller are as under:

- to scrutinise and consider budgets at the commencement of the year and to submit them to the Governing Board;
- to give concurrence within the allotments of funds;
- to exercise a control over the additional staff required;
- to enquire into and report upon departmental excesses of expenditure over allotment;
- to exercise a continuous investigation of current expenditure and unit costs;
- to see that books of accounts are maintained in accordance with statutory/commercial requirements;
- to consider cost centre-wise operating statements and periodical statements of Income, Expenditure and Accounts;
- to examine from the cost and financial point of view all schemes involving expenditure and study cost benefit analysis and viability of the scheme;
- to supervise the methods of internal cost and financial control;
- to examine all financial changes of contracts;
- to examine all policies involving finance;
- to consider the financial basis of all arrangements with other authorities for the treatment of patients;
- to monitor investments;
- to keep a watch over expenditure and loss of revenue;
• to have a watch over fixed assets, minor and expendable equipments and to ensure proper maintenance of books;
• to ensure safety of cash, stores and other valuable items, proper purchases, correct level of inventory, proper consumption of materials, elimination of unnecessary wastage;
• to review scrap and sale of scrap;
• to review utilisation of beds, services, machines and equipments;
• to set up cost analysis system to measure cost effectiveness;
• to fix priorities of expenditure, if need be;
• to evaluate tasks and performance;
• to see that internal resources are generated;
• to see that data planning is generated;
• to use various techniques like break-even point,
• to co-ordinate for improving efficiency of the organisation;
• to see whether costs could be contained by self-discipline comprising humanism, morale and efficiency and by financial discipline consisting of capital controls, utilisation controls and budget controls; and
• to achieve efficiency, effectiveness and improvements with limited resources, which result in maximum productivity by utmost values/utilisation.