CHAPTER 6 – SITE VISITS AND INTERVIEWS WITH HOSPITAL CEOS

Phase 1 and 2 of this study involved the evaluation of documents, reports and budgets. To further strengthen the triangulation of the findings, site visits were undertaken in Phase 3of the study to nine hospitals across five provinces in South Africa. Each visit included a tour of the hospital and of the administrative areas, gaining a visual perspective of what some of the underlying gaps are, and, secondly, an in depth interview with the Chief Executive Officer.

The interview questionnaire used in Phase 3 of this report (see Appendix 5) focuses on elements within the governance domain within the NDoH policy document entitled 'Core Standards for Health Facilities in South Africa' (NDoH, 2008). Chapter 1 of this report explains that the creation of national core standards as a means to evaluate the performance of public hospitals in South Africa is still very much a work in progress. The core standards themselves are however derived from existing legislation and guidance documents, and as such can be seen as a useful tool to assist in evaluating the hospitals visited. The use of the Core Standards as a template for the interview questionnaire helps to correlate the findings of this study with initiatives already being conducted by the National Department of Health. It is the intention of the NDoH to approve a final set of core standards in the forseeable future and these with help evaluate how compliant the various public hospitals are with the PFMA as discussed in detail in chapter 4.

Each interview began with a discussion on hospital specific information and statistics, followed by CEO specific information, and finally the meat of the interview focused on how compliant each CEO felt their hospital was with respect to the Core Standards under review. Each of these sections will be discussed separately.

6.1 SECTION 1 OF QUESTIONAIRE – GENERAL HOSPITAL SPECIFIC INFORMATION

Nine hospitals were visited and the general characteristics of each hospital are shown in Table 6-1 below.

Table 6-1 – Profile of the 9 hospitals visited

TYPE OF HOSPITAL	PROVINCE	2008/9 BUDGET	2007/8 % UNDER/OVER	APPROVED BEDS	BEDS IN USE	STAFF VACANCY ABOVE 5%	REVIT SITE – YES / NO	ACCREDITED WITH COHSASA
District/ ie Level 1	B	R91 M	12% over	200	147	Yes	Yes	No
District/	D	R34 M	10% over	82 (Complex)	82	Yes	Yes	No
District	D	R37 M	8% over	60	42	Yes	Yes	No
District	A	R73 M	2% over	200	165 (30 Step Down)	Yes	Yes	Yes
District	A	R40 M	16% under	69	69	Yes	Yes Rehab Site	Yes BUT Expired
District	E	R19 M	4% under	45	34	Yes	Yes	No
Regionalie Level 2	E	R77 M	8% over	187	187	Yes	Yes	No
Regional	A	R132 M	5% under	312	312	Yes	Yes	No
District	C	R60 M	12% over	122	122	Yes	No	No

In order to get the correct mix of hospitals in the sample of nine, the researcher chose carefully each of the sites visited. The nine hospitals are spread across all five of the provinces focused on in this study. Two regional hospitals and seven district hospitals were visited, and these were spread between larger urban centers as well as smaller rural towns. In four of the five provinces, two sites were visited, but in one province only one visit was made, as it was already clear after analysis of the first six visits that saturation was being achieved.

It is important to note that no academic / tertiary hospitals were visited during this stage, although the researcher had visited two academic hospitals during the Core Standards appraisal process. Academic hospitals are unique in that the CEO's powers and responsibilities differ from those in the smaller Level 1 and Level 2 hospitals, and the heads of Academic hospitals have greater delegations than in the majority of South African public hospitals. It had already been decided when scoping this study that it would focus on the Level 1 and Level 2 hospitals, which together form the majority of hospitals, and where exceptional conditions are less likely to apply.

Eight of the hospitals chosen are Revitalisation or rehabilitation sites which indicates that they have received extra resources, including new buildings and equipment, and also, in some cases, extra training for administrative and other staff. So, in theory they should be among the best-performing public hospitals of their size in the country, with up to date facilities and management systems in place.

Each column in Table 6-1 will be discussed during the course of chapter 6 as this information is discussed as part of the CEO interview analysis process. Each of the hospital CEOs visited were supportive of the research study, and generously provided the researcher with interesting and useful insight into the management and administrative functions within each hospital.

6.1.1 BUDGET ISSUES

Budget allocations are an important area of concern for all nine of the CEOs interviewed. One summed it up by saying that 'we are in the dark a lot of the time' about their hospital budget. Eight of the nine CEOs felt that their opinions are not usually considered when the provinces allocate the hospital budgets.

In some provinces the budgets are often announced as late as July. This means that between 1 April and the date the budget is announced, the CEOs are spending funds without any clear indication of what their actual budget will end up being. By June 2009, only four out of the nine hospitals visited had received their budget allocation for the 1 April 2009 to 31 March 2010 financial year. However all four of the CEOs who had received notification of their budget before June reported that those budgets had been subsequently cut by between 3% and 10% within two months of the allocation announcement.. This situation leads to uncertainty, which in turn inevitably results in over or under spending.

Table 6-1 above shows that eight of the nine hospitals either over or under spent in the 2008/9 financial year by more than 2%, which is the statutory limit of variation set by the PFMA. It was established that the under or over spend excludes all accruals and

commitments in existence as at 31 March 2009. If one took these into consideration then the hospitals would all have overspent significantly. As discussed in Chapter 4, any outstanding amounts owing to suppliers at year end will impact the budget for the new financial year. This puts additional strain on budgets that are already limited. What this means is that payments to suppliers in April generally relate to services rendered or goods acquired in the previous financial year. Because the approved funds never catch up with the accumulation of the accruals, the accruals list increases instead of decreasing on an annual basis.

Table 6-2 – Annual budget allocation process within their respective provinces

Q2.4 DO YOU CONSIDER THE ANNUAL BUDGET ALLOCATION PROCESS, WITHIN YOUR PROVINCE, TO BE AN EFFECTIVE SYSTEM?		
CEO	**Yes / No to question**	**Reasons for answer**
1	No	Political Influence Budget Interrogation
2	No	Historically Based
3	Yes	Consultation with CEO's
4	No	District hospitals not included in the debate
5	No	Medium Term Expenditure Framework not considered when determining budget Motivations by CEO not effective Annual increase not reflective
6	No	Not activity based Ignores peculiarities Delayed & unfunded mandates
7	No	Bottom Down Budget drives activities
8	No	Centrally controlled
9	No	Central decision making

In Table 6-2 above, only one of the nine CEO's interviewed perceived their province's budget allocation process to be an effective system. Eight out of nine expressed frustration. Confusion and anger about the existing process were the more consistent reactions. They all acknowledge a serious need for the processes to be reviewed, stating that budgets should not be historic in nature but rather that they should be adjusted to become more in line with each hospital's specific needs and requirements. It is truly amazing that the CEOs were so truthful, being ultimately the public face of their Provincial Departments, however this emphasizes the level of frustration they have

reached. The one CEO who approved of the process contradicted himself later in the interview when he mentioned various flaws that were clearly budget process related, for example, being at a temporary site, due to a revitalisation rebuild, with no theatre and so all patients requiring c-sections or any other form of level 1 surgery required transporting to the regional hospital 100 kilometers away. These costs were allocated to his hospital and it had not been adjusted for, i.e. it was ultimately unfunded. Having the effective control over the budgets centralized in the provinces results in an allocation process that is ultimately meaningless. All but one of the CEOs interviewed feel ignored and see themselves as the person in the middle, i.e. the person in-between provincial departments of health that control the cash flow, and effective service delivery at their hospitals. All nine indicated some anger and annoyance at how little say and control they truly have.

With budgets that are centrally controlled, it was meaningless to base approved budget actually allocated to each respective hospital on the full package of care for their level of hospital. The reason for this is ultimately a lack of quality data on the changes in the burden of disease and increase in population and demographics over time within each region. The budget process, being historically based, can be seen more as Provincial Governments way of allocated the limited funds they receive in an equitable manner rather than being focused on the assessment of what each regions patient needs truly are and how they can be more appropriately funded and so inevitably the medical needs of each respective community were not being fully met as a result of ineffective date, ineffective communicating of needs as well as financial constraints within each Provincial Government caused by over spending in previous financial years. These problems are further compounded, as table 6-3 shows, in that hospitals are often constrained through poor facilities, and secondly by the lack of both physical and human resources which make it difficult for hospital to provide the services required. These problems affect both service delivery and the costs associated with delivering the full package of care.

For instance, one of the CEOs interviewed gave an example of spending in excess of R500 000 in the previous year for the use of the X-ray facility at the nearby private

hospital, because the public hospital is operating in temporary quarters while a new building is constructed as part of the Hospital Revitalisation programme. The temporary environment does not meet safety requirements in respect to control over radiation. This extra cost was not budgeted for in the hospital's core budget, and there was no separate decanting budget for this item associated with the Revitalisation project.

Another reason for inevitable overspend involves the need to provide services that fall outside the mandate being funded, due to the profile of health care need within the local community, such as the need for emergency orthopedic surgery, which is part of the Level 2 package of services, at a Level 1 facility more than 400 kilometers from the nearest Regional hospital.

Table 6- 3 below shows that eight of the nine CEOs provide some services as unfunded mandates at their hospital. This puts extra strain on the approved budget, as it now must stretch to also pay for expenses that were not anticipated in the budget allocation process – however morally justified and necessary those services might be. Some common unfunded mandate care provisions include the providing of accommodation and meals to mothers of children admitted; having to treat inappropriately more patients caused by a major road or rail accident or an outbreak of diseases such as cholera, measles and more recently rabies. The budgets do not factor in any, out of the norm, instances. HIV/AIDS is another area of concern with often far more patients requiring treatment than was budgeted for.

Table 6-3 – Factors affecting the provision of the full package of care for the level of hospital

Q2.5 DOES YOUR FACILITY PROVIDE THE FULL PACKAGE OF CARE FOR MY LEVEL OF HOSPITAL?				
District/ ie Level 1	**2008/9 BUDGET**	**2007/8 % UNDER/OVER**	**Yes / No to question**	**Reasons for answer**
District/	R91 M	12% over	No	Facility & staff shortages
District	R34 M	10% over	No	Theatre services (Shortage of doctors)
District	R37 M	8% over	No	No theatre X-ray (R500000 at Medi-Clinic) Patient transfer costs unknown as it is centrally monitored
District	R73 M	2% over	Yes	Theatre staffing issues
District	R40 M	16% under	Yes	Staffing issues – standards compromised
Regionalie Level 2	R19 M	4% under	Yes	
Regional	R77 M	8% over	No	Limited with focus more on L1 care rather than L2
District	R132 M	5% under	No	Lack of specialists No internal medicine
District/ ie Level 1	R60 M	12% over	Yes	

The CEOs all state firmly that the need for providing these services, whether or not they are fully funded, is communicated clearly to the provinces in the business plans as well as in their budget interrogation reports on an ongoing basis. The fact that nothing has been done to augment the budget or to prevent the services being offered substantiates the CEOs' claims that their reports are not actually read.

Another serious issue of concern to the CEOs is the staffing level at their hospitals and the extent of their vacancy rates especially among highly skilled staff.

6.1.2 STAFF VACANCY RATES

Although all of the hospitals had received copies of staffing organograms developed by each Province, all nine CEOs complained about serious staffing shortages of both professional and administrative support staff.

In four of the hospitals there was no Chief Financial Officer, in four of the hospitals there was no Clinical Director or Head of Nursing. All of these are key senior management

posts. Further, these posts could not be filled because the approved budget for the financial year did not even cover the staff costs associated with the existing filled posts. So even where a post was of critical importance for ensuring effective service delivery, it was either frozen indefinitely in the first instance if the incumbent resigned or the process of finding a replacement was delayed intentionally by Province and this required campaigning persistence on the part of the CEO before the province considered unfreezing and advertising the post. This issue was highlighted by CEOs from four of the five Provinces visited.

The lack of funds simply meant CEO's needed to make good with existing staff by sharing the responsibilities of vacant posts between the staff that remain. Many key posts have only an 'acting' incumbent for several months or even years until the post is advertised and filled. The timeframe for this process is usually unspecified by the province. Indeed, one the CEOs had himself been acting in post as CEO for his hospital for the past four years when he was interviewed.

According to all of the CEOs, their hospital staff vacancy rates are high. Hospital-specific staff establishments had not been created in 7 of the 9 hospitals visited which made understanding the true staffing needs of the specific hospitals difficult to assess. It was clear that little had changed to actual approved staff establishments over the past fifteen years and where some progress did exist the result was fancy Provincial organograms which implied that all level 1 hospitals had the same staffing needs no matter how big or small they are. This is totally unrealistic in that staff requirements should be determined through an analysis of the hospital size as well as population size and medical requirements. However, staff shortages on the whole are really at critically low levels, and provincial governments need to develop realistic staff establishments, first in collaboration with hospital and district management. This would not only assist with vacancy rates but also make budgeting for these vacant posts more realistic.

6.1.3 ADMINISTRATIVE STAFF AND THEIR EXPERTISE

One of the key reasons for the absence of auditable systems and of effective management information is that there is a real absence of appropriately trained finance and information management staff and supply chain staff in public hospitals in South Africa. There are still hospitals with a budget of R200 million where the lead finance officer only has a school leaving certificate. Even the largest hospitals, with budgets of R500 million or more, don't have a finance officer with more than a Bachelor of Commerce degree. In most hospitals there are approved senior finance posts that are intractably vacant.

There is a very real problem in attracting appropriate finance and administrative 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 these posts require is not reflected in the salary grades on offer within the health service. In all hospitals visited the majority of finance and procurement staff are graded at levels 3 and 4 – below a junior nurse, and at the same level as the cleaning staff. So it is not surprising that the public sector cannot compete with the private sector for staff, and that the level of staffing and expertise in hospital and provincial purchasing as well as stock control and logistics functions, is inadequate. This too places extra demands on the patience and record keeping of the supplier.

Because there are insufficient numbers of supply-chain and finance staff in posts, situations commonly arise where there is no separation of duties, or where the separation is inadequate. Both all 9 hospitals, representing small district hospitals as well as larger facilities we found instances where the same individual was responsible for ordering, payment and checking of deliveries, either in the general supply chain and stock function, or in the pharmacy.

It must however be mentioned that at all nine sites the researcher got the impression that none of the admin staff currently employed were working excessively hard. Most of the time they were at their desks chatting or off drinking tea. This implies either the staff employed are not capable of ensuring quality of data can be restored through adherence

to standard operating procedures or that they are lazy and do not want to work harder than they need to. A noticeable comparison with private sector would be that an effective performance management system would be enforceable in the private sector and this combined with ongoing monitoring and supervision would ensure that staff limit the time they waste.

6.1.4 HOSPITAL MAINTENANCE AND REVITALIZATION

Facilities are another serious challenge facing hospital management, with 6 of the 9 hospital buildings being at least years old. Serious maintenance and structural issues exist even in those parts of hospitals which were constructed within the past ten years and although the budgets analysed imply that between 8% and 10% of capital cost is recommended for maintenance each year, in reality only 2% to 4% is allocated to the three hospitals, within the sample, which have already had a revamp..

All hospitals have maintenance budgets that are split between repairs that will be done in house and repairs that will be performed by the provincial public works department. The majority of each maintenance budget is automatically allocated to the provincial public works department – which then spends this allocation as they choose, often not even at the hospital from which budget the funds are coming from. One such example saw 90% of one CEOs maintenance / improvement budget being allocated to the revamping of a ward at the tertiary facility down the road, even though the roof in the admin block of the district hospital concerned was in need of serious repair due to rain damage.

The hospital maintenance budget includes mechanical, electrical, equipment as well as building maintenance and so when equipment breaks CEOs have no quick fire way of repairing them. At one rurally located district hospital the researcher saw how computers had broken down months prior to the visit and were still not fixed. The CEO had no idea when to expect these computers back, if ever.

All nine respondents emphasized that they were not able to rely on public works performing any of the maintenance required, and that this put considerable strain on the

part of the maintenance budget which they do control, significantly limiting what can be fixed. The maintenance budget specifically allocated to each hospital is not only centrally controlled but is low in comparison to what the true maintenance needs and challenges of these hospitals are. Even the recently revitalized hospitals visited revealed maintenance issues not being addressed adequately and in most instances the one year guarantees on workmanship had lapsed.

Five of the sample hospitals had only one person in post as a general handyman, and this person was not adequately trained.

The national Hospital Revitalisation Project is an initiative funded by the European-Union, which began in 2003. It was initially assumed that this would be a rolling programme over about 20 years, during which time every hospital in South Africa would be revitalized. In this programme it was expected that revitalization would cover the full range of organizational and facility improvements, including training staff, and obtaining the full range of IT and medical equipment necessary for the hospital to appropriately deliver the level of services for which it was responsible, in which funds are made available to improve infrastructure and facilities. However, in most provinces the full revitalization vision has not been implemented, and this discretionary grant has been used almost exclusively for capital improvements, with some equipment purchases, but with negligible organizational improvement. This was initially not the intention, however, due to delays the originally approved budget got consumed by the inflation adjustments these delays have caused.

Prior to this initiative being rolled out the NDOH had various hospital rehabilitation projects in place, usually on a much more modest scale than the revitalization schemes.

Table 6.4 shows the timing and scale of the Revitalisation projects for the sample sites.

Table 6-4 – Revitalisation statistics

HOSPITAL	YEAR COMMENCED	PLANNED COMPLETION	BUDGET
1	2006	2011	Initial R122 M Reduced to R62 M Adjusted to R76 M
2	2002	2005	R37 M
3	2008	2011	R456 M (Rebuild)
4	2009	???	Not finalized
5	1998	2010	R40 M (Rehabilitation)
6	2001	2005	R130 M (Rebuild)
7	2008	2011	R750 M (Estimated) (Rebuild)
8	2003	2013	R450 M (Estimated) (Rebuild)

Out of the eight revitalization schemes, the capital improvements at only two have already been completed. After walking around these two sites one was not impressed overall with the result. Both hospitals were situated in small towns in their respective provinces, and their bed occupancy rates were low, so it was difficult to understand how it was that they had been prioritized for intervention over the larger and busier hospitals in their provinces. One of the CEOs commented that his province had realized that the location of the newly revitalized hospital was wrong, but obviously by that time it was too late. As for the design, it was clear that the formula used, although looking good on paper, made using and managing the facility difficult. Hospital 6, which was completed in 2006, was almost circular in its design, and this resulted in lots of wasted space, but very little space was allocated for administration. In terms of the workmanship it was clear that aspects were rushed and that poor quality materials were used, with some areas already requiring significant maintenance.

In Hospital 1, the capital works for revitalization had been confined to the Out Patient Department (OPD), the kitchen and the administration block. Due to delays in the revitalisation process the pre approved budget ended up being lower true costs incurred and this resulted in the Province deciding to cut corners and not to replace the roof of the

building. But a storm caused part of the roof to cave in, causing severe water damage to the areas which had been refurbished.

Hospital 3 is a complete rebuild on the existing hospital site, however there was woefully inadequate planning for service delivery during the 3-5 year construction period. The old hospital was demolished and a temporary facility borrowed from the municipality is in use during the construction time. The temporary facility does not meet any health and safety standards and this impacts significantly on effective service delivery. As a result the CEO is forced to refer all serious cases to a hospital 100 kilometers away and cover from the hospital budget the cost of transport, which is becoming unreasonably high. Having makeshift facilities also means health and safety protocols are not in place for areas such as X-ray. This has so far resulted in over R500 000 of unnecessary spending by the hospital purchasing radiography services at the private hospital down the road. Due to contractor delays the new hospital is taking longer than anticipated to construct, and might not even be complete by 2011.

On the whole, through the visiting of these nine sites and through the core standard appraisal process, one could easily conclude that little thought had been given to ensuring adequate service delivery during the construction phase where there are major capital schemes. It is good to be positive about what the future holds but without careful focus on the current situation, especially in the health services, lives can and will be lost due to poor planning, poor management and poor focus.

Hospital 5 is a rehabilitation site. Little thought went into location, in that this was part of a complex of two hospitals, in which the less busy of the two was allocated the capital investment. An entire new ward has recently been completed, but the existing workload did not justify opening it. The CEO openly admitted that they do not have the patients or staff capacity to utilize this new ward, and that the hospital management hopes to enter into a public private partnership with local private doctors at some stage in the future. No real planning or strategy went into the process, so money was spent after hasty decision making. Once mandated, the decision was quickly finalized.

On the whole, all the Revitalisation projects were taking longer than originally anticipated, for reasons consistent with the findings in chapters 4 and 5 of this study. These included lack of effective communication, suppliers not getting paid on time or not at all, the use of BEE companies that, even if competent, end up closing due to cash flow constraints, and if not competent, end up delivering work that must be redone at extra cost. These will all impact effective service delivery.

6.1.5 INDEPENDENT ORGANIZATIONS AND PROCESSES IN PLACE TO ASSIST WITH SERVICE DELIVERY

COHSASA stands for the Council for Health Service Accreditation of Southern Africa. This is a non-governmental organization which describes its mission as "to assist healthcare facilities to deliver safe and effective care through sustained quality improvement and internationally recognized accreditation" (COHSASA website, 2009). Currently six provincial health departments have become members of COHSASA. They are: Free State, Kwazulu Natal, Limpopo, North West Province, Mpumalanga and Eastern Cape. Out of the 489 public and private facilities currently affiliated to COHSASA only 14 public hospitals are currently fully accredited, and 81 public facilities are in the process of becoming accredited (COHSASA website, 2009).

According to COHSASA, patients receiving treatment in an accredited facility can rely that the following are in place: first, systems based on best practice to ensure that they function according to quality standards, second, systems to detect poor service and monitor improvements, third, a clear mission statement as well as objectives to guide its practice, fourth, clearly defined methods of interacting with patients to ensure their well-being, fifth, systems that integrate all service areas in a hospital to maximize efficiency, sixth, systems to monitor the level of quality in the delivery of service, seven, appropriate staff development and training programs to ensure ongoing competence, eight, a safe and clean environment for patients, staff and visitors that meets defined safety and legal requirements, and finally the best use of its resources to avoid waste and duplication (COHSASA website, 2009).

Table 6-1 above shows that currently only two of the nine study hospitals are fully accredited by COHSASA, however one of the two has allowed their accreditation to expire, as registration requires an annual fee. The evaluation process is incredibly detailed and provides the facilities with detailed insight into what would constitute a sound system of control, which if implemented would result in quality care, quality data and accountability.

One noticeable improvement in many facilities, as a result of being accredited by COHSASA, has been the creation of protocols and standard operating procedures (SOPs) that detail the processes that must be followed in respect of effective service delivery. But are the protocols implementable?

Evidence from two appraisal processes, namely the Center of Excellence Project in Limpopo Province as well as the Core Standards Appraisal process showed that SOPs are not usually applied (PWC, 2008; NDoH, 2008). CEOs argue that more staffing resources as well as effective training would be required before the staff basically understand why effective systems of control are important, let alone, how to implement these controls. And as in any organization, the understanding should start at the top, namely with the CEO. Province, through sending CEOs on the MPH program, as one example, are ensuring that the CEOs are taught these skills and then they should transfer these skills to their staff. The impression of the researcher is definitely that existing admin staff can be expected to do more than they currently do. A lack of effective monitoring and supervision has created an environment of bad attitude towards the job at hand.

6.2 SECTION 2 : CEO SPECIFIC GENERAL INFORMATION AND OPINIONS

Section 2 of the questionnaire focused on obtaining some insight into what qualifications the CEO's have, what experience they have, and whether they actually believe that they are the accounting officers of their respective hospitals. The answers from the CEOs are summarized in Table 6.5:

Table 6-5 – CEO specific information from the 9 hospital CEO's interviewed

CEO	QUALIFICATIONS	BEEN A CEO FOR	BEEN CEO AT EXISTING HOSPITAL FOR
1	Diploma (Radiography) Qualified Doctor BA (Psychology) MBA	3 years	3 years
2	Nursing diploma Primary Health Care Diploma	3 years	3 years
3	Nursing diploma Labor Relations diploma Advanced Certificate in District Health management	5 years	14 months
4	Masters degree in nursing	4 years	4 years
5	Nursing degree (3 year)	2 years	2 years
6	Nursing diploma Diploma in social welfare, development and health	4 years	4 years
7	Nursing diploma Diploma in health management	19 years	7 years
8	Nursing diploma Advanced management diploma	6 years	2 years
9	Diploma in environmental health Btech degree in environmental health Post graduate diploma in health management	8 years	7 years

Out of the sample of nine CEOs interviewed, seven had nursing qualifications, one was a doctor and the ninth had trained as an environmental health officer. Of the seven nurses, five had diplomas, one had a 3 year degree and one had a master's degree in nursing. In addition, four of the CEOs have diplomas in management, one from the OR Tambo programme and three from the University of the Free State, and only one has an MBA degree.

All the CEOs are required to attend a variety of training events within their provinces, and all of the CEOs surveyed are registered for a master's degree in hospital management at the University of the Witwatersrand, and so they have all had some exposure to management and finance training.

In the interviews, the hospital Chief Executives were asked to rate the importance of managing fraud and corruption, and the maintenance of effective management control

systems, as part of their overall management responsibility. A ranking of CEOs concerns below shows that fraud and corruption was seen as the not an important priority.

This finding is unsurprising for two reasons. For most of the CEOs, delegated authority, or the lack thereof, was seen as their biggest issue. Without such delegated authority, they do not have the authority to control the procurement fraud which happens at the interface with the province. Even where fraud and corruption occurs at hospital level, the Chief Executives' constrained powers to discipline or fire staff is a huge disincentive to investigation and action.

Further the interviews revealed the limitations of the Chief Executives' own understanding of financial issues. Without an understanding of the mechanisms for ensuring probity and the usefulness of effective information management for this purpose, the Chief Executives themselves simply do not know how to value the importance of internal control systems in the management of scarce hospital resources.

When the CEOs, at the end of the interview, were asked to rank their concerns in order of priority the results were as follows:

1. Delegated authority
2. Human resources
3. Centralised services
4. Procurement
5. Information management
6. Fraud and corruption

This lack of understanding is not surprising if one analyses what qualifications they have; both nursing and medicine are clinical not financial disciplines; and only one of the CEOs has an MBA. As the coordinator of the Finance module in the Hospital Management Masters Program, the researcher had already become aware that the CEOs as a group had little or no prior knowledge of accounting, finance, or systems of control. The CEOs interviewed repeatedly emphasized that they were patient-focused, and although they

complained about the centralized control over finance related activities in most health departments, it appeared to the researcher that they were quietly content with the situation.

The PFMA, allocates the responsibilities of accounting officer (see Chapter 4). But table 6.6 shows that while four of the nine CEOs interviewed recognized themselves as having at least some of the functions of the accounting officer, none of them believed that they really had that authority.

Table 6-6 – Do you consider yourself the accounting officer for your hospital?

CEO	YES / NO TO QUESTION	REASONS FOR ANSWER
1	No	GSSC
2	No	Control / Delegations
3	Partly	Appointments / Central Control – can override CEO decisions
4	Partly	Budget
5	No	District Management Control Lack of communication
6	Partly	Ultimately Responsible Central Decision Making
7	No	No clear delegations Centralized System
8	No	Centralized System Delegations
9	Partly	Ultimately Responsible No delegated authority

Not surprisingly, none of the respondents answered yes to this question. And their explanations for why they answered 'no' or 'partly' were reasonable. The fact of the matter is that the legislation, the Auditor General and the provincial departments of health hold CEO's accountable for something that they do not actually control or have authority over. The centralization of control at provincial level remains one of the constraints to achieving effective service delivery. This is because the centralized services, rather than supporting the system, further frustrate the process through poor transmission of responsibilities.

6.3 COMPLIANCE WITH CORE STANDARDS SPECIFIC TO GOVERNANCE

The remainder of the questionnaire required the chief executives to select one of four possible answers: strongly agree, agree, disagree and strongly disagree. The statements all referred to the extent to which core standards developed as part of the national core standard appraisal process were in place at their facility. Each response logically meant something different, and this is explained in Table 6-7 below. Using this technique allowed the researcher to use a Likert scale approach to evaluating the responses, and in doing so to create graphs that provided insights into the CEOs' responses. Six core standard groupings were focused on: first, management and planning, second, financial management, third, procurement and supplies, fourth, human resource management, fifth, information management and sixth audit ability or accountability. The detailed analysis of each CEO's responses can be found in Appendix 5.

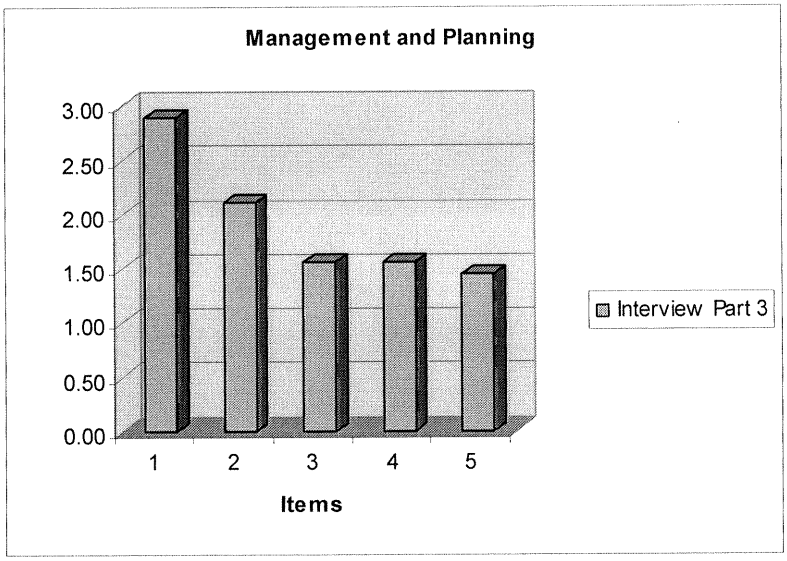
Table 6.7 – What is meant by each response?

RESPONSE	ALLOCATION	EXPLANATION
Strongly agree	4	100% compliant and reliable (No problems)
Agree	3	In place-however with issues that need to be addressed
Disagree	2	Do not agree fully, however hospital beginning to solve some of the problems relating to implementation
Strongly disagree	1	Hospital is not compliant with this statement at all and needs to focus on addressing these issues

Each response is then allocated a numeric allocation; thereafter the numbers to all nine responses to each statement made are added together and an average score is then calculated. These results are shown graphically and are discussed below, with reference also to hospital-specific findings gleaned from the site visits. On each of the graphs, the x axis represents the different core standards in that group, and the y axis represents the consolidated response of the nine CEOs to the statements being made by the researcher.

6.3.1 MANAGEMENT AND PLANNING

Figure 6-1 – Management and planning average responses



Legend

1. *Hospital annual operational plan is consistent with the true medical needs and requirements of the community. (Average score – 2.89)*
2. *The province understands what the true medical needs and requirements of the community are, and annual funding is aligned with these needs. (Average score – 2.11)*
3. *Delegations to CEO level have been received in accordance with PFMA norms and requirements relating to finance. (Average score – 1.56)*
4. *Delegations to CEO level have been received in accordance with PFMA norms and requirements relating to procurement. (Average score – 1.56)*
5. *Delegations to CEO level have been received in accordance with PFMA norms and requirements relating to human resource matters. (Average score – 1.44)*

Given that the annual operational plan is prepared by the CEOs and their senior management teams, one might expect that there would be a high level of agreement to the statement in Item 1 of figure 6.1. It is interesting that this score is as low as 2.89, showing that the CEO's are not satisfied with their understanding of the health needs of their local community. However, as one respondent said, one cannot turn any patients away and this result in patients coming from other districts, provinces and even other countries such as Lesotho Zimbabwe and Mozambique, however, the patients in question are often very

poor informal people that have actually moved into the region to find work and so this more than qualifies these people to health care from the hospitals concerned. This issue is more a lack of appropriate data which could be solved by ensuring hospital occupancy is linked to International Classification of Disease Version 10 (ICD10 Coding) which requires diligent clinical staff to code each diagnoses appropriately and then ensure that this information gets routinely captured into a reliable hospital information system.

The responses in item 2 are more negative, in that the CEOs feel that the provinces ignore the true medical needs of the community when determining annual funding allocations. The respondents see the budget process as historic and without any hospital specific thought.

The impression one gets regarding written delegations is that on the whole they exist only on paper. During the interviews the researcher was provided with examples showing that, in terms of control and decision making, the CEOs have their "hands tied" and have to get numerous provincial managers to approve before any decisions of real importance can be made. CEOs from four of the five provinces researched explained how the hiring of new staff and the firing or disciplining of existing staff was managed centrally and even though some CEOs have paperwork explaining what authority they have this is often ignored be Province who appear to be highly reluctant to decentralize, and this is particularly evident in that all of the provinces visited had been placed under some form of financial administration. Poor planning within four of the five Provincial offices, compounded by the impact of year end accruals, has resulted in serious shortages in usable cash flow.

Visiting the various hospitals, as well as analyzing their correspondence with their respective provincial departments, made it apparent that no one individual knows how much money is available to allocate to each respective hospital, and because of accruals and commitments being carried forward from prior years the CEOs are fighting a losing battle. This pressure and uncertainty has resulted in outstanding hospital debt increasing on a monthly basis instead of decreasing, and, as a consequence of this, in Province A,C,

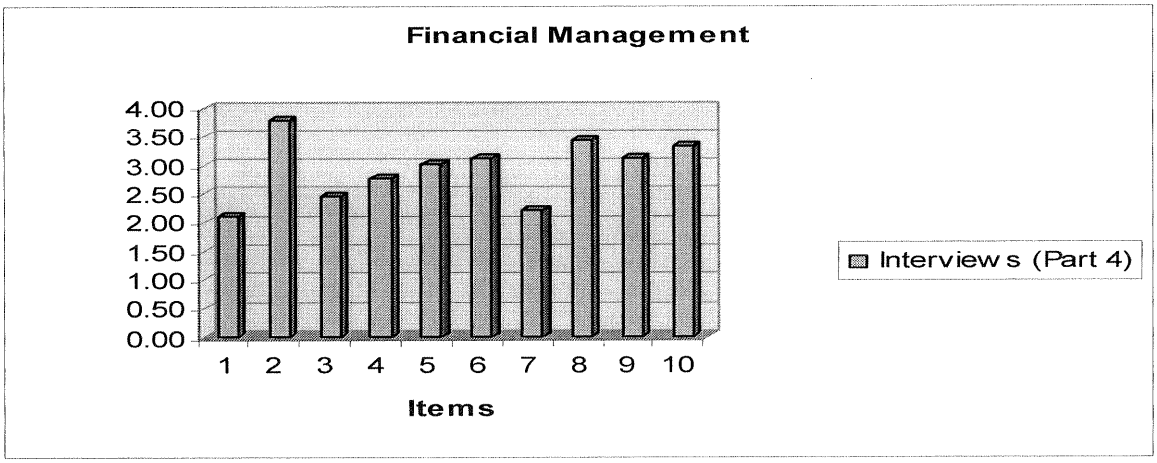
D and E delegations have been suspended or withdrawn, for instance the hiring of new staff as well as the tendering and procurement function.

In each province, the range and extent of a hospital manager's delegations is slightly different, as shown Chapter 4. In some provinces, such as Northern Cape, Limpopo Province and Free State, the range of delegations also varies in relation to hospital size and the seniority of the CEO.

Even where the decision to purchase a commodity is decentralised, and where the hospital has dealt directly with the supplier to specify and even to negotiate the price of the purchase, most provincial Departments of Health still order and pay centrally for goods and services. Purchase orders require approval through layers of hierarchy above the hospital Chief Executive and these delays often result in additional costs being incurred in the recalculation and resubmission of quotes, as they are normally only valid for 15 days.

6.3.2 FINANCIAL MANAGEMENT

Figure 6-2 – Financial management: averaged responses



Legend

1. *Cost centre management is taking place within the hospital (Average score – 2.11)*
2. *Managers can access and analyze information on expenditure (actual and committed) against budgeted costs on a monthly basis (Average score – 3.78)*

3. *Systems are in place to hold department / section managers accountable for monthly expenditure (Average score – 2.44)*
4. *Efficiency targets and anticipated savings are set within the business plan and are monitored regularly (Average score – 2.78)*
5. *Adequate control processes are in place for the charging of services (Road accidents, workman's compensation and private patients) (Average score – 3.00)*
6. *A daily census is performed on all new patients and discharges (Average score – 3.11)*
7. *Inventory counts are performed on a daily basis to reconcile ward inventories with patient issues and variances are investigated (Average score – 2.22)*
8. *There are defined procedures for the collection of debt and these are followed (Average score – 3.44)*
9. *Appropriate controls exist for cash transactions (Average score – 3.11)*
10. *There are clearly developed processes and procedures for the control of cash (Average score – 3.33)*

One financial management technique that has proven to be effective in the private sector is cost centre management. This system allows the CEO to delegate authority and responsibility down to cost centre level and then to hold people accountable for any non delivery of expected outcomes. The National Department of Health's cost-centre initiative has effectively stalled at pilot stage, but cost-centre management has been implemented, through Provincial Department initiatives, in hospitals in both Limpopo and Free State provinces. CEOs, with support of consultants hired at Provincial level, have divided their respective hospitals into up to eleven cost centres, but the provincial departments send the information pertaining to approved annual budget allocations in a more consolidated format, and this makes proper allocation of approved resources down to cost centre level difficult. Training of middle management on the importance of cost centre management as well as quality information management is crucial, but staff are still hesitant to take ownership of these responsibilities.

The National Basic Accounting System (BAS), which is used throughout National and Provincial Government and not just in Health, does provide monthly information on both actual and committed expenditure, and management are able to compare this to the approved budget. However this can only be effective if CEOs can be assured that none of the budget allocated to them will be taken away during the course of the financial year

concerned. Over the past two years, moratoriums have been placed on both hiring of new staff and on spending by all provincial departments for at least part of the last quarter of the financial year. This is mostly due to a lack of cash flow by early January, forcing the provinces to put a hold on spending until April, when the new budgets become active. This puts significant strain on suppliers who sell goods or provide services to hospitals in that they have no guarantee when their next payment will be. With all of these constraints, holding staff accountable for their actions becomes difficult to justify.

Item 4 in figure 6.2 above relates to efficiency targets, which are difficult to meet even in hospitals with sound internal control systems. Every facet of how costs can be cut needs to be considered, and any stumbling blocks in making this possible must be overcome. It includes, at the outset, having a reliable budget , having the correct staff in place to ensure segregation of duties , having the capacity to train staff in why internal controls are important and how to implement a truly effective system, being able to access information online as well as track medical supplies to specific patients and finally being confident that the staff have the best interests of the hospital in mind through their actions, and being able to effectively monitor this on an ongoing basis. Only once a CEO can guarantee that all of these can they truly say that efficiency targets are being properly monitored and included in their business plans. All these potential stumbling blocks, which both Phases 1 and 2 of this study confirmed do exist, will be discussed from the CEO's perspective.

On the whole, the questionnaire scores in relation to the above six core standards were favorable, but the actual site visit to each hospital and the open-ended discussion during the formal interviews contradict these affirmative scores.

Compliance for items 5, 8, 9 and 10 is debatable in that, although there was evidence showing that revenue was being collected, and that in four of the nine hospitals their provincial targets for revenue collection were being achieved, the processes being followed showed signs of significant weaknesses. On a positive note, the Road Accident Fund (RAF) regularly had staff visiting each hospital to assist the hospital and patients

with the documentation required for claims. However, in general the information required was derived from manual reordering processes, so if the patient files were not complete then the information was lost.

In general, both at the hospitals in this study and in the researcher's experience as a team leader in the core standards appraisal process, the completeness and accuracy within patient files was found to be a problem. Clearly, having the standard operating procedures in place did not mean that they were implemented nor that files were routinely checked by senior clinical staff.

It was found that provinces provide little positive incentive to hospitals with respect to the collection of debts. The CEOs felt that the process is demoralizing rather than motivating, with revenue targets simply being increased in response to better debt collection, and no financial rewards being offered to hospitals that achieve these targets. This is one example of a process that leads to an uncaring, unconcerned work culture amongst staff.

Another area where gaps exist which indicated the potential for fraud, corruption or mismanagement is in cash management. All nine chief executives gave generally positive responses in this area, but none of them could show or explain how their systems guarantee that all cash received is properly accounted for and that cashiers are not pocketing a proportion of the money. Examples where cashiers said that they received little or no cash in a shift were common, and with no adequate segregation of duties among the administrative staff this statement could not be verified. So, without evidence to the contrary, management accepts the word of the cashier. Another weakness in the system is that the processes associated with the receipt of cash are mainly manual at all 9 hospitals, and so the key source of evidence of the cash totals received is the paperwork submitted by each cashier. Trust plays an important role here, and with wages as low as they are, any auditor would expect that the temptation to steal is high.

The CEOs all affirmed that a midnight head count is performed daily at each hospital (Figure 6.2, item 6). However, none of them were able to reconcile this against an effective paper trail or electronic record of patient admissions and discharges. So once again it is necessary to trust the staff word without being able to verify it through a system of control.

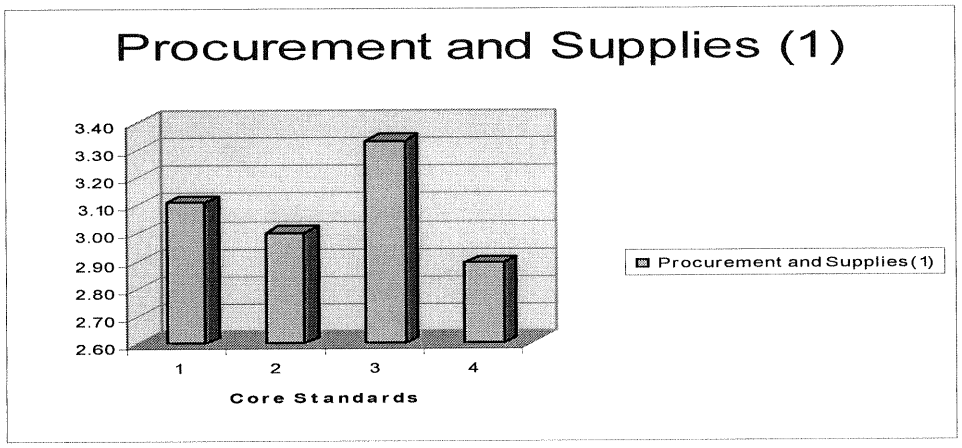
Inventory control in these hospitals, particularly at ward or unit level is a big issue to any knowledgeable accountant or finance person. Yet item 7 of figure 6-3, shows an average response score of 2.22, which, under the circumstances, is worryingly generous of the respondents. Often when inspecting wards at the hospitals, the researcher found the ward stock rooms either unlocked or open, and located where any unauthorized person could have easy and often undisturbed access to the stock of linen, pharmaceuticals or other consumables. Furthermore, the paperwork associated with stock control at ward level was entirely manual at each of the 9 sites, so the accuracy of bin cards was unreliable, and there was no way of consolidating the data relating to stock allocation in the individual patient files.

And to make matters worse, staff shortages in all institutions have resulted in the importance of complete paperwork being the last priority, and so this element often gets either ignored or forgotten. This once again indicates important gaps in the system of control.

6.3.3 PROCUREMENT AND SUPPLIES

The core standards specific to procurement and supplies can be grouped under four main headings: selection and tender processes, ensuring stock and equipment is managed efficiently and effectively, the existence of procurement protocols and standard operating procedures, and the existence of adequate management control procedures within procurement.

Figure 6-3 – Selection processes for procurement average responses



Legend

1. *Selection processes for equipment and consumables are efficient and transparent and reflect the needs of both users and management (Average score – 3.11)*
2. *Users of supplies are involved in discussions on new products and processes, including training needs, and their input is documented (Average score – 3.00)*
3. *A process exists for prioritizing the procurement of appropriate medical equipment (facilities, personnel and budget available) (Average score – 3.33)*
4. *Effective procedures exist to limit / monitor influences on purchasing decisions (e.g. medical reps) (Average score – 2.89)*

Yet again, the positive average scores in figure 6-3 are surprising and in some respect contradictory to the more nuanced information gleaned from the broader discussion with the CEOs and from the site inspections. The interviews revealed that the positive responses are short sighted, and focused on the factors within the authority of the hospital management team. On the whole, procurement decision making, control over tender processes, and interaction with suppliers are centralized at provincial level. As a result, in terms of overall hospital performance, one can argue that all four of the core standards relating to procurement are not met.

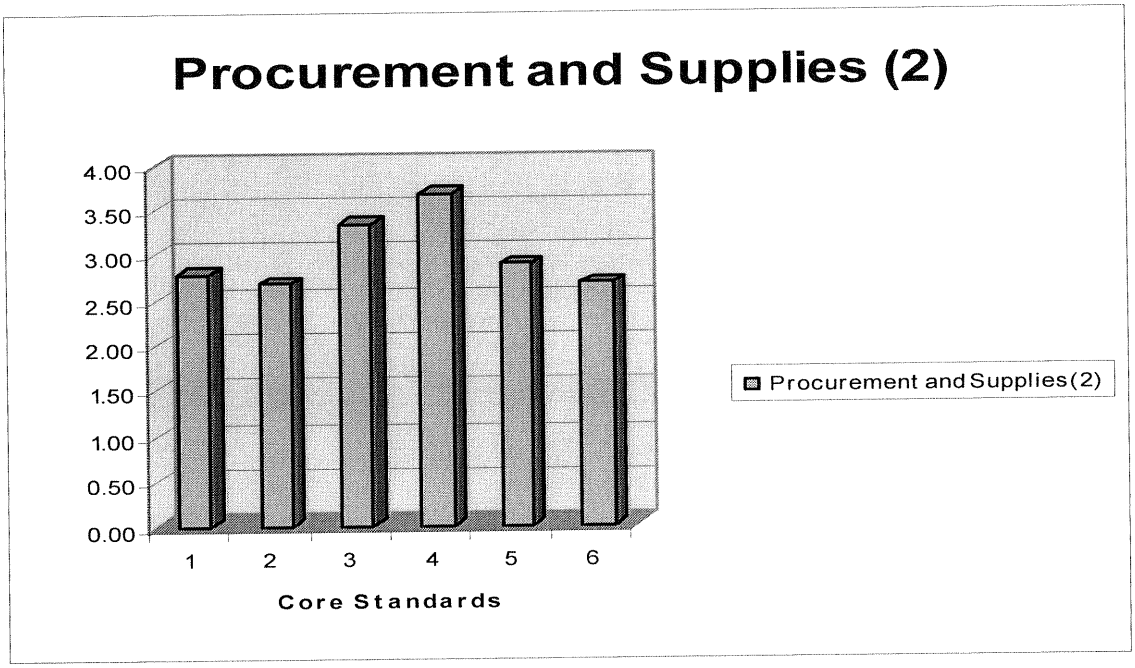
As well as the duplicate oxygen at provincial and hospital level described in chapter 4, other examples included are firstly, at one of the regional hospitals visitors the pharmacy stores department had run out of stitches and had failed to get reorder due to supplier payments being delayed by six months. At another site, the CEO provided quotes where

laptop computers could be purchased for R6 000 each, however, due to the preferred supplier policy these computers ended up costing R18 000 each, incurring unnecessary excess expenditure of R72 000. This is unnecessary and not only places strain on budgeted funds but in the case of shortages in basic hospital supplies the effectiveness and quality of patient care is compromised.

The relatively high average score (3.3) against item 3 in figure 6.3 is also questionable. The semi-structured discussion revealed examples at 6 of the sites of both administrative and medical equipment arriving at the facility without the CEO's prior knowledge or approval of the order. One CEO gave an example of six dialysis machines arriving unheralded at a Level 1 facility which is not empowered to provide that service. This was later revealed as being a provincial wide initiative which was not planned properly and not communicated effectively through to the CEOs concerned. In addition the facilities that received the dialysis machines did not have access to appropriately qualified clinical staff.

These purchases are made without communication with the hospitals concerned and without any clear evidence regarding the community needs or the availability of resources, both human and financial, required to ensure the equipment purchased is utilized in an effective and efficient manner. The processes being currently followed in most provinces illustrated by the examples above, indicate that inappropriate contracts are being entered into, and this implies the possibly that fraudulent activities are taking place.

Figure 6-4 – Effectively and efficiently managed stock and equipment average responses



Legend

1. *Stock and equipment is managed effectively and efficiently to maximize use, maintain adequate levels and reduce losses (Average score – 2.78)*
2. *Information systems to manage stock are in place and functional (Average score – 2.67)*
3. *An asset register of medical equipment is available and updated regularly (Average score – 3.33)*
4. *Medical repair maintenance records are kept (Costs, dates, etc.) (Average score – 3.67)*
5. *Risks due to loss or theft are identified and managed (Average score – 2.89)*
6. *Mechanisms are found to ensure maximum use out of high cost items (E.g. sharing) (Average score – 2.67)*

When walking around the different facilities, it quickly became evident that stock and equipment is not managed effectively and efficiently. As previously discussed in both chapters 4 and 5 staff capacity is an issue, however, at all nine sites visited one never got the impression that the admin staff were over worked and in talking to many hospital employees in the walk around a minimalistic attitude to work was evident. Within supply chain management division in all nine facilities paperwork was available however none of the hospitals in the study had a system which could assist the CEOs in analyzing stock usage at ward level as well as to ensure the supplies are available when needed. The Bin

Cards, although manually captured, were up to date, however they did show that minimum / maximum levels were not being maintained and this has lead to wards running out of crucial supplies required to ensure quality of care. Administratively there are systems that can be used, excel as one example, to ensure better planning is possible, however employees currently tend to fixate themselves on the problems, such as centralized services, rather than attempting to solve the quality of information being produced. Training, computers and then accountability measures could greatly improve the quality of information produced within each hospital.

This is partly an internal staffing issue as per the examples in the previous paragraph and partly an issue between the centralized office and the suppliers. All the provinces have some form of central medical supply depot, and hospitals are required to obtain their basic supplies of drugs and medical consumables from the depots. Evidence shows that these depots are not coping with both the administrative load as well as with the demand for supplies due to the number facilities they are catering for. This is both problematic for the suppliers, being the drug companies, as well as the hospitals themselves. The logic in having centralised procurement services truly makes sense however to be effective this requires well trained staffed, training, organisation and planning. However, all nine CEOs showed how the central depots do not manage stock well. Paperwork often does not reconcile between central depot and hospital admin and this results in both over and under payments being made. In addition, due to a lack of good data which could assist these depots in managing the needs and requirements of all the facilities they service, depots often fail to meet to orders made by hospitals within reasonable time frames and this once again impacts on effective and efficient service delivery.

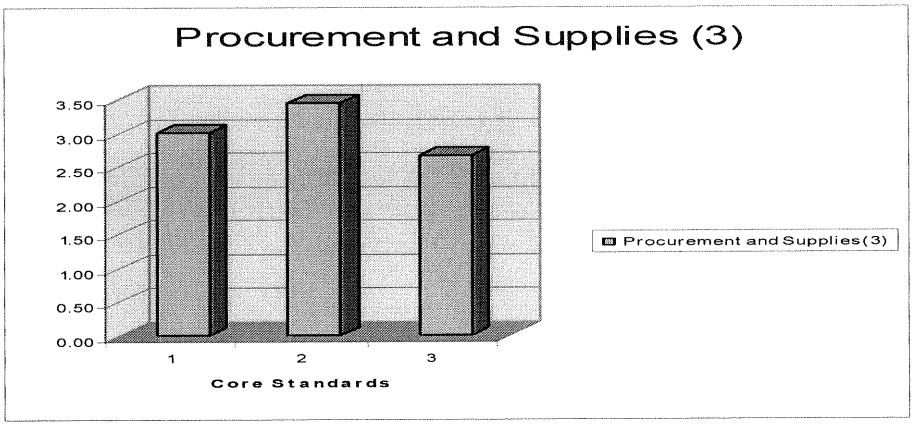
There is little or no evidence that the depots, in any of the provinces analyzed, have the capacity to cater for the demand for supplies. All nine hospitals visited showed evidence of shortages in supplies ordered from the provincial depots. It was found that in many instances hospitals are either short supplied because the depot has run out of a specific product, or hospitals receive products that are short dated, which means that the products are nearing their expiry dates. Four of the CEOs specifically mentioned this as a major

frustration in that they attempt to be proactive by ordering large quantities of important supplies, however, due to the short-dated expiry dates they fail to use the stock in time and end up wasting supplies. To add to the problem, erratic deliveries make it impossible to maintain minimum stock levels. Paperwork reviewed at all nine facilities showed orders for essential supplies still outstanding which were ordered as long as six months prior to the researcher visiting each respective facility. The depots appear to understand the crisis and will distribute whatever they have between the various hospitals, which is appreciated but makes reconciling the paperwork, bearing in mind its manual, nearly impossible.

This affects the availability of goods at the point of use, for instance on the wards and in operating theatres, and therefore it affects the quality of clinical practice. As a consequence of this reality nurses in the wards and theatres tend to stockpile and are also nervous to lend supplies out to other wards in fear that they might never get it replaced. This situation leads to the creation of a web of deception about the real stock needs and levels of need within the hospitals, exacerbating the financial and supply-chain problems to be resolved.

The practice on the part of the suppliers (i.e. pharmaceutical companies and other suppliers) and of the provincial depot, of providing part-deliveries makes it remarkably difficult for hospitals to keep track of orders received and debited for, particularly where the audit trail includes both computerised ordering and paper documentation. Where, for instance, at site A1, R200,000 of goods ordered as one order from the central depot, saw 30% delivered within 3 months of the order, 40% delivered 6 months later, and the remainder still outstanding four years later. As a result it can be difficult to keep track of what has been bought and what is still outstanding. All 9 sites reported this kind of problem.

Figure 6-5 – Procurement policies and procedures average responses



Legend

1. *Procurement policies are in place to ensure adequate stock of the appropriate medicines for the specific level of care (Average score – 3.00)*
2. *A standard operating procedure guides the ordering of medicines from provincial depots, including standard stock levels (Average score – 3.44)*
3. *Sufficient budgetary provision is made for planned medicine usage (Average score – 2.67)*

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

There are wide variations within and between provinces in the rigour of the purchasing and stock control systems used. Most provinces use the national BAS and LOGIS system, but to varying extents, and in many hospitals 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 the hospital visits showed that the cards 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 are clearly not being adhered to 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

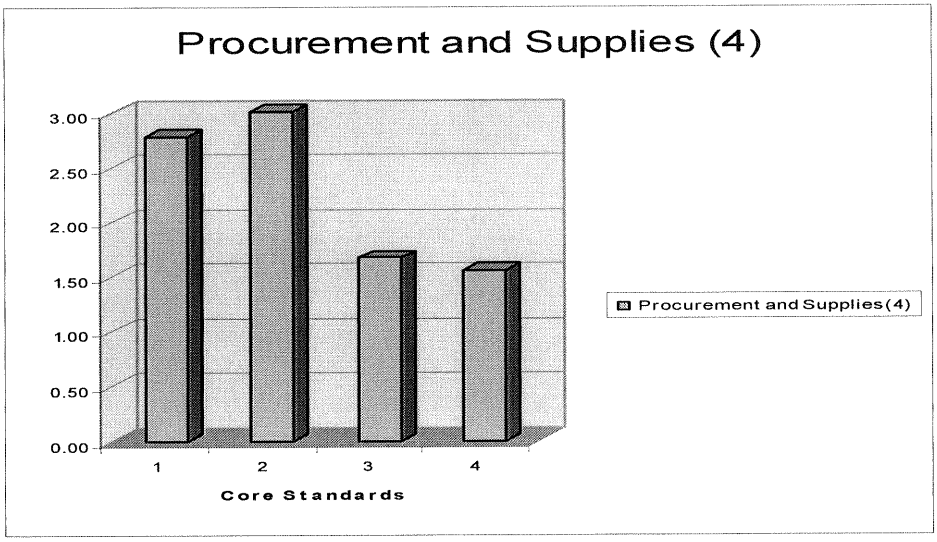
every swab and tablet is charged to the individual patient's account, in the public sector there is no reconciliation between stock distributed to the wards and items actually used.

For instance at one of the district hospitals visited, had a pharmaceutical budget of R7 million in the 2008/9 financial year, though actual spend was closer to R9 million, excluding commitments at year end. But even with this as the baseline, the amount budgeted for the 2009/10 financial year remained at R7 million - until May 2009 when, due to financial constraints in the province, this was reduced to R4 million.

In talking to the pharmacy manager one began to understand that this reduction in budget was compounded further by this hospital providing an unfunded mandate to the clinics in the area, by supplying them with medical supplies out of this already hugely constrained budget. So logically this hospital is going to overspend, and this will undoubtedly put more pressure on a province that is already showing signs of having limited or no cash. The documentation also revealed that the Provincial Department reduced the budget without any review on what the true usage is, which implies that possibly the pharmacy is funded correctly but being wasteful or possibly they are substantially underfunded, nobody knows available data is not accurate.

Theft is also of real concern. Item 5 of figure 6-4, asks specifically whether risks associated with theft are identified and managed effectively. That item scored 2.89, which is high considering that there is little evidence of adequate and effective physical controls and this, exacerbated by the lack of an effective paper trail, implies big gaps in the controlling of this risk. For instance, at one hospital the pharmacy manager stole and sold pharmaceutical supplies to a private practice over a period of years. Nobody within the management team suspected anything, and it took an anonymous tipoff, presumably from one of the junior pharmacy staff, to initiate an investigation which exposed the culprit. However nobody has any idea of the value of the pharmaceutical supplies that were stolen, nor over precisely what period supplies were taken. Even after the theft was exposed, there is nothing in the existing systems of control to ensure the openness and transparency one would expect, so that a similar fraud cannot be perpetrated again.

Figure 6-6 – Adequate management control of procurement average responses



Legend

1. *Adequate management control of procurement process exists (Average score – 2.78)*
2. *Senior management assess the procurement system and ensure maximum value for money (Average score – 3.00)*
3. *The procurement section has adequate staffing and sufficient senior management to meet performance targets (Average score – 1.67)*
4. *Goods are paid for within the required time frame and discounts for prompt payment are received (Average score – 1.56)*

Both for orders processed within the hospitals and for those processed centrally, enormous delays are commonly associated with all aspects of the interaction with suppliers. Below are two examples of these delays and what impact it has on the hospitals:

1. In the Province A, due to the financial constraints within the Provincial Health Department, in early 2009 it was mandated that all purchase orders need to pass through the CEOs office for approval prior to being sent to the Provincial treasury for final approval. This added another tier to the progress of both ordering of supplies and then paying of suppliers, and according to the CEOs interviewed this resulted in days of up to 90 days in receiving the suppliers ordered and then another 90 days for the supplies received to be paid for.

2. In Province E, due to the distance between the hospitals all orders are made by district managers who visit the district hospitals on average every six weeks. The CEOs have capacity to authorise payments to a maximum of R5 000 but all ordering, negotiations with suppliers and tendering processes are centrally controlled and this results in firstly little communication and secondly delays of up to 180 days.

The delays associated with the approval of purchasing orders, especially those requiring central processing or approval at provincial level, can be so long that fluctuations in inflation and in exchange control, or the price of production may be considerably affected, and the cost to the supplier is thereby markedly increased, even to the point that the initial price quoted falls away. Delays in approval may require repeated costing reviews, and may lead to cost and a price change even after the purchase order has been received.

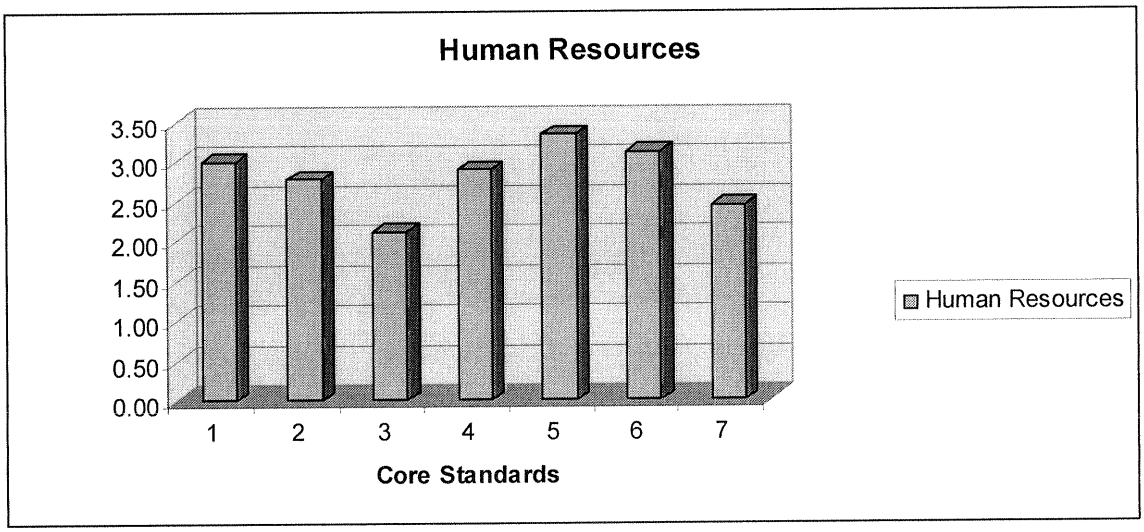
In Gauteng, where, ironically, hospitals have the biggest range of delegations, the Gauteng Shared Services Centre (GSSC) is an especially notorious intermediary, which infuses delay into all aspects of contracting, procurement and payment. In an article in the South African Medical Journal, Bateman (2009) notes contractors views that the GSSC simply cannot cope with the delivery and payment process, and that the ex-CEO of GSSC himself implicitly concurred with that conclusion, citing in his resignation statement that 'skills in audit, finance and IT 'remain a challenge' in GSSC.

Discussions with the CEOs confirmed that sometimes because of simple ineptitude or a lack of procurement staff, sometimes because of wider financial factors, contracts are not renewed or re-advertised in a sufficiently timely way, and the provincial department of health or the individual hospital finds itself with a gap of several months before a new contract is in place. Where it has been agreed that the existing supplier will obtain the new contract, and it is a mere matter of incomplete paperwork; goodwill and eagerness to please on the part of the supplier may well enable the services to continue. This is less likely where there is a backlog of payment due to the supplier.

In the Free State and Northern Cape provinces in the 2008/2009 financial year there were untimely gaps in service provision and this impacted services relating to laundry, food services, garden services and security when contracts expired with effectively no planning, budget or negotiation. For instance in the Free State, some security contracts expired in January 2009, and the process to replace only began in the new financial year, however when the researcher visited the hospital in June 2009 no new contract had been confirmed and this meant no security services for a period of six months and counting. During this period security services cease to function effectively and this opens the hospital up to significant control issues.

6.3.4 HUMAN RESOURCES

Figure 6-7 – Human resources average responses



Legend

Items 1 to 7 from graph 6-8

1. *A human resource plan forms part of the Strategic and Business plans and monitoring system (Average score – 3.00)*
2. *Suitable approved Organograms in accordance with the specified level of care and service package exist to guide staffing and roles (Average score – 2.78)*
3. *These posts within the organogram are fully funded in the business plans and approved budgets (Average score – 2.11)*

4. *Duty planning and management of staff adequately covers duty rosters, overtime, leave, contracting of additional staff (Average score – 2.89)*
5. *All overtime or contracting of additional staff is approved by the departmental head in accordance with the budget and duty plan (Average score – 3.33)*
6. *Leave, sick leave and absenteeism are actively controlled and monitored by the Head of Department and the Personnel department (Average score – 3.11)*
7. *Ongoing monitoring and control as well as regular audits or reviews are conducted in the planning and controls for staff including doctors (Average score – 2.44)*

As indicated earlier in this chapter, see page 116, human resources are seen as their second main area of concern by the CEO's interviewed. Yet not one of the hospitals could provide the researcher with a current, approved, hospital specific staff establishment and as such CEO could not confirm exactly how many staff their respective hospital was short.

Interestingly, when asked whether all positions were funded, the CEOs' answers were disconcerting. Five of the nine indicated that the approved budget did not even cover the staff currently in post. One hospital had an annual staff salary bill of R51 million, but has only been allocated R47 million for the 2009/10 financial year. Not only is the budget allocation lower than the existing salary bill, it is also much lower than the figure which would be needed if the agreed staff establishment were in place. The existing allocation also does not take into consideration occupation specific dispensation (OSD) for pay improvements promised in 2008 which hospitals are still attempting to catch up. Due to the strike action promises were made, however, no provision was made by Provincial governments and so cuts were made to goods and services approved budgets in an attempt to cover the negotiated increases to both nurses and doctors respectively. With the moratoriums on hiring of staff due to the current financial constraints, if staff resigns then their posts are immediately frozen. It must be added that budget cuts are a serious reality in the private sector too and this usually involves in retrenchment of staff and the impression given by public sector is that posts are frozen, however, due to the number of people making decisions within human resources it appears that there is no attempt to stick to available funds.

As in so many other areas, key aspects of human resource management are still centralized at provincial level, such as hiring function, disciplinary action as well as paying of employees. This has resulted in many problems to both hospital management and employees alike and some of the examples obtained at the various sites are listed below:

1. Overtime of nurses and doctors not being paid for three consecutive months in two provinces, creating a real disincentive for staff to provide what is a vital extra service in the context of staff shortages. Doctors and nurses alike have understandably refused to do additional overtime until they are paid.
2. Senior specialists in Province A, D and E being classified in an incorrect salary grade due to an administrative error, and resigning in disgust after six months of waiting for it to be corrected.
3. Professional nurses are offered vacant available posts by hospital management, but as a result of paperwork not being finalized within the provincial department, they eventually give up and leave. This example was given in hospitals from four provinces visited.

These represent a few examples of totally inappropriate human resource management that is destroying the morale and enthusiasm of loyal and hard working staff.

To top this off, where there are disciplinary problems, hospital management is too-often undermined by provincial departments overriding a decision to fire or discipline staff after due processes have been followed. Most respondents commented that taking staff through centralized disciplinary processes is very time consuming. But they also agree that these hearings are necessary in that in many units a poor culture has developed, involving a bad attitude to work, service delivery and patient care. Without provincial support, it is very difficult to manage staff who do not respect you or your authority.

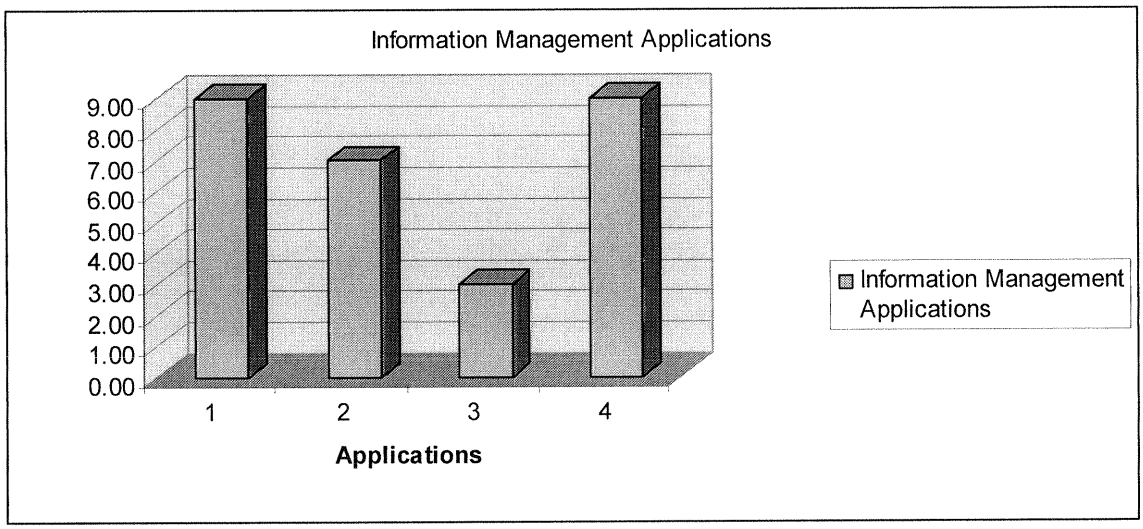
Doctors on duty are commonly off-site consulting with private patients during the time which they are contracted to spend at the hospital. Nurses will call in sick, and spend the day working elsewhere through a nursing agency. Management knows this happens, but do not push the matter in fear that they will lose the few doctors they still have. One CEO

gave an example in which the entire staff of one ward, including the ward manager, made the decision to call in sick on Christmas day. Agency staff had to be called in at the last minute, and this cost the hospital a lot of unbudgeted money. Yet the CEO received no support from the province or from the nursing union in disciplining the staff, So this created a precedent, both in this hospital and elsewhere in the province, for staff to collude in absences on unpopular days to work, such as public holidays and weekends,

Doctors are required, in an attempt to accurately calculate overtime, to sign attendance registers daily to account for their hours, but more often than not they refuse to do so. This was mentioned as a problem in all nine hospitals visited and hospital management do not want to challenge the doctors on this in fear that they would resign.

6.3.5 INFORMATION MANAGEMENT

Figure 6-8 – Facility uses the four national standard computer applications



Legend

Applications specific to graph 6-9
1. Persal
2. BAS
3. LOGIS ON-LINE
4. DHIS

Information management is also weak in the hospitals visited. Most hospitals have computers, however these are usually limited in number, and are often away for repair and it can take more than three months for them to be returned. One extreme example saw one hospital from province E being forced to send broken computers back to suppliers more than 400 kilometers away and after six months they are still waiting for the computers to be repaired and returned..

According to the NDOH core standards (NDOH, 2008), a standard set of four nationally-prescribed computer applications should be operational in every public hospital.

1. 'Persal' is the personnel and salaries management system used by the national and provincial government.
2. 'BAS' stands for Basic Accounting System
3. 'LOGIS' is a provisioning, procurement, and stock-control system
4. 'DHIS' is the District Health Information System

Only seven of the nine hospitals had BAS. This is unacceptable in that this indicates that the finance and accounting routines are entirely manual. Three of the nine hospitals had LOGIS and the others were using manual Bin Cards and VA10 cards to control stock. The LOGIS system is expensive to acquire and to run, but the purchase and rollout of LOGIS is a provincial rather than a local responsibility.

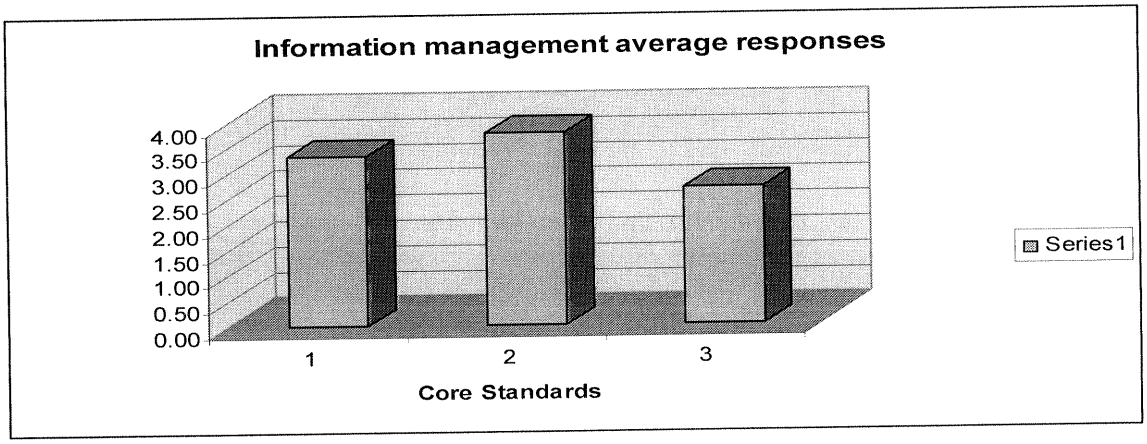
It must be noted that even the hospitals with LOGIS were not fully implementing the system. It was used to assist in basic procurement protocols, but the stock control remained manual at all nine hospitals visited. This is mostly due to lack of staff ability, training, and the reluctance of staff willing to change or upgrade the system. However, the researcher sees this as a lack of supervision, monitoring and failure to implement new systems and then hold employees accountable for their actions.

CEOs are reluctant to train admin staff on these packages and six of the CEOs openly admitted this. The main reason for this is because, once trained, they become more attractive to private facilities and end up leaving to advance their individual careers at the

expense of the hospital concerned. The impression of the researcher on this is that this is once again incredibly short sighted by public sector and could be solved through using private sector techniques where you provide training only on condition the employee agrees to stay employed at the hospital for an equivalent amount of time, i.e. create a process where employees buy into their own development thus ensuring hospitals do not suffer as a result.

Pharmaceutical supplies are being properly accounted for in the main pharmacy; however once dispensed there is no way of reconciling anything. In all nine hospitals visited the process once dispensed in 100% manual. Due to staffing constraints in at least half of the facilities the pharmacies are unable to record what gets dispensed and so they merely presume that any stock missing at the end of the day must have been dispensed. Although the dispensed stock is recorded on the patient files those statistics never filter back to the pharmacy for reconciliation purposes, and so once again a gap exists where management are forced to rely on trust rather than transparent systems of control.

Figure 6-9 – Information management average responses



Legend

Items 1 to 3 from graph 6-10

1. *The pharmaceutical system (remote demanders module) is available online (Average score – 3.33)*
2. *Telephone, faxes, computers, pagers and other communications tools (including networks) are recorded in the asset register (Average score – 3.78)*
3. *The abuse of telephones, faxes, computers, pagers and other communication tools by staff is monitored and controlled (Average score – 2.67)*

A culture of dishonesty and entitlement by public sector employees has resulted in serious abuse of telephones, faxes and computers. All nine of the CEOs indicated that they have systems in place to monitor phone usage however this only leads to collusion between employees to beat the system. And to make matters worse the approved budget specific to telephones in two provinces were so low that it did not even cover the rental costs associated with the lines, let alone the call charges, and so once again the lack of good data and approved budgets have lead to a significant difference between what is being spent versus what is being approved.

6.3.6 AUDITABILITY / PAPER TRAIL / ACCOUNTABILITY

At the end of each interview, after discussing all forty six of the issues reviewed in this chapter, the researcher asked whether the CEO felt that the control systems and paper trail that currently exists is sufficient to make possible an effective audit by the Auditor General. The averaged response score for this item was 3.00, meaning that the CEOs answered affirmatively.

This response is deeply concerning. Despite having spent between two and three hours discussing in detail all the gaps that currently exist in the systems of control, on the whole the CEOs still felt that what was implemented was good enough for an effective audit to occur.

This fundamentally showed that either these CEOs have little understanding of what is meant by internal controls, transparency, accountability and an effective paper trail, or that they have simply given up on trying to resolve the gaps that exist and secretly hope that the Auditor General might solve the problems for them.

6.4 CONCLUSIONS DRAWN FROM THIS CHAPTER

The nine hospital visits were highly informative, allowing the researcher to observe the extent of some of the short comings in the management processes which the CEOs are attempting to implement. The buildings in use are in need of serious maintenance. Even the hospitals that have been recently through a process of revitalization require attention.

In addition, in some instances the facilities have been upgraded with no proper needs analysis being performed and this has lead to significant amounts of money being spent on facilities that the hospital CEOs have no intention to ever use.

Walking around with the CEO's and having discussions with some of the middle management it became clear that staff were not motivated to perform. Staff attitude as poor as it is perceived to be results in CEOs not getting the respect they deserve. And the staff unions also play an important role in this by limiting their power even further. Staff vacancy rates, which are not certain, compound this further as staff currently employed are either over worked in that they effectively perform the duties of two or three staff members, or take advantage of the lack of supervision by doing as little as possible. This hinders a CEO's ability to implement internal controls effectively.

Centralized control over procurement, hiring of staff as well as the Provincial Treasury's ability to freeze approved funds is also hindering the CEO's in their duties as per the PFMA. Having significant hands controlling the funds and how the funds get spent limits the transparency that can be achieved and this has makes holding a CEO accountable impossible.

Chapter 7 will discuss the overall findings from the study, and it includes recommendations on what can be done to improve the CEOs ability to manage their facilities effectively.

CHAPTER 7 – CONCLUSIONS AND RECOMMENDATIONS

This research project indicates that key objectives of the 1994 Health Plan and of the PFMA have yet to be achieved. Hospital CEOs as well as their senior management team have some justification for perceiving that the systems currently being applied are hindering them in their responsibilities.

This is recognized by the Auditor General in qualifying the Department of Health audit reports over the past eight consecutive years. These audit disclaimers are a clear indication of a lack of financial control measures and of ineffective management. The study indicates that the inefficiencies are in part the responsibility of the hospital CEOs and partly that of their respective Provincial Government Departments.

It is clear that delegation of authority down to hospital management level is limited, and that the precise formula for delegation differs between provinces. It is also clear that this limited authority is taken away whenever it suits the province. This situation obviously makes it possible for institutions and provincial governments to pass blame rather than question what went wrong as well as how it can be remedied.

The CEOs involved in this research have expressed frustration at the lack of control that they have over their respective budgets. They are often identified as the scapegoat when bad publicity provides evidence which indicates firstly, poor service delivery and secondly, a lack of efficient and implementable internal control systems. However, it is clear that many of the reasons for system failures rest at provincial rather than hospital level, and that even the most effective CEO has only limited powers to ensure that effective management systems are in place and functioning within their hospital, But it is also clear that the majority of CEOs interviewed do not use their circumscribed powers effectively and appropriately.

The research questions posed at the start of this study have been confronted during phases one, two and three of this study, and the conclusions to these questions will now be detailed below.

7.1 BUDGET AND AVAILABLE CASH RESOURCES

The data indicated that there are significant gaps in the budgeting process, and gave rise to doubt that the cash available was being spent in an effective manner. If one considers that the 40 hospitals studied in phase 1 of the research overspend by a total of more than R400 million in one year, and that large Level 2 and Level 3 hospitals consistently over spend year after year, in some cases by as much as R100 million, one is led to ask what consequences exist and whether management is being held accountable. The answer is that there are no obvious adverse consequences to the hospital or provincial management teams, and that there is little evidence of management accountability for overspending. This indicates various possibilities:

Firstly, it is possible that the hospitals are under budgeted.

This is a definite possibility; however, based on current statistics and the quality of data available, one cannot properly confirm this. The budgets analysed within the sample of hospitals indicated that budgets were still being calculated using historical data, relating to previous allocations, and which failed to take account of community growth and true medical needs. The analysis also indicated that a disproportionate share of the total budget continues to be allocated to preferred hospitals, so that, the previously poorer hospitals were still, in 2009, having to fight for their equitable share of the budget allocation.

In addition, the budget allocated to line items within budgets appeared to be haphazard, with many examples of line items showing significantly low allocations, markedly below previous real expenditure on that item. In addition, these same hospital budgets would see this fault repeated one year after the next. This implies that no true thought is going into the allocation of individual budgets for line items at provincial level, and that provincial

departments are merely allocated the budget they have available based on how things were done in previous years. Committees, both hospital specific and provincial, as well as protocols on strategic planning and budget allocation do exist, but the underlying principles within these protocols, such as cost centre management, timely payment of suppliers, completeness of paper trail, to name a few, are not being implemented effectively or even at all.

Secondly, the hospital management team is not effectively managing spending, and this is resulting in overspend. Chapters 4, 5 and 6 show that failure to implement effective control systems and failure to appoint suitable staff, the hospital and provincial management ultimately failed to manage spending, and this resulted in overspend.

And thirdly, funds are being stolen through collusion and blatant fraud and corruption, both at hospital level and at provincial level, and this is resulting in overspend and in the under-availability of resources such as medication, and in the perception that hospitals are even more underfunded than is in fact the case. The impact of fraud and theft on total hospital spending is unknown due to the lack of an effective paper trail and the absence of effective control systems producing data that management and auditors might regularly analyse. Until hospitals are provided with the skills and resources necessary to institute effective control systems, the real impact of corruption is hidden, as most fraud is simply not detected, even where its existence is strongly suspected.

The fact that accruals and commitments at year end are not included in final actual expenditure, as they are carried forward to the next financial year, is another problem which is only getting bigger. This is evidenced by the fact that during the study period, three provinces, namely Free State, Limpopo and Northern Cape, were currently under financial administration. This implies that the cash flow has dried up - which further implies a total lack of planning and communication. This has resulted in moratoriums on both spending and the hiring of new employees. In the private sector this situation would be evidence of insolvency; however, as essential public services it is simply not possible for the hospitals to cease trading, even though the scope and range of the services which

they supply may shrink relative to the real health need of the population which they serve.

7.2 DECENTRALIZATION OF AUTHORITY CAN BE THE SOLUTION

The findings of this study indicate that the full delegation of authority envisaged in terms of the PFMA is also not currently feasible, as the findings of this study show that many of the CEOs currently cannot cope with the areas of control they do have within their budgets. Chapter 4 shows that even where internal control measures exist, the issue of compliance is still a problem within all of the hospitals studied.

It seems evident that a total lack of political commitment exists around the issues faced by public hospitals. Hospitals lack proper financial and systems staff, and the grading of finance posts remains far too low to attract and retain people capable of adequately discharging the responsibilities placed on financial officers within the hospital structures, even in the smallest of public hospitals. All of this emphasizes the reality that hospital chief executives in the public sector in South Africa still lack the skills, the senior management support and the resources necessary to effectively manage their hospitals. The CEOs' lack of accounting knowledge adds to their inability to understand truly what is meant by internal controls, and as a result very little evidence exists to prove that these CEOs are utilizing the resources they are allocated efficiently.

Training is crucial, and this should begin at an undergraduate level, where BComm students should develop an understanding of how public sector finances operate.

All CEOs and senior management should be placed on accounting courses designed specifically for them, so that the extremely large knowledge gap that exists can slowly be dealt with.

Programmes such as the national Hospital Revitalization Programme are in place, ostensibly intended to improve the functioning of the hospital organization as a whole. However, in practice, the real focus of revitalization as it has been undertaken seems to

be on capital improvements rather than the facility as a whole, including training needs and the application of effective systems. Having a new building is one thing, but being capable of managing it effectively is far more important.

The CEOs are aware of this reality, so are the provincial governments, but the only way this is going to change is if hospital management becomes more active in terms of the finding of solutions, using the powers they have under the PFMA. Change can occur through determined, active CEOs. Ultimately effective change is up to them.

7.3 EFFECTIVE MANAGEMENT CONTROL SYSTEMS TO ASSIST CEO'S IN EFFECTIVELY AND EFFICIENTLY MANAGING THEIR BUDGETS

All three phases within the research confirmed that significant issues are present in the existing management control systems in public hospitals in South Africa. The issues are however not clean cut, making it impossible to put the blame on the respective accounting officers in charge. This study concludes that four overarching shortcomings exist which explains CEO's effective inability to implement these management controls effectively, and these provide good insight into the issues at hand. These are: centralized services, human resources, training and the ability of staff to implement systems capable of providing transparency as well as procurement and tender protocols. These will be discussed in more detail below:

7.3.1 CENTRALISED SERVICES

South African public hospitals are required by provincial Departments of Health to rely on centralized services that are indicated in this study as hindering the CEOs in their responsibilities under the PFMA. All the evidence analysed has indicated significant shortcomings in the ability of central departments, such as Gauteng Shared Services, provincial Public Works departments, and Central Provincial Medical Supply Depots, to fulfill all their responsibilities in a manner conducive to good management.

As in the sample hospitals, these provincial services demonstrate a lack of resources and effective management control systems, as well as a situation where employees would

appear, either through lacking skills or through poor attitude, to be failing to implement and adhere to protocols in place.

7.3.2 HUMAN RESOURCES

Human resources are without doubt the biggest challenge facing CEOs. Staff establishments which are either in draft format or are provincial templates for that particular 'level of care' do exist. However very little evidence exists of any analysis of what the true staff needs are within each department of each hospital, based on community needs as well as number of beds and bed occupancy rates. This creates uncertainty, as well as the perception in the eyes of the CEOs that they are significantly under staffed.

This may be true with respect to specialist doctors and nurses, and in many cases is true with respect to certain administrative posts. However, the site visits in phase 3 of the study provided many examples of both clinical and administrative staff sitting around doing no work at all. An effective internal control system would require paper work that is properly filed and captured onto the system, as well as the constant verifying, correcting and updating of information that moves around the hospital, detailing, for instance, complete patient files as well as information specific to the movement of medical supplies through the wards.

Administrative staff in many hospitals, partly in response to their low salary packages, and partly through the serious lack of effective performance management, have developed a minimalistic culture of working just as hard as one needs to so as to avoid management being alerted to a problem. This is becoming more and more of an issue in that even those employees passionate about making a difference begin to give up and to conform to the prevailing attitude and approach to work. These passionate, hard working employees are the staff government should fight to retain, because if they leave all that remains are the staff determined to milk the system for as long as they can.

The retention of the human resource function centrally within the provincial office further hinders CEOs. It reduces the ability of the CEO to manage the performance of their staff, as well as to discipline those caught in committing fraud or being corrupt. If provinces wish to retain control, then they need to work within protocols and ensure that the respective CEO is included in decisions affecting their hospital, and that the HR tasks retained at provincial level are undertaken timeously, for example in the advertising and recruitment of staff to vacant posts. Again, as discussed in chapter 6, losing the opportunity to employ valuable nursing candidates, who fall away during the course of a slow recruitment process, is unacceptable, and evidence of this phenomenon was plentiful. In most cases the reasons for key staff not being employed revolved around the lack of communication between hospital and province, and failure at provincial level to efficiently complete the paperwork required to confirm the employment. .

Communication is the key to success, and there was a distinct lack of communication evident in most of the facilities visited. One can only implement sound systems and place expectations on staff if they fully understand what is expected of them, and if the necessary training has been made available.

In all hospitals visited, it was found that at least some of the administrative staff had never even read the standard operating procedures which were relevant to their role and responsibilities. Because senior posts were vacant, junior staff with no prior training or qualifications for the task in hand are often required to act in the senior role as best they can. What adds to the problem further is that employees 'acting' in post are less likely to make decisions, and nor do they have the authority to ensure that decisions they do make are carried out. This problem existed at all nine of the hospitals visited, and is discussed in chapter 6.

7.3.3 TRAINING AND STAFF CAPABILITIES

Training, or lack of it, is the next big problem faced by hospital CEOs. Plenty of training is available, but much of it is in the form of three or five day 'certificate of attendance' programmes, which are seen as pleasant outings but not ones which require much

commitment either to learning or to the subsequent application of the skills learned. The interviews with the 9 CEOs, observations through walking around the hospitals as well as the Auditor General reports revealed that inappropriate people were commonly given training opportunities, and that favored individuals might have repeated opportunities for training, while other employees received little or no in-service training. Also, there appears to be a high turnover of employees who have benefitted from training, and who now wish to better themselves, but who leave the hospital without transferring the lessons learnt to the other staff in their department.

At three of the nine hospitals visited, it was found that the finance officers were currently studying for their BComm degrees part time, which was encouraging; but none of them showed urgency about applying their learning at the hospital, by improving of the systems of control.

The visits to the facilities revealed that many employees understood what some of the system weaknesses were, but did not have any idea as to how to solve these problems. This included five of the nine CEOs interviewed.

Now this indicates either that they have lost interest in fighting what in many instances is a losing battle, or that they truly do not understand what needs to change and why. One is led to conclude that both these issues are real and need to be urgently addressed.

7.3.4 PROCUREMENT AND TENDER PROCESSES

In every phase of this research, it was found that procurement and tender processes were significantly lacking in control and good management. Once again, the disjointed systems in place, where some functions are provided within the hospital and some services are centralized, create the space for inefficiency. The lack of communication and cooperation from provincial offices further exacerbates this problem, and creates many opportunities for corrupt suppliers and employees to enter into fraudulent activities.

With most key tasks, such as paying, distributing and approving, being centralized within the procurement and tendering systems, it is evident from the site visits and interviews that hospitals no longer recognize these functions to be as important as they really are.

Hospitals have effectively 'passed on the blame' rather than chosen to respond by strengthening their in-house systems so as to support the province in their role. In contrast, provincially centralized departments have taken on more responsibility than they can cope with, and this results in delays, lost paperwork, lack of transparency, failure to follow protocols and meet deadlines, hospitals receiving services without having copies of the service level agreements, communication breakdown as well as severe payment delays.

7.4 AUDITOR GENERAL EXPECTATIONS

The study shows that the financial control situation at hospitals is complex, and that because there are so many decision-makers involved, it is difficult to blame any single individual for the weaknesses at hospital level. However, in terms of the PFMA and of the Auditor General's expectations, the CEO is ultimately responsible for the management of their hospital, so they should be actively identifying and seeking to fix any shortcomings that may exist.

Auditors raise the same matters more than once, but no positive progress is seen year after year. One reason for this lack of systematic action is personnel shortages in key areas such as supply chain management and information management; however this excuse is not an acceptable one from the Auditor General perspective. Not having systems in place makes that hospital un-auditable, and not implementing and enforcing systems that do exist compounds the issue further.

Auditability of public spending is a non-functional requirement and concerns the transparency of a system with regards to external audits. This implies that financial and management systems are working effectively in the organizations concerned such that the Auditor General is able to audit the hospital effectively. This allows senior management,

provincial government and national government the ability to prevent and detect fraud, corruption and mismanagement of funds. Having systems in place creates a structure within which people can be held accountable for their actions. Decentralization of authority would provide the facility for provinces to set realistic performance expectations, and then hold hospital CEOs accountable for their hospitals performance.

Accountability involves holding responsible people accountable for their actions, However, the site visits and interviews, discussed in chapter 6, indicated that officials are content with existing systems, and the lack of transparency, which implies either that they are content with the current levels of fraud and corruption, in which they may even participate, or that they do not understand how to enhance transparency and openness within their hospital systems, implying the need for expert intervention and training of hospital employees.

It is clear that the current haphazard application of financial control systems is hindering rather than assisting progress. This study has revealed a situation in which hospital CEOs are complacent that their systems are already audit worthy, despite repeated adverse comments by the Auditor General; a significantly understaffed Auditor General, insufficiently resourced to give quality support to hospitals in the prevention of irregularities; and provincial governments which are themselves not audit-worthy and which remove key decisions from the remit of the hospital managers, it is very difficult to discern how local accountability will ever be achieved.

7.5 INTERNATIONAL RECOMMENDATIONS

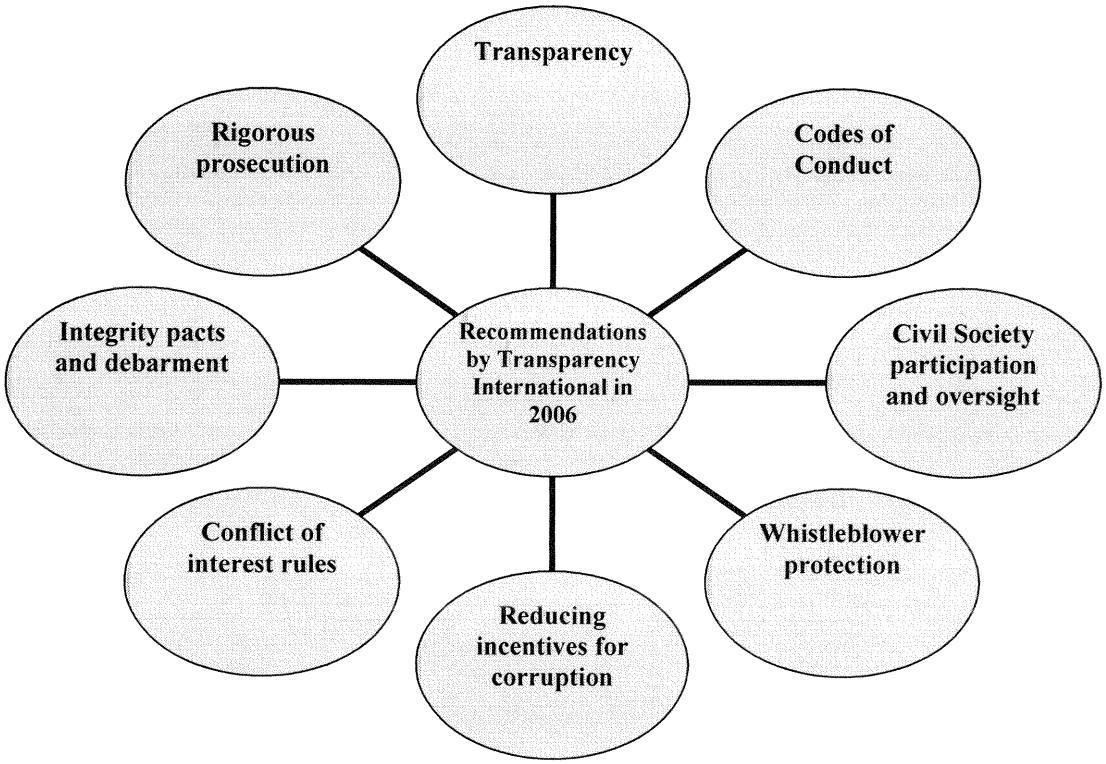
The Audit Commission in the United Kingdom audits the 200 billion pounds spent by 11 000 public bodies in the United Kingdom each year, mainly National Health Service (NHS) and local authority organisations. The Audit Commission, with assistance by the Academy of Medical Royal Colleges in July 2009 brought out a manual for doctors entitled, "A guide to finance for hospital doctors." (Guide, 2009) They see the administrative role of the doctors and nurses to be just as important in as that of the financial and general administrative staff in the effective and efficient running of the

hospital. This manual explains to doctors that, "understanding a budget and how it can be managed will put you in a better position to determine the future for your service" (Guide, 2009: paragraph 1) and continues by stating that "This is not about turning doctors into accountants; it is about enabling doctors properly to engage with finance colleagues so as to make the best use of NHS resources for patients." (Guide, 2009: paragraph 1).

The aim here is to ensure better understanding of how the money flows in the National Health System (NHS), as well as some insight into principles of financial management in making hospital doctors more equipped to deliver better patient care (Audit Commission, 2009).

Transparency international (2006) made the following recommendations to world health sectors about to what should be in place to effectively manage public hospitals as well as how to reduce fraud and corruption. These are graphically represented below in figure 7-1.

Graph 7-1 – Graphical representation of recommendations to combat fraud, corruption and mismanagement



These recommendations emphasize the need for openness and sound systems that enhance transparency and ultimately reduce the incentives to be corrupt. This form of system requires comprehensive protocols to be in place and understood by all employees detailing expectations management have on them.

The consequences of not complying or being corrupt need to be firstly, severe enough, and secondly, enforced through rigorous prosecution. Information is a key to success, and should be available and open to public scrutiny. Every person involved in the health system should be required to act in an ethical manner and to perform their duties in full. The data analysed indicates that this ideal situation is far from the case currently occurring in the South African public health service.

7.6 RECOMMENDATIONS FOR SOUTH AFRICA

Arising from the findings in this study, it is suggested that effective financial management improvement in South African public hospitals requires four main changes to the systems currently in place:

First, the budget process should be totally revised. There should be active participation by the from the individual hospital CEOs in the budget-setting process, and once the budget has been agreed by the CEO and the province, the CEOs must then be held accountable for the use of the allocated budget and for any areas of overspend. The budgets should not be generically allocated. Different communities have different medical needs, and hospitals vary in size and characteristics and in the range of services provided; all this needs to be factored into the budget requirement, and then re-evaluated on an annual basis. Both over and under spend can only be effectively managed if the responsible people are held accountable.

Ideally this would mean decentralizing the authority down to CEO level, giving them complete control over their approved budget allocation. The CEOs would need to be realistic in their demands and would need to accept that the budget they ideally want is

not feasible in the current economic climate where, due to the recession, budget cuts tend to be the norm in both private and public sector institutions. It is recommended that CEOs, in conjunction with their respective Provincial Treasury, analyse the actual spending of their respective hospital over the past three years, noting areas of significant over or under spend and then undertake an investigation as to the actual reason for this. If the issue really is that there has been an insufficient allocation for a particular function, the investigation will help to substantiate and validate the hospital's request for extra funding, but if the issue is weaknesses in control, then this once proven can be appropriately solved.

Secondly, a realistic staff establishment should be developed, specific to each hospital, taking account of the services each respective hospital is providing and the characteristics of the health need of the local community which it serves. It is recommended that urgent action be taken by CEOs to fill vacant finance and administrative posts with properly trained and qualified staff, this would require appropriate cooperation by the respective Provincial departments to ensure that an appropriate appointments system be implemented which avoids unnecessary delays in the recruitment process.

Employees should be provided with key performance areas that are actively monitored by their managers. Staff must be given the resources and training necessary to achieve this, and then non-compliance can be dealt with accordingly. This recommendation could result in the realization that sufficient staff are actually already currently employed, but that they are not working productively. An appropriate performance management system would help to resolve this problem.

Third, a new and revised system of control should be developed and disseminated that is simple to implement and user friendly in its style. There was evidence at several sites that provincial and even hospital-specific systems and protocols have been developed. However, once the consultant or member of staff who set up the system leaves, the hospital staff often lack the training and expertise to continue. Systems for transparency and auditability do not need to be complicated. They involve having information and

communicating it effectively to management, as well as having the supporting documentation to back this up. This involves training and ongoing communication with staff at all levels. Communication, team work and cooperation are the key to successful implementation. Provincial Departments need to ensure hospitals are appropriately resourced with computers, software and communication devices necessary to implement these systems effectively; and then hospital administrative staff need to use the resources properly. It is further recommended that Excel training become a priority, as this is a tool which is already available at most hospitals for analyzing information, and which could easily contribute to much better analysis and use of existing data about volumes and trends in many different departments and contexts. Training should be linked to performance management agreements which require hospital staff to implement lessons learnt, ensuring that the hospital benefits from its investment of time and money in funding the training of staff members.

Finally, the system should be regularly evaluated and reviewed by independent third parties. The Auditor General needs to be more active in public hospitals, and this will require Auditor General staffing to be significantly strengthened. Also, as in the United Kingdom and Canada for example; value for money audits should be conducted regularly. Hospital CEOs need feedback from objective experts in respect to what makes a system auditable and this will further strengthen their understanding on what changes are required as well as why they are important. The majority of the CEOs do not have a business or an auditing background, so if one wishes to hold them accountable for poor systems of control one first needs to ensure they have been provided with the correct skills and training, and that they have been given access to the correct expertise to assist them in this role.

Many of these recommendations will, at least in the short term, result in additional costs being incurred. So a level of upfront funding would be required to, for example, appoint or train appropriate finance staff, purchase computers and other essential resources as well as to address the problems associated with the carrying over of accruals from one financial year to the next. It is recommended that National and Provincial governments

look at an appropriate means of making adequate provision for prior year accruals. This would firstly ensure that current debt to suppliers of essential goods and services are at last caught up, and secondly ensure that CEOs begin the next financial year will the assurance that all approved funds are specifically allocated to that year in question. It is only once that is in place that the implementation of accountability measures being implemented can really be meaningful.

Public hospitals provide medical services, a basic human right to all individuals. It is simply not appropriate to close these hospitals down because of poor service delivery or corruption; but it should be possible to make it increasingly difficult to commit fraud or be corrupt through transparency. It is extremely unlikely that corruption will ever be totally defeated, but sound internal controls reduce gaps which in turn reduce the opportunities for fraud and corruption, and so ultimately improve service delivery and patient care.

7.7 AREAS FOR FUTURE RESEARCH, THE WAY FORWARD

Public hospitals are responsible for providing essential healthcare services to the majority of South Africans. More than 80% of the population relies on the public health service, and this segment includes the poorest members of the community and the majority of those with chronic illnesses.

It is an academic's responsibility to identify the weaknesses that exist, so that we can ensure hospital structures improve. Senior representatives from the Directorate of Finance at the National Department of Health and a health finance spokesman at the National Treasury have both expressed eagerness for real, robust information at hospital level, which is presently lacking for some of the reasons discussed above.

Some further areas for research which are specific to accounting include:

- Accounting Education
    - An evaluation of the knowledge gaps that exist in terms of management and employees within the admin structures of government hospitals and how these gaps can be incorporated into both undergraduate and postgraduate degrees.
    - Adapting public hospital financial control systems to fit the requirements for accrual basis accounting.

- Cost Accounting and Financial Management
    - The development of a model that can be applied to government hospital structures in order to solve the issues that exist around procurement of goods and services as well as supply chain management
    - An evaluation of human resource management as it exists in government hospitals and the development of a model to assist in ensuring more accountability for the information being produced, thus ensuring better control
    - Detailed appraisal of the impact theft and corruption is having on CEO's in government hospitals ability to maintain spending within annual approved budgets.

REFERENCES

1. African National Congress (1994) *A National Health Plan for South Africa.* Prepared by ANC with technical support of World Health Organisation and UNICEF. May 1994. Available from http://www.anc.org.za/ancdocs/policy/ (Accessed 8 January 2008).

2. African National Congress (1994a) *Preparing to Govern.* Prepared by ANC with technical support of World Health Organisation and UNICEF. Available from http://www.anc.org.za/ancdocs/policy/ (Accessed 8 January 2008).

3. Akin, J., Hutchinson, P. and Strumpf, K (2005) *Decentralization and government provision of public goods: the public health sector in Uganda.* Journal of Development Studies. 41 (8): 1417 - 1443.

4. Audit Commission (2001) *Acute hospital portfolio. Accident and emergency. Review of national findings.* September 2001, No. 3. London: Audit Commission. Available from http://www.audit-commission.gov.uk/nationalstudies/health/ (Accessed 10 July 2009).

5. Audit Commission (2002) *Acute hospital portfolio. Procurement and supply. Review of national findings.* May 2002, No. 5. London: Audit Commission. Available from http://www.audit-commission.gov.uk/nationalstudies/health/ (Accessed 10 July 2009).

6. Audit Commission (2009) *Value for money audit protocols.* London: Audit Commission.
   Available from http://www.audit-commission.gov.uk/nationalstudies/health/ (Accessed 10 July 2009).

7. Audit Commission (2009) *'Guide to Finance for Hospital Doctors'*. London: Audit Commission. http://www.audit-commission.gov.uk. (Accessed 10 July 2009).

8. Audit Commission (2010) *Community Pharmacy.* London: Audit Commission. http://www.audit-commission.gov.uk/nationalstudies/health/ (Accessed 10 August 2010).

9. Benatar SR (1997) *Health care reform in the new South Africa.* Journal of Medicine. New England: 336 (12): 891- 896

10. Boulle, A., Bletcher, M. and Burn, A. (2000) *Hospital Restructuring*. Health System Review of 2000. Durban: Health Systems Trust. 231 - 250

11. Cohen, J. C. (2002) *"Improving Transparency in Pharmaceutical Systems: Strengthening Critical Decision Points against Corruption"*. Washington, D.C.: World Bank. Mimeo. http://siteresources.worldbank.org/ (Accessed 15 February 2008)

12. Cronje, M., Murdoch, N. and Smit, R. (2003) *Reference Techniques: Harvard method and APA style.* http://library.dut.ac.za/ref%20guide%202010.pdf (Accessed 5 July 2010)

13. Das Gupta, M., V. Gauri, and S. Khemani (2003) *"Primary Health Care Service Delivery in Nigeria. Survey Evidence from Lagos and Kogi"*. Washington D.C.: Development Research Group. World Bank.

14. Decrop, A (1999) *Triangulation in qualitative tourism research.* Tourism Management. Elsevier Science Ltd. Pergamon 20: 157 – 161.

15. Dehn, J., R.Reinikka, and J. Svensson (2003) *"Survey Tools for Assessing Performance in Service Delivery."* In Francois Bourguignon and Luiz Pereira da Silva, eds., *Evaluating the Poverty and Distributional Impact of Economic Policies.* Washington D.C. Oxford University Press and World Bank.

16. Di Tella, R. and Savedoff, W. D (2001) *Diagnosis Corruption.* Washington, DC: Inter-American Development Bank. http://siteresources.worldbank.org/**date** (Accessed 15 March 2008).

17. Ely M. and Anzul M (1997) *On writing qualitative research: Living by words.* The Farmer Press. London.

18. Eskeland, G., Lewis, M. and Traa-Valerezo, X (2004) *Primary health care in practice: is it effective?* Health Policy Review Denmark: Elsevier.

19. Gauteng Department of Health (2008) *Gauteng Department of Health budget information session presentation.* Johannesburg: Gauteng Provincial Department of Health

20. Giedion, U. Morales, L. G. and Acosta, O. L (2001) *The Impact of Health Reforms on Irregularities in Bogotá Hospitals.* In Di Tella, R. and Savedoff, W. D. (eds.). *Diagnosis Corruption.* Washington, DC: Inter-American Development Bank. http://siteresources.worldbank.org/**date** (Accessed 15 March 2008).

21. Hickey, A (2005) *Tracking progress toward the Abuja target: Are African states allocating 15% of their annual budget for health?* Pretoria: IDASA.

22. Jones, C.S (2002) *The attitudes of British National Health Service managers and clinicians towards the introduction of benchmarking.* Financial Accountability and Management. 18(2): 163 – 188.

23. Kaufman , D. and A. Kraay (2003) "*Governance and Growth: Causality which way? – Evidence for the World, in brief.*" Washington, D.C.: World Bank Website: http://www.uoit.ca/sas/governeaceAndCorr/GovGrowth. (Accessed – 16 October 2008).

24. Kaufman, D, A. Kraay and M. Mastruzzi (2005) *"Governance Matters III: Governance Indicators for 1996-2002."* Washington, D.C.: World Bank. Website: http://siteresources.worldbank.org/. (Accessed – 16 October 2008).

25. Khemani, S (2006) *Local Government Accountability for Service Delivery in Nigeria.* World Bank Journal of African Economies Washington: CSAE

26. Kurunmaki, L (2004) *A hybrid profession – the acquisition of management accounting expertise by medical professionals.* Science Direct. Accounting, Organisations and Society, 29 (3-4): 327 – 347.

27. La Forgia, G., Levine, R., Dias, A. and Rathe, M (2004) *Fend for yourself, systematic failure in the Dominican Health System.* London. Health Policy 67: 173-186.

28. LeCompte, M.A (2000). *Analyzing Qualitative Data. Theory into practice.* Journal of Studies in International Education. Cambridge. 39 (3): 146 – 154.

29. Leedy, P.D. and Omrod, J.E (2001) *Practical research: planning and design.* 7th edition. New Jersey. Prentice Hall

30. Lewis M (2006) *Governance and corruption in public health care systems.* World Bank. Washington D.C: Working Paper 78.

31. Lindelow, M., P. Ward, and N. Zorzi (2004) *Expenditure Tracking and Service Delivery Survey, The Health Sector in Mozambique.* Washington D.C.: World Bank. Processed. http://siteresources.worldbank.org/. (Accessed 8 January 2009).

32. Lindelow, M., Serneels, P. and Lemma, T (2003) *Health care on the frontlines. Survey evidence on public and private providers in Uganda.* Africa Region Human Development Working Paper Series. Washington D.C.: World Bank. http://siteresources.worldbank.org/. (Accessed 8 January 2009).

33. Llewellyn, S. (1998) *Pushing budgets down the line: ascribing financial responsibility in the UK social services.* Accounting Auditing and Accountability Journal. London

34. Llewellyn, S. and Tappin, E. (2003) *Strategy in the public sector: Management in the Wilderness.* Journal of Management Studies, London: 40 (4): 955 – 982.

35. Marshall, M.N. (1996) *Sampling for qualitative research.* Family Practice Journal. Oxford: Oxford University Press. 13 (6): 522 - 525

36. McPake, B., Asiimwe A.D., Mwesigye F. (1999) *Informal Economic Activities of Public Health Workers in Uganda: Implications for Quality and Accessibility of Care.* Social Science and Medicine. 49: 849-865

37. Merriam, S.B. and Associates (2002) *Qualitative research in practice.* San Francisco: Jossey-Bass. Chapter 1 and 3

38. Mihret, Dessalegn Getie and Yismaw, Aderajew Wondim (2007) *Internal audit effectiveness: an Ethiopian public sector case study.* Managerial Auditing Journal, 22 (5). pp. 470-484

39. Morin D (2001) *Influence of value for money audit on public administrations: Looking beyond appearances*. Financial Accountability and Management Journal. London: 17: 99-117

40. Nyland, K. and Pettersen, I.J. (2004) *The control gap: The role of budgets, accounting information and (non-) decisions in hospitals settings*. Financial Accountability & Management Journal. London: 20(1): 77 – 102.

41. Pollack, Allyson M; Leys, Colin; Price, David; Rowlands, David; Gnani, Shamini (2004) *NHS plc: The privatisation of our health care.* London, Verso

42. Piercy, F.P., Moon, S.M. and Bischof, G.P. (1994) *Difficult journal article rejections among prolific family therapists: A qualitative critical incident study.* Journal of Marital and Family Therapy. Upland: 20 (3): 231 – 240.

43. Rethelyi, J.M., Miskovits, E., Szocska, M.K. (2002) *Organizational Reform in the Hungarian Hospital Sector. Institutional Analysis of Hungarian Hospitals and the possibilities of corporatization.* HNP Discussion Paper. Washington D.C. World Bank. http://siteresources.worldbank.org/. (Accessed 8 January 2009).

44. Republic of South Africa: Auditor General (1994, 2006 to 2009) *Auditor General: Provincial and hospital Audit Irregularity Reports.* 20 reports anonymously analysed as phase 2 of the study. Pretoria: Auditor General (See appendix 2)

45. Republic of South Africa: Auditor General (2003 to 2009) *Auditor General Reports on Gauteng Province.* Pretoria: Government Printers. www.agsa.co.za (Accessed 15 March 2010)

46. Republic of South Africa: Auditor General (2003 to 2009) *Auditor General Reports on North West Province.* Pretoria: Government Printers. www.agsa.co.za (Accessed 15 March 2010)

47. Republic of South Africa: Auditor General (2003 to 2009) *Auditor General Reports on Limpopo Province.* Pretoria: Government Printers. www.agsa.co.za (Accessed 15 March 2010)

48. Republic of South Africa: Auditor General (2003 to 2009) *Auditor General Reports on Free State Province.* Pretoria: Government Printers. www.agsa.co.za (Accessed 15 March 2010)

49. Republic of South Africa: Auditor General (2003 to 2009) *Auditor General Reports on Northern Cape Province.* Pretoria: Government Printers. www.agsa.co.za (Accessed 15 March 2010)

50. Republic of South Africa: Auditor General (2003 to 2009) *Auditor General Reports on Mpumalanga Province.* Pretoria: Government Printers. www.agsa.co.za (Accessed 15 March 2010)

51. Republic of South Africa (1973) *Companies Act No. 61 of 1973.* Pretoria: Government Printers. www.agsa.co.za (Accessed 15 March 2010)

52. Republic of South Africa (2009) *Gauteng Department of Health budget information session presentation.* Johannesburg: Gauteng Provincial Department of Health

53. Republic of South Africa (2003) *Health Act No 61 of 2003.* Pretoria: Government Printers

54. Republic of South Africa: National Treasury (2004) *Guidelines for the implementation of accounting standards of generally recognised accounting practice.* Pretoria: National Treasury

55. Republic of South Africa: National Department of Health (1996) *'A policy for the development of the district health system in South Africa.'* Pretoria: National Department of Health

56. Republic of South Africa: National Department of Health (1997) *White paper for the transformation of the health system in South Africa.* Pretoria: National Department of Health

57. Republic of South Africa: National Department of Health (2000) *Policy on uniform patient fee schedules.* Pretoria: National Department of Health

58. Republic of South Africa: National Department of Health (2008) *'Core Standards for Health Facilities in South Africa'*. Pretoria: Government Printers

59. Republic of South Africa (1999) *Public Finance Management Act No. 1 of 1999.* Pretoria: Government Printers. Paragraph 36 – 45

60. South African Institute for Race Relations. (1995) *Race Relations Survey. 1994/5* edition. Pretoria.

61. Republic of South Africa (1996) *South African Constitution No. 108 of 1996.* Pretoria: Government Printers

62. Savedoff WD. and Hussmann K (2006) *Why are health systems prone to corruption?* 2006 Global Corruption Report. Transparency International. London

63. Schargrodsky, E., Mera, J. and Weinschelbaum, F. (2001) *Transparency and Accountability in Argentina's Hospitals.* In Di Tella, R. and Savedoff, W. D. (eds.). *Diagnosis Corruption.* Washington, DC: Inter-American Development Bank. http://siteresources.worldbank.org/**date** (Accessed 15 March 2008).

64. School of Public and Development Management (2009) *Public Discussion with Mr. Themba Godi (Chairperson of SCOPA)* Johannesburg: Unpublished discussion

65. Transparency International. (2006) *Global Corruption Report*. Published by Transparency International. London

66. Vian, T. (2008) *Review of corruption in the health sector: theory, methods and interventions*. Health Policy and Planning. Oxford University Press. London. 23 : 89 – 94

67. Vitsha X. (2003) *Promoting accountability in the budget cycle: The experiences of the Public Service Accountibility Monitor in South Africa.* Grahamstown: Public Service Accountability Monitor

68. Von Holdt, K & Maserumule B. (2005) *After apartheid: Decay or reconstruction? Transition in a public hospital* Webster, E & Von Holdt K: Beyond the Apartheid Workplace. Durban: UKZN Press.

69. Western Cape Department of Health (2007) *Comprehensive Service Plan for Western Cape Department of Health.* Cape Town: Western Cape Provincial Department of Health

70. Western Cape Department of Health (2003) *Western Cape Department of Health - Healthcare 2010.* Cape Town: Western Cape Department of Health

71. World Health Organisation / UNICEF (1978) *Primary Health Care Declaration of Alma Ata* Washington D.C.: World Health Organisation

72. World Health Organisation (1981) *Health for all by the year 2000.* Washington D.C.: World Health Organisation

73. Yin, Y.K. (1994) *Case study research: Design and methods, applied social research methods series*. Los Angeles: Sage Publications. Volume 5

APPENDIX 1 – PHASE 1

SOURCE DATA FROM THE 40 PUBLIC HOSPITALS

Appendix 1

Source Data collected from CEO's and through analysis of hospital documentation - Phase 1						
DATA SUMMARY			BUDGET STATISTICS		BUDGET STATISTICS	
Code	Type of Hospital	Beds	Annual Budget	Over/(under) spending	Rand per bed	% under/over
B8	ACADEMIC	802	R 752,000,000.00	R 96,700,000.00	R 937,655.86	12.86%
B10	ACADEMIC	2800	R 1,100,000,000.00	R 110,000,000.00	R 392,857.14	10.00%
D1	DISTRICT	68	R 17,300,000.00	R 260,300.00	R 254,411.76	1.50%
E1	DISTRICT	64	R 17,446,701.00	R 1,270,000.00	R 272,604.70	7.28%
A7	DISTRICT	48	R 18,300,000.00	R 500,000.00	R 381,250.00	2.73%
E4	DISTRICT	45	R 19,000,000.00	R 3,000,000.00	R 422,222.22	15.79%
D3	DISTRICT	67	R 19,070,000.00	R 650,000.00	R 284,626.87	3.41%
C7	DISTRICT	189	R 29,000,000.00	-R 131,141.00	R 153,439.15	-0.45%
C1	DISTRICT	105	R 34,000,000.00	R 2,228,000.00	R 323,809.52	6.55%
D5	DISTRICT	60	R 37,000,000.00	R 4,100,000.00	R 616,666.67	11.08%
A3	DISTRICT	200	R 37,800,000.00	R 717,625.00	R 189,000.00	1.90%
A8	DISTRICT	74	R 40,000,000.00	R 8,000,000.00	R 540,540.54	20.00%
C5	DISTRICT	324	R 43,200,000.00	R 1,020,000.00	R 133,333.33	2.36%
C3	DISTRICT	122	R 47,000,000.00	R 300,000.00	R 385,245.90	0.64%
A2	DISTRICT	180	R 48,700,000.00	R 2,860,000.00	R 270,555.56	5.87%
C2	DISTRICT	117	R 50,010,000.00	R 1,300,000.00	R 427,435.90	2.60%
C6	DISTRICT	340	R 53,600,000.00	R 1,060,000.00	R 157,647.06	1.98%
B1	DISTRICT	125	R 53,900,000.00	R 14,100,000.00	R 431,200.00	26.16%
C8	DISTRICT	300	R 55,890,000.00	R 14,108,814.00	R 186,300.00	25.24%
D2	DISTRICT	323	R 57,900,000.00	-R 873,300.00	R 179,256.97	-1.51%
A1	DISTRICT	165	R 59,800,000.00	R 5,130,000.00	R 362,424.24	8.58%
E2	DISTRICT	80	R 60,000,000.00	R 2,500,000.00	R 750,000.00	4.17%
B4	DISTRICT	178	R 61,800,000.00	R 1,500,000.00	R 347,191.01	2.43%
C4	DISTRICT	288	R 67,000,000.00	R 2,697,716.00	R 232,638.89	4.03%
B12	DISTRICT	248	R 82,470,000.00	R 3,758,000.00	R 332,540.32	4.56%
E3	DISTRICT	90	R 96,000,000.00	R 3,000,000.00	R 1,066,666.67	3.13%
D4	DISTRICT	400	R 109,159,715.00	R 6,129,651.00	R 272,899.29	5.62%
A9	DISTRICT	356	R 234,500,000.00	R 13,850,000.00	R 658,707.87	5.91%
A10	DISTRICT	450	R 322,000,000.00	R 8,000,000.00	R 715,555.56	2.48%
E6	REGIONAL	189	R 70,000,000.00	R 6,000,000.00	R 370,370.37	8.57%
A5	REGIONAL	350	R 81,000,000.00	R 7,200,000.00	R 231,428.57	8.89%
A4	REGIONAL	312	R 116,000,000.00	-R 1,000,000.00	R 371,794.87	-0.86%
B7	REGIONAL	540	R 183,700,000.00	R 17,500,000.00	R 340,185.19	9.53%
B9	REGIONAL	870	R 250,000,000.00	R 21,584,000.00	R 287,356.32	8.63%
E5	REGIONAL	800	R 268,000,000.00	R 1,230,000.00	R 335,000.00	0.46%
B6	REGIONAL	480	R 299,000,000.00	R 22,000,000.00	R 622,916.67	7.36%
A6	REGIONAL	720	R 353,000,000.00	R 27,000,000.00	R 490,277.78	7.65%
B11	SPECIALISED	300	R 11,000,000.00	-R 2,764,000.00	R 36,666.67	-25.13%
B5	SPECIALISED	350	R 22,400,000.00	-R 2,719,272.00	R 64,000.00	-12.14%
B3	SPECIALISED	141	R 38,500,000.00	R 580,000.00	R 273,049.65	1.51%
TOTALS		342	R 5,316,446,416.00	R 404,346,393.00	R 377,543.23	7.61%

Phase 1	Budget's Specific to the 2006/7 and 2007/8 periods for phase 1
Phase 2	Phase 2 data - Auditor General Reports for periods from 2006 to Current
Phase 3	Phase 3 data - Intereviews produced data that focuses on budget information for 2008/9 and 2009/10

APPENDIX 2 – PHASE 2

SOURCE DATA FROM 20 AUDIT IRREGULARITY REPORTS ANALYSED

Appendix 2

Auditor General issues specific to Management Control Systems of the Annual Budget - Phase 2

Number	Internal Control Issue	A1	A4	A6	A8	A9	A11	B	B1	B5	B12	B13	C2	C3	D2	D4	E1	E4	E5	E6	F1	Total	Factor	%
1	**Procurement and supplies**																							
	Bin cards missing leading to possible stock losses not being detected	1	1		1	1	1	1	1	1		1		1	1		1	1	1	1	1	16	20	80%
	Non-adherence to documented policies and procedures	1	1	1	1	1	1	1	1	1	1	1	1	1	1		1	1	1	1	1	19	20	95%
	Physical access to stores not restricted		1		1			1	1	1		1		1		1			1		1	10	20	50%
	Delivery notes / invoices not signed confirming receipt of correct goods / services	1	1	1	1	1	1	1	1	1	1	1	1	1			1	1	1	1	1	18	20	90%
	Difference between actual stock and stock record balances	1	1		1	1		1	1	1	1	1			1			1	1		1	13	20	65%
	Disregard in relation to delegated authority with respect to paying suppliers	1	1				1	1	1	1			1		1			1	1		1	11	20	55%
	Expenditure - payments not within 30 days	1	1	1	1	1	1	1	1	1	1	1	1	1	1		1	1	1		1	18	20	90%
	Installation of goods purchased incomplete due to supplier not being paid		1		1			1				1					1	1		1	1	8	20	40%
	Invoices received and dated an earlier date than the approved order form			1				1		1		1			1			1			1	7	20	35%
	Lack of segregation of duties in ordering/authorising/receiving	1	1	1	1	1	1	1		1		1	1				1	1	1	1	1	15	20	75%
	Requisitions not attached to payment vouchers - not appropriately motivated or approved	1	1	1		1	1	1		1		1				1		1	1		1	12	20	60%
	SLA's with vendors not in place	1	1		1	1		1		1	1	1	1	1				1	1	1	1	14	20	70%
	Stock received not processed on VA10/bin cards leading to possible stock and financial losses.	1	1		1	1	1	1	1	1		1			1		1	1	1		1	14	20	70%
	Unused parts of issue vouchers / stock cards not crossed out	1	1			1	1	1	1		1	1	1					1			1	11	20	55%
	Value for money not achieved as excessive consumption not followed up	1	1	1	1		1	1				1		1		1		1	1	1		12	20	60%
	VAT paid on invoices to suppliers not officially registered for VAT	1					1								1							3	20	15%
	NHLS invoices paid without proof that they had been verified and adequately checked	1	1	1			1	1			1	1			1	1		1	1	1		12	20	60%
2	**Tender processes**																							
	Minimum number of quotes as per treasury not obtained	1		1	1	1		1					1					1	1	1	1	10	20	50%
	Payments for services/goods paid without appropriate documentation	1		1	1	1	1	1	1				1		1	1		1	1	1	1	14	20	70%
	Tender processes not complied with as per provincial guidelines			1	1	1	1	1	1				1					1	1	1	1	11	20	55%
3	**Pharmacy**																							
	Delivery notes / invoices not signed confirming receipt of correct goods / services	1	1	1	1	1	1	1	1		1	1		1		1	1	1	1	1	1	17	20	85%
	Expired medication not adequately stored, recorded and safeguarded	1			1		1	1			1	1	1				1	1	1	1		11	20	55%
	Lack of internal controls over the recording of pharmacy stock movements	1	1		1	1	1	1	1			1	1	1	1	1	1	1	1	1	1	17	20	85%
	Lack of segregation of duties in ordering/authorising/receiving	1	1	1	1	1	1	1	1	1		1	1	1			1	1	1	1	1	17	20	85%
	No controls relating to expired stock in place	1	1		1	1	1	1		1	1	1	1	1			1	1	1	1		15	20	75%
	Precautionary factor quantities (Minimum or maximum) not kept or maintained	1		1			1	1	1		1	1	1				1	1	1	1	1	13	20	65%
	Register not maintained in regards to schedule 6 & 7 medicines due to staffing shortages	1			1		1	1				1			1		1			1		8	20	40%
	Stock counts not performed on a regular basis	1	1	1	1	1		1	1		1	1	1	1				1	1	1	1	15	20	75%
	Stock sent to ward without signiture by chief user or acknowledgment of receipt by ward	1	1	1	1		1	1		1		1	1	1		1	1	1	1	1	1	16	20	80%
4	**Finance**																							
	Amounts owed from patients lost due to lack of evidence in terms of patient files being incomplete	1		1	1		1	1		1	1				1	1	1	1	1	1	1	14	20	70%
	BAS amounts captured differ significantly from invoiced amounts as per documentation			1				1		1		1				1			1	1	1	8	20	40%
	Commitment and accruals register not kept or updated		1		1	1	1	1		1	1	1						1		1	1	11	20	55%
	Control weaknesses over supporting documentation - revenue related	1		1	1		1	1	1	1		1	1		1		1	1	1	1	1	15	20	75%
	Inaccurate BAUD/LOGIS and BAS reconciliations / MEDITECH processing	1	1	1		1	1	1		1	1	1						1	1		1	12	20	60%
	Insufficient controls over recovery of private telephone calls.		1	1	1			1		1		1						1	1		1	9	20	45%
	Journals not captured timely pushing expenditure into subsequent financial years					1	1	1		1		1				1		1	1		1	9	20	45%
	Journals processed using incorrect expenditure allocation codes					1	1	1		1		1	1			1		1		1		9	20	45%
	Lack of control over recording and recovery of debtors	1		1	1		1	1		1		1	1		1		1	1	1	1	1	14	20	70%
	Patient fees - files not available for audit and files not complete	1		1	1		1	1		1	1	1	1	1				1	1	1	1	14	20	70%
	Lack of supervision over cash clerks		1		1		1	1		1		1		1								7	20	35%
	Policies and procedures for managing of cash not adhered to		1		1		1	1		1		1		1								7	20	35%
	Money exceeding R500 is not banked timeously		1		1			1		1		1		1								6	20	30%
	Weaknesses in petty cash processes		1		1		1	1		1				1								6	20	30%
5	**Human resources**																							
	Computed overtime a problem	1		1	1		1	1		1	1	1	1	1		1		1	1	1		14	20	70%
	Incorrect or uncaptured leave application forms	1		1	1	1	1	1		1	1	1	1	1				1	1	1	1	15	20	75%
	Insufficient supporting documents for journals	1			1		1	1		1		1		1				1			1	9	20	45%
	Leave forms not in employee files	1		1	1	1	1	1		1	1	1	1	1				1	1	1		14	20	70%
	Normal overtime not verified on attendance register	1		1	1		1	1		1	1	1	1	1				1	1	1		13	20	65%
6	**Economic and efficient use and safeguarding of assets**																							
	Asset register not complete with asset specific information making managing assets impossible	1	1	1	1	1	1	1				1	1	1	1	1	1	1	1	1	1	17	20	85%
	Asset transfers not updated on the BAUD / LOGIS system	1	1	1	1	1	1	1			1	1						1	1	1	1	13	20	65%
	Assets on floor with no barcodes			1		1	1	1			1	1	1	1			1	1	1	1	1	13	20	65%
	Assets physically on hand not captured onto fixed asset register	1	1	1	1	1	1	1			1	1		1		1	1	1	1	1	1	16	20	80%
	Assets that could not be physically verified	1	1	1	1	1	1	1			1	1	1	1			1	1	1	1	1	16	20	80%
	Description per asset register differ from physical assets	1		1	1	1	1	1			1	1		1			1	1	1	1	1	14	20	70%
	Lack of internal controls over vehicle management		1		1		1	1				1			1	1						7	20	35%
	Security insufficient resulting in possible unrestricted access to hospital				1		1	1				1	1	1	1	1	1	1	1	1	1	13	20	65%

APPENDIX 3 – PHASE 3

SOURCE DATA FROM THE 9 HOSPITAL CEO'S INTERVIEWED

Analysis of Data from interviews		Interview Responses											
PART 3	MANAGEMENT AND PLANNING	1	2	3	4	5	6	7	8	9	Total	Factor	Average
3.1	CEO's develop and monitor comprehensive annual strategic and business plan for hospital												
3.1.1	Hospital annual operational plan is consistent with the true medical needs and requirements of the community.	3	3	3	3	4	2	3	2	3	26	9	2.89
3.1.2	The Province understands what the true medical needs and requirements of the community are and align annual funding with these needs	3	2	2	2	2	2	2	2	2	19	9	2.11
3.1.4	Delegations to CEO level have been received in accordance with PFMA norms and requirements relating to finance.	2	2	2	2	1	1	1	1	2	14	9	1.56
3.1.4	Delegations to CEO level have been received in accordance with PFMA norms and requirements relating to procurement.	1	2	2	2	1	1	1	1	3	14	9	1.56
3.1.4	Delegations to CEO level have been received in accordance with PFMA norms and requirements relating to human resource matters.	1	1	2	2	1	1	1	1	3	13	9	1.44
PART 4	FINANCIAL MANAGEMENT												
4.1	Appropriate tools, information and skills are available to enable management of expenditure.												
4.1.1	Cost centre management is taking place within the hospital	1	2	1	3	3	2	2	2	3	19	9	2.11
4.1.2	Managers can access and analyse information on expenditure (actual and committed) against budgeted costs on a monthly basis.	4	3	4	4	3	4	4	4	4	34	9	3.78
4.1.3	Systems are in place to hold department / section managers accountable for monthly expenditure.	1	2	2	4	3	2	2	3	3	22	9	2.44
4.2	Resources are adequately managed and efficiency savings are achieved.												
4.2.1	Effieciency targets and anticipated savings are set within the busines plan and are monitored regularly.	3	2	3	3	3	2	3	3	3	25	9	2.78
4.3	Aqeduate control processes are in place for the charging of services (Road accidents, WCA, private patients)	3	3	4	3	3	2	3	3	3	27	9	3.00
4.3.1	A daily census is performed on all new patients and discharges.	4	1	2	3	3	4	4	4	3	28	9	3.11
4.3.2	Inventory counts are performed on a daily basis to reconcile ward inventories with patient issues and variances are investigated.	2	3	3	1	4	1	3	1	2	20	9	2.22
4.3.3	There are defined procedures for the collection of debt and these are followed.	4	3	3	4	4	2	4	4	3	31	9	3.44
4.4	Appropriate controls exist for cash transactions.	4	3	3	3	3	3	4	3	2	28	9	3.11
4.4.1	There are clearly developed processes and procedures for the control of cash.	4	3	2	3	3	4	4	4	3	30	9	3.33
5	PROCUREMENT AND SUPPLIES												
5.1	Selection processes for equipment and consumables are efficient and transparent and reflect the needs of both users and management.	4	3	2	4	3	2	3	3	4	28	9	3.11
5.1.1	Users of supplies are involved in discussions on new products and processes, including training needs, and their input is documented.	4	3	2	3	3	3	3	4	2	27	9	3.00
5.1.2	A process exists for prioritising the procurement of appropriate medical equipment (facilities, personnel and budget available)	4	3	3	4	3	2	3	4	4	30	9	3.33
5.1.3	Effective procedures exist to limit / monitor influences on purchasing decisions. (e.g. medical reps)	3	2	3	4	3	3	2	3	3	26	9	2.89
5.2	Stock and equipment is managed effectively and efficiently to maximise use, maintain adequate levels and reduce losses	3	2	3	3	4	2	2	3	3	25	9	2.78
5.2.1	Information systems to manage stock are in place and functional	2	2	3	3	4	3	2	3	2	24	9	2.67
5.2.2	An asset register of medical equipment is available and updated regularly.	4	3	3	3	2	3	4	4	4	30	9	3.33
5.2.3	Medical repair maintenance records are kept (Costs, Dates, etc.)	4	3	4	4	4	3	4	3	4	33	9	3.67
5.2.4	Risks due to loss or theft are identified and managed	3	3	4	3	3	3	3	3	1	26	9	2.89
5.2.5	Mechanisms are found to ensure maximum use out of high cost items (E.g. sharing)	2	2	4	3	3	2	3	3	2	24	9	2.67
5.3	Procurement policies are in place to ensure adequate stock of the appropriate medicines for the specific level of care.	4	1	2	3	3	4	3	3	4	27	9	3.00

5.3.1	A standard operating procedure guides the ordering of medicines from provincial depots, including standard stock levels.	4	2	3	4	4	4	3	3	4	31	9	3.44
5.3.2	Sufficient budgetary provision is made for planned medicine usage.	4	3	2	2	1	4	2	3	3	24	9	2.67
5.4	Adequate management control of procurement process exists.	3	3	3	2	3	4	2	2	3	25	9	2.78
5.4.1	Senior management assess the procurement system and ensure maximum value for money.	4	3	2	3	4	2	3	3	3	27	9	3.00
5.4.2	The procurement section has adequate staffing and sufficient senior management to meet performance targets.	3	2	1	1	1	2	1	2	2	15	9	1.67
5.4.3	Goods are paid within the required time frame and discounts for prompt payment are received.	1	2	2	1	1	1	2	1	3	14	9	1.56
6	HUMAN RESOURCE MANAGEMENT												
6.1	A human resource plan forms part of the Strategic and Business plans and monitoring system.	3	3	2	4	4	2	3	3	3	27	9	3.00
6.1.1	Suitable approved organograms in accordance with the specified level of care and service package exist to guide staffing and roles.	4	3	3	4	3	1	3	1	3	25	9	2.78
6.1.2	These posts within the organogram are fully funded in the business plans and approved budgets.	1	3	4	2	1	2	3	1	2	19	9	2.11
6.2	Duty planning and management of staff adequately covers duty rosters, overtime, leave, contracting of additional staff.	4	3	2	1	2	4	3	4	3	26	9	2.89
6.2.1	All overtime or contracting of additional staff is approved by the Departmental head in accordance with the budget and duty plan.	3	3	2	4	3	4	3	4	4	30	9	3.33
6.2.2	Leave, sick leave and absenteeism are actively controlled and monitored by the Head of Department and the Personnel department	3	4	2	4	3	3	3	3	3	28	9	3.11
6.2.3	Ongoing monitoring and control as well as regular audits or reviews are conducted of the planning and controls for staff use including doctors.	4	3	2	1	3	2	3	2	2	22	9	2.44
7	INFORMATION MANAGEMENT												
7.1	The facility is able to use:												
	PERSAL	1	1	1	1	1	1	1	1	1	9		9.00
	BAS	1	0	0	1	1	1	1	1	1	7		7.00
	LOGIS ON-LINE	0	0	0	1	1	0	0	1	0	3		3.00
	DHIS	1	1	1	1	1	1	1	1	1	9		9.00
7.2	The Pharmaceutical system (remote demanders module) is available online.	4	3	4	2	4	3	2	4	4	30	9	3.33
7.3	Telephones, faxes, computers, pagers and other communications tools (including networks) are recorded in the asset register.	4	4	4	4	4	4	4	2	4	34	9	3.78
7.4	The abuse of telephones, faxes, computers, pagers and other communications tools by staff is monitored and controlled.	2	4	2	2	3	3	4	2	2	24	9	2.67
8	AUDIT ABILITY / PAPER TRAIL / ACCOUNTABILITY												
8.1	The control systems and paper trail that currently exists is sufficient for an audit by the Auditor General to be possible.	3	4	3	3	3	3	3	3	2	27	9	3.00
8.2	When last did the Auditor General conduct an audit at your facility?												
	WITHIN THE PAST 12 MONTHS	1		1	1	1		1	1		6		6.00
	BETWEEN 12 AND 24 MONTHS AGO		1								1		1.00
	BETWEEN 24 AND 36 MONTHS AGO						1				1		1.00
	MORE THAN 36 MONTHS AGO									1	1		1.00
8.3	Rate the following areas / issues pertaining to the implementation of effective control systems in order from the biggest problem to the smallest problem. (From 1 to 6)												
	DELEGATED AUTHORITY	2	1	2	2	1	4	2	2	2	18	9	2.00
	PROCUREMENT	4	4	4	4	3	5	3	4	3	34	9	3.78
	CENTRALISED SERVICES	1	2	5	1	4	2	5	3	6	29	9	3.22
	HUMAN RESOURCES	5	3	3	3	2	1	4	1	1	23	9	2.56
	FRAUD / CORRUPTION	3	6	1	6	6	6	6	5	4	43	9	4.78
	INFORMATION MANAGEMENT	6	5	6	5	5	3	1	6	5	42	9	4.67

APPENDIX 4 –

ETHICS CLEARANCE CERTIFICATE

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Mr Andrew Colin Jones

CLEARANCE CERTIFICATE	M090455
PROJECT	Financial Management Controls in the South African Public Hospital Sector
INVESTIGATORS	Mr Andrew Colin Jones.
DEPARTMENT	School of Accountancy
DATE CONSIDERED	09.04.29
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 09.04.29 CHAIRPERSON .....
(Professor P E Cleaton Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Prof K Sartorius

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

.....

APPENDIX 5 – INTERVIEW QUESTIONAIRE

SURVEY QUESTIONAIRE - CHIEF EXECUTIVE OFFICER

Prepared By: Andrew Jones (ACIS)
Lecturer - School of Accountancy
University of the Witwatersrand
Johannesburg

Prepared For Use In: Masters dissertation entitled:
"Management controls and accountability in the South African Public Hospital Sector"

The purpose of this study is to identify and evaluate the factors within the management control systems of government hospitals in South Africa that assist or hinder the CEO in their role as accounting officers with respect to the successful planning and implementation of annual budgets.

Instructions: Additional information that you feel could assist the researcher in compiling a report that would honestly and accurately provide insight into your role as a CEO can be sent to the researcher as follows:

Email: andrew.jones@wits.ac.za
Fax: 086-627-5840
Post: PO Box 16145
Dowerglen
1612

Anonymity: All information received as well as the answers to this survey questionaire will be kept totally anonymous.

Feedback: All respondents to this questionaire will receive a copy of the results as well as an explanation as to what the key findings were and how it can be useful to improving the way in which you manage your hospital facilities

PART 1 GENERAL HOSPITAL SPECIFIC INFORMATION

1.1 Type of Government hospital being managed

DISTRICT HOSPITAL
REGIONAL HOSPITAL
TERTIARY / ACADEMIC HOSPITAL
SPECIALISED INSTITUTION / HOSPITAL

1.2 Province in which the hospital is located

GAUTENG
FREE STATE
LIMPOPO PROVINCE
NORTHERN CAPE
NORTH WEST PROVINCE
KWA-ZULU NATAL
WESTERN CAPE
EASTERN CAPE
MPUMALANGA

1.3 2008/9 budget allocation (Including Compensation of employees) for your facility

R

1.4 2007/8 budget UNDER/OVER spend (Including Compensation of employees) for your facility (percentage)

% under
% over

1.4a Number of approved beds

1.4b Number of beds in use

1.5 Number of approved posts on staff establishment (Funded)

ADMIN
PHARMACISTS
MEDICAL (NON SPECIALIST)
MEDICAL (SPECIALIST)
OTHER

1.5 Number of vacant posts

ADMIN
PHARMACISTS
MEDICAL (NON SPECIALIST)
MEDICAL (SPECIALIST)
OTHER

1.6 Hospital revitalisation?

Year started / scheduled to start
Planned completion date

1.7	**Is the hospital being assisted by COHSASA regarding implementation of effective management control systems?**	
	YES	
	NO	
IF YES	DATE OF FIRST COHSASA ACCREDITATION	

PART 2 CEO SPECIFIC GENERAL INFORMATION

2.1	**In which of the following fields of study have you obtained a University / College degree or diploma? (Tick all applicable and state whether undergraduate or post graduate)**	
	ACCOUNTANCY & FINANCE	
	HR & PERSONNEL	
	MEDICINE	
	NURSING	
	OTHER (PLEASE SPECIFY) -	

2.2	**For how many years have you occupied the position of hospital CEO?**	

2.2	**For how long have you been the CEO at your current hospital?**	

2.3	**In your opinion, are you the accounting officer for your hospital?**	
	YES	
	NO	

Give reasons for you answer.

1
2
3

2.4 **Do you consider the annual budget allocation process, within your Province, to be an effective system?**

YES
NO

Please give reasons for your answer.

1
2
3

2.5 **My facility provides the full package of care for my level of hospital?**

YES
NO

Please give reasons for your answer.

1
2
3

2.6 Due to community needs does your hospital provide services that are outside your funded mandates?

YES
NO

IF YES **PLEASE LIST AND EXPLAIN**

Please answer the following questions in the following manner:
Strongly Agree - 100% compliant and reliable (No problems)
Agree - In place however with issues that need to be addressed
Disagree - Do not agree fully, however hospital beginning to solve some of the problems relating to implementation
Strongly Disagree - Hospital is not compliant with this statement at all and needs to focus on addressing these issues
Reason's for your answers will be discussed as part of the interview process.

PART 3 MANAGEMENT AND PLANNING

SECTION 3.1 CEO's develop and monitor comprehensive annual strategic and business plan for hospital

3.1.1 Hospital annual operational plan is consistent with the true medical needs and requirements of the community.

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

3.1.2 The Province understands what the true medical needs and requirements of the community are and align annual funding with these needs

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

3.1.4 Delegations to CEO level have been received in accordance with PFMA norms and requirements relating to finance.

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

3.1.4 Delegations to CEO level have been received in accordance with PFMA norms and requirements relating to procurement.

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

3.1.4 Delegations to CEO level have been received in accordance with PFMA norms and requirements relating to human resource matters.

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

PART 4 FINANCIAL MANAGEMENT

4.1 Appropriate tools, information and skills are available to enable management of expenditure.

4.1.1 Cost centre management is taking place within the hospital

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

4.1.2 Managers can access and analyse information on expenditure (actual and committed) against budgeted costs on a monthly basis.

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

4.1.3 Systems are in place to hold department / section managers accountable for monthly expenditure.

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

4.2 Resources are adequately managed and efficiency savings are achieved.

4.2.1 Effieciency targets and anticipated savings are set within the busines plan and are monitored regularly.

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

4.3 Aqeduate control processes are in place for the charging of services (Road accidents, WCA, private patients)

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

4.3.1 A daily census is performed on all new patients and discharges.

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

4.3.2	**Inventory counts are performed on a daily basis to reconcile ward inventories with patient issues and variances are investigated.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

4.3.3	**There are defined procedures for the collection of debt and these are followed.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

4.4	**Appropriate controls exist for cash transactions.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

4.4.1	**There are clearly developed processes and procedures for the control of cash.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5 PROCUREMENT AND SUPPLIES

5.1	**Selection processes for equipment and consumables are efficient and transparent and reflect the needs of both users and management.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5.1.1	**Users of supplies are involved in discussions on new products and processes, including training needs, and their input is documented.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5.1.2 A process exists for prioritising the procurement of appropriate medical equipment (facilities, personnel and budget available)

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5.1.3 Effective procedures exist to limit / monitor influences on purchasing decisions. (e.g. medical reps)

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5.2 Stock and equipment is managed effectively and efficiently to maximise use, maintain adequate levels and reduce losses

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5.2.1 Information systems to manage stock are in place and functional

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5.2.2 An asset register of medical equipment is available and updated regularly.

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5.2.3 Medical repair maintenance records are kept (Costs, Dates, etc.)

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5.2.4 Risks due to loss or theft are identified and managed

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5.2.5 **Mechanisms are found to ensure maximum use out of high cost items (E.g. sharing)**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5.3 **Procurement policies are in place to ensure adequate stock of the appropriate medicines for the specific level of care.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5.3.1 **A standard operating procedure guides the ordering of medicines from provincial depots, including standard stock levels.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5.3.2 **Sufficient budgetary provision is made for planned medicine usage.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5.4 **Adequate management control of procurement process exists.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5.4.1 **Senior management assess the procurement system and ensure maximum value for money.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5.4.2 **The procurement section has adequate staffing and sufficient senior management to meet performance targets.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

5.4.3 **Goods are paid within the required time frame and discounts for prompt payment are received.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

6 HUMAN RESOURCE MANAGEMENT

6.1 **A human resource plan forms part of the Strategic and Business plans and monitoring system.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

6.1.1 **Suitable approved organograms in accordance with the specified level of care and service package exist to guide staffing and roles.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

6.1.2 **These posts within the organogram are fully funded in the business plans and approved budgets.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

6.2 **Duty planning and management of staff adequately covers duty rosters, overtime, leave, contracting of additional staff.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

6.2.1 **All overtime or contracting of additional staff is approved by the Departmental head in accordance with the budget and duty plan.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

6.2.2 **Leave, sick leave and absenteeism are actively controlled and monitored by the Head of Department and the Personnel department**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

6.2.3 **Ongoing monitoring and control as well as regular audits or reviews are conducted of the planning and controls for staff use including doctors.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

7 INFORMATION MANAGEMENT

7.1 **The facility is able to use:**

PERSAL
BAS
LOGIS ON-LINE
DHIS

7.2 **The Pharmaceutical system (remote demanders module) is available online.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

7.3 **Telephones, faxes, computers, pagers and other communications tools (including networks) are recorded in the asset register.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

7.4 **The abuse of telephones, faxes, computers, pagers and other communications tools by staff is monitored and controlled.**

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

8 AUDIT ABILITY / PAPER TRAIL / ACCOUNTABILITY

8.1 The control systems and paper trail that currently exists is sufficient for an audit by the Auditor General to be possible.

STRONGLY AGREE
AGREE
DISAGREE
STRONGLY DISAGREE

8.2 When last did the Auditor General conduct an audit at your facility?

WITHIN THE PAST 12 MONTHS
BETWEEN 12 AND 24 MONTHS AGO
BETWEEN 24 AND 36 MONTHS AGO
MORE THAN 36 MONTHS AGO

8.3 Rate the following areas / issues pertaining to the implementation of effective control systems in order from the biggest problem to the smallest problem. (From 1 to 6)

DELEGATED AUTHORITY
PROCUREMENT
CENTRALISED SERVICES
HUMAN RESOURCES
FRAUD / CORRUPTION
INFORMATION MANAGEMENT

APPENDIX 6 – EXAMPLE OF LETTER TO PROVINCIAL DEPARTMENTS

SCHOOL OF
ACCOUNTANCY

School of Accountancy
University of the Witwatersrand
First National Bank Building
West Campus
Braamfontein
Johannesburg
South Africa

Gauteng Provincial Department of Health

Date: _____

RE: Request to interview CEO's within your province as part of a MCom (Accounting) for the University of the Witwatersrand

Dear _____

I, Andrew Jones, hereby request permission to interview two CEO's of hospitals within your province. The results of the interviews will be included in a research report I am writing as part of his MCom (Accounting).

The purpose of this study is to identify and evaluate the relevant management control systems (MCS) of government hospitals in South Africa with respect to better understanding 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?

I have already analysed pub domain material such as xxx and these interviews are to triangulate/confirm conclusions reached. I hipe the interview process will also b useful tot eh ceos concerned, as they will help to focus the ceo's attention on fin and management imprivements wh might be possib le at their hospital,.

In g I would like to visit x and y hosp, because…

The information included in the final research report, which has obtained ethics clearance from the University of the Witwatersrand, is 100% anonymous.

Please understand that the information included in the final research report is 100% anonymous. On conclusion of the research I will send you a copy of the findings and would be delighted to personally discuss them with you.

If you have any queries or concerns about xxx, please xxxxxx
contact me on:

Cellphone: 082-469-7586
Fax: 086-627-5840
Email: Andrew.jones@wits.ac.za
Postal: PO Box 16145
Dowerglen
Edenvale
1612

Yours truly

Andrew Jones
School of Accountancy
University of the Witwatersrand
Johannesburg

APPENDIX 7 – PHASE 3

EXAMPLE OF PERMISSION TO BE INTERVIEWED COMPLETED BY EACH CEO

SCHOOL OF ACCOUNTANCY

INFORMATION DOCUMENT – RESEARCH TO BE CONDUCTED BY ANDREW JONES AS PART OF HIS MCOM (ACCOUNTING)

Study title: FINANCIAL MANAGEMENT CONTROLS IN THE SOUTH AFRICAN PUBLIC HOSPITAL SECTOR

Introduction:

Hello my name is, Andrew Jones, I am doing research for my Masters degree in Accountancy at the University of the Witwatersrand and it is on financial management controls in the South African Public Hospital Sector. Research is just the process to learn the answer to a question. In this study we want to identify and evaluate the relevant management control systems (MCS) of government hospitals in South Africa with respect to better understanding whether the budgetary control systems are 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?

Invitation to participate: I am inviting you to participate in this research study. If you have any questions please do not hesitate to ask me now or contact me later at the following numbers:

What is involved in the study: My research is focused on the perspectives of Chief Executive officers in government hospitals around the country. The study will involve a 3 to 4 hour interview. I will use a semi-structured questionnaire in the interview process. This will be followed by us taking a walk through your facility and me reviewing documentation that is hospital specific. This includes budget interrogation reports, approved budgets, auditor irregularity reports as well as any other document that you, as CEO, feel might be useful in obtaining a clear and accurate picture of the management controls within your facility. I have been given permission by your HOD to do this study.

There are no risks associated with this study in that the material used and obtained during the interview, document review and hospital walk through will be kept totally anonymous.

Benefits of being in the study - The visit and interview will contribute to your understanding and perhaps prioritizing of financial management issues within the hospital. Obtaining perspective from an independent source on what the overall concerns will allow management an opportunity to deal with these issues in a informed manner. **Each participating CEO will be given hospital specific feedback and suggestions on the study while involved in the research as well as a copy of the final research report.**

Participation is voluntary, that refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and that the subject may discontinue participation at any time without penalty loss of benefits to which the subject is otherwise entitled.

Confidentiality: All personal information will be kept confidential. The information will be aggregated and there will be no links to the hospital. All interview material will be confidential and findings from these interviews relating to individual hospitals will be anonymised in the text of the final research report. I will use codes on the questionnaire and keep a register linking the codes to your hospital in my locker under lock and key. If you have concerns regarding the conduct of the study you may contact the Chair of the Human Research Ethics Committee Professor Cleaton-Jones through his secretary Ms Anisa Keshav at tel. no. 011 717 1234.

Contact details of researcher/s – for further information:

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Dower glen, 1612

S C H O O L O F

ACCOUNTANCY

Date:_____

Letter of Consent to be included in research study

I _____ hereby agree to be interviewed by Andrew Jones and accept that the information obtained at the interview will be included in a research report Andrew Jones is writing as part of his MCom (Accounting).

The purpose of this study is to identify and evaluate the relevant management control systems (MCS) of government hospitals in South Africa with respect to better understanding whether the budgetary control systems are 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?

I understand that the information included in the final research report is 100% anonymous. I also understand that I am volunteering my involvement in the research and can at any time discontinue my involvement should I wish to.

I also understand that on conclusion of the research Andrew Jones will send me a copy of the findings and that he would be delighted to personally go through them with me.

Signature _____

Hospital _____

Position Held _____