CHAPTER 2 : THE PRESENT SITUATION

2.1 Introduction

This chapter summarises the current situation relating to financial management of South Africa's public hospitals. It does this within the framework of guidelines set out by the Department of State Expenditure, the Treasury and generally accepted financial management principles. The analysis is based on a process of investigations undertaken between October and December 1995. A draft Report was prepared. This was discussed during January and February 1996 with representatives from the Provincial Treasuries and provincial health departments in seven provinces (**Annexure A**).

The analysis is set out according to five broad categories of issues:

- the present budgeting process,
- the accountability framework,
- the staff involved with financial matters,
- current discretionary authority for operational decision-making, and
- the systems used to manage financial information.

Evidence given is deliberately not attributed, although references are available on request. Whilst this study was not initiated to be negative, the investigation found that the situation relating to the financial management at hospitals has many shortfalls. Effective financial management does not appear to be a priority for public sector management:

- no management resources - people and systems - exist to relate the control of service delivery to the costs involved;
- where managers have wished to contain costs, they have not had the operational powers to change the activities necessary to achieve this; and
- managers have never really been held accountable for expenditure in the sense envisaged in the Exchequer Act.

It should be noted that, whilst these observations are generally applicable, there are some exceptions which show that it is possible, given current constraints, to manage finances well.

2.2 The Budgeting Process

This section identifies the issues related to how the budget process for hospitals takes place. It looks both at how budgets are allocated, and their current format. Although individual details might differ slightly, the general trends tend to be similar in all provinces visited.

2.2.1 Budget Allocations

2.2.1.1 National Allocation to Provincial Health Departments

The 1995/96 national budget was split by function. Within each function the split to a provincial allocation was made by the Function Committee. The Health Function Committee made its allocation based on a formula developed to take the population numbers weighted by per capita income into account, thereby beginning to relate expenditure to the Department of Health's policy for equitable allocation. Some provinces feel that the allocations were unsatisfactory for various reasons including:

- although all nine provinces are represented on the Function Committee there is no independent arbiter; and
- decisions are made on a majority consensus basis which means that in certain cases the most sound arguments are overridden because too many role-players are negatively impacted by these.

It is generally accepted that an impartial body looking after everyone's interests is necessary to overcome the conflict inherent in the present system. The Finance and Fiscal Commission (FFC) could play this role. The Interim Constitution (paragraphs 194-197) specifies that the FFC must look at allocation per province and not per function. The approach of the Function Committee and the FFC are diametrically opposite. It is as yet unclear from Government when and if the FFC process will be adopted.

In one province visited the view was put forward that the Department of State Expenditure does not allow provinces discretion over allocations within the province. It is also felt that, although all provinces are represented on the Function Committee, the Department of State Expenditure at national level makes the final allocation. It was forcefully suggested that this meant that the Department of State Expenditure actually treats provinces as administrations and not as legislative authorities with a degree of autonomy.

Once the funds have been allocated at national level to the Provinces, it is the Provincial Treasury, in conjunction with the Provincial Departments of Finance and Health which accept these allocations as appropriated for the Department of Health

It should be noted that current skills and systems do not enable multiyear budgeting, which is a basic requirement of good strategic planning.

2.2.1.2 Provincial Health Departments' Allocations to Hospitals

The budget allocation per hospital was determined at provincial level (with the exception of the NITER allocations which were earmarked by the Function Committee). The allocation of budgets from the provincial health departments to hospitals has theoretically taken place in a parallel bottom-up and top-down process. Most hospitals submitted estimates of their annual requirements. However, the differences between the provincial budget and the hospital budget are not negotiated and the provincial health department has the final word on the amount that each hospital receives. Budget differences are in most cases not resolved. The consequences of this process are:

- the budgeting process is widely described as "not transparent" since variances between the requests from hospitals and the allocations received are seldom explained;
- no buy-in (ownership) at hospital management level ("It is not our budget");
- no "contracting" in respect of the budget allocation between provincial and hospital management, i.e. there is no agreement on performance targets or indicators;
- the separation of the process of planning from the process of budgeting;
- hospital management is forced to accept their allocated amount often knowing that they are going to overspend as they do not have the operational authority to reduce expenditure significantly;
- no community or hospital representation (i.e. through a board) in the allocation process which can relate community service demands to performance targets;
- the general belief that budgets are "unreal", so should be disregarded, demotivates managers and staff;
- since budgets are thought to be unreal, it is often not considered that inefficient activities in the hospital may be causing overspends; and
- in some cases where allocations to the hospital bear no relation to prior expenditure or expected needs of a hospital, managers are using the budgets that they prepared to monitor expenditure, rather than the allocated budget that is entered into the FMS.

The current budgeting process is based upon the historical allocations to the hospital, and there are considerable inequities between allocations given to similar hospitals which cannot be clearly explained. Budgets are stated in terms of inputs alone, with no consideration given to outputs and outcomes:

- budgets in certain cases were lower than the prior year's expenditure, without an agreed change in service delivery levels or patient profile;
- there has been a general increase in the number of attendances over the last twelve months. New free services have also increased the number of people presenting. In cases there has been a dramatic reduction in the number of private patients attending public hospitals. All of this have not been clearly reflected in allocations at hospital level; and
- in some hospitals new departments had been opened, which created extra costs, not being reflected in the allocation given.

Allocations to hospitals do not include all expenditure incurred at hospitals. In many provinces the provincial department of Transport and Works control budgets for some of the activities of hospitals. This does not allow effective management of significant proportions of hospitals budgets by provincial departments of health. Similarly, provincial departments of health seldom hold contingency budgets which can be used for either managing unforeseen and avoidable events effectively or used as tools for implementation of strategic interventions when required.

2.2.2 Format of Budgets

The Department of State Expenditure currently requires that the allocations to hospitals should be based on the following steps:

- identification of activities;
- definition of the goals of the government and formulation of missions;
- examining the rationale for all activities;
- discarding of existing activities and establishing new activities;
- costing of activities based on the most economical, efficient and effective ways of providing the service;
- prioritisation of activities; and
- determining of alternative spending options for a vote as a whole and the implications thereof.

This can be summarised as budgeting from zero. Whilst there is a clear intention to arrive at truly zero-based budgets this process has not yet taken place.

Little attention has been given in most provinces to specifying what the broadest levels of goals for health care departments and institutions should be:

- missions *which can be translated into outputs/outcomes* have not been established for hospitals, or provincial departments of health;

- most respondents said that their mission 'was to serve all people who arrive at the hospital in the best way possible';
- hospital management often expressed the desire to have a tailored mission, not merely being all things to all people, but few had any clear idea of the particular services and service levels which were required to be provided by their hospital (i.e. the difference between a primary, secondary, tertiary and teaching hospital);
- academic hospitals were unclear about the proportion of their budget which should be allocated for "teaching" purposes, and what should be used for tertiary level patient care; and
- no evidence was found of clear definitions of outputs and outcomes.

It is recognised that provinces are aiming to implement zero-based budgeting. The format presently used for the budgets of hospitals does not enable effective financial management, and inhibits the efficient and effective use of resources:

- budget formats are not based on the organisation of activities, but only detail expenditure by standard items (i.e. personnel costs, consumable costs, professional services and capital), and by capital versus recurrent expenditure;
- the purpose of expenditure (i.e. the specific needs to be met, the problems to be dealt with, the benefits to be achieved and the results or outputs envisaged) is not established and is therefore not specified in the budget format;
- present systems used for budgeting do not enable the process to conform to Department of State Expenditure requirements; and
- not all the real costs relating to hospitals are reflected in the budget (such as depreciation costs and some capital costs).

2.2.3 Performance reporting

It is generally accepted as good practice, not least of all by the Department of State Expenditure, that budgets should be related directly to activities and outputs. This requires specific monitoring of the performance of budgets and activities. (Framework for Normative Measures for Financial Management in the Public Sector - **Annexure B**). At present:

- staff are not able to monitor activity levels, given the present systems, and in some cases could not see what benefits this information would give them;
- where performance indicators are used, they are limited to the number of patients in total for the hospital, the total expenditure to date etc.- information which is not detailed enough to be meaningful for operational managers; and
- meaningful measures that could be used as benchmarks between institutions are very rarely collected, and in the case of one province

where such indicators had until recently been collected, they had not been used and the practice has been discontinued.

2.3 Accountability for Financial Performance

Performing to budget at provincial and hospital level is almost always disregarded by managers. There may be several reasons for this:

- the allocation process is seen as inequitable and having no relation or regard to service demands;
- managers firmly believe they do not have the ability to contain costs. In an emotionally-loaded function, such as health care, limiting services usually result in severe political pressure;
- budgets are rigid. Managers have little or no flexibility for allocating funds according to requirements; and
- no penalties have ever been implemented on departmental or hospital managers for non-adherence to the budget.

From the investigations, it appears that there is no working accountability mechanism for the financial performance of South Africa's public hospitals:

- there was no evidence that managers at provincial level are held financially a accountable;
- there was no evidence of individuals being held financially accountable at hospital level to meet their budget, and over-spends are not being dealt with through disciplinary measures against the manager responsible;
- control of expenditure is not integrated into the processes of line management and is seen as a separate function of hospital administration;
- over-spends have become part of the accepted budget and management process, with projected expenditure exceeding budget levels by 30-50% in many cases. In one hospital an over-spend of R 100 m is projected for year end 1995/96; and
- in a number of cases, managers expressed the view that they were only really concerned with the non-staff allocation since they had no authority to manage their establishment, (authority for this being retained by the provincial Director-General, Public Service Commission and the Health Department), and since they had always been able to show that increased staff costs were 'uncontrollable and unavoidable' (staff-costs make up approximately 60%-70% of total expenditure in most hospitals).

2.4 The Staff involved in Financial Matters

This section considers staffing issues related to financial management of hospitals, however, the trends tend to be repeated at provincial level. The management of finances is currently conducted as an administrative function, divorced from the activities which take place in the service delivery departments of hospitals. The Public Service did not historically treat the management of its finances as important, and has

neglected the development and use of high levels of skills for this role. This has contributed to the current situation in hospitals, as described below.

2.4.1 The role of staff in financial management

- the financial tasks performed are being carried out by general administrative departments;
- the primary function of staff is to monitor and report on expenditure by line item on a monthly basis - they are not held accountable for expenditure or fully explaining variances; and
- staff at all levels of the health system are frustrated by their lack of operational authority and decision-making powers, specifically to prevent over-spending on their budgets.

2.4.2 The skills of staff who are responsible for finances in hospitals

- the usual formal qualifications of staff responsible for overseeing financial matters is Matric. In all the eleven hospitals visited, the highest qualification was a B.Comm, with budgets of over R 100 m overseen by people with no tertiary qualification whatsoever, let alone a financial specialism; and
- the staff who are available for financial departments in hospitals are clerks or administrative officers who:
  - have no formal financial skills and very little training
  - are perceived to be currently over-worked with their present tasks
  - have limited knowledge of the existing systems.

2.4.3 The attitude of staff towards financial management

- management and staff in general underestimate the value of financial and activity data, and in cases could not see what benefit improved systems and reporting could give them; and
- the apparent shortage of staff is sometimes used as an excuse for poor controls within the financial function, including revenue, stock, debtors, fixed assets.

2.4.4 Financial Managers

- the individual in charge of the administrative departments (and hence financial function) is usually the Hospital Secretary, who has other responsibilities and is thus not fully dedicated to financial tasks;
- financial managers have not yet been appointed at a provincial or hospital level. In instances the usefulness of the financial manager was

questioned, especially linked to the weakness of the financial systems in present use, and the inability of managers at hospital level to take decisions to enable expenditure to be controlled;

- managers in hospitals have very little contact with the financial staff at provincial level. The current financial administration function of the Provincial Government must serve all the departments including the health department. Financial management is divorced from the Department of Health and the hospitals (which deliver the service) and therefore the department and hospitals have little or no understanding of financial management processes or priorities; and
- provinces did not have skilled financial managers capable of providing support to hospitals regarding financial management issues.

2.5 Current Discretionary Authority for Operational Decision-Making

This section details the current ability of staff at hospital level to make key decisions allowing them to control expenditure in the context of decentralised management. The following was observed:

- staff are not able to vire (move money between budget lines) between standard items of the budget to maximise the efficiency of the allocation;
- hospitals are required to use the state tendering procedure for all items covered in it, even when considerably lower prices can be obtained locally, which happens frequently;
- hospitals are not able to open bank accounts;
  virement from capital to recurrent budget is excluded by the Department of State Expenditure;
- hospitals have no authority to change their establishment, or manage staff expenditure;
- hospitals must have all capital purchases approved by the province even though the capital budget has already been allocated to the hospital;
- the approval of large capital expenditure is protracted, and is usually made on the basis of cost alone regardless of quality. This is not always cost-effective;
- hospitals are not able to retain the revenue generated by them, which in most hospitals acts as a disincentive for the collection of user fees; and
- hospitals wishing to generate income from the use of surplus resources are restricted from doing so.

2.6 The Systems used for Financial Management

This section refers to the accounting and management information systems used to monitor, report and control financial information. Without adequate accounting and financial management information systems, financial managers are unable to perform their roles effectively. At present most hospitals are limited to the FMS, PERSAL and a stock management system (the PAS (Procurement Administration System), which covers consumable stores, not pharmaceuticals), which were designed as expenditure

and budget control systems, but are unable to provide management with the necessary financial information.

It should be noted that the format of all information systems, reports and forms is controlled by the PSC, and the provincial departments of health, let alone the hospitals, do not have discretionary authority to design and implement systems, forms, etc. which best meet their needs. This directly restricts the responsiveness of the health departments in the provinces.

It is unknown how many hospitals are not yet computerised and are using manual systems, but the percentage is believed to be significant. The observations relating to financial management systems are detailed below.

2.6.1 Accounting Systems

- there is no accrual accounting system, and the systems in place predominantly record payments and budgeted expenditure to date per line-item;
- there are no balance sheets;
- recording of creditors take place as "commitments", and the system of recording "commitments" is not operating in many hospitals. They are in some cases being manually calculated whereas other hospitals simply ignore unpaid items;
- the stock systems and controls are generally very weak, especially for pharmacies (drugs constitute the single largest expenditure group after staffing);
- in some cases management is unable to account for stock, and is not even able to establish whether supplies are delivered to the hospital in the first place;
- stock counts are not regularly or timeously performed to check reports;
- debtors/ revenue systems are very weak in most hospitals because:
  - ...there is a lack of incentive to maximise revenue since hospitals are not able to retain funds collected
  - ...billing systems often do not provide for billing on discharge so accounts have to be sent to patients
  - ...patient information is inadequate to support billing since addresses given on discharge are often untraceable, or patients do not have addresses
  - ...some hospitals do not make any effort to trace bad debts, as the cost of physically collecting the fees was in some cases perceived to be higher that the potential income from fees to be collected. Some hospitals have good systems to trace bad debts, and do it well
  - ...the fees charged are often seen as insignificant. Even private fees, compared with RAMS rates, are seen as negligible
  - ...in one case it was noted that invoices are only issued when the invoice book is full, which usually meant invoices sent to Medical

Aids arrived too late for payment; and

- debtors outstanding and revenues collected are often not looked at by hospital management as they see themselves as only responsible for the overall expenditure.

2.6.2 Management Information Systems

Structure of information

- information captured and generated does not fulfil the needs of management, and some hospitals are keeping a system of manual journals so that they are able to get a better idea of the real financial situation and of the operating results of the hospital;
- there is no processing of data by cost centre; and
- the system does not enable performance measures to be calculated, and management is therefore not able to measure outputs, efficiency or effectiveness.

Reports Generated

- it was noted that some reports available on FMS were not being used;
- reports generated were criticised by users:
  - ...as not user-friendly
  - ...seen as difficult to understand
  - ...not providing useful management information;
- reports are sometimes only available over a month after the reporting date. Reasons for the delay lie both at provincial level and hospital level, and include poor communication, slow data entry and the lack of computer hardware;
- in some cases, where hospitals are on-line with the provincial department of finance, they are sometimes able to obtain up-to-date reports where the province is processing journals timeously;
- current activity reporting to provincial level is manually based, and is not meaningful for hospital managers;
- some hospitals, however, are keeping meaningful activity data for their use, but this has little relationship to the budget allocated;
- management throughout the provinces and hospitals expressed the desire to have a transparent system of reporting for all hospitals, whereby comparisons between hospitals could be made easily for performance data (such as cost per inpatient, outpatient etc.); and
- PSC controls all reports, the structure of the information and the system used, thereby inhibiting the ability of the departments of health to implement an appropriate system.

2.5 Summary of the Present Situation

By investigating the current situation regarding the financial management of hospitals it was found that:

- the budget allocation process is neither respected, appropriate or effective;
- hospital and provincial managers are not in fact accountable for financial performance;
- the staff "managing" the finances are not adequately skilled and motivated to do so;
- those who nominally hold accountability do not have the ability to control expenditure; and
- current systems will not be able to support proper financial management and they do not promote efficiency or effectiveness.