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Mcom Research Report – 50% Component

FINANCIAL MANAGEMENT CONTROLS IN THE SOUTH AFRICAN PUBLIC HOSPITAL SECTOR

By

ANDREW JONES

Supervisor: Ms Penelope Cummins (MA MSc MA)

50% Research Report

Submitted in partial fulfilment of the degree of:

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CHAPTER 1 – BACKGROUND, PROBLEM AND PURPOSE STATEMENTS AND IMPORTANCE OF RESEARCH

1.1 BACKGROUND TO THE STUDY

The focus of this study is the financial management, internal control systems and the effective implementation of internal control systems over annual budgets and the spending in public hospitals in South Africa.

The chief executive officers (CEOs) of public hospitals in South Africa are, in terms of section 36(1) of the Public Finance Management Act (PFMA) of RSA No. 1 of 1999 (as amended), the accounting officers of their respective hospitals. As such they have many responsibilities, some of which specifically relate to the management of the hospital budget.

The PFMA addresses the range and scope of financial and control systems that should be implemented in all public bodies in South Africa. It is effectively the public sector equivalent of the Companies Act no. 61 of 1973 (as amended), which sets out the legislation specific to private and publicly listed companies. The PFMA has contributed to health system reform in South Africa by emphasizing the importance of control systems and probity as well as setting out the financial management and accountability regulations with which public institutions are expected to comply.

This research investigates the extent to which the CEOs are in a position to meet the PFMA requirement in that they are able to control their budget, and to ensure that the hospital does not either under or over spend its budget by more than 2%, as per section 25(5). Secondly, it seeks to understand what delegated authority has been given to the CEOs. Thirdly, it attempts to assess what management control systems have been implemented by the CEOs' in order to assist them in effectively and efficiently managing their budgets, and fourthly it seeks to assess whether these controls are effectively ensuring that the information available from these systems is audit- worthy in terms of

the expectations of the Auditor General. Public hospitals are financed mostly through taxes and so the public has the right to expect value for money.

Since as far back as 1977, the Auditor General in developed countries such as Canada and the United Kingdom has included value for money (VFM) auditing as one of their tools in assisting the respective public sectors (Morin, 2001, p100). As well as undertaking financial audits, auditors are also required to evaluate the extent to which the management of the public organizations is economical, effective and efficient (Morin, 2001, p101). In Britain, the National Audit Office, the Audit Commission and the Quality Commission are all public audit bodies with specific responsibilities for auditing aspects of financial and VFM provision in hospitals and other National Health Service bodies. The VFM studies have included audits of accident and emergency services, procurement and supplies and community pharmacy, to name a few examples (Audit Commission 2001, 2002, 2009 and 2010).

The National Department of Health (NDoH) in South Africa is also concerned that hospitals operate in an efficient and transparent manner, and in 2008 it began to develop a set of national core standards for hospitals (NDoH, 2008). These standards were distilled from the existing standards and requirements in policy documents and legislation already in place in South Africa. These core standards embody the performance expectations with which hospitals should comply in order to guarantee effective service delivery.

The researcher was a team leader in the core standard appraisal process in June and July 2008, and has aligned his expectations in this report on the requirements of the core standards, so as to further add value to the process already started by the NDoH. Internationally this process has already developed itself over more than three decades, and although South Africa is late in implementing a means of assessing hospitals on how their funds are spent, in a hope of ensuring value for money, this appraisal process can be viewed as a step closer to this being achieved.

A key reason for the focus in this study on financial management in public hospitals in South Africa is that these organisations form a significant component of public spending. They use up the majority, nearly 70%, of the National Health Budget, which, since 1994, has consistently hovered between 10% and 13% of total government annual spending, or 3.3% of Gross Domestic Product (GDP). Many of the organizational and probity issues raised in this study are not unique to the Health Service, so this research is also a case study of financial management in the public sector in general.

CONTEXT

1.2 THE PFMA

The Public Health Service in South Africa is subject to GRAP (Generally Recognised Accounting Practice) and to the provisions of the Public Finance and Management Act of 1999 (the PFMA). Department of Health has not yet adopted the accrual basis approach within GRAP but should be completely compliant, according to National Department of Health, by 2012.

The basis for this study is derived from the Public Finance Management Act RSA No 1 of 1999 as amended (PFMA). It states that every constitutional institution, which includes public hospitals, must have an accounting officer (Section 36(1). Furthermore the CEO of the constitutional institution must be the accounting officer for that institution (Section 36(2) (b).

The first responsibility of the CEO as accounting officer is to create and maintain effective, efficient and transparent systems of financial and risk management and internal control (Section 38(a) (i)). In addition, a system of internal audit must be established under the control and direction of an audit committee complying with and operating in accordance with regulations prescribed in terms of section 76 and 77 of the PFMA (Section 38(a) (ii)). The regulations stated in section 77 of the Act discuss the independence of the audit committee, and require that the majority of its members should not be in the employ of the Department of Health. The balance of the accounting officers' responsibilities revolve around procurement, capital projects, use of resources, cash

management and collection, safe guarding and the maintenance of assets. Other duties include the managing of contractual obligations (Section 38 (f)), fraud prevention (Section 38 (g)), human resource management (Section 38 (h)), budget responsibility and reporting responsibility to Provincial and National Government (Section 39). Finally, accounting officers are responsible for delegating responsibilities to officials within the public hospitals themselves (Section 44).

Provincial governments are required to formally, in writing, delegate authority down to the CEO; ensuring they can effectively manage their budget in accordance with this legislation (PFMA, Section 44). This delegated authority should entail that the CEO can be held accountable for unauthorized expenditure as well as for over or under expenditure that impacts negatively on effective service delivery. The PFMA requires the accounting officer to ensure that effective systems of control are in place and that these are monitored by an internal audit committee on an ongoing basis (Section 38 (1) (a)). But is this the case within public hospitals in South Africa?

Consistently qualified audit opinions in the Department of Health indicate an unexplained absence of controls over spending, ineffective systems for ensuring transparency and accountability, and senior management that frustratingly are not able to solve the problems they face (Auditor General 1994 & 2006). This research seeks to map the nature and extent of the problems specific to public hospitals.

1.3 HISTORY OF PUBLIC HOSPITAL SPENDING IN SOUTH AFRICA

During the apartheid period there was an enormous inequality in hospital spending between 'white' and 'black' areas (Benatar, 1997; Race Relations Survey, 1994/5). Ideally, the new, democratically elected government should have required the National Department of Health to reassess hospital spending entirely, and to redistribute the Health Budget equitably in South Africa, especially developing those areas which were previously neglected. Evidence from budget summaries across various provinces suggest that this is still a work in progress in 2009, and that the Health Department is still struggling in this regard.

According to a report commissioned in June 1994 by the African National Congress (ANC, 1994a), entitled 'Preparing to Govern', the Pretoria-Witwatersrand-Vereeniging (PWV, now roughly equivalent to Gauteng) actual spending was R300 million over the amount budgeted in the 1993/4 financial year. The document went on to state that the overspending was 223% higher than in the 1992/3 financial year, and that this was mostly due to inefficient management (Race Relations Survey, 1994/5) The ANC was therefore faced with a drastic need to expand the scope and coverage of the Health Budget, facing a reality that its funding and the effective managing of funding in the early 1990's was already constrained.

Fifteen years later and funding of government hospitals as well as effective control over how government hospitals spend still pose a problem to Treasury. For example, for the period 1 April 2006 to 31 March 2007 (Gauteng Health information session, 2007) hospitals within the Gauteng Province overspent by R531 million when total expenditure is compared to the actual adjusted budget. This amount represents overspend of 16.4%. The public hospitals within this province comprise the large academic hospitals, the medium sized regional or district hospitals, and small rural hospitals, with annual budgets ranging from R11 million to R1.5 billion (Gauteng Health information session, May 2009). This indicates that the problems that existed in the early 1990s have continued into the current decade, with no sign of improvements.

In 1994 the ANC released the National Health Plan (ANC, 1994b) and within this plan the three key objectives were: firstly, to encourage and develop comprehensive health care practices that are in line with international norms, ethics and standards, secondly, to introduce management practices that is aimed at efficient and compassionate health care delivery and thirdly, to ensure respect for human rights, as well as accountability to the users of health facilities and the public at large.

Achieving the objectives set out in the ANC Health Plan meant that authority over, responsibility for, and control over funds should be decentralized to the lowest level

possible that is compatible with rational planning and the maintenance of good quality healthcare. In addition, appropriate and reliable data would be systematically collected and analyzed as a part of a comprehensive health information system essential for NHS planning and management purposes.

It was only in terms of the Health Act of 2003 (RSA No 61 of 2003) that the role of hospital CEO was created, and that it became legally possible to appoint hospital chief executives whose base training may be in management or finance rather than in medicine. Until then, South African hospitals worked on the model used by Florence Nightingale, of a triumvirate of doctor, nurse and administrator running the hospital, with final authority being vested in the doctor, the medical superintendent. In most developed countries, an increased emphasis on economy, efficiency and probity required a greater emphasis on financial and general management skills (Llewellyn, 2003, p292).

1.4 THE INSTITUTION FOR WHICH A SOUTH AFRICAN HOSPITAL CEO IS RESPONSIBLE

South African public hospitals range very widely in size and in function. Acute hospitals range from Tertiary/quaternary institutions with up to 2800 beds down to Level 1 or district hospitals, which are part of the primary care system, and which may have as few as 48 or whatever beds.

Table 1-1 – Levels of hospital in South Africa in 2008/9

NUMBER IN SA	NUMBER IN SAMPLE	LEVEL OF HOSPITAL	DESCRIPTION
9	2	Tertiary / Level 3	Acute general hospital with super-specialist services
66	8	Regional / Provincial / Level 2	Basic specialties only
269	27	District / Level 1 (Part of primary health care system)	Staffed by doctors without specialist training
84	3	Specialised	Acute Psychiatric, TB or other step down care

(Source: National Department of Health 2008)

Tertiary hospitals can undertake the most complex treatment and surgery. They are expected to have a full range of specialty and sub-specialty staff and equipment.

Specialty teams are led by consultants who are specialists or sub-specialists in their discipline. Although the tertiary hospital usually also provides general acute care for its local population, it provides specialist care to a wider population.

In South Africa, a level 2 hospital is expected to have consultants only in core specialties, such as general medicine, surgery and gynecology. It serves as a local referral hospital for the clinics and Level 1 hospitals for which it is responsible. Patients requiring more complex care are referred upwards to Level 3.

The majority of hospitals in South Africa are Level 1, district hospitals, which support the clinics in their area, but which are not expected to be staffed by doctors with post-basic training. There are more than 260 level 1 hospitals in South Africa, ranging in size from 30 to 450 beds. They are part of the primary health care system and support the clinics in their local catchment area.

The size of a hospital is not necessarily an indicator of the complexity of its caseload, nor of the range of services which it supports. In the Western Cape for instance, it is the current provincial policy to downgrade almost all hospitals to Level 1 status, regardless of the size of the population which they serve or of the complexity of the local disease pattern (Western Cape Department of Health 2003, 2007).

The specialist hospitals, mainly TB and psychiatric hospitals, also range in size and in budget, but they have a much smaller budget relative to bed numbers compared to an acute hospital.

1.4.1 Number of approved beds and its correlation to the size of annual approved budget

Since 1994 the individual hospital budgets have generally remained historically based, consequently, some of the historical inequalities that evolved through the Apartheid era have remained. This means that hospitals in the same province may receive budgets that are not comparable, even if their size and level of service is similar. Table 1-2, below,

shows the range in budget and bed size at each level of facility among the hospitals appraised in this study.

Table 1-2 – Range of annual budgets & number of approved beds (Sample Specific)

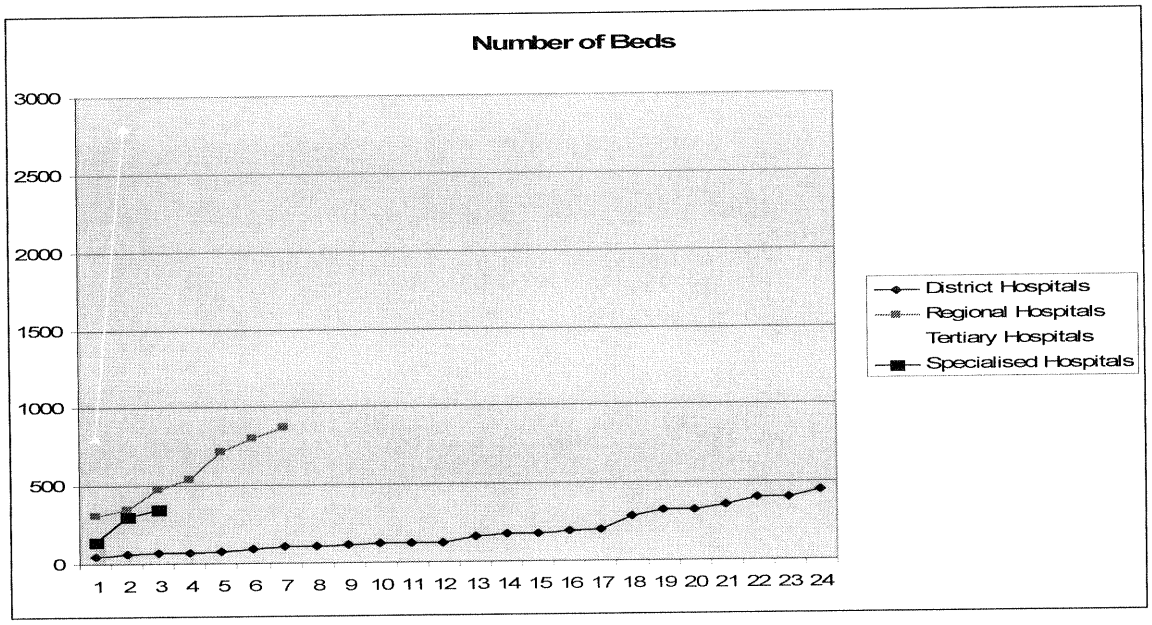
LEVEL OF HOSPITAL	RANGE OF ANNUAL BUDGET		RANGE OF BED SIZE	
Tertiary / Level 3	R752 million	R1.1 Billion	802	2800
Regional / Level 2	R81 million	R353 million	312	870
District / Level 1 (Part of primary health care system)	R16.9 million	R322 million	48	450
Specialised	R11 million	R38.5 million	141	350

Source: Appendix 1

Graph 1-1, below, shows the variation in hospital size as measured by bed numbers in the hospitals sampled. The largest hospital in this sample is Chris Hani Baragwanath (CHB), the Level 3 facility on the outskirts of Soweto, which is one of the largest hospitals in the world. It serves as the local hospital for Soweto, so its workload includes Level 1 and Level 2 services as well as the more highly specialized services of a Level 3 Academic hospital.

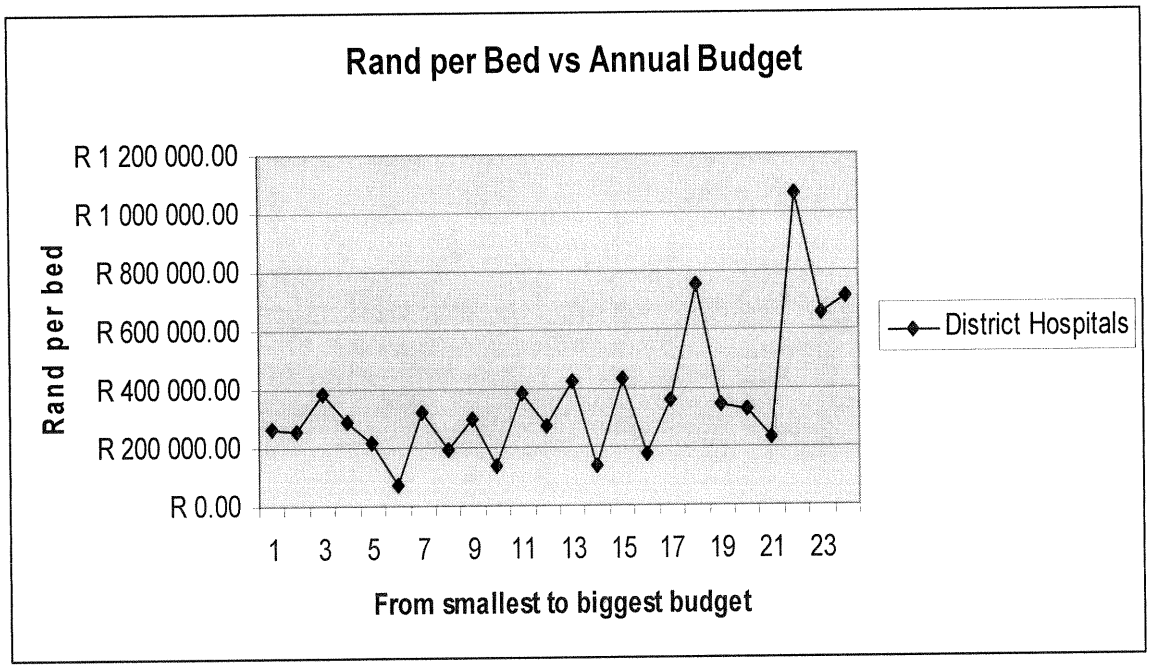
Because of the vast distances in South Africa, coupled with the low income of the majority of the rural population, there are many rural hospitals which are so small that their total budget and workload is smaller than that of a single ward in an urban hospital. The smallest hospital in this sample is a remote rural facility with only 48 beds, and a budget of R18.3 million. The hospital with the smallest budget has 64 beds and a budget of R16.9 million.

Graph 1-1 – Bed numbers at 40 South African Hospitals

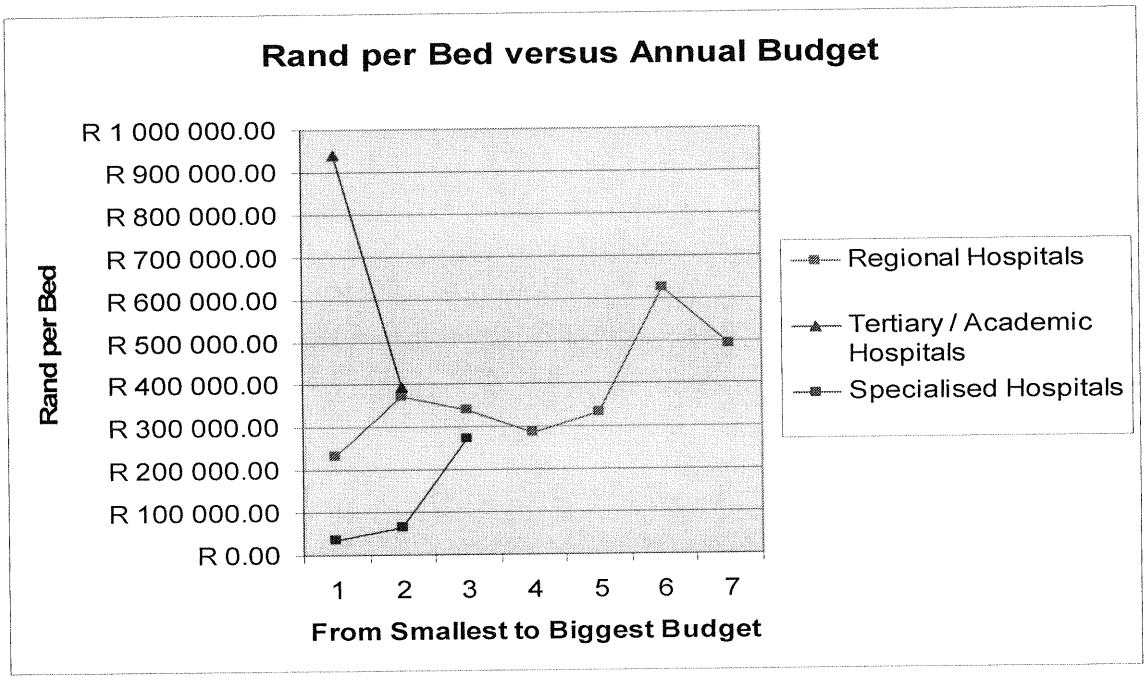


Source: Hospital Annual Reports from 5 provinces

Graph 1-2 – Variations in Rand per bed at 27 South African District Hospitals analysed in Phase 1



Graph 1-3 – Variations in Rand per bed at the study sites not shown in Graph 1-2. Includes 2 Tertiary hospitals, 8 L2 (Regional) hospitals and 3 Specialised Hospitals



Hospital budgets are not standard within or between provinces relative to activity, bed numbers or population served. The budgets at the 40 hospitals sampled ranged from R16.9 million to more than R1.2 billion, yet this variation was not consistent with the variations in bed numbers, even within provinces, for hospitals providing the same Level of care (i.e. Level 1, District; Level 2, Regional or Level 3, Tertiary hospital). For instance, Graph 1-3 below shows that there is considerable difference in resources per bed between the two Tertiary hospitals, in the same province. Similarly, graph 1-2 shows the resources per bed at District hospitals (Level 1) range from R72 500 to R1.07 million.

Much of the budget variation between hospitals of similar size and responsibility is attributable to the weak adjustment of current budgets relative to the historic allocations dating from apartheid days, when hospitals for "white" users were better resourced than those for "coloured" or "black" communities. In their discussion of budget cuts and staff shortages in South African hospitals, Von Holdt and Maseremule (2005 p245) note that Chris Hani Baragwanath Hospital, the tertiary hospital on the edge of Soweto, still suffers from this legacy: it "fairs worse on all measures in comparison with the formally white

Johannesburg General Hospital. While the former has almost 2.5 times the beds of the latter, its expenditure is only 14% more".

Von Holdt and Maseremule (ibid) remind us that while the overall budget for health has remained fairly constant since 1996, there has been a redistribution of resources from tertiary level to primary level health care, and from well resourced provinces to the more rural provinces.

Where there has been a redistribution of budget between hospitals, it tends to have benefited Level 1 hospitals, which are part of the primary care system, at the expense of Level 3 hospitals, where spending is still greatest. However, this redistribution has not always been quick to take account of changes in population and health-need in particular localities. The National 'Rand per patient equivalent per day' formula, which takes some account of outpatient attendances and which has been used to some extent in the redistribution of resources, has not been updated since 2002. National Treasury has, during 2009, begun the process of redefining the formulas used to calculate hospital budgets; however this process is still very much a work in progress. Currently for a level 3 academic hospital, the cost per patient equivalent per day is set at R1877. However a team at CHB hospital calculated the costs to be closer to R2400 per day in 2008, so this calculation was performed in 2009 it would be undoubtedly higher due to inflation (Interview with CEO during Core Standards appraisal process, June 2008).

1.5 PROBLEM STATEMENT

Public hospitals in South Africa find it challenging to fully achieve the strategies within their annual operational plans. The problem often lies in the lack of implementation rather than the lack of strategy. More specifically, poor budgetary control systems have resulted in the inefficient allocation of resources, as well as an inability to operate within the constraints of annual budgets.

From a completely different perspective, one also asks whether those public hospitals which are managing to operate within the budget allocated to them are perhaps only

achieving part of the strategies they set out to achieve. It appears likely that meeting one's budget targets does not necessarily mean meeting one's strategic objectives.

1.6 PURPOSE STATEMENT

The purpose of this study is to identify and evaluate the management control systems (MCS) within public hospitals in South Africa, with a view to gaining a better understanding as to why the budgetary control systems are not being properly implemented. More specifically, the following research question will be addressed: are suitable management control systems in place to ensure the successful planning and implementation of budgets?

1.7 IMPORTANCE OF THE RESEARCH STUDY

It is of vital importance to the functioning of the public hospitals in South Africa that the CEOs understand what is required of them in terms of the PFMA, as well as what their responsibilities are in terms of them being the accounting officer of their specific hospital. The Department of Health has consistently focused on strategies to improve the quality and effectiveness of the services delivered through South Africa's health facilities. This is not possible to achieve without effective management controls ensuring an understanding of the true costs incurred, as well as ensuring that documentation is available to substantiate these needs.

The Auditor General has issued audit disclaimers or qualified audit opinions to the Department of Health for the past eight years and more. In many cases, the paper trail one would expect is absent or only partially complete, and as a result the Auditor General is unable to express an opinion because the financial statements do not accurately represent how the Department spent the money (Vitsha, 2003). These disclaimers indicate the evidence of corruption within the health sector in South Africa, which according to Vian, 2008, p83, is a pervasive problem which is having negative impact on health status and social welfare. This research is aimed at identifying where the gaps in the systems are and what is required to fill them so as to provide these CEOs with a starting point to

improving the management control systems, thus aiding them in acting in conformity with the PFMA.

1.8 STUDY OUTLINE

Chapter 2 focuses on the academic literature, both local and international, in order to better understand the public hospital management issues globally and provide insight into both lessons learnt and issues uncovered. The literature illustrates how management in public hospitals have been faced with similar challenges for decades, some of which have been solved but these solutions have at times been short lived due to the complexities in effectively controlling the spending of public funds within this sector (Transparency International, 2006).

Chapter 3 will then discuss the research methodology used in this study, including the importance of the 3 phase approach used in the study in order to achieve triangulation.

Chapter 4 discusses the findings from phase 1 of the study, in which budget information from 40 public hospitals and internal control systems was analysed. In order to begin the process of triangulation - Chapter 5 then confirms what internal control weaknesses exist through the analysis of 20 Auditor General Irregularity Reports.

Chapter 6 finishes off the triangulation of findings through the visiting of nine public hospitals in five provinces in South Africa. The visits included both a visit to each hospital as well as an in-depth interview with the CEO, in which the researcher questioned the CEO on how compliant their hospital is with respect to the National Core Standards. Finally conclusions and recommendations are made in Chapter 7.

CHAPTER 2 - LITERATURE REVIEW

Over the past twenty years financial management control within public hospitals has become increasingly important. This is not surprising when, according to Transparency International (2006) the world spends more than $3 trillion annually on health services and most of this is financed by taxpayers. Control over this amount of money demands resources, skills, efficiency, transparency and accountability.

Control or controls are seen with respect to this research project as one of the managerial functions within a public hospital. It is an important function because it helps in identifying errors and in take the corrective action required to ensure that deviation from standards are minimized and that the stated goals of the organization are achieved. Control in management means setting standards, measuring actual performance and taking corrective action and thus ensure that accountability measures within public health are effective (Brinkerhoff, 2004 and Di Tella, 2001). Thus, control comprises these three main activities and this research is focused on whether the systems applied within management structures of government hospitals are able to ensure this level of control is possible (Brinkerhoff, 2004).

Within the literature it is clear that the issues faced by public hospitals in South Africa are not unique to the South African context. Rethelyi, Miskovits and Szocska (2002) noted that organizational reform of public hospitals is part of the health policy agenda worldwide as a reaction to inefficient and low quality of performance in public institutions.

So in the past twenty years, due to pressure from the hospital owner, namely the state, there has been an international trend for public sector hospitals to begin introducing private sector management techniques into their management systems (Nyland and Pettersen, 2004). These reforms place accounting information as being the central element in control systems (Nyland and Pettersen, 2004).

2.1 ORGANISATIONAL STRATEGY WITHIN THE HEALTH SECTOR

Llewellyn and Tappin (2003, p961) suggest two reasons why organizational strategy has become increasingly important in the public sector. Firstly, 'strategies' focus the organisation through identifying the aims, outputs and outcomes that an organisation wishes to achieve as well as who is responsible for each outcome. This ensures transparency, and being transparent secures on-going funding. Furthermore, as 'strategies' are being produced vision is created and this vision potentially attracts additional funding agencies. Secondly, government encourages strategy as it places more responsibility on management in the acquisition of resources, and achieving results. It is also suggested that governments desire more control over the professionals that dominate the public sector, whilst wanting these professionals to become more responsible for the outcomes achieved.

This is especially important to health departments in that a lack of transparency implies gaps within the systems of control and gaps lead to abuse, corruption and mismanagement. "The diversity of health systems worldwide, the multiplicity of parties involved the paucity of good record keeping in many countries, and the complexity in distinguishing between corruption, inefficiency and honest mistakes make it difficult to determine the overall costs of corruption in this sector around the globe. The stakes are high and the resources precious, and money is being lost to corruption & inefficiency rather than being used to buy medicines, equip hospitals or hire more medical staff" (Transparency International, 2006, page xvi).

There are particular characteristics which make all health systems, public or privately funded, in rich and poor countries, vulnerable to corruption. Regulators, funders, health care providers, suppliers and consumers face a complex mix of opportunities associated with the health system that lead to corruption. They include:

- Embezzlement and theft, either from health budget or user-fee revenue
- Corruption in procurement
- Corruption in payment systems
- Corruption in pharmaceutical supply chain

- Corruption at the point of health service delivery

(Transparency International, 2006, p14)

From a South African point of view the PFMA has created an expectation that similar reforms, signifying transparent systems of control, are being implemented (PFMA, 1999). The CEO is responsible for the implementation of management control systems in order to assist with meeting their objectives and strategies within the budget framework made available to them. Even if expenditure cannot be contained within this budget, then effective management controls would assist management in the verification of this reality (Llewellyn, 1998). The creation of verifiable information allows management to argue for additional funding. Reliability of information helps to ensure that these requests can be reasonably justified. The CEO, being responsible for this, needs to ensure that the provision of appropriate budget and accounting information is part of the management control system.

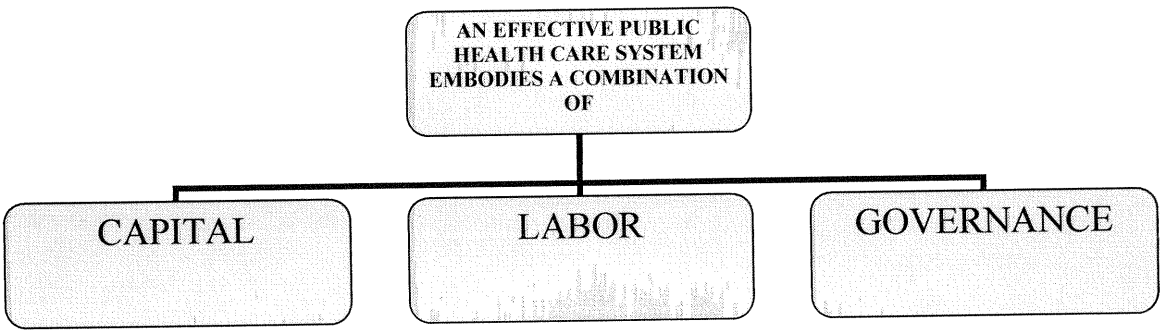
2.2 PUBLIC SECTOR REQUIRES ACCOUNTABILITY AND GOOD GOVERNANCE

The accountability and efficiency of management, as well as the effectiveness of management control systems, is growing in importance within public hospital structures worldwide and this has lead to widespread public sector reforms (Nyland et al., 2004). These reforms have been reasonably successful in some countries while remaining problematic in others (Kurunmaki, 2004; Rethelyi et al., 2002; Nyland et al. 2004).

The problems of public hospitals internationally have also been compounded by poor managerial practices and weak financial control systems in the system (Kurunmaki, 2004). Furthermore, inefficient hierarchical management structures, combined with medical professionals' resistance to change, have commonly resulted in irresponsible resource management (Jones, 2002). Frequently, a culture of blaming has developed, in which no party felt the need to take responsibility for their actions (Rethelyi et al., 2002).

Maureen Lewis's World Bank working paper in 2006 was a key reference to this research. Her report collated and evaluated studies, undertaken internationally in both developed and developing countries, of weaknesses in systems of control in health care. Many studies were included in her research, covering a period of up to 10 years. Her work supports the findings in the present study, and provides crucial insight into international issues facing public health.

There are unique characteristics arising from market failures described in the World Bank study which are specific to public hospitals around the world. Firstly, the imbalance between available information and the challenges associated with medical doctors acting as agents to patients, secondly, the high costs imposed by medical aid companies leading to an increased number of people without medical aid support. These mostly comprise those in need of health care, being the chronically ill, the poor, and those having experienced catastrophic illnesses. Thirdly, the moral dilemma of over-consumption by the wealthy few able to afford a private medical aid, often at the expense of effective health care for the remainder of the population (Lewis, 2006, p4).



Graph 2-1 Andrew Jones (2009) - Graphical representation of Lewis (2006)

Lewis (2006, p5) describes public health care systems comprising a combination of capital, labor and governance. Understandably, increasing either the availability of labour, which encompasses management, clinicians, nurses and other staff; or capital, which includes infrastructure, equipment, and other fixed assets as well as financing; can improve outcomes. However the extent of effective governance will enhance or dampen these effects.

Within public health funds are available to ensure the relevant posts are available and policies do exist to ensure the purchase of appropriate drugs through appropriate procurement practices, however, but this only constitutes inputs. Complexities, according to Lewis, 2006, p6) within this sector are focused around implementation and these measures include:

- Ensuring staff perform in accordance with intended outcomes
- Ensuring availability of drug and medical supplies
- Ensuring regular funding transfers which are timely and within regulated timetables
- Improving the state of physical infrastructure
- Ensuring the existence of appropriate inventory as well as functioning equipment
- Ensuring the completeness and existence of patient records

"All these measures show whether health systems are meeting minimal efficiency and quality standards" (Lewis, 2006, p6).

Health systems require efficiency in financial resources, human resources, and supplies. As the public health sector is responsible for health and wellbeing of people, it is expected that service delivery happen in a timely fashion and that it is distributed spatially throughout a country. Lewis, (2006, p6) suggests that this requires a comprehensive "system" that works systematically in distributing resources, processes information and acts upon it. The system should motivate service providers' to act appropriately and motivate staff to want to do the right thing. Training and good governance is very important if this type of "system" is to become implementable. Responsibility leads to accountability and management need to implement accounting controls to ensure reliability. However, change is often difficult to accept (Vian, 2008), and often even harder to implement. This also implies that senior management needs a sound knowledge and understanding of financial management in order to implement this type of "system".

Kaufman and Kraay (2003, p2) defined good governance as the capacity of government to formulate and implement sound policies, manage resources and provide services efficiently and hold government accountable for their actions. Kaufman, Kraay and Mastruzzi (2005) defined the indicators of governance which were mentioned above; however Lewis (2006) focused on three indicators as being relevant to health. These were voice and accountability, government effectiveness, and control of corruption and will be discussed in more detail below.

Voice and accountability represent the external accountability, the effectiveness of citizen and institutional influences on government actions. Government effectiveness means the efficiency of public servants, roles and responsibilities of local and regional governments, including administrative and technical skills of government, effectiveness of policy and program formulation, governing capacity and the effective use of resources (Kaufman, Kraay and Mastruzzi, 2005; Lewis, 2006; Vian, 2008). Lewis (2006) adds that decentralization that lacks funding and local management undermines potential management effectiveness.

Control of corruption includes dealing with incidents of nepotism, cronyism, and bribes among civil servants, and irregularities in public purchasing and oversight. It also includes the techniques and extent to which government manages corruption. Good government exists when the incentives for and accountability of public servants is managed effectively. (Lewis, 2006) Examples from Mozambique, Nigeria and Uganda suggest that corrupt practices are difficult to identify, separate or control, and that this is due in part to the level of mismanagement, poorly understood performance expectations as well as no accountability at any level (Lindelow et al, 2004; Das Gupta et al, 2003; McPake et al, 1999). One is however left with the question, is poor service delivery a direct consequence of corruption or of mismanagement, or a combination of the two?

2.3 PUBLIC FUNDING AND THE LEAKAGE OF PUBLIC FUNDS

Bureaucratic problems, corruption and mismanagement lead to inadequate availability of public funds at the point of service delivery (Lewis, 2006). Dehn et al. (2003) describe

this as leakage of public funds. Lewis (2006) provides examples of evidence of leakage from Nigeria, Papua New Guinea, Rwanda and Senegal. However neither the extent nor the precise sources of all leakages can be determined. Leakages may include delays and bottlenecks in budgeting and in spending, and in supply management, poor record keeping and underutilization of audits. Incomplete paperwork complicated efforts to track financial flows and this limited the evidence and comparable data these countries could produce (Lewis, 2006, p13).

2.4 MISMANAGEMENT IN HEALTH CARE SERVICE DELIVERY

Lewis (2006) concludes that within public health systems, both irregularities and poor governance stem from poor management, and that the functions being managed badly include human resource management and supervision as well as basic systems of control, such as procurement and the logistics around the movement of drugs, efficiency of fiduciary transfers, input availability, and satisfaction of the target population. Ultimately hospitals are still managed by doctors or nurses who are often are not trained to effectively perform their job.

The lack of good performance management through rigid civil service rules can often lead to low productivity or outright abuse (LaForgia et. al., 2004) and this coupled with low wages often leads health workers to seek additional employment outside government (Das Gupta, 2003). Another study in Nigeria showed that the greater the lag in paying salaries, the more likely it is that health workers will engage in stealing and selling pharmaceutical and other items from the hospital, and that they will seek other employment in private sector parallel. This suggests that family survival plays a role in both absenteeism and low productivity (Khemani, 2006). Evidence from a number of countries, including Mozambique, suggests that vague and poorly understood policies, uneven recordkeeping and minimal use of such information contribute to poor management (Lindelow et. al., 2004). Despite all the chronic weaknesses within the systems of control, active management is critical to performance and improved effectiveness. Lewis (2006) finds that the following four factors are important ingredients

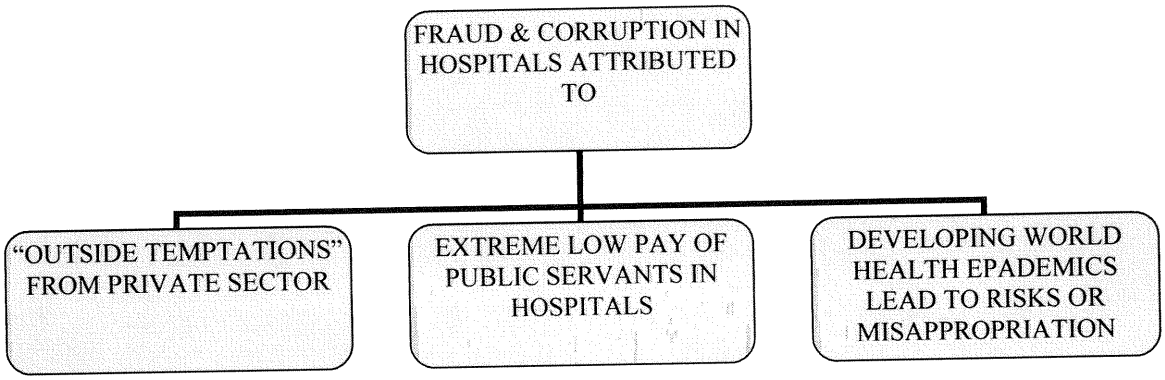
to ensure effective health care delivery: the availability of funds, hiring and deploying staff, maintaining basic record systems, and tracking facility performance.

2.5 STAFFING AND HUMAN RESOURCES WITHIN PUBLIC HEALTH

The effective and appropriate managing of public hospitals requires, the presence of sufficient, appropriately qualified staff is a key ingredient of effective service delivery, so human resources and their management are both vitally important. Eskeland et al. (2004) warn that absenteeism poses a chronic and often unmeasured problem in publicly financed health care in developing countries, and this can seriously limit patients' access to services. Capturing the extent of this problem among public service staff is made difficult by the lack or incompleteness of staff attendance records (DiTella and Savedoff, 2001). "Unproductive or absent workers who do not receive any punishment for substandard performance, and whose promotion and pay remain the same as those with better performance, undermine morale and reduce output and this leads to poor performance" (Lewis, 2006, p20). Another staff management issue relates to the extent to which public officials collude with each other for financial gain, for example the World Bank in 2001 reported that in Bosnia and Herzegovina 35% of officials surveyed said that health colleagues who refuse bribes face retribution.

2.6 MANAGEMENT AND CORRUPTION IN PROCUREMENT AND SUPPLIES

Human resources are only fully effective if the necessary drugs and supplies are also available at the point of patient care. As with staffing, their absence indicate underfunding, poor management or corruption. Vian (2008) found that nearly all qualitative studies of corruption in procurement have shown that quality and availability of goods are synonymous with one another. Cohen, Mrazek and Hawkins (2007, p448) indicates that the biggest issues lie within procurement, specifically in the lack of performance monitoring, quality monitoring, audits and uncontrolled political interference; and in distribution where inventory management, security and information systems were particularly bad. Cohen et al (ibid p448) concluded that the lack of controls within public hospitals resulting in the availability of crucial drugs being problematic and suggested that this can be seen as an important indicator of ineffective management.



Graph 2-2 – What is fraud and corruption in hospitals attributed to? (Lindelow et al, 2003)

Instances include Ethiopia, where focus groups explained that the stealing and re-selling of public sector drugs to the private sector was attributed to 'outside temptations' and the extreme low pay of public servants (Lindelow et. al., 2003). Another example is Nigeria, where mismanagement resulted in 28 PHC facilities not receiving any drugs from the federal government in two years. Lewis (2006) discusses a World Bank report by McPake, Asiime and Mwesigye in 1999 that stated that this was common to more than half the health facilities in both Lagos and Kogi. The report discussed another case in Uganda, where high demand drugs, such as those used to treat malaria, were the least available because health workers and Health Unit Management Committee members expropriated them (McPake et. al., 1999). Both Vian (2008) and Lewis (2006) conclude that pharmaceutical fraud is widespread; it ranges from the importation of substandard medications to the repackaging of drugs, substituting lower cost or quality medications, to the pilfering of drug supplies at hospitals or clinics. The culprits in these frauds are rarely identified, partly because key and important individuals may be party to them, and also due to ignorance of stock and procurement control mechanisms, lack of regulations, and weak enforcement.

Health, being an essential service, requires a constant supply of goods and services to complement the skills and infrastructure investments of government. To safeguard these one requires clearly articulated policies and procedures. Ensuring adherence to these

policies and regulations and the consistent enforcement of rules should discourage illegal behaviors from occurring (Lewis, 2006). Both tendering and contracting processes for construction, as well as the purchase of supplies, offer a rich source of returns for corrupt officials through kickbacks or over-invoicing (Savedoff, 2007, P7).

Further examples within the literature include Argentina, Bolivia, Columbia and Venezuela in which overpayment of supplies in public hospitals clearly pointed to a combination of gross mismanagement and corruption (DiTella et. al., 2001). In Columbia, in 2001, an estimated 11 percent of costs could have been saved if accepted public tendering rules had been followed (Giedion et. al., 2001). Also in Argentina, when the health system transparency policy was introduced the prices of procured supplies dropped sharply and then rose again when the policy was no longer being enforced (Schargrodsky et. al., 2001). The major problem is that inappropriate management of the problem results in a lot of anecdotal evidence but very little hard evidence (Lewis, 2006; Vian, 2008).

2.7 THE CHANGING NATURE OF HOSPITAL MANAGEMENT AND THE GROWING NEED FOR GOOD GOVERNANCE

Hospitals, with their many different departments and functions, are very complex organizations. But internationally, researchers have found that the problems of running public hospitals are commonly compounded by poor managerial practices and financial control systems (Kurunmaki, 2004). Inefficient, hierarchical management structures combined with medical professionals' resistance to change have also contributed to irresponsible resource management (Jones, 2002).

These insights, together with the political imperatives towards increased economy, efficiency and transparency in the public sector, as well as the spread of New Public Management (Pollack et al 2004; Nyland et al 2004) have, since the 1980s, led to widespread management reforms in public hospitals around the world. These reforms have been more successful in some countries than in others (Kurunmaki, 2004; Rethelyi et al., 2002; Nyland et al. 2004).

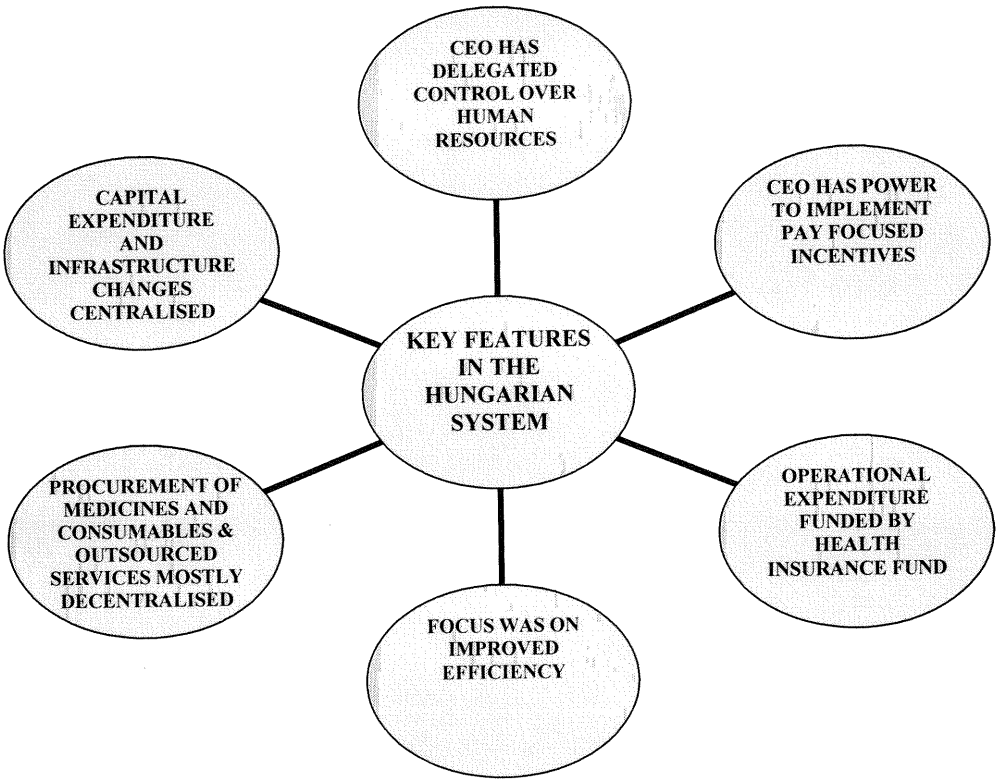
The Finnish public sector saw a willing adoption of management accounting techniques by the medical professionals within the hospital structure. The key here seemed to be the involving of the medical professionals in the very early stages of the budget setting process. Management opted for a gradual shift to decentralized budgets and used management consultants to assist with training sessions and other seminars. Participants, at all levels within the hospital structure were encouraged to join or form networks of responsibility. These networks would work together and prepare the budgets and this was encouraged even if it meant more work for the operational manager. Management saw the encouragement of this commitment to teamwork crucial to the success of the reforms (Kurunmaki, 2004).

From these budgets, management was able to design control systems that could focus on both financial and non-financial measures. The achieving of targets became important to all involved, from both an operational and financial perspective. Networks were able to access the bookkeeping records on an ongoing basis. Training was available and encouraged, and comparability on a month by month basis became standard, ensuring that each unit attempted to stay within the budget framework (Kurunmaki, 2004). In conclusion, the success in Finland seemed to be the focus on gradual change and implementation, training, as well as a commitment to teamwork.

Hungarian government hospitals have gone through structural, regulative and financial changes in the 1990's due to dramatic politic and economic change. Government hospitals were managed centrally in the past, however in the 1990's the ownership control was transferred to the local government/municipalities, and the hospital structures became autonomous (Rethelyi et al., 2002).

Some key features of the approach in Hungarian public hospitals have been tabled below. Accountability in their system was important. However, some hospitals, such as, medical universities, enjoyed broad academic autonomy and this resulted in that management being irresponsible in the accumulation of debt. In summary, Hungary saw some success

as well as some failure with respect to the management controls of its hospitals. The importance of hospitals socially made management complacent (Rethelyi et al., 2002).



Graph 2-3 – Jones (2009) - Hungarian public hospital system characteristics

Improving efficiency seemed to be the focus, however, gradually one saw the funding to government hospitals decreasing and the overall debt caused by these hospitals increasing Capital investment required local government approval and this infrastructural development was never planned, making capital spending on government hospitals accidental and uneven. Procurement of pharmaceuticals and consumables, as well as outsourcing of services was hospital management responsibility within certain limits. Above these limits formal public bidding procedures were fixed (Rethelyi et al., 2002).

Nyland et al (2004) suggest that public hospitals in Norway could be seen as hesitant reformers. Norwegian public hospitals saw accounting, auditing and accountability systems introduced in the hope of gaining more relevant information, as well as enhancing efficiency and effectiveness. The capital investment budget and total salary

expenditure budget was centralized and the balance of the budget was delegated down the management structure to the individual sections within the hospital. The results showed delegated budgets overspending by 8%, which equaled 22 million Euros.

Clinical managers' adherence to budget limits at departmental level within the hospital was considered important, yet no negative effect on the evaluation of the clinical department managers' performance was noticed should a budget deficit occur. Budget deficits were seen as a means of getting more resources from the state and were effectively considered by the hospital staff as flexible budgets.

2.8 HOSPITAL MANAGEMENT IN THE NEW SOUTH AFRICA

2.8.1 ANC NATIONAL HEALTH PLAN

In 1994 the African National Congress released a National Health Plan for South Africa which included three key objectives: to encourage and develop comprehensive health care practices are in line with international norms, ethics and standards, to introduce management practices to facilitate efficient and compassionate health care delivery, and to ensure respect for human rights and accountability to the users of health facilities and the public at large.

In order the achieve these objectives, the Health Plan stated that authority over, responsibility for, and control over funds should be decentralized to the lowest level possible that is compatible with rational planning and the maintenance of good quality care. In addition, appropriate and reliable data would be systematically collected and analyzed, as a part of a comprehensive health information system essential for National Health Service planning and management purposes.

In 1999, a ministerial task team on decentralization recommended that cost centre management should be implemented in hospitals as a means of identifying and managing costs. It also proposed that performance management agreements should be instituted, and that Chief Executive Officers should be appointed, to strengthen the management capacity within hospitals. At that stage, it was hoped that by 2003 computer systems

would be installed in all hospitals creating conditions for decentralization of management as well as to improve the performance and efficiency in key expenditure areas (Boulle, Bletcher and Burn 2000).

All of these objectives harmonized with those of the Public Finance Management Act (PFMA) of 1999 (RSA 1999), which applies to all public institutions, including public hospitals. However, the findings of this research project indicate that key objectives of the 1994 Health Plan and of the PFMA have yet to be achieved.

2.8.2 DECENTRALIZATION OF AUTHORITY

2.8.2.1 INTERNATIONAL PERSPECTIVE

As far back as 1978 in policy documents such as the World Health Organization / UNICEF *Primary Health Care Declaration of Alma Ata* and then again in 1981 in the *Health for All be the year 2000* there has been an international awareness of the importance of primary health care and the involvement of community participation in planning and providing health services (World Health Organization, 1978, 1981). Another argument for the promotion of decentralization has been because of the dissatisfaction with the efficiency of centralized provision of public services. Akin et al (2005) suggest that greater autonomy in decision making by localized agents would remove layers of bureaucracy, decrease decision-making times as well as reduce information costs associated with diseconomies of scale. Evidence from a range of sources indicates that the promotion of primary health can be seen as incompatible with centralized systems of health care (Akin et al, 2005).

Akin et al (2005) argued for caution in decentralizing systems, particularly in countries without well-functioning democratic systems or mechanisms for community representation, warning that this could pose risks associated with higher degrees of corruption that the centralized systems. They conclude that decentralization is so well accepted that most of the literature on decentralization is focused on how to carry if out rather than on whether it actually increases social welfare. The move towards decentralization also points to the need for greater monitoring of expenditures and

budgets at sub-national levels of government, linked with measures of regional epidemiological profiles and costs of service delivery, in order to ascertain how decentralization impacts upon the health of populations (Akin et al, 2005).

2.8.2.2 A PLAN TO DECENTRALISE AUTHORITY IN SOUTH AFRICA

In 1996 the NDoH developed a policy document entitled 'A policy for the development of the district health system for South Africa' (Department of Health, 1996) that set out proposals for the development of a District Health System in South Africa. It stated (p7) that the "health district needs to be large enough to have the financial and management capacity to provide essential care, including environmental health services, emergency services and first level hospital care. It must contain all elements required for comprehensive primary health care services" (Department of Health, 1996: p7).

According to the NDoH's *White paper for the Transformation of the Health System in South Africa* (1997), the department must "provide leadership and guidance to the National Health System in its efforts to promote and monitor the health of all people in South Africa and to provide caring and effective services through a primary health care approach" (Department of Health, 1997: p1).

In terms of the White Paper, the provinces must establish a district health system and in particular roll out the Primary Health Care (PHC) approach in this system (Department of Health, 1997: p46). The White Paper continues by noting that the role of hospitals will be redefined in line with the PHC approach and that plans will be developed to rationalize public hospital services, facilities, staffing and capital investment.

The White Paper furthermore states that: first, decentralized hospital management will be introduced to promote efficiency and cost effectiveness; second, hospital boards will be established to increase local accountability and power; third, a targeted, efficient and equitable user fee system will be introduced and facilities will retain part of the revenue generated to encourage efficient collection and improved services; and fourth, hospitals

providing unique or highly specialized services will be treated as a national resource (Department of Health, 1997).

Subsequently, the preamble to the National Health Act RSA No 61 of 2003 states that this Act is intended to provide for a system of co-operative governance and management of health services, with national guidelines, norms and standards, in which each province, municipality and health district must address questions of health policy and the delivery of quality health care services. Also to establish a health system based on decentralized management, principles of equity, efficiency, sound governance and internationally recognized. It is intended to promote a spirit of cooperation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans (National Health Act preamble, 2003).

However having the legislation and policies in place is one thing, but ensuring that they are implemented is another problem. Internationally this implies that operationally hospitals almost always operate in contravention to at least some aspects of public policy, and even of legislation. The committed employees may accomplish satisfactory service delivery, but for others, Transparency International (2006) notes that finding ways to cheat the system is a primary preoccupation for many hospitals and other public sector staff around the world.

2.8.2.3 APPROVED FUNDING

All these objectives relating to improvements in health service delivery are limited by the availability of financial resources and so an understanding how much funding is provided is important. Is this funding adequate? Are the existing approved funds being utilized in an efficient, transparent and effective manner? In Abuja in April 2001, African Heads of States and governments pledged to allocate at least 15% of their annual budget to improvement in the health sector. This became known as the Abuja target (Abuja Report, 2001; Hickey, 2005).

Table 2-1: Ministry of Health budget (only) as share of total annual budget excluding debt payments (recurrent and development)					
	2001/2	**2002/3**	**2003/4**	**2004/5**	**2005/6**
The Gambia (DOSH only)	12.65%	10.62%	13.59%	13.25%	14.99%
Malawi	11.57%	10.06%	10.31%	12.91%	9.03%
South Africa	13.37%	12.71%	12.52%	12.17%	11.86%
Swaziland	6.47%	7.30%	8.71%	6.51%	7.42%
Cameroon	6.59%	6.59%	5.60%	4.98%	4.84%
Kenya	6.71%	7.80%	7.21%	6.84%	7.58%

(Hickey – 2005)

From the table above it is evident that the Abuja target is not yet a reality in Africa. South African health spend has remained fairly consistent at between 11.86% and 13.37%. For 2006/7, 2007/8, 2008/9 and 2009/10 the health budget in South Africa has hovered around 13%. To a reasonable person it would appear to be nonsensical to be throwing more money at a government department in South Africa that over the past 8 financial years has not received a clean audit report even once. This research will provide some insight into this dilemma.

2.9 THE IMPORTANCE OF VALUE FOR MONEY AUDITS AND AN INTERNAL AUDIT FUNCTION

The theory around value for money audits is that the Auditor General, through a review of the system within one particular aspect of organizational spending, will make recommendations to the management of that organization as to how the system can be improved, thus ensuring value for money. It is then up to the management of the facility being audited to decide on whether the must comply with the Auditor General recommendations (Morin, 2001). The Auditor General will then aim to reassess that particular area of spending every two to three years in order to record improvements.

In essence, value for money audits are a means for the external auditor to play a role in the internal audit process. The literature has shown where these audits have been successful in more developed countries such as Canada, United Kingdom and Australia (Morin, 2001). However Transparency International (2006) indicates that internal audit and the implementation of recommendations to improve systems of control are only as effective as the ability of the management to ensure effective implementation. For public hospitals in developing countries the human resource shortages and significant lack of proper training makes implementation of these systems of transparency difficult (Transparency International, 2006).

For effective implementation of the improvements identified in the VFM audit process, the Audit Commission believes that training is essential, as well as structured and understandable communication to all parties involved in service delivery (Audit Commission, 2009).

In April 2008 the NDoH introduced the Core Standards Appraisal Process in an effort to evaluate the performance of public hospitals across the country. This was a Presidential initiative aimed at developing core national standards, criteria and indicators, as well as the tools required for their assessment in health establishments. National standards are internationally recognized and are used as a way of establishing expected minimum safety standards required across a health system, as well as the desired best practice. Up to this point, hospital management expectations were detailed in broad policies and guidelines that were developed by numerous organizations, both public and private. These contributions were often in different formats and had different monitoring systems which made the task of performance assessment and benchmarking difficult (NDoH 2008).

Being a new initiative to the South African public health system, the process of evaluation was designed to facilitate dialogue, and in doing so improve the development of core national standards. A framework using seven core domains aligned with hospital management areas was used, namely: safety, clinical care, governance, patient experience

of care, access to care, infrastructure and environment, and public health. This initiative has been positively supported by hospital management across South Africa and is an important first step to ensuring value for money.

Value for money audits should be supported within each government hospital by an effective internal audit function. Internal auditing is defined by the Institute of Internal Auditors as an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes (IIA, 1999a).

Mihret et al (2007) argued that internal audit effectiveness was a result of four factors, namely, internal audit quality which implies internal audit team members within the internal audit office and their capability to firstly provide useful audit findings and secondly their ability to provide recommendations that would help raise management's interest. Secondly, management support with resources as well as a commitment to implement the recommendations made. Thirdly, organizational setting which implies that the organisations policies and procedures are such that they ensure smooth audits that lead to useful audit findings. And finally the capabilities, attributes and level of cooperation of the auditee.

2.10 OBSERVATIONS ONE CAN MAKE FROM THE LITERATURE

Newspaper reports in South Africa over the past eight years about serious shortages of basic medical consumables, mismanagement of processes within procurement of goods and services as well as tendering of contracts and these issues definitely impact on budget (News24, 2001; Sunday Times, 2009). These report on fraud, corruption and mismanagement, and although often populist, they are incredibly important and often a result of excellent investigative journalism. This study aims to paint a more methodical and in-depth picture into public hospital management in South Africa and in so doing, will substantiate these newspaper reports further.

The international literature however confirms that all these issues, such as fraud and corruption in supply chain management and procurement and mismanagement caused by a lack of effective implementable systems, are internationally problems in public health systems. In addition public health systems, out of all public service departments, are the most susceptible to fraud and corruption as a result of the number of role players within the system (Transparency International, 2006).

The international literature emphasizes that poor governance and the culture of fraud and corruption amongst public health officials is a world wide phenomenon. Literature also states that there are solutions to these and many of these solutions are decades old.

So what within the South African public hospitals is causing the problems that the newspapers consistently report on? The data analysis phase of this research aims to uncover these answers and hopes to find solutions to these issues.

Chapter 3 will now explain the methodology used and how the data analysed provided answers to the following research questions:

1. Is the budget process which operate in South African public hospitals effective?
    a. Are public hospitals under or over spending in contravention with the PFMA and if so what are the repercussions?
    b. Have hospital CEOs been delegated authority in writing in terms of the PFMA, as well as in line with the philosophy of decentralization both locally and internationally, and is this authority real?
2. Do effective management control systems exist to assist CEOs in effectively and efficiently managing their budgets?
3. Are these controls in line with the expectations of the Auditor General?
4. What do the CEOs truly understand about what being auditable means and what is hindering them in their ability to implement sound internal control systems?

CHAPTER 3 - RESEARCH METHODOLOGY

A three-phase approach was used in this research study, involving firstly: a detailed survey of hospital specific public domain material from 40 public hospitals, augmented by a written statement by the Hospital Chief Executive identifying key problem areas (See Appendix 1); secondly, reviews of 20 Auditor General audit irregularity reports (See Appendix 2) specific to hospitals within the initial sample; and thirdly, site visits and in-depth, semi-structured interviews with the CEO at nine hospitals chosen from the initial sample of 40 hospitals, spread across five provinces (Appendix 3), .

The reason for adopting this approach has been to allow the researcher to explore a wide range of variables and experiences that contribute to the successful management of control systems in the Healthcare Sector. This use of a range of data from multiple sources has helped in strengthening the validity of the conclusions drawn through triangulation of the findings. This follows the guidance of Yin (1994) and Leedy & Ormrod (2001).

3.1 PRELIMINARY INFORMATION

Before this study was designed, the researcher already had some awareness of the nature and intensity of the problems of hospital financial management in South Africa. This was obtained from three main sources:

1. The comments and experiences of 66 hospital chief executives who were enrolled in a Masters' programme in Hospital Management at the University of the Witwatersrand in 2007, 2008 and 2009. This programme, the first Masters in Hospital Management in South Africa, began in 2006, as a Presidential Initiative to improve management capacity in public hospitals.
2. In March and April 2008, the researcher was part of a University of the Witwatersrand team which appraised the Price Waterhouse Centre of Excellence programme in seven hospitals in Limpopo. This programme focused on

management improvement in areas such as HR, Finance, supplies and procurement,

3. Also in 2008, the researcher was a team leader in the National Department of Health pilot Core Standards Appraisal process. During this process 31 public hospitals were audited based on core standards identified by the National Department of Health. Within these standards were: requirements in terms of corporate governance, financial management, procurement, human resource management, information management and risk management, all of which are relevant to this research. As team leader for the pilot audit in Gauteng, the author visited 4 hospitals and 1 community health centre.

3.2 THE DATA

The data analysed in this study is drawn from five of the nine provinces in South Africa: Gauteng, Free State, North West Province, Limpopo Province and Northern Cape. The public domain data used in this paper includes hospital documentation such as budget reports, financial reports, internal management control reports and audit irregularity reports. This is augmented by site visits to nine hospitals and in-depth semi structured interviews with their CEOs.

The decision was made to confine this study to five of the nine provinces in South Africa with a view to obtaining greater depth of understanding about the situation in the provinces studied, which together comprise a sample of more than half of the provinces, rather than universal coverage. This decision was justified by the findings of the Auditor General Provincial Audit Reports of 2008 and 2009 which indicate that the issues identified in the five provinces are fully representative of the situation nationally.

Phase 1 of the study focuses on hospital financial and management data relating to the 2006/7 and 2007/8 financial years. Phase 2 evaluates Auditor General audit irregularity reports relating to periods from April 2006 to March 2009 – depending on when the site and the topic were last audited, and Phase 3 provides a current and up to date perspective through hospital site visits and interviews with nine hospital CEOs between March and

July 2009. This enabled the researcher to note any changes which happened during the period of the study between the different hospitals and to note any improvements in internal controls.

3.3 SAMPLE

The sample of hospitals reviewed in this study was drawn from among those managed by the 66 hospital CEOs who were registered on the Masters in Public Health in Hospital Management between 2006 and 2009 at the University of the Witwatersrand.

This European Union-funded programme was a Presidential Initiative in capacity building for managers in the health service, By definition, all of the students nominated to take part in this programme are seen as 'high flyers' by the provinces which employ them and which bear the full cost of their training. This means that all of the hospitals from which the sample is drawn (40 of the 66 students' sites) can be understood to be among the better-managed sites in the five provinces, from which the students were drawn.

At this point it became necessary to decide on a sample size that would be appropriate in adequately answering the research questions. The nature of the study was predominantly qualitative in nature and Marshall (1996, p523) states that for this type of study the required number within the sample only becomes obvious as the study progresses as new categories, themes or explanations stop emerging from the data. Once this occurs the researcher has effectively reached data saturation.

Phase 1 involved an analysis of data specific to 40 public hospitals. This was more than sufficient sample size in order to reach an informed decision about what issues exist which hinder the implementation of sound internal control systems as well as to assess the extent over or under spending is having on ensuring effective service delivery. This sample represents close to 10% of public hospitals in South Africa and the mix of profile corresponds to the overall profile of public hospitals nationally. In addition to this enough hospital data was analysed to reach saturation of findings.

Phase 2 involved the analysis of Auditor General Audit irregularity reports from 20 public hospitals spread across six provinces. During this phase it was possible to analyse one audit irregularity report from a sixth province, Mpumalanga. This further strengthened the results of the research as it confirmed saturation in that the hospital analysed from that province was a large tertiary hospital that had Auditor General irregularities that were consistent with the findings from the other five provinces in the study. The sample size here was again more than sufficient with the researcher obtaining significantly similar findings within each report, and once again reaching saturation.

Phase 3, being focused on triangulation of findings, required the researcher to personally observe the systems of control through actual visits to public hospitals spread across the five provinces chosen. Many of the students whose public-domain material was analysed volunteered for the in-depth interviews, and the nine sites studied were chosen on the basis that they were identified by their provinces as existing or potential centre's of excellence.

The School of Public and Development Management in the Faculty of Commerce at the University of the Witwatersrand recommends between five and ten in-depth interviews for this form of research, and so nine were chosen.

The data analyzed in phase one and two indicated that district and regional hospitals had the most issues around internal control procedures, and so seven district hospitals and two regional hospitals were visited across five provinces in South Africa. Each province has a different management style, and so focusing on five provinces ensured that a mix between both centralized and decentralized management was included.

Seven of the nine hospitals chosen for phase 3 were Hospital Revitalisation sites, the eighth had been improved and extended as part of the provinces' own capital improvement programme. The ninth hospital is managed by a CEO who has been nominated by his province for several prestigious training opportunities, indicating that

his superiors hold his management skills in high regard. In other words, all nine of the study sites were seen as 'flagship' hospitals within their own provinces, and they are or should be among the best in the country when it comes to management and to service delivery,

As in phases 1 and 2 above, saturation occurred by the sixth visit.

3.4 THE ANALYSIS PHASE

Phase 2 involved obtaining an independent perspective on the internal controls within public hospitals by examining Auditor General irregularity reports from hospitals among the sample used in Phase one. This phase of the study was very important as it provided the researcher with a structure used to confirm and interrogate the conclusions already drawn within the first phase. This process is crucial to both the trustworthiness of the report as well as enhancing the ethical manner in which the research is conducted (Merriam 2002).

The data obtained from phases 1 and 2 was analyzed through techniques of analytical induction and constant comparison analysis (LeCompte, 2000, p147). These processes include summarizing the data into patterns, themes and categories that exist within the data. It entails coding and categorizing the data into 'bins' that are relevant to the researchers' questions. On completion of the analysis in phase 1, the themes and conclusions reached were taken back to the data, helping to verify that the themes and conclusions are a reliable and fair representation of the data (Ely et al., 1997).

On completion of phases 1 and 2, triangulation of the data was attempted. Triangulation means looking at the same research question from more than one source of data. Information that is derived from different angles can be then used to corroborate the research problem. This form of research also allows the researcher to limit personal and methodological biases and thus enhances a study's trustworthiness and credibility (Decrop 1999, p157). Merriam (1998, p15) notes that because qualitative researchers intervene in people's lives, the research has to be valid. She goes on to list four criteria

for judging qualitative research, namely: credibility, transferability, dependability and confirm ability, and she concludes that any biases within the researcher's conclusions should be minimized through the use of triangulation of data which was discussed earlier.

Phase 3 involved the creation of a survey questionnaire that would assist the researcher in confirming the conclusions drawn from Phase 1. The questionnaire was used as the basis for in-depth semi structured interviews with nine CEO's spread around five provinces in South Africa. Part of the questionnaire was structured on the basis of a Likert Scale so that the responses can be quantitatively analysed and represented through graphs and tables (Piercy et al., 1994). The content of the questionnaire drew closely from the National Department of Health Core Standards checklist (DoH 2008), as all of the issues identified in the Core Standards document are ones which are unquestionably seen by the Department of Health to be important in the management of a South African public hospital, and to be issues which the hospital chief executive is understood to have responsibility over. In other words, the questionnaire contains no irrelevant or controversial questions, and all of the issues covered are ones which have been objectively seen to be relevant.

The material obtained from phase 3 includes interview transcripts and observations made by the researcher. Also at this stage, some more detailed hospital and budget reports were received from the nine hospitals.

Phase 3 of the study strengthens further the validity and reliability of the initial conclusions drawn by the researcher and ultimately ensures triangulation.

3.5 LIMITATIONS OF THE STUDY

One limitation is the reality that only 40 hospital's budgetary information was analysed. These hospitals were however perceived to being the 'good' examples of public hospitals with all the CEOs involved currently completing their Masters degree, and 22 of the facilities currently being revitalized. Saturation of the findings did occur in that the same

problems specific to control and the implementation of sound internal control systems reoccurred.

Within Phase 1, information from two tertiary hospitals was included, however no Level 3 hospitals were analysed in Phase 2 or 3. These hospitals, being much larger than the average level 1 or level 2 facility, often have similar problems, however are given different powers and a lot more national and provincial support.

Phase 2 focused on twenty Auditor General Reports and Phase 3 involved only nine in-depth interviews; however saturation occurred in both, with common problems being identified.

This study also confines itself to interviews only with hospital CEOs, and doesn't include interviews with other hospital staff. It also does not draw on the perspective of provincial or national Departments of Health. The perspective of the national Treasury would have also been relevant However, these would have extended both the scope and focus of the research towards the level of detail demanded from a PhD study.

In addition only five of the nine provinces in South Africa were included, but the variety and different governing styles has resulted in the achievement of a comprehensive research report.

Phase 3 was limited to nine CEOs as this stage was more a confirmation and interrogation of conclusions drawn from phase 1. By interviewing CEOs from five different provinces the researcher was able to triangulate not only from a hospital perspective, also to compare the different provincial styles. After nine interviews the researcher had reached saturation in terms of findings, which further confirmed the effectiveness of the sample size used.

3.6 ETHICS CLEARANCE AND ANONYMITY

In terms of the Health Act (RSA Act No. 61 of 2003) any research which includes interviews with health service staff requires an ethics clearance certificate from a University Medical Ethics Committee. This was obtained, and a copy can be found in Appendix 4.

Each provincial department was also approached for permission to interview their staff and to visit their hospitals (see Appendix 5), and they provided both their support and approval for the study. In addition all the CEOs interviewed volunteered to take part in the research. They acknowledged this in writing prior to each interview. Copies of this permission have been filed by the researcher; however for anonymity purposes they are not included in this report. A blank version of this letter has been included and can be found in Appendix 6.

Anonymity is of critical importance to ensure that nobody involved in the study will be judged or affected in any way because of their comments and answers to the questions during the interview process. Anonymity was maintained in that only the researcher and his supervisor has access to the raw data, and the report is also written in a manner to ensure that the identity of all parties involved in the study remains hidden. In addition all interviews were audio recorded and these will be kept by the researcher in his safe for the required period of 5 years and they will not be accessed by anybody except the researcher.

If South African public sector facilities are going to improve in implementing systems of control then information such as that contained within this report is vitally needed for an understanding of the weaknesses and of the areas for improvement. Making the findings totally anonymous ensures that all parties involved can focus on the findings and learn from the process rather than engage in passing blame.

CHAPTER 4 : PHASE 1 - ANALYSIS OF INFORMATION FROM 40 HOSPITALS

Phase 1 is an analysis of public domain material from 40 public hospitals in South Africa. The chapter begins by clarifying and explaining which of the financial management responsibilities described within the PFMA are the focus of this research. This is then followed by a discussion of each of these responsibilities, with reference to evidence from each of the forty hospitals. By the end of this chapter one has a perspective on the ways in which the senior management within the hospitals in the sample perceive their internal control systems to be failing them, as well as examples of how these issues impact negatively on the hospitals' ability to spend within their approved budgets.

4.1 EXPECTATIONS IN TERMS OF THE PUBLIC FINANCE MANAGEMENT ACT RSA NO 1 OF 1999 (PFMA)

The basis for this study is derived from the Public Finance Management Act No 1 of 1999 (PFMA). This Act states that every constitutional institution, which includes public hospitals, must have an accounting officer (Paragraph 36(1). It goes on to state that the CEO of the constitutional institution must be the accounting officer for that institution (Paragraph 36(2) (b).

The PFMA places the ultimate responsibility on the CEOs for the transparency and accountability on financial information within their respective hospitals. For this research, which includes an appraisal of how the annual budget is used, the emphasis is on the following provisions of the PFMA: Accounting officers responsibilities relating to budgetary control, ensuring that:

a. Expenditure is in accordance with the approved budget from Province (paragraph 39(1) (a).
b. Effective and appropriate steps are taken to prevent unauthorized expenditure (paragraph 39(1) (b).

c. An accounting officer must, for the purposes of budgetary control, take effective and appropriate steps to prevent overspending (paragraph 39(2) (a).
    i. To report to their provincial department an impending either under-collection of revenue due, shortfalls in budgeted revenue and over expenditure as well as
    ii. Comply with any measures imposed by their provincial treasury to prevent overspending (paragraph 39(2) (b & c).

2. To ensure that their hospital has an efficient, effective and transparent system of financial and risk management and internal control (paragraph 38(1) (a) (i)) that ensures:
    a. An appropriate procurement and provisioning system which is fair, equitable, transparent, competitive and cost-effective (paragraph 38(1) (a) (iii)) and,
        i. The settlement of all contractual obligations and payment of all money owing within the prescribed or agreed period (paragraph 38 (1) (f).
    b. Effective, efficient, economical and transparent use is made of resources (paragraph 38(1) (b)
    c. Effective and appropriate steps are taken to:
        i. Collect all money due to the hospital
        ii. Prevent unauthorized, irregular and fruitless expenditure and losses resulting from criminal conduct
        iii. Manage available working capital efficiently and economically (paragraph 38(1) (c).

4.2 STRUCTURE OF A HOSPITAL BUDGET

Within all provinces the annual budget is split between 8 main categories of expenditure, shown in Table 4-1 below. Each category is then split up into specific line items used to explain exactly what has been included in the budget and what has not. Most provinces allow some reshuffling between specific line items within each budget category during a

financial year, but expenditure must at all time stay within the budget categories. Any deviation to this is classified as unauthorized expenditure and will negatively impact on a CEO's ability to stay within budget. This is concerning if one analyses the budget allocated to the different line items as they indicate very little thought or planning.

Examples provided by the CEOs include:

- In one highly centralized province, a hospital was allocated a budget of R20, 000 for telephone expenditure. However the line rental alone amounted to R30, 000 per annum, before any calls were made. Therefore it is not surprising that there was a considerable over expenditure associated with telephone costs.
- Another province simply failed to allocate a line item for National Health Laboratory Service (NHLS), rendering it almost impossible to pay for laboratory services, as the system could not allocate the payment. This mistake is quite simply an administrative error at provincial level, but until it is fixed the NHLS cannot get paid by any of the hospitals in that province.

Table 4-1 – Categories used in Annual Approved Budget

CATEGORY DESCRIPTIONS
Compensation of employees
Transfer payments
Administrative expenditure
Inventory
Consultants and professional services
Goods and services – other
Machinery, equipment, furniture and office equipment
Buildings and other fixed structures

4.3 UNDERSTANDING THE ANNUAL BUDGET ALLOCATION PROCESS

4.3.1 THE BUDGET CYCLE WITHIN EACH PROVINCE

The budget process is fairly consistent across the different provinces included in the study as they are derived from templates circulated by the National Department of Health. Hospitals are required to submit budget needs using these templates as adjusted by each provincial department. These needs are determined using a combination of, but not limited to, the hospital's human resource plan, overtime plan, maintenance plan, procurement plan, skills development plan and equipment plan, as well as goods and services and contractual obligations. Hospitals are required to factor in all sources of funding received from province and national department including for example, revitalization grants and Anti Reterol Viral (ARV) grants.

As required in terms of the Health Act (RSA No. 61 of 2003) hospital budget requests for district hospitals are submitted in the first instance to their respective district office. The district finance manager then verifies, corrects and endorses the budget requests, consolidates the needs of the district as a whole, and then submits a single consolidated document to the provincial Department of Health. Examination of the hospital documentation repeatedly and consistently showed how different the actual approved budgets were to the budgets requested within the individual hospital business plans. In many instances there was no logic to the amount allocated to each line item - other than its similarity to the previous year's allocation. This indicated that hospital budgets are approved through central decision making processes that, rather than focusing on the true needs of patients and achieving effective service delivery, are mainly informed by what was done in the past.

Provincial departments develop three-year rolling budgets and within this plan, based on what is actually allocated to the province by the national Department of Health, the provincial treasuries will make commitments to hospitals in terms of each respective hospitals actual approved budgets. In theory, these budgets are determined firstly through hospitals being awarded their equitable share of the provincial budget allocation, based

on population estimates, and then also by ensuring that estimated operational costs, including compensation of employees and the expected cost of goods and services, are covered. Secondly, to ensure the improvement of hospital service delivery, provinces are supposed to then allocate additional budget spread over the three year plan, specifically for the filling of key vacant posts and for the purchasing of key items of capital equipment . But does this actually happen?

4.3.2 HOW THE CYCLE ACTUALLY WORKS AND WHAT THIS MEANS – THE VARIOUS WAYS IN WHICH THE BUDGET IS TAKEN AWAY

The budgets analyzed in the sample showed little evidence that the strategic and operational plans created at institutional level were considered by provinces when allocating the final budgets. The allocated budgets commonly show no year on year increase in the goods and services budget line, not even inflation-related increases. They often show only nominal increases in the budget for compensation of employees, insufficient to cover the annual pay increases agreed at provincial level for the different categories of hospital staff, or to meet the demands of the new Occupation Specific Dispensation (OSD) that has been promised to health professionals since the national public sector strike in June 2007.

Table 4-2 below shows what is expected of provinces in terms of deadlines within the budget cycle, as required by National Department of Health, as well as what actually happens. Such delays place undue pressure on the management of hospitals, often making it impossible to operate effectively. They also mean that for much of the financial year, the CEOs are often functioning in the dark; not knowing what will happen within the province from one month to the next. Any good system will work effectively if deadlines are kept. However, if Provincial Treasuries fail to communicate key budgetary information to public hospitals in a timely manner, this creates a gap that may put the system at risk.

Table 4-2 – Budget cycle analysis in 5 provinces

BUDGET PROCESS	EXPECTED DATES	REALITY
Budget Interrogation process	September	September to December
Adjustment budget	September	December to March
Budget letter to CEOs	End March	March to July
Year end closure	Mid March	Mid December to Mid January

The budget cycle allows for the province to adjust the approved budget, often allowing additional funds for specific line items. CEOs require enough time within the financial year concerned to spend these funds once they have been allocated. However, poor administration at provincial level often leads to the final budget adjustments only occurring as late as February. If the funds are not spent by 31 March they are lost, and as a result the lateness of the adjustment budget causes unnecessary accumulation in commitments at year end. If these commitments are paid only after 31 March they are met from the budget allocated for the subsequent financial year, negatively impacting on spending and budget management in the new financial year.

To a large extent, the scale and range of the hospitals' commitments for the acquisition of goods and services at 31 March are a consequence of when the respective province starts the year end closure process. Once this process begins, hospitals are not able to pay any bills other than commitments for the compensation of employees and to meet existing contracts, until the new financial year, which starts at 1 April. Effective service delivery places the expectation on this process begins in mid- March, but in all provinces included in this study cash flow constraints result in the process starting as early as mid-December. These cash flow constraints are a direct result of accruals and this puts significant strain on suppliers, forcing them to wait for up to 120 days for payment.

In addition, each hospital should be able to expect to receive their budget letter by 31 March so that they can begin the new financial year knowing exactly what they are able to spend. However, budgets may be finally announced by the provinces only several months into the financial year. In 2007, three provinces, Northern Cape, Free State and Gauteng, only announced the individual hospital budgets in July. And then, in the second

half of the year, funds were withdrawn, resulting in the CEOs never knowing truly what they might or might not spend.

Sometimes, this is for very specific reasons. For instance, by the middle of 2007, Limpopo Province had accumulated debts in excess of R180 million, from other provincial departments such as Education, and from other sources including bank overdrafts. The Department of Health was forced to institute hostility measures, with the funds within all hospital budgets being frozen indefinitely. So, for instance, in one District hospital, R1.5 million of 2007/8 commitments were only paid out of 2008/9 budget, putting initial strain on the new financial year. The same province later announced, in June 2008, that in addition to the hostility measures remaining in place for the duration of the entire current financial year all approved 2008/9 hospital budgets will be cut by an undisclosed amount. This kind of situation leads almost inevitably to an 'overspend' at hospital level on the eventual budget for the year, and means that the hospital starts the subsequent financial year with a deficit which may run into millions of rand.

The hospital budgets are split into eight main categories. As explained in Table 4-1, on average 95% of the approved budget is allocated to three categories: compensation of employees, goods and services, and capital expenditure. Each category is then split into the individual expense items. It would appear from detailed examination of the budgets that not much thought in terms of actual expenditure is given to each respective line item. It is also evident that provinces regularly top-slice these approved budgets, often without any consultation with the hospital CEOs.

An important example of this involves the budget for oxygen. At one hospital the annual cost of oxygen used to be R582 017 per annum (R48, 501 per month). The hospital's contract with the supplier still holds, and has to be honored. But the provincial department of health in 2007 set up a new contract with a different supplier, for oxygen provision throughout the province. This requires the hospital to spend a further R137, 000 per month on oxygen which is not actually needed. It was not budgeted for, and is

therefore an unfunded mandate. The hospital CEO was not consulted in the discussions leading up to the allocation of the provincial contract, but the institution is committed to paying almost 13% of the hospital's total budget for goods and services. Now this example represents one specific hospital, however, through a review of the Provincial Auditor General audit report for 2006/7 it became clear that the contract in question had been rolled out to all the public hospitals in the province, with no investigation as to whether there truly was a need. This contract has resulted in a provincial over supply of oxygen and the reality that huge over expenditure, specific to oxygen, is the result going forward.

This example raises many questions relating to firstly, why the lack of communication with hospital management, secondly, why did province not question how long the existing contracts would last before signing the new contract. These unanswered questions suggest that the new contract is a direct result of fraud and corruption and this was confirmed by the Auditor General who confirmed that the tender process was under investigation.

4.3.3 MOTATORIUM ON SPENDING OR HIRING OF NEW EMPLOYEES

If the budgeted funds are not spent by the end of the financial year, they are lost, and the lateness of the adjustment budget leads the hospitals to carry unnecessary levels of commitments at year end. Any commitments remaining after 31 March are paid from the following year's budget, adversely affecting the next year's spending. Due to the Department of Health still implementing a cash focused approach to budget expenditure management and not an accrual focused approach as recommended by GRAP, this form of role over of commitments into the new year's budget is inevitable.

In terms of the PFMA, hospitals are not allowed to contract loans or overdrafts. Only the provincial MEC (Member of Executive Council for a particular Department such as Health) can authorise a loan at provincial not facility level. In recent years, both Limpopo province and the Free State have had to massively curtail spending as a result of having undertaken inappropriate levels of debt (Sample hospital data, 2008, 2009).

So when the province calls for a moratorium on spending, or announces an early Year End closure, the hospitals have no capacity to continue spending as budgeted. They have to continue providing services, and they have to honour existing contractual commitments, but they cannot undertake new items of spending without specific permission.

A large portion of the year end commitments for the acquisition of goods and services are also a direct result of the timetabling of the year end closure process. When this process begins hospitals are not able to pay any bills until the start of the new financial year in April. National and Provincial protocols reviewed state that this process to begin mid-March, however cash flow constraints result in the process starting, in some provinces, as early as mid-December. This puts significant strain on suppliers, forcing them to wait up to 120 days for payment for services rendered in the second half of the financial year. This is in contravention of the PFMA which requires suppliers to be paid within 30 days of the public institution being invoiced.

Where it is necessary for the continuation of services that specific goods are procured, such as pharmaceuticals, food or other basic consumables, the hospital accumulates accruals which must be paid out of the following year's budget. Similarly, for any large purchases ordered but not paid for in the old financial year.

Every year, this means that the hospital's budget, formulated in terms of the current year's spending needs, is compromised because of spending accruals from the previous year.

At hospital level, the effect of inappropriate budgets being approved, further budget cuts from an already unrealistic budget, accruals and interventions severely compromises the services delivered. To cite only one example; at a specific district hospital, the effective laundry budget for 2007/8 was effectively five times smaller than actual spend. This is made worse when one adds that the hospitals in this province utilise a centrally controlled

provincial laundry that, when compared to private laundries, is significantly more expensive. In theory centrally run services should reduce costs; however in public hospitals in South Africa the opposite is true. This kind of situation is replicated at hospitals throughout the country. These increased costs impact on cash flow provincially and this aggravates the accrual and commitment lists even further.

It would appear that in 2009/10 the repeated accumulation of accruals throughout the whole provincial budget has finally caught up with several provinces. It is probably the main factor which has caused provinces such as Free State and Limpopo to implement draconian measures to monitor and curtail spending, as they are effectively bankrupt.

Since February 2009, the Free State Department of Health has effectively been under administration because accruals and commitments from previous years are now beginning to afflict the Department of Health in terms of the National Credit Act of 2007. A Provincial Health Finance Circular of May 2009, reviewed during one of the hospital visits, requires that the provincial Treasury must give approval for payments on suspense accounts to be paid, and that all purchases must be signed off by the provincial Treasury. All delegations have been effectively taken away from the hospital CEO and the provincial treasury is attempting to manage the movement of cash centrally. However with human resource constraints and paperwork which gets sent back and forth between hospital procurement office and central admin offices, this process is slow. It of course also adds further administrative layers to the payment process, rendering payment within the statutory 30 days less likely than ever, and extending payments even at best practice sites to something closer to 60 days.

In terms of the National Credit Act (RSA No. 34 of 2005) banks were required in 2007 to reassess the credit-worthiness of their client organisations, so in late 2007 the banks effectively foreclosed on the Limpopo government requiring a large overdraft facility to be repaid immediately. This forced a freeze on all spending for the remainder of the 2007/8 financial year, as well as major uncertainty on what could be truly allocated in the 2008/9 financial year.

4.4 HOW REVENUE COLLECTION WORKS AND IMPACTS BUDGET

The provincial governments get the majority, almost 90% on average (Provincial DoH Annual Reports 2009/10, various Provinces), of their funds from the national government. However, it is expected that a proportion of the funds allocated to hospitals will be generated from the collection of revenue. The bulk to this revenue is from the fees expected for treating patients, either from patient fees, private patient accounts or claims from medical aids, workmen's compensation or the road accident fund. The remaining hospital-specific revenue is collected from a number of sources, for example, mortuary fees, letting of Governmental property, the holding of money and property in trust on behalf of patients, employees reimbursing the hospital for private telephone calls or selling of food to visitors.

4.4.1 PATIENT FEE SPECIFIC REVENUE

In November 2000 the Department of Health adopted the Uniform Patient Fee Schedule (UPFS) in order to provide a simpler charging mechanism for publicly funded hospitals to use when recouping patient fees from medical aids and other sources. In this system all tariffs, with the exception of anesthesia, are divided into two components, namely, a facility fee and a professional fee. The 'facility fee' represents, in theory, the cost of providing an environment within which health services can be delivered, while the 'professional fee' represents the value of the professional component associated with providing that particular service. This component can be independently levied in the event that the professional is not employed by the facility concerned (NDoH, 2000).

The UPFS splits patients into full-paying patients and subsidized patients. Patients who receive social pensions or are formally unemployed can obtain almost all hospital health services free of charge. Other patients with low incomes are partially subsidized, while patients who have an annual income of more than R72 000 for a single person or R100 000 for a family, will be classified as full-fee paying patients, however these fees when compared to private hospitalization is still significantly subsidized.. All patients who are externally funded through Compensation for Occupational Injuries and Diseases

Fund, Road Accident Fund, Medical Aid Schemes, another state department, a local authority, a foreign government or an employer, pay full fees. The UPFS requires accurate and complete information to ensure proper billing of patients as well as a system that stores patient specific data that can be retrieved simply (NDoH, 2000).

Sound internal controls help to ensure complete and accurate production and safe-guarding of information necessary to ensure that effective revenue collection is possible. This includes the processes from the completion of patient admission forms to the managing of patient debtors and finally to the actual collection of debt. It is essential to have sufficient and adequately trained staff working in this department to ensure effective revenue collection. Table 4-3 below shows an analysis of certain key internal controls within this department, as well as comments within the sample hospitals internal management reports on whether or not compliance is an issue. The table will show what the internal control expectation is, and how many of the sample hospital reports state compliance, or the absence thereof.

Table 4-3 – Internal controls specific to revenue collection process

NO.	INTERNAL CONTROL REQUIRED	COMPLY WITH INTERNAL CONTROL	
		Yes	No
1	Are admission forms completed in full for all patients admitted to hospital?	0	40
2	Are admission forms completed with credible patient information that is substantiated?	0	40
3	Are hospital fees charged according to the latest approved UPFS tariffs?	40	0
4	Are patient accounts and records of debtors properly maintained?	0	40
5	Does the management of the institution take the necessary steps to collect revenue due?	40	0

(Jones (2009) Analysis of internal control checklists Free State, Gauteng and Limpopo Province, 2008)

The provincial governments perceive revenue collection to be a weakness at local level and so too do other departments, such as the Road Accident Fund, Workman's Compensation and private medical aids. All of the CEO's involved in this study

confirmed that a combination of inadequate patient information and a shortage of skilled staff involved in revenue collection gave the impression that this function within public hospitals was not a priority. This was confirmed by the Auditor General in 2009, who reported that, for example, Gauteng was owed nearly a billion rand (Auditor General, 2009). However the provinces provide hospital management with very little incentive to achieve better results. The targets set are, according to the hospital reports, excessive and unobtainable. However, from the centre these targets may appear to be reasonable, assuming that the hospital has the human and IT resources to administer an effective system of control.

All forty of the hospitals in Phase 1 indicated a serious lack of resources and of qualified staff capable of implementing a system of control. Administrative clerks assigned to the revenue administration department ranged from salary scale Level 2 to Level 7 (a pay scale ranging from R40 000 to R150 000 per annum). In addition more than half of the hospital CEOs confirmed that there was a shortage in approved posts and this meant that, mostly due to poor planning and human resource policies, the majority of the posts were Level 5 or lower, and this meant that suitable qualified personnel were not interested in the posts available. And this, combined with ineffective information systems in all the hospitals analysed, resulted in employees working to their own agenda – which often saw patient files vanishing and being used in fraudulent claims to the road accident fund, as one example and as one of the CEOs stated, "With the state of our buildings, lack of storage and insufficient admin staff you can forget about controlling access". And with no effective control systems in place this could occur with little or no adverse consequence to the dishonest employee.

4.4.2 OTHER FORMS OF REVENUE GENERATION

Collection of mortuary fees, letting out of government property or ensuring the hospital is reimbursed when, for example, hospital telephones are used for personal calls or food is sold to employees also requires serious scrutiny. Protocols for these items exist within every province, and these protocols spell out all the procedures which should be followed to ensure that transparency exists. The protocols are sent to hospital

management, who should ensure that they are implemented, but this is often not the case. Hospital management reports and minutes from management meetings showed that even when some aspects of the controls functioned effectively, such as in regards to employees being billed for their personal telephone calls, that the receiving of this money did not result in an adjustment to actual telephone expenditure. These areas of revenue collection on the whole are managed with a very limited paper trail, and as such one can only imagine how much fraud and corruption exists. Without being forced to follow and stick to effective standard operating procedures, employees are left to their own devices, and management ultimately trusts that these employees perform their duties ethically and honestly.

4.4.2.1 GRANTS IN AID

In any financial year, public hospitals also receive addition grants which are shown as a separate line item on their approved budget. Examples of these include grants for HIV / Aids initiatives or Revitalisation projects. These grants are given to hospitals for specific purposes, such as to provide Anti Reterol Viral (ARV) drugs to aids patients, but the hospital expenditure reports provided showed evidence where these grants were either not allocated to the intended hospital at all, or if allocated, there was under spending with respect to the specific intended outcomes. These initiatives, vital to the needs of the community being serviced by each respective hospital, still need to happen whether funds are available or not and this in itself often leads to overspend.

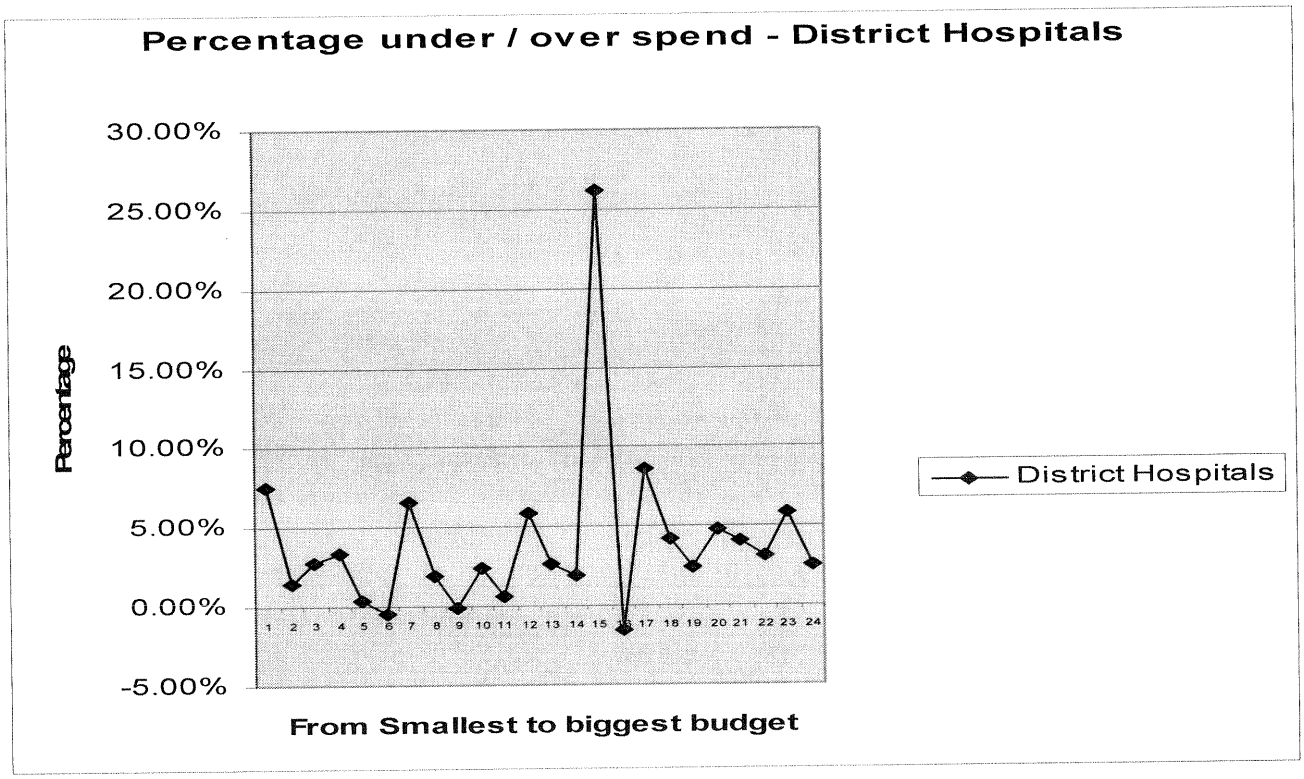
One example of this involves grants associated with Revitalisation projects, which, due to their scope, are usually spread over a number of financial years. Progress reports analyzed provided examples of significant issues within administration that resulted in large amounts of allocated grants being wasted as a result of penalties from suppliers for late or nonpayment, BEE companies failing to complete jobs resulting in other companies being given contracts to fix the problems. This meant paying two contractors to do one job.

4.5 PUBLIC HOSPITAL SPENDING

In terms of the PFMA (RSA No. 1 of 1999), public hospital spending in South Africa is required to be within 2% (Section 25(5)) of the hospital's annual budget. Based on the sample of 40 hospitals this law is being broken by the majority of public hospitals. The combined approved budget for the 40 hospitals in this sample for the 2007 financial year was R5, 316, 446, 416; and the hospitals overspent on this amount by 7.61%, or R404, 346, 393. Now considering that the sample is close to 10% of the total 428 public hospitals in South Africa one can only imagine the value of what total public hospitals overspend is likely to be countrywide.

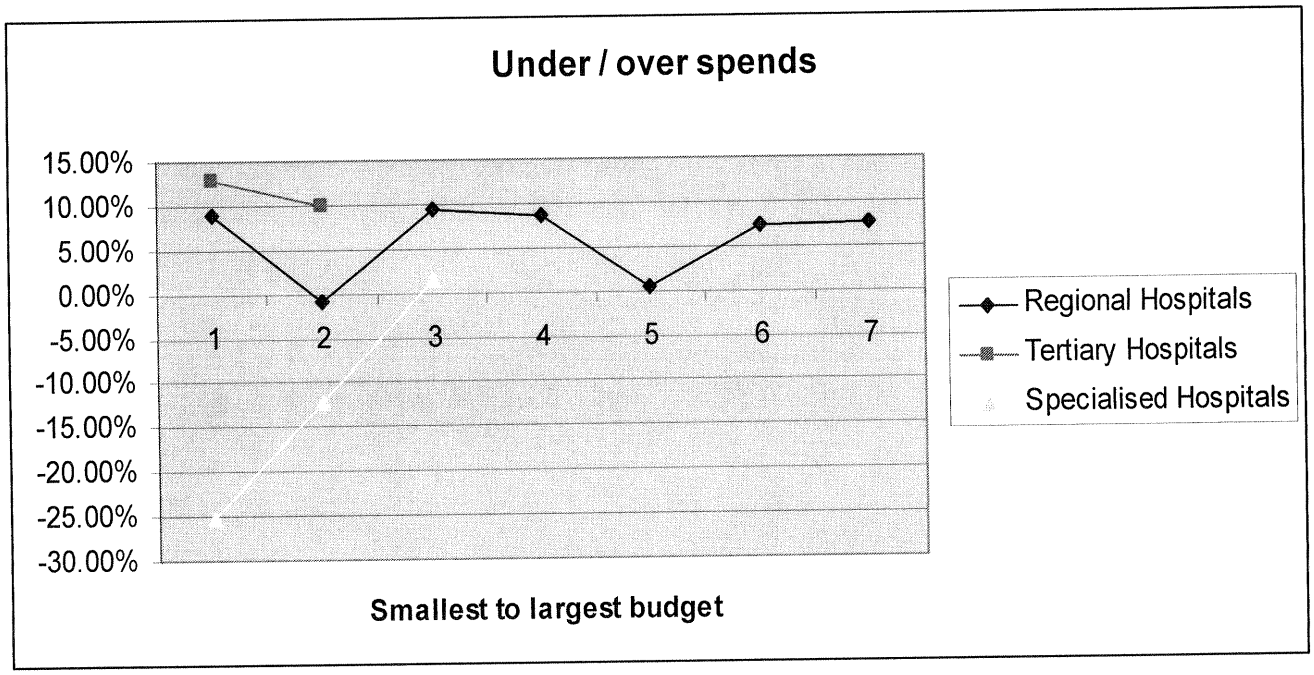
Graph 4-1 and Graph 4-2 show that 26 hospitals out of the sample of 40 had a greater than 2% overspend in the 2006/7 financial year, and that 12, some 34% of the sample, had overspent by between 5.8% and 12.8%.

Graph 4-1: Overspend and under spend among 28 South African district hospitals in the 2006/7 budget year



Graph 4-1 shows that one hospital, with a budget of R54 million, had a 26% overspend, but this is a very particular situation. This is a new facility, opened only in 2006 in the vacated premises of a tertiary hospital which had moved into a new building on the same site. The current workload of the new Level 1 hospital considerably exceeds that which was envisaged by the Provincial Authority when it was setting the budget, both in terms of volume and intensity of the caseload. Because of limited bed numbers in the new Level 3 facility, the Level 1 hospital accepts Level 2 patients as an unfunded mandate.

Graph 4-2: Overspend and under spend among 12 South African regional, tertiary and specialised hospitals in the 2006/7 budget year



Two of the seven Level 2 hospitals in the sample were within 1% of budget, but all of the others overspent by between 7% and 10%.

Apart from the single, conspicuous, Level 1 hospital, the institutions with the highest percentage overspend were the two Level 3 (Academic/tertiary hospitals), which had the biggest budgets in the sample, so they also had the biggest overspend in rand terms. They accumulated overspend in 2007/8 of 12.8%, R96.7 million and of 10%, or R110million respectively.

Two of the three specialized hospitals in the sample recorded an under spend of between 18% and 25% in the same period. These are both TB hospitals for which the province had recently assumed responsibility, and which had not yet attained their necessary staffing or resource levels, and had therefore also not yet attained their full workload.

Common areas of large scale overspend in the budgets analysed included:

- Staff overtime and agency staff payments
- National Health Laboratory Services (NHLS)
- Blood and blood products
- Pharmaceuticals

In some provinces, overspend is inevitable. There are some provinces which have not actively reviewed the budget allocation for five years or more. In localities where there has been massive in-migration associated with mining or other foci of employment, such as in parts of North West or Limpopo Provinces, or where there is a growing population of Zimbabwean or other refugees, the pressure of local demand for even basic services considerably exceeds the budgeted capacity at hospitals where annual budget allocations have been historically based.

4.6 UNFUNDED MANDATES

Another uncontrollable source of overspending arises when a hospital is required to undertake activities which comprise an unfunded mandate – whether this is the provision of accommodation for the mothers of sick children, or an increased number of X-rays or laboratory tests due to the establishment of a new, separately funded, HIV/AIDS service at the hospital, where the full cost of the total services has not been well calculated.

In some cases, the overspend really is because the hospital management has deliberately decided to expand services, or not to curtail services, sometimes outside the core bundle of services which that level of hospital is required to provide. Where a province has re-defined a hospital's function, and has downgraded it to a lower level, hospital managers have on the whole been reluctant to reduce services which are manifestly needed by the

local population, so have often continued to operate at least part of their previous mandate, with a reduced budget.

There is also a particular tendency for unfunded expansion of services to occur where the hospital staff already includes people capable of undertaking the new intervention, for example, a general surgeon with a particular interest in cardiology, or the provision of neonatal high care in a locality where low-birth-weight or otherwise frail babies are not uncommon.

All the above provide one with insight into the complexities within hospital structures where medical preferences and provincial goals often take precedence over budgetary constraints. However, these constraints, in most instances, can be solved through the effective implementation of a workable internal control system.

4.6.1 BUDGETING, ROLL OVER OF FUNDS AND PROJECTIONS

4.6.1.1 REPETITION OF OVERSPEND

In some provinces the 'overspend' is rolled into the following financial year, making it even less likely that the hospital will stay within budget in the subsequent year. In others, once the CEO has explained and justified the overspend, there are no repercussions and overspend gets erased with no sign of any accountability. In addition to the actual overspend by the hospitals, accruals and unpaid commitments at 31 March will get paid for in the new financial year and this increases the overspend figures further. However, this does not mean to say that valid reasons for overspend are necessarily taken account of in the subsequent year's budget allocation, thus giving rise to yet another year of overspending against an inadequate budget, and, even if adequate, this is negated by the commitments at 1 April. And so the cycle continues.

In all provinces, one sees no facility to retain the accounting for accruals / commitments at year end into that budget. Even if the budgeted funds exist, they are lost come 1 April, and all unpaid commitments relating to the previous year are paid out of the new budget. For instance in the Northern Cape the existing commitments and accruals within the

Health department at the start of the new financial year in April 2008 were more than R160 million (Interview with CEO – July 2009). This province does not provide full tertiary services, so its spending per capita on health is less than other provinces.

4.7 DELEGATED AUTHORITY TO CEOs

In none of the five provinces within the sample do the hospitals CEOs have full power over the spending associated with their hospital. To a large extent, this power remains with the provincial government, although each province has its own recipe for the distribution or retention of responsibility. Table 4-4 shows the range of purchasing delegations to CEOs in the different provinces.

Table 4-4 - Purchasing delegations for hospital managers in 5 provinces

PROVINCE	CENTRALISED	DELEGATED AUTHORITY
Gauteng	Centralised	R1.5 million
North West	Centralised	R100 000
Limpopo	Decentralised	R50,000 upwards, depending on hospital size and administrative capacity
Free State	Centralised	R100 000
Northern Cape	Centralised	R5 000

The package of responsibilities delegated to hospital level varies from one province to the next, but one element that is common to all is that many key powers, such as tenders for procurement of goods or services, and powers over the hiring and firing of staff, is retained by the provincial Departments of Health. This affects the hospital budget as well as human resources, procurement and spending.

4.7.1 FINANCIAL DELEGATIONS AND PROCUREMENT RESPONSIBILITIES

The size of the price-tag on single or extraordinary items for which a hospital CEO has financial delegation to purchase varies between provinces. In the Northern Cape a CEO can spend only R5 000 without provincial approval, while in two provinces, namely

North West Province and Free State, a CEO can spend up to R100 000 on their own initiative. This delegated authority can be as much as R1.5 million in Gauteng but is limited to CEOs of the larger tertiary hospitals. However with many aspects of the procurement process being centralized, CEOs make procurement decisions and these are nullified by the central body. These delegations are removed totally when funds dry up, as is the case currently in three of the provinces analysed.

The centralized procurement procedures that are in place are onerous. They lead to delays both in the purchasing and supply of goods and services. Payments for goods and services are also commonly centralized at Provincial level. This often leads to commitments existing at financial year end, 31 March. This means that those commitments paid after 31 March will utilize funds approved for the new budget, as there is no roll-over of funds from one financial year to the next.

This means that many hospitals start a new financial year already in a negative position. Depending on the size of the hospital, the commitments range in value; in the sample they range from R400, 000 in the smaller district hospitals, to nearly R100, 000 000 in the large tertiary hospitals. This constrains the CEOs even further in fulfilling their responsibilities.

4.8 THE NEED FOR IMPLEMENTABLE INTERNAL CONTROL SYSTEMS

4.8.1 ROLE OF INTERNAL AUDITORS WITHIN EACH PROVINCE

The PFMA requires that each institutional entity sets up an independent internal audit function to assist in assessing the transparency of information being produced. Within the health service, in practice, this function is usually implemented only at provincial level, and significant human resource constraints in the internal audit function mean that hospitals may be inspected only once every three to five years. When they are inspected, the internal control unit normally focuses only on one area, for example, revenue collection, finance, or procurement. This places the day to day responsibility for implementing and assessing internal controls on the CEOs and their senior management teams. This means that each CEO requires implementable control systems, enough staff

to ensure transparency within these systems, and the resources to deliver the services rendered effectively, as well as good governance and staff willing to perform their duties responsibly.

4.8.2 INTERNAL CONTROLS WITH WHICH CEOS ARE EXPECTED TO COMPLY, IN TERMS OF BOTH NATIONAL AND PROVINCIAL NORMS AND STANDARDS

In order to assist the CEOs with the implementation of effective internal control systems, provincial departments of health supply protocols and check-lists to the facilities which report to them;, with explanations of the internal control measures required to be implemented. These controls would, if implemented effectively, ensure that information and decisions are being produced in a transparent manner as well as minimize unauthorized expenditure.

The checklists and protocols should provide information about the internal controls necessary, and then it is up to the CEO to implement them. Before one is in a position to assess the effective implementation of internal control systems one requires insight into what is considered acceptable. The following analysis outlines what makes public hospital internal controls effective, in terms of provincial expectations.

Table 4-5 - The main categories identified as important within provincial internal control systems

NUMBER	INTERNAL CONTROL FOCUS AREAS
1	Revenue
2	Banking, cash management and investment
3	Human resources and issues around personnel
4	Supply chain management
5	Information management and source documentation
6	Budgeting, rollover of funds and projections

(Combined information from internal control checklists Free State, Gauteng and Limpopo Province, 2008)

The internal control checklists, which in many instances are lengthy documents of up to 100 pages, require management to answer detailed questions assessing control systems. Each question is answered in the following manner. Firstly, yes or no to compliance, secondly, if no, then detailing the reasons for non-compliance as well as the action plan proposed in order to address this issue. The hospital data analysed from the 40 hospitals did not provide a clear confirmation that these checklists were taken seriously. None of the hospitals involved in the study had the human resource capacity or the inclination to employ internal auditors full time. The templates reviewed were all Provincial templates that were either incomplete or blank as they were merely given to the researcher as examples. However, they do provide the researcher with a good indicator as to what the expectations are and what the internal control process being implemented is expected to achieve.

The six areas mentioned in table 4.5 above are all relevant to assisting senior management in the administering of their annual approved budget and the check list questions provide insight into aspects of expenditure management requiring focus. Only once one understands what would constitute an ideal system of internal control is one able to assess what flaws exist in the systems of individual hospitals. Items 1 and 6 have already been discussed above, so now the focus will be on items 2 to 5 which will be evaluated in more detail below.

4.9 A CEO SPECIFIC PERSPECTIVE OF WHAT THE WEAKNESSES ARE THAT EXIST IN THE INTERNAL CONTROL SYSTEM BEING IMPLEMENTED IN PUBLIC HOSPITALS WITHIN THE SAMPLE

The internal control check list will be used to assist in assessing whether or not weaknesses exist within the sample hospitals. This will be determined through the review of the hospital specific documentation, including budget, budget interrogation reports, reports from the CEOs in which weaknesses are explained, as well as supporting hospital documents used to substantiate the claims made by the senior management of these institutions. Banking and cash management, human resources and issues around personnel, supply chain management and information management will be the focus.

4.9.1 BANKING AND CASH MANAGEMENT

Figure 4-3 below provides a summary of key weaknesses mentioned by the CEOs in their internal control management reports specific to banking and cash management. These were common within most of the hospitals, with 27.5% [eleven out of forty] emphasizing this as an area of major concern. However, although only a quarter of the CEO's were majorly concerned about their cash management, from analyzing the data, the researcher sees this as a lack of understanding. The CEOs in their responses fail to recognize the true extent of the risks. The lack of effective control systems ensure that fraud associated with cash is often not obvious and that the perpetrators are not caught. All the hospitals within the study admitted to the processes involving cash management being manual, either in terms of what the cashiers produce, or in the documentation linking payments made directly to patient files, or in both instances and this makes tracing of payments difficult. Five examples were given by CEO's from different provinces where investigations into cashiers for suspected theft were being conducted and in all the cases is was either luck or a tip off that highlighted the theft to management.

The documentation provides clear evidence that protocols are in place, and it is further understood that the protocols are explained to the administrative staff mandated to implement them. However, due to the significant levels of staff vacancies as well as the reliance on manual processes, more than 80% of the facilities indicated that segregation of duties as well as effective supervision of cashiers is impossible. The use of CCTV was mentioned by more than 60% of the sample CEOs as being important, however all required funds and additional staff to administer this process, however in terms of cash management CCTV would achieve less than merely insisting on sound cashier supervision as well as control over paperwork and receipt books. CCTV would merely allow security to monitor the number of patients paying at each respective cashier but this would also be time consuming and impracticable.. In addition cashiers often performed their own daily reconciliations, and, due to shortages within middle management, this process was in many cases never verified.

It was also not clear whether effective training takes place to educate cashiers on what performance expectations exist. Together with a distinct lack of supervision combined with largely manual processes, one would see this area as a significant audit risk. On top of this, the impact this risk is having financially on hospitals is unknown, and with no clear answers as to how to solve these internal control inconsistencies one has to accept that the door is effectively open to corruption.

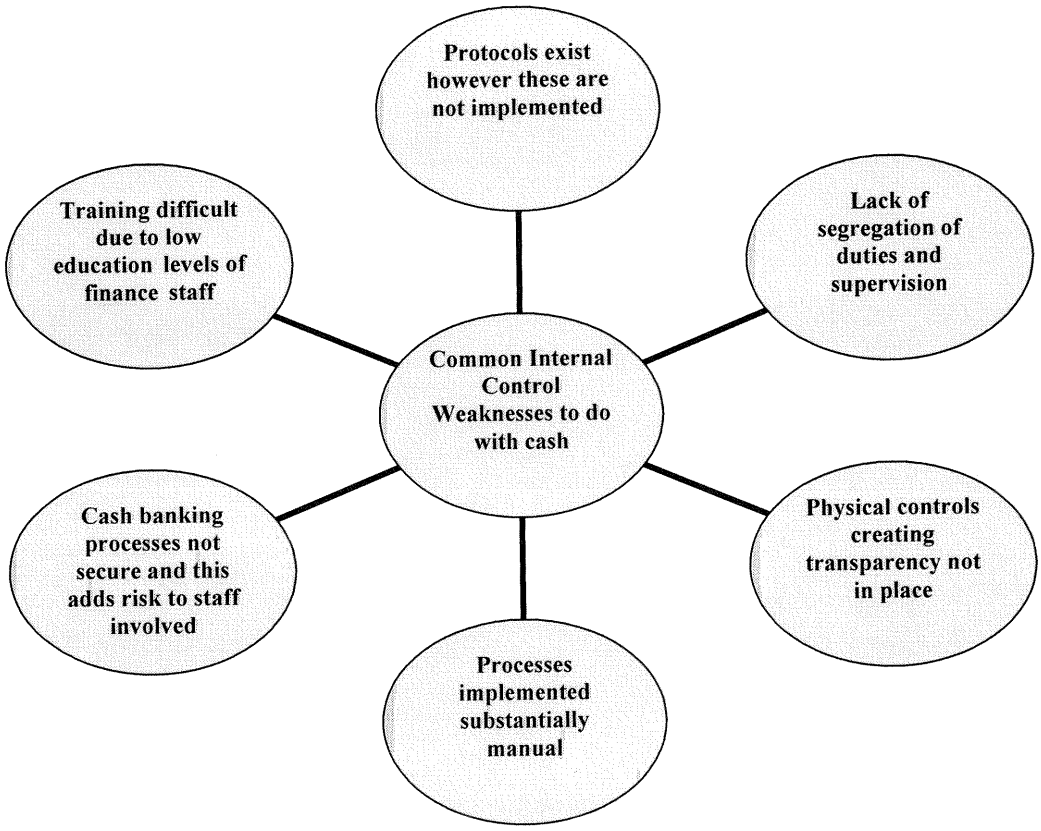


Figure 4-3: Graphical representation of internal control weaknesses specific to cash at the 40 hospitals studied

4.9.2 HUMAN RESOURCES AND ISSUES AROUND PERSONNEL

With the vacancy rate in finance and administrative posts both high and increasing, and the very real shortage of nurses, doctors and pharmacists at all levels as indicated by the staff establishments analysed, segregation of duties becomes an almost impossible task to achieve throughout most of the hospitals in the sample. Workloads are heavy for the existing staff according to the CEOs. However, this perception is mostly due to actual

employed staff being compared with provincial based staff establishments which imply a massive shortage of staff in key areas, such as procurement, human resources and records. These staff establishments have in 4 of the 5 provinces studied been standardized and as such are the same for all district hospitals no matter how big or small they happen to be. The CEOs and staff within each facility then fixate themselves on the empty posts without objectively assessing the need for staff specific to their hospital. As a consequence staff are often unwilling to do extra duties and to assist with performing duties specific to vacant posts, and this often leads to internal controls being overlooked, greatly reducing the reliability of the information being produced by the hospitals studied. Figure 4-4 below illustrates the shortcomings within the human resource function of the hospitals analysed, and all of these open each hospital to a wide range of potential gaps further increasing them to risks of fraud and corruption.

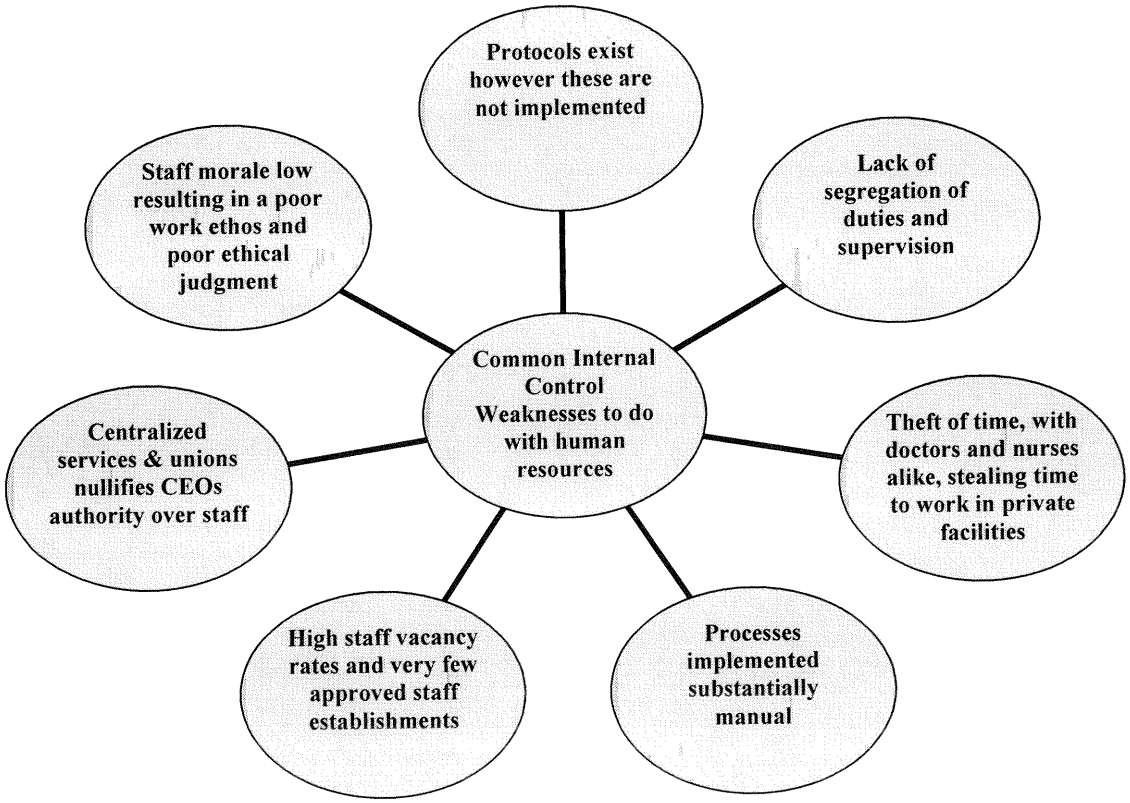


Figure 4-4: Illustration of internal control weaknesses in Human Resources at the 40 hospitals under review

4.9.2.1 THEFT OF TIME

The hospitals have very weak controls over unrecorded leave and over sick leave, especially the sick leave taken by staff who put in for overtime payments or who do paid shifts at another hospital. This is seen more in institutions that have low staff morale, which is often a result of weak supervision as well as a lack of follow-up when employees call in sick.

The data found that South African hospitals are particularly poor at controlling private practice by doctors in their public-sector working hours. We are not aware of any provinces which require hospital consultants to sign contracts specifying, for example, the number of out-patient clinics or operating theatre sessions which they will attend in a week or a month. Observation and interviews indicate that senior management tends to leave doctors alone for fear that they might leave. In all the hospitals sampled one sees evidence in the approved budget that the approved funds available for compensation of employees is less than what the actual employed staff will cost in that year. This result in posts being immediately frozen should an employee resign, leave or die. This has been evident in the analysis of budgets and Auditor General reports over the past eight years at least. This is another clear indication that the amounts within each hospitals budget are not aligned with any realistic human resource plan, and once again provides a clear indication that useful dialogue between hospital management and Province is limited. This limits accountability and transparency, as senior management would prefer to turn a blind eye to misdemeanors, simply for fear of losing staff, as it is better to have staff in post than not to have staff.

4.9.2.2 STAFF ISSUES AFFECTING PROBITY

4.9.2.2.1 LEADERSHIP AND MORALE

The morale and attitude of the CEO, senior management team and hospital staff in general can be an important factor in explaining why the systems of internal control that do exist are not reducing the incidence of theft, fraud and corruption.

Hospital managers in South Africa are all too aware that they are managing in a hostile and often violent environment. At least five of the hospital CEOs sampled had been subject to death threats, usually after disciplinary enquiries or after the discovery of fraud. But sadly, malefactors don't always stop at threats. In 2007, a hospital CEO in Limpopo (a Masters' student at the University of the Witwatersrand), was shot and killed along with three of her senior staff, by an employee who had been subject to a disciplinary hearing. Given that the initial offence had been the employee's use of a hospital vehicle for private purposes, it could be argued that the lives of the four managers would not have been lost if only the hospital systems had been more robust, making illicit use of hospital property more difficult.

4.9.2.2.2 THE SKILLS OF THE HOSPITAL CEOs

A hospital CEO is the accounting officer for the institution, and is required to sign off budget proposals as well as to ensure that accounting records are maintained within their facility. Yet none of the CEOs in the sample hospitals were able to express confidence in their own mastery of financial issues at the hospital. Some were hesitant about interpreting the subtexts and hidden assumptions in a budget or expenditure report, while others struggled with basic bookkeeping concepts, such as assets, creditors and debtors.

This makes it difficult to conclude that they and the other hospital CEOs in South Africa are equipped to fulfill their responsibilities under the PFMA, or to proactively manage the budget of their institution.

Unfortunately, in many of the hospitals, the finance staff are no better equipped, and so cannot advise their CEO.

As one CEO, with an annual budget of more than R250 million poignantly said:

> "I struggle with financial issues; I know that I know nothing. But, believe it or not, I know more than my finance officer does. But he only has a matric certificate".

4.9.2.2.3 SHORTAGES OF APPROPRIATELY TRAINED FINANCE STAFF

One of the key reasons for the absence of auditable systems and of effective management information is the fact that there is a real absence of appropriately trained finance staff in public hospitals in South Africa. There are still hospitals where the lead finance officer only has a school leaving certificate. Even a Level 2, Regional hospital is unlikely to have a finance officer with more than a Bachelor of Commerce degree. In most hospitals there are approved finance posts which are intractably vacant.

There is a very real problem in attracting finance staff with the skills and experience needed to manage and improve the internal control processes in public hospitals in South Africa. The level of skill and responsibility that the finance posts require are not reflected in the salary grade on offer. So it is not surprising that that public sector cannot compete with the private sector for staff, and that many hospital finance staff openly admit that they are using their time in the public sector as a stepping-stone to more lucrative work elsewhere.

An analysis of ten hospitals within the sample provided the following insight into this problem and this is tabled below. Two of the ten hospitals in the table had success in retaining their Chief Financial Officers (CFOs). Both these CFOs were ladies aged between 40 and 55 and had both worked at the hospitals in question for many years and had developed themselves practically over time. In addition both ladies showed a willingness to advance their studies further and seemed passionate about their jobs. This unfortunately was an exception rather than a norm and in discussions with the various CFOs if became evident that they saw their jobs as stepping stones to private sector. Two openly admitted this to the researcher.

In addition tertiary qualifications are few and far between for both CEO and CFO which raises the question does the CFO truly understand the financial information he/she is expected to produce and is the CEO able to pick up errors when they occur. This is clearly a risk which does result in fraud being committed and these frauds are easily hidden from an untrained eye.

Table 4.6 Illustration of finance staff experience, training and availability up to August 2009

Hospital	Does CEO have training in finance other than MPH?	Chief Finance Officer (CFO)Training	Has the post been filled for the past 2 years?	Salary Level of CFO	Has the CFO been in the post for more than 3 years
A1	None	Currently studying for a Bcom (UNISA)	Yes	L8	Yes
A4	Diploma in Advanced Hospital Management	NA	Currently Vacant	L8	NA
A8	None	Currently studying for a Bcom (UNISA)	Yes	L9	Yes
B1	General MBA	Currently studying for a Bcom (UNISA)	Yes	L8	No
B10	General MBA	Bcom	No	L10	No
C3	None	NA	Currently Vacant	L8	No
D3	None	NA	Currently vacant	L8	NA
D5	None	None	No	L8	No
E4	None	NA	No CFO Post	NA	NA
E6	None	NA	Currently Vacant	L10	NA

4.9.2.2.4 SHORTAGES OF CLINICAL AND OTHER PROFESSIONAL STAFF

The hospital vacancy rates relating to approved posts for specialist doctors, nurses and pharmacists range from 20% to 80% at the sample hospitals.

Where there is a shortage of nurses or doctors, the likelihood of accurate record keeping in the patients' notes diminishes, leaving the hospital without a paper-trail for medico-legal investigations.

It is difficult, for instance, to maintain the controls required in terms of the Pharmacy Act 53 of 1974 in a situation where there is a shortage of qualified pharmacists in public hospitals. For example, in the 2007/8 financial year the five pharmacists at one 800 bed

Level 2 hospital failed to undertake the annual stock- take required in terms of the Pharmacy Act. This was a failure both in terms of professional regulations and in terms of audit probity, but is perhaps not entirely unexpected given the volume of the daily workload in relation to the tiny complement of staff in post. This is one of the many problems facing these pharmacies which undoubtedly lead to theft, corruption and misuse of pharmaceutical supplies.

4.9.2.2.5 VACANCY RATES AND RECRUITMENT DELAYS COMPROMISING THE USE AND MAINTENANCE OF MANAGEMENT INFORMATION SYSTEMS

The difficulty of employing replacement staff when a post is vacated is not simply a symptom of a shortage of appropriately qualified staff willing to work at the grade levels offered by the health department, it is also a symptom of the great difficulties hospitals in different provinces have in surmounting the hurdles of the recruitment process. Some provinces do not yet provide the delegations promised in the 1994 Health Plan to hospital managers over recruitment and other Human Resource issues.

In Gauteng Province, a hospital CEO is empowered to employ staff up to the level below their own, so a Grade 12 CEO can employ individuals up to Grade 11. But in both the Northern Cape and North West provinces, to employ anyone, from a doctor to a cleaner, the CEO has to obtain clearance from several other signatories in the Province. In North West, the recommendation to open a post for recruitment goes up within the hospital to the CEO, after which six more signatures are needed within the provincial structures:

In the North West the CEO passes the recommendation to:

- the District Chief director, who passes it to
- the HR Director of the Province, who passes it to
- the Corporate Services Director, who passes it to the Deputy Director General, who passes it to
- the Superintendent General, who passes it to
- the Departmental Executive Committee

If, by then, the recommendation to fill the post has not been refused or mislaid on its way up the hierarchy, it is finally possible to go forward with the advertisement. Even within the hospital, the process of recruitment can normally only start once the previous incumbent has left the post, and the process of obtaining permission to advertise can easily take up to nine months, during which time even key professional posts are likely to remain vacant. This is also true for Free State and Northern Cape who both have just as onerous procedures in place which ultimately hinder rather and support the hiring process. One would be foolish not to question whether this delaying tactic, based on financial constraints, is not deliberate.

4.9.3 SUPPLY CHAIN MANAGEMENT AND PROCUREMENT

A hospital's operating budget is distributed between standard line items. The largest single item is staff pay, but the goods and services budget is also substantial, consistently between 30% and 40% of a hospital's total budget. At an operating level, a hospital's goods and services budget divides into three main categories:

- Contracts and contracting out (e.g. kitchen services, security)
- Goods delivered
- Agency staff costs

The actual distribution between these three categories varies mainly in relation to the hospital's use of agency staff to substitute for unfilled permanent posts. This varies even within a single province, in the Northern Cape for instance, one remote rural hospital relies heavily on the use of agency nursing staff, but a hospital in a more urban centre does not use agency staff at all. There are also wide variations, usually between provinces, in the contracting out of cleaning, security and food services.

The evidence shows that this function was in many instances the most problematic to the CEOs. The budget information showed goods and services as the category within most budgets that either stayed constant or decreased from one year to the next. If one factored basic inflation, and the increase in petrol as well as food prices, this would indicate that

hospitals were facing the certainty of overspend from the outset of each new financial year.

The data also revealed enormous shortcomings in the accounting for and distribution of pharmaceutical stores. Pharmacies in all provinces are extremely under-staffed, and this often means that staff rotation is required to ensure service delivery in hospitals and their associated clinics. Security controls are often adequate within the main hospital pharmacy, but as soon as stock is allocated to wards and leaves the pharmacy, the ability to track this stock disappears. In all provinces most public hospitals, including the large Academic Hospitals with annual budgets of up to R1.2 billion, have only partially computerized or manual stock management systems, and this makes proper stock management impossible. Manual processes at ward level exacerbate the problem, as there is often no way of tracing allocated stock back to individual patients for whom it may have been prescribed.

Figure 4-5 below shows some of the main issues within supply chain management and procurement.

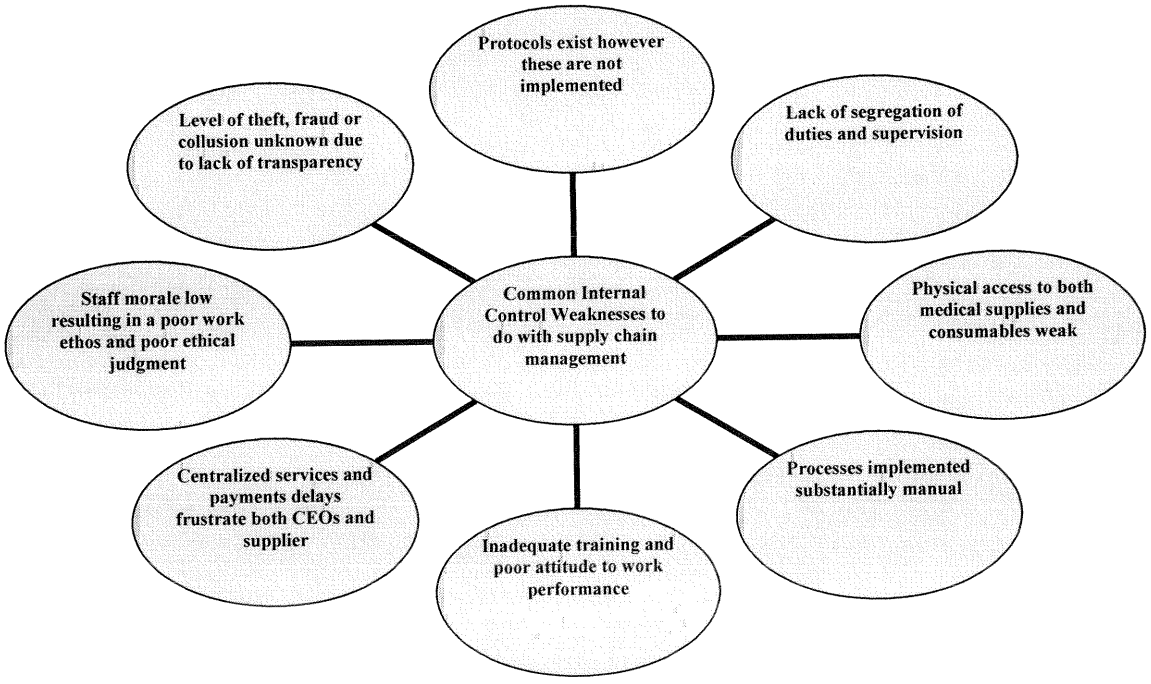


Figure 4-5: Internal control weaknesses specific to supply chain management

Additionally, supply chain management is not efficient in all hospitals within the sample to varying extents. The systems in place cannot adequately track goods ordered or received. There is no alert when stocks reach minimum levels, and due to extreme staff shortages, untrained and unauthorized personnel may commonly place orders. This often creates duplication of orders that is not noticed until it is too late. Expired stock is a common consequence of hospitals over-ordering, sometimes due to uncertainty of what they will receive due to delivery problems from the supplier or from the provincial central stores.

Food and laundry services are two areas which provide evidence of poor stock management and, at some sites, a total lack of control. Unacceptably weak levels of supervision lead to wastage and theft. At one of the large academic hospitals, an audit of linen in 2007 reflected a loss of R2.4 million specific to the laundry in the 2007/8 financial year.

These examples highlight the importance of good internal controls. The reality is that good internal controls are only possible with sufficient staff and this is in the eyes of many of the CEOs an issue that under the current provincial government policies is impossible to solve. Provincial governments are required to create annual financial statements and these are audited by the Auditor General. The financial records of each hospital within the province forms part of these financial statements, but it is impossible to verify the accuracy of the consolidated information being produced, and this has lead to audit irregularity reports and comments that the hospital specific information included is not auditable.

4.9.3.1 THEFT AND STOCK CONTROL

There are national and provincial protocols for supply chain management, but they are not necessarily followed at individual hospital level.

All provinces in the study use the national Basic Accounting System (BAS) and two of the provinces have installed LOGIS procurement management system, but to varying extents, and in all of the hospitals visited a proportion of purchasing and distribution is

still done manually. Even in hospitals where there is electronic ordering, once the items leave the stores and reach the individual departments where they are used, the departmental stock-control system is usually manual, where it exists at all. Bin-cards may be used in the hospital's main store and in the pharmacy, but they tend not to be conscientiously maintained in the wards and other end-use units, even where they are in place at all.

There is little auditability of stock usage and protocols and, in the case of pharmaceutical items, even legal requirements demanding that stock is kept in locked stores at unit level are often ignored. Unlike in the private sector, where every swab and tablet is charged to the individual patient's account, in the public sector there tends not to be any reconciliation between stock distributed and items actually used.

It is clear that in many cases, overspend is due to a lack of controls in various parts of the system. A large proportion of overspend can be accounted for by petty theft of individual consumables, pharmaceuticals, or food, and lack of control over the use of hospital resources such as the telephone. The extent of these thefts on the hospitals budget are unconfirmed due to the manual processes being applied. At one large hospital, the recorded incidence of pilferage of pharmaceuticals is easily in excess of R50 000 per month as discussed in the Core Standards appraisal process with the CEO in charge at the time (July 2008). This however does not take account of large scale theft of pharmaceuticals, which management at that hospital estimates, as per a detailed internal study by senior management of the hospital concerned conducted in 2008, to account for something closer to R12 million per annum – 10% of the hospital's total pharmacy budget of R120 million.

All of the hospital chief executives in the sample interviewed (see Chapter 6) acknowledged that policies and procedures are not followed, and internal control systems, where they exist, are not nearly sufficient to ensure that theft does not occur. One manager explicitly said that the worst-performing staff from other departments were

redeployed to supply chain management. This admission clearly indicated that the hospital management truly did not understand the importance of this function.

This coupled with totally inadequate manual checks and balances, amounts to unlimited possibilities for supply chain staff to steal or to collude with suppliers. The managing, collecting and analyzing of information, as well as ensuring each employee within supply chain understand how important paperwork is to the process of transparency, would be a crucial first step towards probity and towards effective implementation of a control system.

Both at hospital level and at provincial level, there is little or no accountability for supply-chain failures. At neither level is a single individual seen to be responsible for failure to deliver. Actually, given that even in situations where managers can and do clearly identify system failures, it would indeed be unfair to blame and scapegoat an individual for failures if they do not have the power to intervene and to change the situation.

But without accountability, no-one in the supply-chain function accepts the blame when clinical services or patients' experiences are compromised due to a lack of consumables or equipment.

In Gauteng, for instance, no one individual is blamed when there is no paracetamol – or gloves, or soap, or defibrillators - at a state hospital. The failure to deliver is the result of the sum of individual and system failures both within the hospital and throughout the Gauteng Shared Services organisation. Apathy, indifference, slow work, computer problems, work that is heaping up on individual desks, slowness to pass the order from one clerk to another, all these combine to delay the order, and the paperwork required for delivery.

One of the CEO's commented that:

"For hospital staff trying to trace the progress of a particular order, it's like trying to contact a remote, Mephistophelean call centre. Each time one phones, a different staff member responds, and needs to be told the whole story yet again."

4.9.4 INFORMATION MANAGEMENT AND SOURCE DOCUMENTATION

Figure 4-6 below represents short comings within information management common in the 40 sample hospitals.

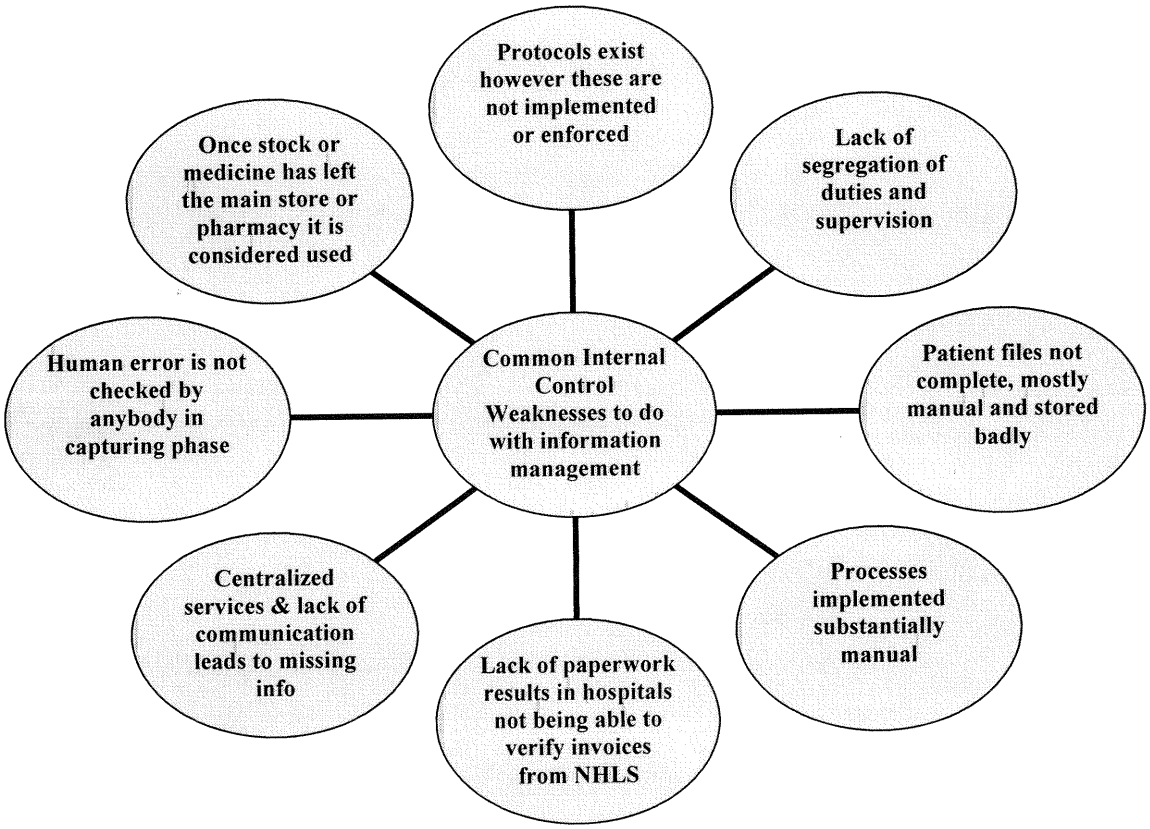


Figure 4-6: Internal control weaknesses specific to information management

One of the important factors impacting the effectiveness of internal controls is that many processes within public hospitals are still manual. And with significant shortages of appropriately skilled administrative staff in key disciplines, this makes the managing and verifying of the manual data almost impossible. Patient records are another significant area of concern, with evidence from Core Standards appraisals as well as the nine

hospital visits in Phase 3 of this study showing how the lack of effective systems of control result in the completeness of and validity of the information within the patient files being a problem. Even the information that is included in the patient files cannot always be verified, often resulting both in extra clinical costs and in patient outstanding fees being written off. The fact that so many aspects, including procurement, are still largely manual processes makes safe guarding, backing up and ordering of data impossibly difficult. And with the significant staff shortages within the administration functions this is compounded further.

It was confirmed that systems, specific to the managing of patient files do exist and are followed however these are flawed as the systems are often old and outdated. This is partly due to available personnel skills where we see many employees having worked for the respective hospital for decades within the same or similar role. Over the decades these hospital administrative departments have become accustomed to the way they process information, and on the whole are not motivated or willing to change.

4.10 CONCLUSIONS ONE CAN DRAW FROM THE ANALYSIS THUS FAR

South Africa has been very late among developing and developed countries to recognize that hospital management is a particular professional field, which draws on general management expertise as well as an understanding of health issues. This is seen in the significant gaps with respect to processes and controls used to hold people accountable, as well provide the transparency necessary for the Auditor General.

The conclusion reached from the analysis of the data thus far, in Phase one, is that the hospitals are under-funded and under managed. The majority of the sites show overspends in excess of the 2% allowed by the PFMA; this is without including the accruals that exist as at 31 March each year, which only compound the problem further. However, are the hospitals simply under-funded or are they spending the available and approved funds poorly? The study reveals that there are weak financial management control systems at both hospital and provincial level, making it difficult for managers and

auditors to prove or to quantify the extent of corruption. Specific examples only show the existence but not the extent of fraud and corruption in the health service.

The next phase in the research begins the process of triangulation. In Chapter 5 of this report, an analysis of Auditor General Reports will provide an independent assessment of the internal controls, their implementation and systems in place in order to further strengthen these findings.

CHAPTER 5 – PERSPECTIVE OF THE AUDITOR GENERAL (PHASE 2)

During phase one of this report, in Chapter 4, public domain documentation relating to 40 public hospitals was analyzed. Through this, it was possible to form a view about why hospitals were under or over spending on their approved budget allocation. The analysis indicated a lack of effective internal controls being implemented within these hospitals. This represents gaps that could expose the hospitals to many forms of risk.

Phase 2 will focus on the views of the Auditor General so as to confirm or refine the conclusions drawn thus far. This will represent the first of two phases aimed at triangulation of the overall findings and in so doing will strengthen the final conclusions and observations made. Chapter 5 reviews twenty audit irregularity reports from hospitals spread across six provinces and focuses on audit irregularities that were common at the different sites. Nineteen of the reports were specific to the 40 hospitals analysed in Phase 1 and the 20th report from Mpumalanga Province relating to a large Level 2 hospital was included here to further confirm that saturation had been reached.

Hospital specific Auditor General reports are often difficult to get access to. Hospitals are often audited with specific areas of concern, such as supply chain management as an example, and so this limits the scope of those findings. The Mpumalanga audit report was useful in that it reported on hospital wide irregularities. As such the researcher used this report as a basis for what irregularities exist and then compared these to the other audit reports analysed in order to obtain a reliable opinion on whether the irregularities where common throughout the sample or not.

The South African Constitution (RSA 1996, paragraph 188) establishes the Auditor-General as the external auditor of all national and provincial state departments and municipalities and of any other institutions or accounting entities, including public hospitals. Each year, the staff of the Auditor General, as part of their audit of the various Provincial Departments of Health, visit a representative sample of hospitals in each province, so as to make an informed opinion on the accuracy of the consolidated

financial statements being prepared. Each hospital is seen by the provincial department as a cost centre, and the actual expenditure reports of public hospitals are therefore incorporated into the consolidated provincial department of health annual financial statements.

Over the past 8 years the Auditor General has not once given the National Department of Health a clean audit report. In six of these years the report has been qualified and twice they received an Emphasis of Matter.

The Auditor General defines a qualified audit opinion as:

- A *'Qualified Audit Opinion'* indicates that there are certain aspects of the financial statements on which the Auditor-General cannot express an opinion because they are false or incorrect and do not accurately represent how the department spent its money.

And the term *Emphasis of Matter* as:

- When the Auditor General has particular concerns that do not relate directly to whether the financial statements of a department are accurate or not, i.e. matters concerning policy and proposed programs of action or non compliance with statutory requirements, these are expressed as *'Emphasis of Matter'*.

Emphasis of Matter can be, and often is, a very serious opinion. In many cases it means that the Auditor-General has raised serious concerns about weaknesses in the financial management procedures of a department or entity. The Auditor General opinions on the six provincial departments included in this study are summarized below in table 5-1.

Year in question	Free State	Gauteng	Limpopo	Mpumalanga	North West	Northern Cape
2008-09	Qualified	Disclaimer	Qualified	Qualified	Qualified	Disclaimer
2007-08	Qualified	Qualified	Qualified	Qualified	Qualified	Disclaimer
2006-07	Qualified	Financially Unqualified (With other matters)	Qualified	Qualified	Qualified	Disclaimer
2005-06	Financially Unqualified (With other matters)	Qualified	Qualified	Financially Unqualified (With other matters)	Qualified	Disclaimer
2004-05	Financially Unqualified (With other matters)	Qualified	Financially Unqualified (With other matters)	Financially Unqualified (With other matters)	Qualified	Disclaimer
2003-04	Qualified	Qualified	Financially Unqualified (With other matters)	Financially Unqualified (With other matters)	Qualified	Disclaimer

Table 5-1 Summary of Provincial Department of Health Auditor General Audit Opinions 2003 to 2009

The Auditor-General every year since 2006 has consistently reprimanded government on achieving qualified audit reports and provided examples in Provincial Audit Reports where Departments of Health paid out more than R1.3 billion in conditional grants before receiving the necessary business plans stating how the money would be spent. The business plans and the way in which funds were paid out demonstrated that no real planning or strategies were in place over the spending of funds within the Provincial budget. It was done is a unplanned and often haphazard manner and this in 2006/7 in the Eastern Cape, as an example, resulted in irregular and wasteful expenditure within Health, the majority of which had no paper trail making it impossible to trace. And even with this overspend in the 2006/7 financial year, the National Department of Health ranked among the top five most expensive government departments for Christmas parties, with an outlay of R91 728 (Auditor General, 2008).

Each province has an internal audit staff which, at minimum, rotates through the individual hospitals, and each hospital is audited on rotation by the provincial Auditor General. Yet neither of these bodies are able to ensure that their recommendations are implemented. Internal audit reports and Auditor General Reports regularly repeat findings noted in previous visits, and note that the necessary systems have not yet

been put into place. The reports go on to comment that in many instances no paper trail exists, making it impossible for the Auditor General to perform an effective audit.

Observations and interviews revealed that the majority of the public hospitals in the study do not have risk management departments within their organizational structures. Senior management is assisted by internal auditors attached to the provincial head office that conduct annual audits of specific areas, such as supply chain management. Even for internal audits, provincial staff shortages and time constraints make it impossible for each hospital to be audited on an annual basis. However, where internal audits have been conducted they reveal that, in public hospitals, the internal controls are inadequate and ineffective to provide reasonable assurance that the processes audited will achieve their objectives.

The Standing Committee on Public Accounts (SCOPA) reported in 2009 that there were large and long term staff shortages in the Auditor General's Department, This level of staff shortage makes it simply impossible for the Au Gen to visit each institution annually, and when they do visit they focus each time on a specific area, such as supply chain management, finance or revenue collection. So this means that the Auditor General only assessing each area in any one facility at best once every 3 to 5 years. This lack of continuity and follow up also helps to explain why irregularities recur year after year.

Mr. Themba Godi, the chairperson of SCOPA, in a public lecture at the University of the Witwatersrand on 13 August 2009 added to the discussion by stating that 60% of managers in Health in South Africa have no real management training or experience. Accountability and good governance are crucial to ensuring clean audits as the "human element" is ultimately the decisive factor in ensuring compliance to regulations and protocols. He argued that South Africa has no legislative gaps relating to the achieving of good governance in public institutions and thus ensure accountability, the problem is implementation. If implementation could be accomplished, this would lead to good governance being achieved. Godi continued by confirming that some training does exist, but often the incorrect people are

nominated, or they and their managers see the training more as a holiday than as a tool to help them improve the implementation of management control systems.

Godi emphasized 3 challenges facing public sector facilities: Firstly, the actual deficits of human capacity within the public sector is not properly quantified. Statistics from the Persal system indicate high vacancy rates, but Persal is not accurate and so the actual truth is not known. Secondly, internal controls are in general not being complied with. He believes that there is a culture of non-compliance; and when public officials break the law the consequences are not severe enough to discourage subsequent incidents. Thirdly, Godi deplores the lack of a sense of responsibility among public sector staff, and he concludes that the urgency, initiative and accountability of public sector staff is bad. He commented that management that are often corrupt, and if caught merely resign and move on before official action is taken. Finally, the power of SCOPA and Auditor General is merely one of investigating and reporting, and neither SCOPA nor the Auditor General have the power to force the National Executive to take action against corruption or to fire senior officials caught defrauding government.

It is important to note that over the past 7 years the Auditor General has not expressed a positive opinion on the financial statements of all Provincial Health Departments due to the significance of the irregularities uncovered. Examples of these irregularities at the sample of hospitals studied is discussed in detail below.

5.1 AN EVALUATION OF THE 20 AUDIT IRREGULARITY REPORTS

The PFMA requires an appropriate procurement and provisioning system which is fair, equitable, transparent, competitive and cost effective (PFMA, 1999: paragraph 38). Yet our findings indicate that that this is far from current practice. A mixture of centralised or decentralised procurement practices exist in the different provinces, with none of them truly operating in a true, fair or transparent manner.

A review of Auditor General Reports, over the period 2006 to 2009, for 20 different hospitals in six of the nine provincial Departments of Health in South Africa reveals many common problems relating to the procurement of goods and services. These

affected the financial accuracy of the financial statements so seriously that in one province the Auditor General could not make an opinion on their accuracy.

Both internal audit reports and Auditor General Reports repeat findings noted in previous visits, and note that the necessary systems have not yet been put into place. The reports go on to comment that in many instances no paper trail exists making it impossible for the Auditor General to perform an effective audit.

The performance of these audits is essential to ensure that systems of internal control established are adequate to provide reasonable assurance that the Department of Health's objectives and goals will be achieved effectively, efficiently and economically. The audits include an evaluation of the controls and procedures in place through including a random sample of selected documentation for the particular year under review. The review of the audit encompasses compliance with policies, procedures, laws and regulations, reliability and integrity of information; economical and efficient use of resources as well as safeguarding of assets.

Using this approach, the intention is to highlight gaps inherent in the systems of control being implemented. Where gaps exist, these represent risks that need to be addressed. Risks represent the possibility of fraud, corruption and mismanagement. Without having effective management control systems in place to provide transparency, there is no way of assessing the extent to which the risk is translated into actual fraud or corruption.

As indicated earlier, the Auditor General can only sample the situation at particular sites each year, and, only one or two areas within each hospital are focused on at any one time. However each audit was sufficiently significant to provide evidence as to what gaps were common across each province, and these will be discussed in detail below.

The main areas focused on within the audit irregularity reports were:

1. Tender processes
2. Procurement and supplies

3. Pharmacy
4. Finance
5. Human resources
6. Economic and efficient use and safeguarding of assets

In the present study, the auditor's findings in each of these six areas was analysed at each of the 20 study sites, and the findings are presented in tabular and graphical format. It must be understood that due to the Auditor General's practice of sampling, each audit irregularity report only focused on specific areas, so if a specific irregularity is not mentioned in the audit report that does not necessarily imply that the problem does not exist, only that it was not appraised. The evidence from Phase 1 indicates that more often than not, these irregularities are likely to exist even at those sites where the irregularities are not specifically noted.

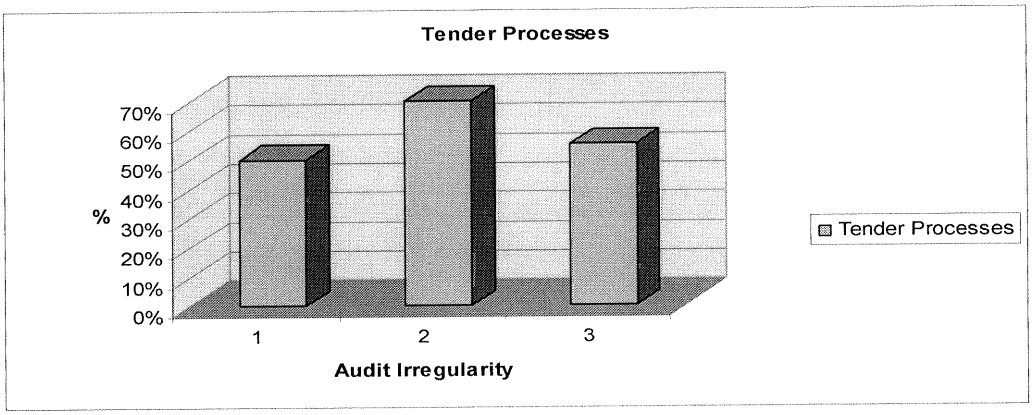
The format of each Auditor General report involves firstly stating what the specific audit finding is, then discusses what might be the root cause associated with this finding, and categorizing the findings as relating specifically to financial activities, operational activities or policies and procedures. The report then explains in detail what the risks are, and what recommendations the Auditor General has proposed to remedy the issue at hand. Examples of these findings will be discussed in detail below.

The six areas mentioned above will now be individually discussed and the audit irregularities uncovered by the Auditor General specific to this area will be analysed. The results will be disclosed in graph format with each respective x-axis representing the audit irregularities and the y-axis representing the percentage of sites in the total of 20 audit irregularity reports, where this irregularity was mentioned. Each graph is accompanied by a legend explaining what each audit irregularity was. This leads into a discussion around the irregularities and the risks identified by the Auditor General, illustrated by some hospital specific examples.

5.2 TENDER PROCESSES

There were only 3 audit irregularities specific to tender processes that were picked up in the Auditor General reports and these are tabled below.

Figure 5-1 - Audit irregularities specific to tender processes



Legend:

1. *Minimum number of quotes as per treasury not obtained (mentioned at 50% of sites)*
2. *Payments for services/goods paid without appropriate documentation (70%)*
3. *Tender processes not complied with as per provincial guidelines (55%)*

5.2.1 TENDER ALLOCATION

In terms of procurement protocols within each province, all suppliers tendering are required to be on an approved vendor list. This list should be updated regularly, and the suppliers should be investigated to verify that they are real entities, and not merely a front for an existing vendor to submit a second or third bid. The Auditor General reports show the tendering processes to be weak, and they record instances where tenders have been awarded without the required minimum of at least three quotes being received. Further, subsequent events show that in many instances the company that wins the tender cannot even adequately supply the product tendered for.

Auditor General Investigations reveal many instances of fraudulent documentation and collusion, but the Auditor General also warns (Audit Reports, 2007, 2008, 2009) that these are only the cases which have been identified, and that there are likely to be many others which have not been uncovered due to staff shortages in the internal and external audit functions.

Examples from three different provinces are:

1. Procurement of telecommunication equipment for EMS vehicles totaling R459 804. Apart from the successful supplier, the existence of none of the companies which submitted quotations could be confirmed by the Auditor General.
2. A tender amounting to R2 415 145 was analysed by the Auditor General, who found that all three quotations received had been faxed from the same fax number, being the fax number of the successful supplier.
3. No tender processes were followed in respect of food parcels to the value of R1 827 259.

One Auditor General report noted that all quotations received for one tender were at a premium above the market rate. This implies collusion between suppliers and government officials, or at very least a failure of the supply chain staff to check and verify tender prices. However the lack of accountability and transparency in the systems currently in place see these irregularities continuing.

According to tender policy documents in all provinces, once a supplier has been awarded a contract for a particular period in a province, the hospital management cannot use any other supplier, even when they have identified that the preferred supplier is charging above the market rate.

It is vitally important that tenders and potential tender bid winners are fully investigated. One extreme, but not uncommon, example put forward by a hospital manager, was the case of two new laptop computers for senior staff. The retail price in a shopping mall was R9 000 each. But the hospital had to go through the preferred suppliers – who offered the same model at R24 000 each.

5.2.2 COLLUSION BETWEEN SUPPLIERS AND PURCHASERS

Obviously, the whole point of introducing supply chain regulations and controls is to improve probity and to diminish the opportunity for fraud, theft and unfair contract

allocation. Where any of these are undetected, it is impossible to quantify the extent of their occurrence.

The 2006/7 audit of the Northern Cape Provincial Department of Health revealed a substantial case of undetected significant fraud: an R1.7million fraud by Health Department staff in collusion with suppliers. The officials had altered the bank details of an existing supplier, and compiled a batch of payments into a private bank account.

Both in the public and the private Health Sector there have been many recorded cases of collusion and kickbacks in the procurement of pharmaceuticals and medical supplies, for so long and so extensively that this has been acknowledged internationally as the status quo (Lewis, 2006, p23). The Auditor General confirms that failure to adhere to tender policies and procedures creates risks that suppliers and procurement staff alike will use this as easy opportunity for committing fraud.

There has been a lack of close investigation of the relationships between hospital and provincial senior management and procurement staff and the directors of companies which have won tenders. A 2007/8 report by the Attorney General, (Sunday Times June 15 2009) revealed that more than R600 million of government contracts have been inappropriately awarded to companies in which officials or their relatives have had a financial interest. Obviously, this kind of collusion is likely also to occur in contracts awarded by Provincial Health Departments or by hospital CEOs using delegated authority, but without close investigation there is no way of quantifying this problem.

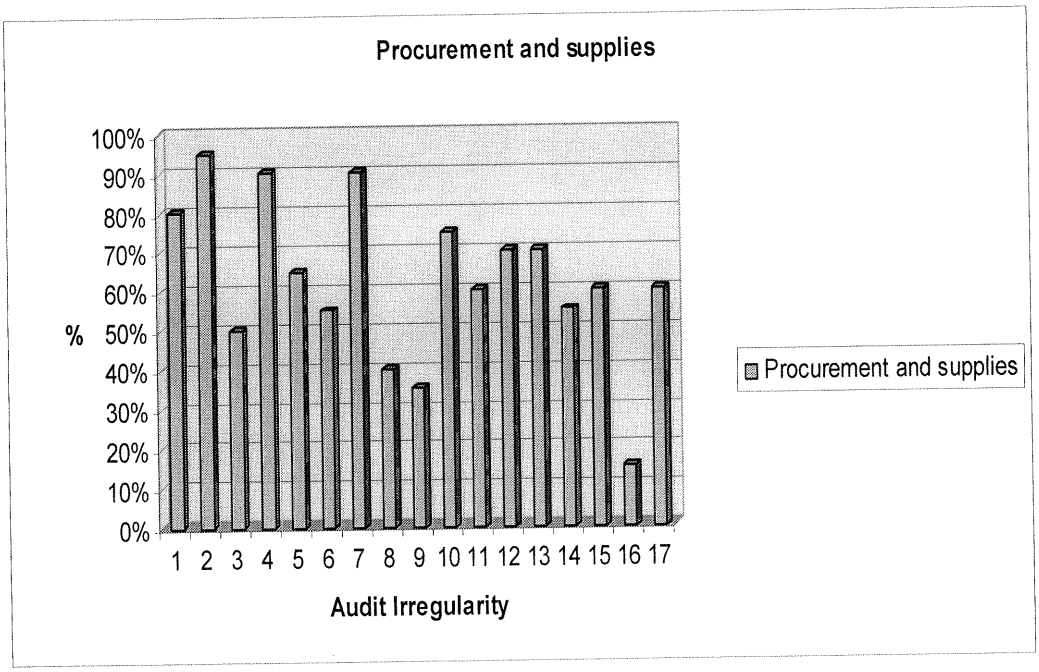
Usually at a much smaller scale, the Auditor General and the internal auditors repeatedly identify instances at provincial and at hospital level where an invoice has been paid twice, both on receipt of the paper invoice and on receipt of a faxed copy. Senior management at several hospitals where this kind of activity was uncovered are sure, without evidence that it happens 'frequently'. But without effective systems, and without effective audit, these frauds will only continue. Von Holdt (2009) endorses this perception, reporting that in one particular South African hospital, union shop

stewards estimate that 80% of staff perceived corruption as being a part of their job description.

5.3 PROCUREMENT AND SUPPLIES

Figure 5-2 shows that there are 17 common audit irregularities associated with procurement and supplies:

Figure 5-2 – Audit irregularities specific to procurement and supplies



Legend:

1. *Bin cards missing leading to possible stock losses not being detected (80%)*
2. *Non-adherence to documented policies and procedures (95%)*
3. *Physical access to stores not restricted (50%)*
4. *Delivery notes / invoices not signed confirming receipt of correct goods / services (90%)*
5. *Difference between actual stock and stock record balances (65%)*
6. *Disregard in relation to delegated authority with respect to paying suppliers (55%)*
7. *Expenditure - payments not within 30 days (90%)*
8. *Installation of goods purchased incomplete due to supplier not being paid (40%)*
9. *Invoices received and dated an earlier date than the approved order form (35%)*
10. *Lack of segregation of duties in ordering/authorising/receiving (75%)*
11. *Requisitions not attached to payment vouchers - not appropriately motivated or approved (60%)*
12. *Service Level Agreement's with vendors not in place (70%)*

13. *Stock received not processed on VA10/bin cards leading to possible stock and financial losses. (70%)*
14. *Unused parts of issue vouchers / stock cards not crossed out (55%)*
15. *Value for money not achieved as excessive consumption not followed up (60%)*
16. *VAT paid on invoices to suppliers not officially registered for VAT (15%)*
17. *NHLS invoices paid without proof that they had been verified and adequately checked (60%)*

Figure 5-2 shows that the Auditor General sees procurement and supplies as a significant area of concern. The Auditor General reports which were analysed consistently noted that good financial discipline requires management to prepare reconciliations on key accounts, and to follow up on reconciling items. However during the audits it was repeatedly found that no reconciliations are done on a monthly basis between the recorded stock levels and the physical stock holdings.

The reports continue by explaining what is meant by control activities. These comprise the policies, procedures and practices that ensure management objectives are achieved and risk mitigation strategies are carried out. It was noted however that directive, preventive and detective controls were not in place or adequate, also that no evidence existed which proved that ongoing monitoring and supervision are not undertaken to enable management to determine whether internal control over financial reporting is present and functioning.

Some examples of the sorts of risks indentified are: First, the failure to perform reconciliations may result in an inaccurate and incomplete inventory list. For instance, when comparing the LOGIS figures pertaining to unpaid supplier invoices of R7 463 943.05 to a schedule prepared by the hospital management, the Auditor General report, it was found that this schedule was only R2 346 210.60, a difference of more than R5 million. Second, the lack of supporting documentation is likely to result in unreliable and inaccurate financial information, and all this poses the risk that fraud could be perpetrated without detection.

5.3.1 PROCUREMENT AND PAYMENT DELAYS

The PFMA requires all public bodies to pay suppliers within 30 days the prescribed maximum payment period, and failure to meet this deadline constitutes breaking the law. The Auditor General reports commonly record payment delays of between 30 days and 180 days even at hospital level, for the goods and services which fall within the range for which they are empowered to take full responsibility. Where procurement is consolidated at provincial level, delays of between 60 days and 400 days have been commonly identified.

To some extent, it is inevitable that a small proportion of payments will exceed the 30 day limit, as moneys are only distributed quarterly to provinces and to hospitals, so there are obviously going to be some months, especially where major equipment or other occasional large ticket items are bought, when the commitments outstrip the money in the bank. However, the Auditor General is not interested in why the payments were late, and sees this failure as the fault of the accounting officer in question, namely the CEO, even if the delays were caused by slow centralised processes.

But there are far too many instances where payments are deferred for reasons which are not inevitable. A common thread indicated by the both the analysis of Auditor General findings as well as from phase 1 of this study is the lack of capacity, training and understanding as to what systems and controls should be in place, and this results in significant gaps in the necessary paperwork. And with the payments often being made at a central point, the responsible party in the province may delay payments due to the incompleteness of the paperwork, or due to their own inability to keep up with the volume of invoices to be processed.

Table 5-2 shows 4 typical examples from the Auditor General Reports of payment delays at individual hospitals:

Table 5-2: Payment delays by Hospitals

HOSPITAL CODE	SUPPLIER / DESCRIPTION	AMOUNT	DAYS OVERDUE
B1	Various suppliers	R948 488	Various, all between 30 days and 180 days
D2	Eskom	R48 534.94	200 days
V4	AB's Hyper World	R33 800	More than 400 days
V4	African Oxygen Ltd	R104 791.92	More than 9 months
A6	Various suppliers, 23 orders	R26,059,853.64	Various, all between 30 days and 180 days

Source: Auditor General Irregularity Reports for 20 hospitals (2006 to 2009)

Not only has the health service forfeited the opportunity to drive down costs by demanding concessions by suppliers in return for prompt payments, it also lays itself open to unnecessary charges and penalties for late payment. In a provincial audit of the Northern Cape Health Department in 2007/8, R27 035 058 worth of supplier invoices where paid as late as 180 days from date invoice was received.

Suppliers are of course badly affected by delayed payment for goods and for services rendered. One reason for these unnecessary delays is the use of centralised offices within provinces to administer the function of paying suppliers The suppliers supply the hospitals directly but are then paid centrally, so harassing the administration clerks at hospital level for payment is often a fruitless exercise. There is however remarkably little outcry from suppliers, either in their interactions with the hospital or province, or in the public domain.

Hospital managers interviewed in part 3 of this study indicated that this was at least partly because suppliers live in fear of being deleted from the provincial tender list. So any criticism, complaints or adverse publicity can easily mean that they are deemed too troublesome, and while they might eventually get paid, they will not be considered for further contracts.

The CEOs added that smaller suppliers are, obviously, worse affected than large ones, which can more easily roll-over deferred payment. But, especially in a period of high

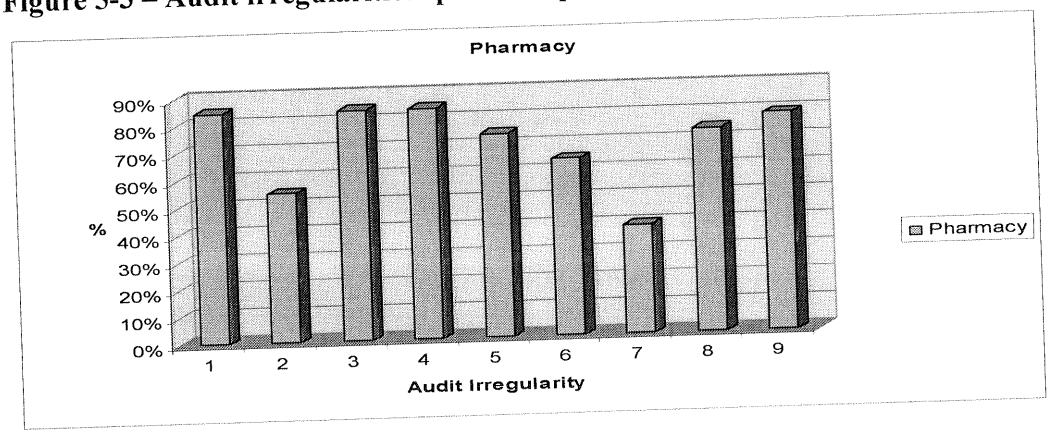
interest payments and of overall reduced cash-flow, small, locally based suppliers are more likely to go to the wall than are their international competitors.

In the long term, the practice of deferred payment must adversely affect the public sector as well as their suppliers, as the potential range of suppliers diminishes, together with the range of choice and the potential to compare and to pare costs.

5.4 PHARMACY

The audit irregularities below, with respect to pharmacy, are alarming if one considers that pharmacy budget consistently represents between 35% and 50% of a public hospital's goods and services budget. The audit reports repeatedly provided examples of where actual stock items on the shelf differ from that which is recorded on the bin card. This clearly indicates inadequate control over inventory movements, and inventory records which are unreliable. This situation can easily result in undetected misappropriation of medical supplies. The Auditor General, due to the lack of an auditable paper trail at most hospitals, had no way of ascertaining the extent to which stock is misappropriated, so is forced to merely conclude that these risks do in fact exist.

Figure 5-3 – Audit irregularities specific to pharmacy



Legend:

1. *Delivery notes / invoices not signed confirming receipt of correct goods / services (85%)*
2. *Expired medication not adequately stored, recorded and safeguarded (55%)*
3. *Lack of internal controls over the recording of pharmacy stock movements (85%)*

4. *Lack of segregation of duties in ordering/authorizing/receiving (85%)*
5. *No controls relating to 'expired stock' in place (75%)*
6. *Precautionary factor quantities (Minimum or maximum) not kept or maintained (65%)*
7. *Register not maintained in regards to schedule 6 & 7 medicines due to staffing shortages (40%)*
8. *Stock counts not performed on a regular basis (75%)*
9. *Stock sent to ward without signature by chief user or acknowledgment of receipt by ward (80%)*

Hospitals suffer from stock shortages due to failures in the delivery system both from central stores and direct from suppliers. This, as shown in Figure 5-3 item 6 above, results in hospitals failing to maintain minimum and maximum stock levels.

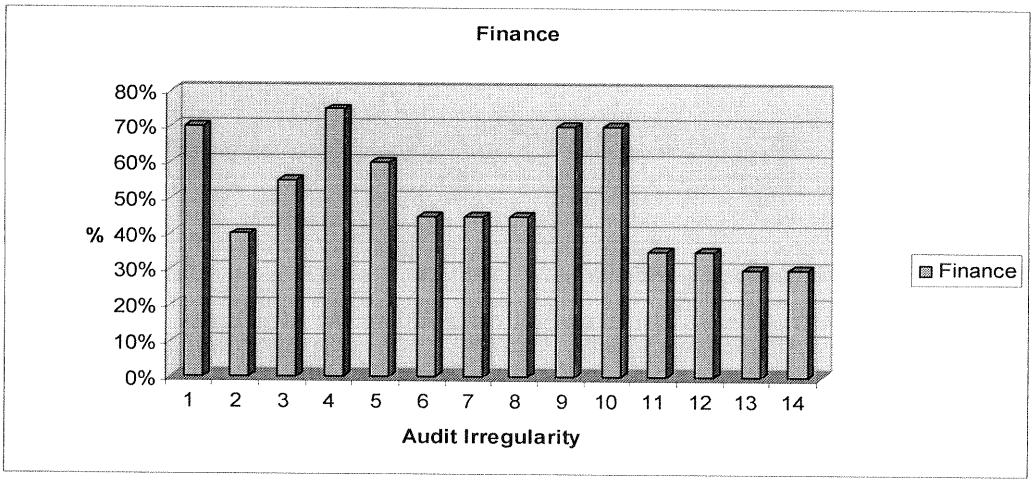
5.4.1 Deliveries

18 of the 20 Auditor General Reports noted that supplies are sometimes accepted without being checked or signed for. This situation may be associated less frequently with the delivery of large, big-ticket items, but is not at all uncommon in the routine delivery of stock such as pharmaceuticals, food, and fresh linen from outsourced laundry services.

This of course leaves the hospital wide open to fraud on the part of the supplier and to theft due to collusion between stores clerks and the delivery team.

5.5 IRREGULARITIES SPECIFIC TO FINANCE

Figure 5-4 – Audit irregularities specific to finance



Legend:

1. *Amounts owed from patients lost due to lack of evidence in terms of patient files being incomplete (70%)*
2. *BAS amounts captured differ significantly from invoiced amounts as per documentation (40%)*
3. *Commitment and accruals register not kept or updated (55%)*
4. *Control weaknesses over supporting documentation - revenue related (75%)*
5. *Inaccurate BAUD/LOGIS and BAS reconciliations / MEDITECH processing (60%)*
6. *Insufficient controls over recovery of private telephone calls. (45%)*
7. *Journals not captured timely pushing expenditure into subsequent financial years (45%)*
8. *Journals processed using incorrect expenditure allocation codes (45%)*
9. *Lack of control over recording and recovery of debtors (70%)*
10. *Patient fees - files not available for audit and files not complete (70%)*
11. *Lack of supervision over cash clerks (35%)*
12. *Policies and procedures for managing of cash not adhered to (35%)*
13. *Money exceeding R500 is not banked timorously (30%)*
14. *Weaknesses in petty cash processes (30%)*

The finance and other administrative offices are responsible for the safe guarding of all documentation. This includes patient files, supporting documentation specific to revenue collection as well as expenditure incurred, and human resource management, including the inputting of this information into the Basic Accounting System for budget related inputs, Persal system for employee related inputs and the LOGIS system if available for procurement. These are all discussed in detail in chapter 6. The Auditor General reports indicate significant shortcomings in the safe-guarding and updating of this paperwork. This opens each hospital up to risks associated with loss of revenue, over expenditure and, without doubt, fraud and corruption.

5.5.1 Cash and banking

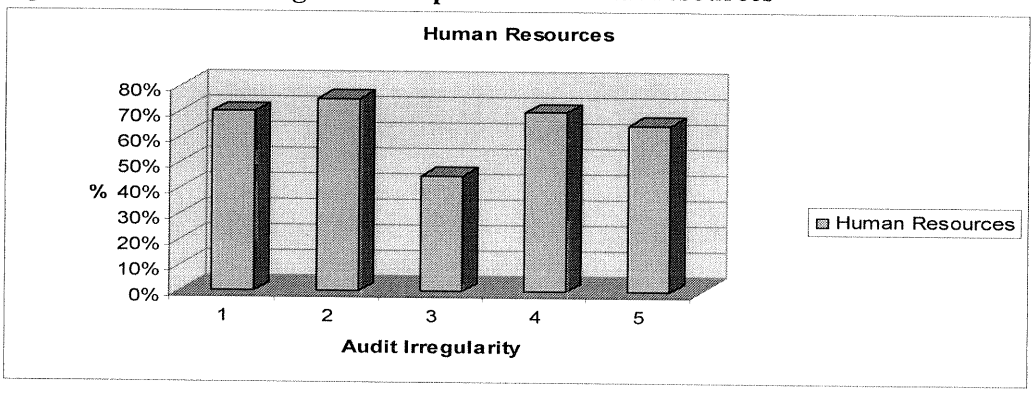
The seven Audit Reports that mentioned cash management all included weaknesses within this function, such as inconsistencies specific to banking cash, improper control over banking documentation, as well as reserve stock register not being properly completed and issues to cashiers not being sequential.

This opens the hospitals up to additional risks, and the Auditor General Reports provide the following examples:

- Lack of adequate checking of records may result in funds not being banked
- Large amounts of cash kept on the premises may result in theft
- Financial loss to the department due to the misappropriation of funds
- Documentation could be used for fraudulent activities which are undetected
- The cash up and balancing procedures may not be relied upon to ensure that funds are banked timeously and intact.

5.6 HUMAN RESOURCES

Figure 5-5 – Audit irregularities specific to human resources



Legend:

1. *Computed overtime a problem (70%)*
2. *Incorrect or not captured leave application forms (75%)*
3. *Insufficient supporting documents for journals (45%)*
4. *Leave forms not in employee files (70%)*
5. *Normal overtime not verified on attendance register (65%)*

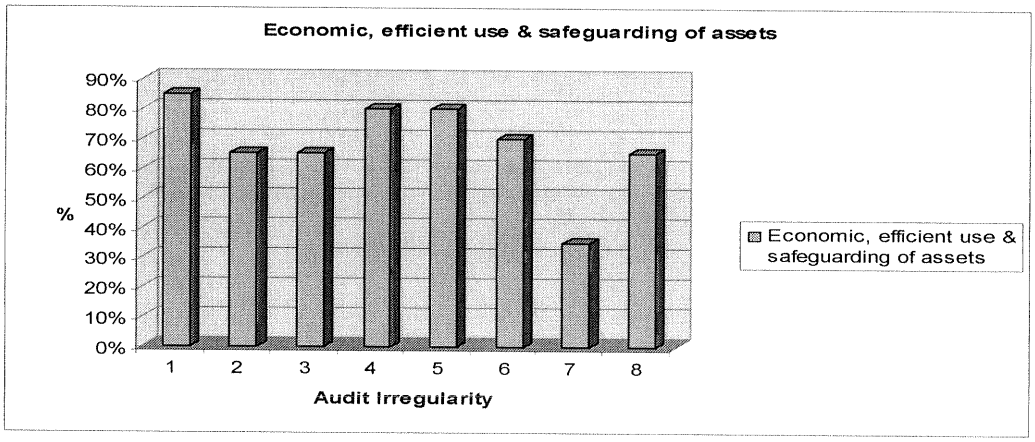
There was considerable discussion within the reports regarding human resource management and the need for an orderly filing system relating to HR issues, as well as consistent adherence to standard operating procedures. This area was also found to be inadequate, and posed risks. For instance, leave records on the system may not reflect accurately the number of leave days, resulting in employees being free to take more leave than is actually due to them.

If HR files and documents are misplaced, this exposes the department to the risk of losing confidential information. The Auditor General also discussed the risk associated with dishonest administrators working with other employees, to steal time and money from the institution.

5.7 EFFECTIVE AND EFFICIENT USE AND SAFEGUARDING OF ASSETS

Given all the irregularities mentioned above, it was unsurprising that the risks associated with the use and safeguarding of assets were also found to be significant. It was confirmed in many of the Auditor General reports that inadequate controls over assets existed, and also that the record-keeping associated with these assets was incomplete. This resulted in the hospitals being open to risks associated with the misappropriation of assets.

Figure 5-6 – Audit irregularities specific to economical and, efficient use & safeguarding of assets



Legend:

1. *Asset register not complete with asset specific information making managing assets impossible (85%)*
2. *Asset transfers not updated on the BAUD / LOGIS system (65%)*
3. *Assets on floor with no barcodes (65%)*
4. *Assets physically on hand not captured onto fixed asset register (80%)*
5. *Assets that could not be physically verified (80%)*
6. *Description per asset register differ from physical assets (70%)*
7. *Lack of internal controls over vehicle management (35%)*
8. *Security insufficient resulting in possible unrestricted access to hospital (65%)*

5.8 CONCLUSIONS DRAWN FROM THIS CHAPTER

Analysis of Auditor General Reports at 20 hospitals confirms that the conclusions drawn from Phase 1 of this study were accurate, and that significant weaknesses do in fact exist in the internal control processes, and that all these pose risks that could significantly increase expenditure for each of the hospitals concerned.

These gaps represent financial risks and imply the possibility that fraud and corruption exists. The Auditor General is concerned about the recurrence of significant irregularities from one year to the next, and this is also of concern to the National Department of Health (NDOH).

The Auditor General is not concerned about how centralized or decentralized the processes may be. Even in provinces where processes are highly centralized, the Auditor General indicates that the irregularities are the responsibility of the individual hospital CEO.

It is the CEOs' duty to ensure that the internal control systems are sound; and if centralization is a hindering them in achieving this, it is their responsibility to implement change, at least within their own institution. But actually, how much can a hospital CEO change within the existing systems? Chapter 6 discusses the findings from visits to nine public hospitals, which included in depth, semi-structured interviews with each CEO. So by the end of chapter 6 one will be in a better position to answer this question.