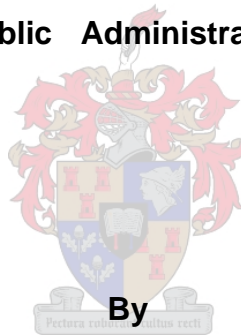


AN ASSESSMENT OF FINANCIAL AND SUPPLY CHAIN MANAGEMENT OUTCOMES IN WESTERN CAPE PUBLIC HOSPITALS

**A thesis presented in partial fulfilment of the requirements for the
degree of Master of Public Administration at the University of
Stellenbosch**



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Study Leader : Prof A P J Burger

Date : April 2005

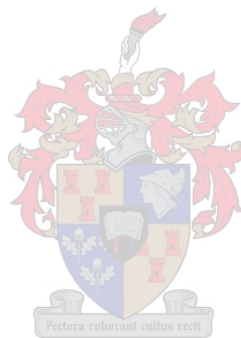
DECLARATION

I, Hendrik Archie Lewis, do hereby declare that this thesis is my own original work and that all sources have been accurately reported and acknowledged, and that this document has not previously in its entirety or in part been submitted at any university in order to obtain an academic qualification.

.....

H. A. Lewis

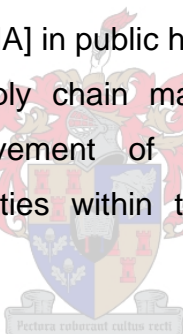
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ABSTRACT

South Africa, as a young and emerging democracy, faces many challenges regarding the transformation of the socio-economic landscape of the South African society. The provision of better health care services and the overall development and empowerment of society are some of the many challenges government has to resolve. This research focuses specifically on service delivery in public hospitals with special emphasis on:

- ❖ An assessment of financial management outcomes within the context of the implementation of the Public Finance Management Act (Act 1 of 1999, as amended) [PFMA] in public hospitals; and
- ❖ An assessment of supply chain management (SCM) outcomes in relation to the achievement of empowerment and equity of disadvantaged communities within the context of Black Economic Empowerment (BEE).



The PFMA is the result of financial reform in South Africa. The PFMA emphasises effective, efficient, economic and transparent use of public funds. This research assessed the financial management at the Head Office of the Western Cape Health Department, as well as at Karl Bremer, Lentegeur and Swellendam Hospitals for the financial years 1998/99 to 2002/03.

The Western Cape Tender Board ceased to exist in December 2003. The procurement and provisioning processes have now been decentralised to the various departments with effect 1 January 2004 and have become the responsibility of supply chain units within departments. BEE and the preferential procurement policy are government initiatives that had to be executed on SCM as platform. The three hospitals were also used to assess

progress on the implementation of SCM, as well as the realisation of BEE objectives.

Annual Reports, Audit Reports and Strategic Planning documentation were used to extract the relevant information necessary for the research. Interviews with nineteen (19) officials were conducted.

Good progress has been made with the implementation of the PFMA. All those officials that were interviewed displayed sensitivity for the responsible management of public funds. A lack of internal control measures was identified in almost all audit reports. The absence of a risk management plan and a functional internal audit unit is hampering the realisation of the objectives of the PFMA.

With health care service delivery and black economic empowerment being topical issues in SA, this research endeavours to make recommendations that could assist the Western Cape government with the realisation of the intended objectives of better health care services delivery by public hospitals, transformation of the economy, equity and empowerment of the disadvantaged through SCM processes and eventually to secure “a better life for all”.

OPSOMMING

Suid Afrika, 'n jong en ontwikkelende demokrasie, staan menige uitdagings in die gesig met betrekking tot die transformasie van die sosio-ekonomiese landskap van die Suid-Afrikaanse samelewing. Die voorsiening van beter gesondheidsdienste en die ontwikkeling en bemagtiging van gemeenskappe is van die vele uitdagings wat oplossings soek. Hierdie navorsing fokus spesifiek op dienslewering in openbare hospitale met die klem op die volgende twee aspekte:

- ❖ 'n Evaluering van finansiële bestuurs-uitkomst binne die konteks van die implementering van die Openbare Finansiële Bestuurswet (Wet 1 van 1999, soos gewysig); en
- ❖ 'n Evaluering van voorsieningskettingbestuurs-uitkomst in verhouding tot die bemagtiging en gelykberegtiging van benadeelde gemeenskappe binne die konteks van Swart Ekonomiese Bemagtiging.



Die Openbare Finansiële Bestuurswet is die resultaat van finansiële hervorming in SA. Die wet plaas klem op effektiewe, doeltreffende, ekonomiese en deursigtige gebruik van openbare fondse. Hierdie studie het die finansiële bestuur by Hoofkantoor en by die Karl Bremer, Lentegoor en Swellendam hospitale vir die finansiële jare 1998/99 tot 2002/03 geassesseer.

Die Wes-Kaapse Tenderraad is in Desember 2003 ontbind en die verkrygings- en voorsienings-administrasie is na die onderskeie departemente gedentraliseer, gesetel as 'n verantwoordelikheid van 'n voorsieningskettingbestuur eenheid in elke departement. Swart Ekonomiese Bemagtiging en die voorkeur voorsieningsbeleid is regerings-inisiatiewe wat op die platvorm van voorsieningsadministrasie van regerings-tenders geloods moet word.

Jaarverslae, Oudit-verslae en Strategiese Beplanningsdokumente is gebruik ten einde die relevante inligting nodig vir die studie te bekom. Onderhoude is met negentien (19) amptenare gevoer.

Goeie vordering is gemaak met die implementering van die Openbare Finansiële Bestuurswet. By alle amptenare wat ondervra is, kon 'n sensitiwiteit rondom die verantwoordelike gebruik van openbare fondse bespeur word. Die gebrek aan interne maatreëls is in byna al die oudit-verslae aangedui. Die afwesigheid van 'n risiko-bestuursplan en 'n interne oudit eenheid belemmer die realisering van die doelwitte van die Openbare Finansiële Bestuurswet.

Gegewe die feit dat diensverskaffing in die gesondheidsektor en swart ekonomiese bemagtiging aktuele sake in SA is, poog hierdie studie om aanbevelings te maak wat die Wes-Kaapse regering kan help met die realisering van beoogde doelwitte van beter gesondheidsdienste deur openbare hospitale, transformasie van die ekonomie, gelykberegtiging en die bemagtiging van die benadeeldes deur voorsieningskettingbestuur prosesse ten einde 'n "beter lewe vir almal" te verseker.

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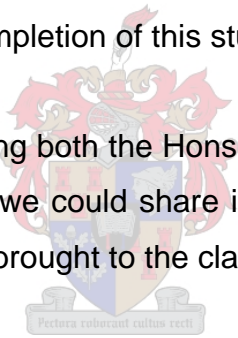
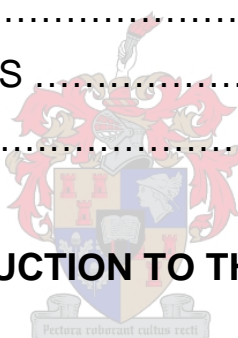
1. My wife, Irma, and children Rene, Hadley and Ilse for their understanding and moral support.
 2. My Heavenly Father for the grace, health and wisdom granted to me.
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 4. All my class mates during both the Hons-BPA and MPA study years for the frank way in which we could share in a diverse pool of knowledge and expertise that was brought to the classroom as individual students.
- 
- The crest of the University of Stellenbosch is a watermark in the background of the text. It features a shield with various symbols, including a book and a torch, and is topped with a crown. Below the shield is a banner with the Latin motto 'Pectus roborant cultus recti'.
5. The caucus of the African National Congress (ANC) in the Western Cape Legislature for having allowed me space to have pursued my studies and indirectly assisted me to improve my knowledge, especially on financial management matters, to fulfil my oversight function in the Legislature.
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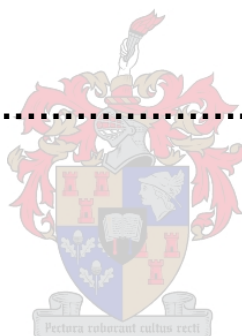
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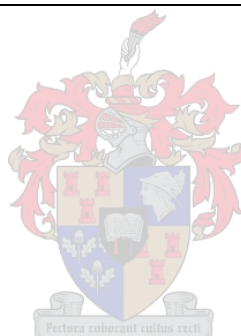


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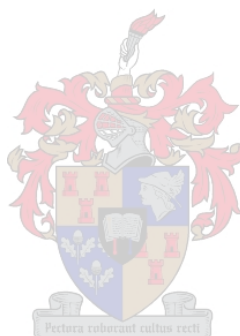
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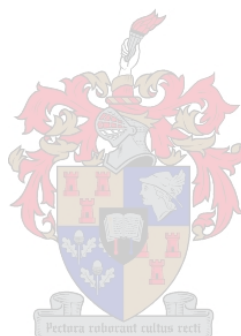
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LIST OF ABBREVIATIONS

4Es	: Effectiveness, efficiency, economy, equity
AG	: Auditor-General
ANC	: African National Congress
AO	: Accounting Officer
BAS	: Basic Accounting System
BEE	: Black Economic Empowerment
CFO	: Chief Financial Officer
COSATU	: Congress of South African Trade Unions
CSR	: Civil Service Reform
DTPW	: Department of Transport and Public Works
EA	: Executive Authority
GEAR	: Growth Employment and Redistribution
HDIs	: Historically Disadvantaged Individuals
ITC	: Information technology and communication
KMOs	: Key measurable objectives
LOGIS	: Logistical Information System
MEC	: Member of the Executive Committee
MTEF	: Medium Term Expenditure Framework
NEDLAC	: National Economic Development and Labour Council
NGOs	: Non-governmental organisations
NPM	: New Public Management
OECD	: Organisation for Economic Co-operation and Development
PDIs	: Previously Disadvantaged Individuals
PFMA	: Public Finance Management Act (Act 1 of 1999 as amended by Act 29 of 1999)
PPPs	: Public-Private Partnerships
PRC	: Presidential Review Commission
SA	: South Africa

SABS	: South African Bureau of Standards
SC	: Supply Chain
SCM	: Supply Chain Management
SMMEs	: Small Medium and Micro Enterprises
VSPs	; Voluntary Severance Packages
WCHD	: Western Cape Health Department



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CHAPTER 1

INTRODUCTION TO THE STUDY

1.1 Introduction

South Africa (SA), both as developing country and emerging democracy, faces many socio-economic challenges. Trevor Manuel, Minister of Finance (2003: 1), summarises the context – past history and future commitment – in the following extract from his 2003 Budget Speech within which the SA government will have to operate:

“... our long walk to freedom bears testimony to a leadership and a people driven by a commitment to democracy, human rights, peace, shared opportunities and a better life for all (own emphasis). Our history bears testimony to our commitment and determination to do the right thing. We have always done so with the courage, integrity, energy and selflessness borne from the knowledge that our principles and our values are worth fighting for.”

He continued to re-emphasise government's dedication to the many challenges by reminding the members of the National Assembly of government's commitment with the following words:

“when on the 8th May 1996, in this very House, we adopted our new constitution, embraced our history and accepted the enormous challenge of rebuilding our country and economy, of healing a nation, of restoring dignity, of inspiring hope and nurturing dreams, of assuming the benefits and responsibilities of our freedom” (Manuel, 2003: 2).

This commitment of government manifests itself in the many policies and legislation that have been promulgated over the last 10 years. The Public Finance Management Act (PFMA) [Act 1 of 1999 as amended by Act 29 of 1999] is one of those pieces of legislation that was meant to drastically change the financial management of public funds in order to promote better service delivery within the public sector. Hence, the focus of this research is to assess the outcomes of the implementation of the PFMA and supply chain management (via Black Economic Empowerment) on health service delivery in public hospitals in the Western Cape in specific, but also to assess its impact on and sustenance of stability in communities.

Chapter 1 gives a background of the situation at public hospitals in the Western Cape and sets the context for the research question, research objectives, research design and the research methodology to be applied. This chapter will be dealt with under the following sub-headings:

- Background;
- Access to health care services as a Constitutional right;
- Description of concepts;
- Research question and objectives;
- Research design and methodology; and
- Outline of chapters.

1.2 Background

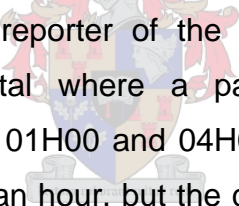
Before the implementation of the Public Finance Management Act (Act 1 of 1999, as amended by Act 29 of 1999), hereafter referred to as the PFMA, on 1 April 2001, the budgeting and spending processes in the public sector were governed by the National and Provincial Exchequer Acts. The application of these acts focused more on budget compliance than on budget outcomes. The application of these acts often resulted in “fiscal dumping” close to the end of the financial year, because departments wanted to clear their books in

anticipation of the impending budget. “Fiscal dumping” refers to the procurement of goods and services by state departments just before the close of the financial year in March to circumvent possible underspending of the budget. During the performance of an audit, departments have to convince the office of the Auditor-General (AG) that they have spent their annual allocations (irrespective the outcome of such spending). “Fiscal dumping” was also used by departments to protect a possible decrease in budget allocation for the ensuing financial year. The purpose of the procurement of items during this “fiscal dumping” process was to use available money that was allocated to a department before the close of the financial year in March, and not necessarily to add value to strategic objectives and service delivery programmes in departments. According to Cloete (1999: 94) underspending of departmental budget votes often happened. Today, underspending of departmental budget votes, against the backdrop of so many socio-economic needs in South African communities, equates to an act of criminality.

The PFMA will help to address the issue of “fiscal dumping”. The PFMA shifted the focus on outputs and responsibilities, rather than the rule-driven approach of the old Exchequer Acts (PFMA, 1999; Van der Linde, 2000; Du Preez, 2000). The budget is promulgated by the Legislature after it has been informed by strategic plans from the respective departments. The Strategic Plan of a department spells out clearly how the budget has to be allocated to the different programmes in the vote. Every programme has outputs (short- and medium-term) that will have to be realised within the context of the broader outcomes (long term objectives) of a department. Furthermore, according to section 39 of the PFMA (1999), the accounting officer (AO) must exercise tight financial control over expenditure and is obliged to report all irregularities to the provincial treasury. Section 40(4)(b) further provides for a mechanism whereby the AO must report on a monthly basis to treasury on the previous month’s revenue and expenditure (PFMA, 1999). This will ensure

that expenditure is spread over the financial year and will thus prevent a situation of “fiscal dumping” close to the end of the financial year.

The services that the general public receive at clinics, day hospitals and state hospitals represent the face of government. Citizens judge government's commitment, and hence the effective and efficient spending of taxpayers monies, at the hand of the type and quality of services they receive. Consequently, a huge responsibility lies on the shoulders of politicians, but especially on the shoulders of management and all health officials, to develop an attitude of care and an inclination to provide the best health care services at all times. The following incidents provide a background to the challenges that the provincial government in general, but the Western Cape Health Department (WCHD) specifically, face in the provisioning of proper and quality health care services.



Jo Breach (2004a: 2), staff reporter of the Cape Argus, reported on an incident at Somerset Hospital where a patient was brought into the gynaecological ward between 01H00 and 04H00 on Tuesday, 23 December 2003. The patient died within an hour, but the corpse was only removed from the ward at 10H30. The corpse was lying in the ward for about five hours, which seriously questions the ethics and procedures at the hospital. Mrs. Lindsay Rall, who was a patient in the same ward, complained that no soap or toilet paper was available and that her family had to provide it from home. On enquiring why those necessities were not available in the hospital, the answer was that “it gets stolen.” Her neighbour patient rang the bell for nursing attention, but no one arrived. The situation got so bad that Mrs. Rall discharged herself from hospital on 25 December 2003. In a letter to the hospital Rall criticised the hospital for having “uncaring nurses, a lack of working medical equipment, unclean conditions and broken beds.” Dr Ria Kirsten, senior medical superintendent at the hospital, promised that Rall's allegations would be investigated. However, incidents like these that have

happened at the same hospital raise public concern about the effective and efficient management of the hospital. The consequence is that the financial management at such a hospital implicitly comes under suspicion. The general public, unfortunately, equates poor services at hospitals to an uncaring government and with a waste of taxpayers' money. Hospital staff gets paid by government and if they fail to execute their duties with diligence and responsibility, the public perceive their appointments as a waste of state funds.

The primary function of hospitals is to assist patients to relief pain, to preserve life and to promote healing of the sick. Breach (2004b) reports that doctors at Groote Schuur Hospital sent Jade Willemse, a pregnant woman, home not realising that she was carrying twins and that she had already miscarried one of the foetuses. The 24-year-old's unhappiness at and disappointment in the hospital staff is understandable. Although she was bleeding heavily when visiting the hospital, she had to wait for an hour before she was helped and felt that hospital staff did not subject her to a proper medical examination. Treatment of patients at public hospitals is increasingly coming under the spotlight. It is the poorest of the poor and the socially most vulnerable people that are using state medical facilities. Jade Willemse's incident illustrates the necessity that hospital officials need to be educated about government's Batho Pele principles – principles that “put the people, as beneficiaries of state goods and services, first” (Batho Pele Handbook, 1997). The Batho Pele principles are intended to guide the transformation of the public service – from a rule-bound bureaucracy to a dynamic, results-driven organisation, committed to delivering appropriate services to the people. An adherence to these principles imply that public officials should at all times exhibit a deep sense of dedication and commitment to higher levels of service delivery.

Human resource management decisions have certain financial implications on the budget of the department. The maintenance of healthy labour relations is

one of management's challenges in the workplace. Two of the objectives of the Labour Relations Act (Act 66 of 1995) are to advance labour peace and to democratise the workplace. Labour unrest at any health care facility can potentially have severe implications for patients at such facilities or for those who would like to make use of such facilities. Sixty paramedics have been suspended by the Western Cape Emergency Medical Services, following an intensifying row between staff and the government agency over service contracts. The workers were suspended for failing to obtain code 10 drivers' licenses required for driving newly purchased ambulances that fall in the heavy vehicle category (Lloyd, 2004). The irony is that the suspension of these ambulance staff happened in the festive season – a period which is generally characterised by an abnormally high rate of road accidents.

These dismissals could have resulted in staff shortages with a concomitant negative impact on service delivery. Volunteers were eventually canvassed to assist. The paramedics complained that the suspension was unfair and that their employer changed the rules for ambulance drivers without consulting them. Although the decision on the ambulance drivers was linked to human resource management, decisions of this nature are often taken within the context of financial affordability, etc. As alluded to earlier, financial management constitutes part of public governance – a management model that must ultimately assist to ensure maximum provisioning of services to citizens.

The allegation of “unfair treatment” of employees reflects poorly on management's responsibility and ability to maintain good labour relations in the workplace on the one hand and a possible disregard for the interruption of continuous services delivery that the dismissal of these paramedics could have caused on the other hand. Human resource and financial management form part of the broader governance responsibility of senior management in the Health Department. Sound human resource or financial management

eventually impact in one or other way on the quality of health care services to be rendered to communities.

The annual losses of linen from Western Cape health care facilities remain a reason for concern. Proper control measures and a risk management plan are needed in hospitals to curb the huge losses of linen. Brümmer (2004a) reported that the monetary value of linen losses in hospitals in the province during the 2002/03 financial year amounted to R 7 million. Table 1 (p. 7) provides information of linen that disappeared from certain state hospitals during the 2002/03 financial year.

Table 1: Linen losses from state hospitals (2002/03)

Name of hospital	Number of items missing	Value of items in Rand
Tygerberg Laundry	27 008	R1 279 020.94
Paarl Hospital	2 868	79 354.88
Karl Bremer Hospital	3 791	112 189.24
Groote Schuur Hospital	26 219	954 009.60
Stikland Hospital	1 176	159 493.09

Source: Die Burger: 2004

It was further established that certain companies - that had been contracted to do the washing of linen – could be involved in a syndicate (which includes hospital staff) that recycles linen (that has been written off) to hospitals. Mr Piet Meyer, then provincial Minister of Health, referred the matter to the Scorpions - a national investigating unit that reports to the National Director of Public Prosecutions - for investigation. The superintendent of Groote Schuur Hospital, Dr N Maharaj, recently witnessed the sale of linen belonging to the Western Cape Health Department (WCHD) - all linen in health care facilities under the jurisdiction of the WCHD is clearly and visibly marked - in a hospital

in Barcelona, Spain (Khoisan, 2004). All these incidents of linen loss point to a lack of internal control measures or proper monitoring mechanisms. Suppliers of services to government institutions should share in the moral responsibility of ensuring that government spends its limited funds to the best use of the citizenry. However, the onus rests with the WCHD to ensure that the selection of suppliers of services is done in such a manner that those suppliers in the supply chain add value to the services ultimately to be rendered to patients.

The Western Cape is the province in SA that has shown the best progress in terms of rolling out the HIV and AIDS anti-retroviral medication strategy. This achievement serves as an example of the results that can be achieved if politicians and officials in the WCHD are committed to the Batho Pele principles. According to Brümmer (2004b), the Western Cape has fourteen operating anti-retroviral medication sites and intends to have close to 50 000 patients in attendance by March 2004. According to Dr. Fareed Abdullah, coordinator for the HIV and AIDS programme (as cited in Brümmer, 2004b), it is the department's intention to increase the sites to 45 by the end of 2005. If the same dedication that is driving the HIV and AIDS campaign could rub off onto all health officials in the WCHD, then more satisfied patients will utilise public health care facilities.

The Auditor-General's Report on the Financial Statements of Vote 7-Health for the year ended 31 March 2000 (PR 147/2001: 2-3) reflects an overspending of R33 816 524,95. The AG pointed out in the Report that management did not comply with tender board regulations in the procurement of an autoclave (a high-pressure steam sterilising machine), valued at R143 350,00. Furthermore, the Report refers to numerous irregularity aspects at academic hospitals in the province, e.g. the late payment of providers or suppliers of goods and services. Paragraph 3.1.1(1)(b) indicates that at the Red Cross Hospital "Payments to the value of R2 466 198,00, which represent 71% of the sample tested, were accepted and delayed for periods

longer than 30 days, which is contrary to the finance instructions” (PR 147/2001).

The late payment of suppliers can have major implications for continued quality service delivery at any hospital. Late payments can interrupt the flow of goods and services in the supply chain.

The Western Cape government recently announced that it wants to speed up delivery at day-hospitals (Essop, 2004a). Dr Fareed Abdullah, Deputy Director-General in the WCHD submitted an action plan to the Standing Committee on Health in the Western Cape provincial legislature. This action plan, intended to improve service delivery at nine identified day-hospitals, includes the upgrading of waiting-rooms, cutting waiting times for patients, faster issuing of chronic medication and to ensure that relevant medication are available at all times.

The above-mentioned incidents could be used as an indication of the level of effectiveness and efficiency of administrative and financial management at public hospitals. One main objective of the PFMA is to serve as a tool that would assist officials in their attempts to provide better public services to all SA citizens. Further, the implementation of the PFMA is also intended to assist management to prevent fruitless and wasteful expenditure. These wasted monies could have been used to address other urgent needs and services within the WCHD – needs and services at hospitals as reported in the media and referred to earlier in this chapter. These reported incidents further support the need for the implementation of measures by government and by the WCHD to address or correct the identified shortcomings and to ensure that public monies are accounted for. The PFMA must be seen as an important tool to help public sector managers with effective, efficient, economic and transparent financial management.

1.3 Access to health care services a Constitutional right

An assessment of any claim by the general public that they have not received proper attention and or medical help from hospitals, must be done within the context of the constitutional imperatives regarding health care services.

The Bill of Rights in the Constitution of the Republic of South Africa (Act 108 of 1996) [hereafter referred to as the Constitution] prescribes certain measures to be taken by government regarding the provision of health care services to South African citizens. Section 27 of the Constitution (1996: 13) states the following:

“27(1) Everyone has the right to have access to –

- (a) health care services, including reproductive health care;
- (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.”

Section 28 of the Constitution (1996: 13) is more specific about health care services for children. It states, amongst other, the following:

“28(1) Every child has the right –

- (b) to basic nutrition, shelter, basic health care services (**own emphasis**) and social services;”

Access to health care services in South Africa (SA) is thus a constitutional right and government will have to take reasonable steps to provide such services within the context of limited resources.

According to Abedian, Strachan and Ajam (1998: 23) the decentralisation of the governance of health services implies that the provincial health department will have to establish, enhance and improve its delivery capacity.

They emphasise that “provinces need to establish the full range of competencies that are required to engage in policy formulation, resource allocation, financial planning and management, monitoring and evaluation.”

Some of the strategic objectives of the national Department of Health, contained in the White Paper on Health (1997), are to:

- improve health and well-being of all South Africans;
- ensure an effective referral system for primary, secondary and tertiary levels of care;
- prioritise health promotion and maternal, child and women's health;
- mobilise all partners in health, including the private sector, non-governmental organisations (NGOs) and communities;
- develop human resources for new strategic objectives;
- ensure information for strategic management; and
- ensure quality, effectiveness and efficiency.

Section 16 of the Health Act (Act 63 of 1977, as amended: 673-675) allocates the following functions to provincial administrations:

- 1.3.1 To provide hospital services;
- 1.3.2 To provide ambulance services within its province or to share such services with adjacent provinces if there is a need for it;
- 1.3.3 To provide facilities for the treatment of patients suffering from acute mental illness;
- 1.3.4 To provide facilities for the treatment of outpatients in hospitals or elsewhere;
- 1.3.5 To provide and maintain maternity homes and services;
- 1.3.6 To provide personal health services, either on its own or in cooperation with local authorities;
- 1.3.7 To promote family planning in the province; and
- 1.3.8 To perform any function as may be assigned by the national Minister.

It is evident from the above-mentioned legal mandate that all health care facilities are tasked with the obligation to provide at all times, within the constraints of limited financial resources, the best possible health care services to the citizens of South Africa.

1.4 Description of concepts

Some of the concepts that will be used and or referred to in the study will now be briefly discussed under the following sub-headings:

1.4.1 Performance budgeting

Performance budgeting is an integrated approach of budgeting aimed at value-for-money results. It focuses on service delivery outputs as well as on inputs. It is a process that looks critically at the efficiency and effectiveness of spending. The performances can either be 'output'-based or 'input'-based. Performance management further encourages delegation of functions and responsibilities to lower levels of management (Shall, 2001: 8-9).

1.4.2 Supply Chain Management

According to Korosec (2003) supply chain management (SCM) is a widely successful private sector-based strategy tool. SCM can also be utilised as a means to decentralise decision-making and service delivery. Further, SCM is a procurement management system with four main areas, viz.:

1.4.2.1 Capitalising on the newest and best forms of information technology in order to enhance quality considerations and operating capabilities within purchasing and procurement;

1.4.2.2 Encouragement of a decentralised model of decision-making to promote innovative solutions that would effectively meet the customer's needs;

1.4.2.3 The use of a collaborative model of partnership (both internal and external agents) promotes a more representative and comprehensive view of service delivery; and

1.4.2.4 A focus on integrated project management "chains".

1.4.3 Value

Value refers to the value that beneficiaries of health care services receive when visiting health care facilities, and specifically public hospitals. Value can be measured by the following indicators: effectiveness, efficiency, economy and equity (4Es). These indicators are now briefly explained:

1.4.3.1 Effectiveness, efficiency and economy

Performance management is about aligning strategies, objectives and expectations. All performance indicators should measure one of the following principles in financial management: appropriateness, effectiveness, efficiency and economy (Du Randt, 2000; Shall, 2000; 2001; Abedian, Strachan & Ajam, 1998). Table 2 (p. 14) provides a summary of these principles. Performance indicators should further comply with the following four performance criteria: relevance, reliability, timely and value (Du Randt, 2000).

Table 2: Performance management principles

Effectiveness	<ul style="list-style-type: none">➤ Effectiveness captures the degree to which objectives are achieved.➤ Effectiveness measures the question “Did the job achieve the desired result?”➤ Effectiveness concentrates on outputs and outcomes.
Efficiency	<ul style="list-style-type: none">➤ Efficiency should be a demonstration of value for money and productivity.➤ It further relates inputs to outputs and outcomes.
Economy	<ul style="list-style-type: none">➤ Economy denotes the cheapest possible option for the production of a chosen output.➤ Economy is concerned with inputs.

1.4.3.2 Equity

The Report of the Expert Group Meeting (United Nations, 2003) regards equity as one of the drivers for public sector effectiveness and performance. The public sector must ensure greater equity in the distribution of the benefits of developmental programmes, usually assessed on the basis of needs. Equity within the context of public sector supply chain management, as well as within the context of black empowerment, endeavours to help change the economic face of South Africa to one that is more representative (see Figure 1, p. 18). Representivity should focus especially on the inclusion of black women and black enterprises. The term black refers to African, Coloured and Indian South Africans (Code of Good Practice for Black Economic Empowerment in Public Private Partnerships: 2003).

1.4.4 Governance outcomes

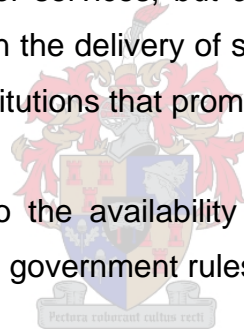
One of the ultimate objectives of government is to provide public services to all its citizens, within the constraints of its limited budgetary capacity. These services must be rendered in an effective, efficient, economic and equitable manner. This delivery of services must further be realised within a context of

continuous public service reforms. The final result of reform, namely societal “paradise”, is never attained (Pollitt & Bouckaert, as cited in Burger, 2005: 1). Even where reforms eventually come close to establishing such a paradise and bring the reforms to an end, the forces surrounding that paradise will soon turn complacency into stagnation. Reform initiatives should help to establish a trustworthy administration in order to uphold an orderly society, a well-oiled machine consisting of value-neutral power and infallible systems and structures and fixed spheres of competence that will assist to achieve government’s delivery outcomes (Burger, 2005: 1). Public Governance is a management philosophy that is intended to achieve such outcomes.

According to Burger (2005: 4) Public Governance does not deny the positive applications of Traditional Bureaucracy and New Public Management, but places them on the tactical and operational and support levels where they belong and provides the strategic integrity to use them appropriately. It is about ensuring that appropriate public services, like health care services, are delivered and society is developed in a context-sensitive manner. Furthermore, that this delivery and development and their long-term impacts are sustainable, thereby providing real investment in society, the environment and the economy.

Webster (as cited in Burger, 2005: 4) defined governance as “the manner in which power is exercised in the management of a country’s economic and social resources for development”. This definition remains relevant, but in the context of “good” and “progressive” public governance it implies ensuring that all services and their delivery aligned with the strategic vision. Accountability, predictability, participation and transparency are key features of Public Governance (Fuhr & Asian Development Bank, as cited in Burger, 2005: 4). According to Burger (2005: 5) these four key features of Good Governance have inherently the following characteristics:

- Accountability refers to holding governments responsible for their actions as undertaken through the combination of democratic, hierarchical, market and managerial accountability systems and micro-level organisational arrangements. It implies authority and capacity to deliver appropriately.
- Predictability refers to the legal architecture that must ensure stability in order to allow for rational assessment of risks and costs relating to behaviour of transactions.
- Participation acknowledges that people (individuals and groups) are at the heart of delivery and development. Citizens are not only the ultimate beneficiaries of services, but also the agents that should be allowed to participate in the delivery of social benefits. Citizens need to have access to the institutions that promote delivery and development.
- Transparency refers to the availability of information to the general public and clarity about government rules, regulations and decisions.



These four features are interdependent, and in a progressive governance philosophy jointly contribute towards strategic integrity (Burger, 2005: 5). These features can also be found in the PFMA [sections 2; 38(1)(b) & 51(1)(a)] and the Constitution of the Republic of SA [sections 41(c); 215 & 217). Management in the WCHD is responsible for the delivery of health care services. Hospitals and hospital officials have an important role to play in assisting government to provide health care services to all South Africans, but more so, to the poor, the needy and the vulnerable. Health care services cannot be rendered without finances and the effective and efficient management thereof. Hence, the focus in this research is to establish eventually how the management of the budget and the management of

procurement and provisioning in the health system impact on Public Governance.

Further reference is made about good governance in Chapter 2, paragraph 2.4 (p. 26).

1.5 Research question and objectives

The purpose of this research is to assess the following:

- Financial management outcomes in the Health Department;
- The role that the PFMA has played in such outcomes;
- Supply chain management outcomes at Head Office and at the selected public hospitals; and
- To assess the relationship between supply chain management (SCM) and Black Economic Empowerment (BEE) as administered in the Western Cape Health Department (WCHD).

In order to assess the focus areas identified above, this research will endeavour to:

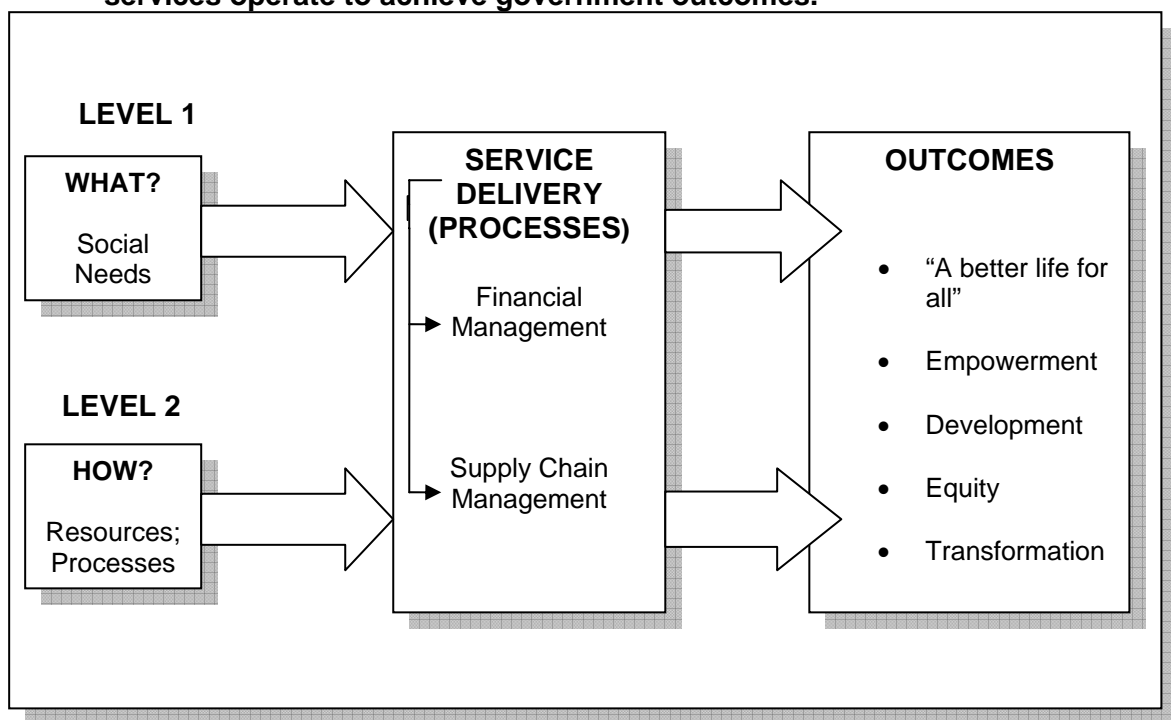
1.5.1 Analyse Budget and spending patterns in the Programme: Hospital Services in the Budget Vote: Health of the WCHD for the financial years 1997/98 to 2002/03;

1.5.2 Analyse Budget and spending patterns at the three selected hospitals for the financial years 1997/98 to 2002/03 with special emphasis on effectiveness, efficiency, economy and equity (4Es);

1.5.3 Assess the progress and effect of supply chain management on health care service delivery at three selected hospitals for the financial years 1997/98 to 2002/03; and

1.5.4 Evaluate progress of BEE within the context of SCM. The relationship between socio-economic needs, available resources, delivery processes and visualised outcomes can be depicted as in Figure 1 (p. 18). Level 1 illustrates the workflow between social needs and outcomes, whilst Level 2 illustrates that SCM should be used as a process to manage available resources to derive outcomes like empowerment, development and equity, which should eventually manifest in “a better life for all”.

Figure 1: Two mutually inclusive levels on which delivery of goods and services operate to achieve government outcomes.



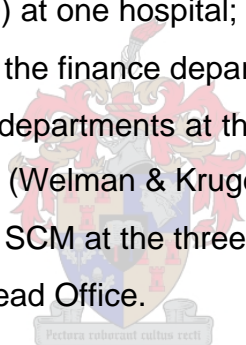
1.6 Research design and methodology

The study is empirical qualitative evaluation research (Mouton, 2001: 161). The study is aimed at evaluating the impact of the implementation of the PFMA on improved financial management, as well as to assess BEE within

the SCM context. The research is ethnographic in nature and three hospitals will be used as case studies. Furthermore, the study includes quantitative research methods and techniques for analysing existing information from budgets. Because annual and audit reports will be analysed and evaluated, the research also applies content analysis as a method of analysis (Mouton, 2001: 165). Three public hospitals, viz. Karl Bremer, Lentegeur and Swellendam Hospital will be used as the unit of analysis (purposive sampling – Welman & Kruger, 2001: 63).

Individual and focus group interviews at Head Office and at the three hospitals will be used to gather information from officials (Welman & Kruger, 2001: 187). Interviews will be conducted with the following officials:

- the superintendent (AO) at one hospital;
- officials responsible for the finance department at each hospital;
- the staff in the finance departments at the three hospitals to be used in a focus group interview (Welman & Kruger, 2001: 187);
- officials responsible for SCM at the three hospitals; and
- the Director: SCM at Head Office.



Existing documentation in the Health Department will be used to source information necessary for this research. The following documentation forms part of the research design:

- Audit and Annual Reports of the WCHD for the period 1997/98 to 2002/03;
- Strategic planning documents of the WCHD for the period 1997/98 to 2002/03; and
- Strategic Planning Reports for the period 1997/98 to 2002/03.

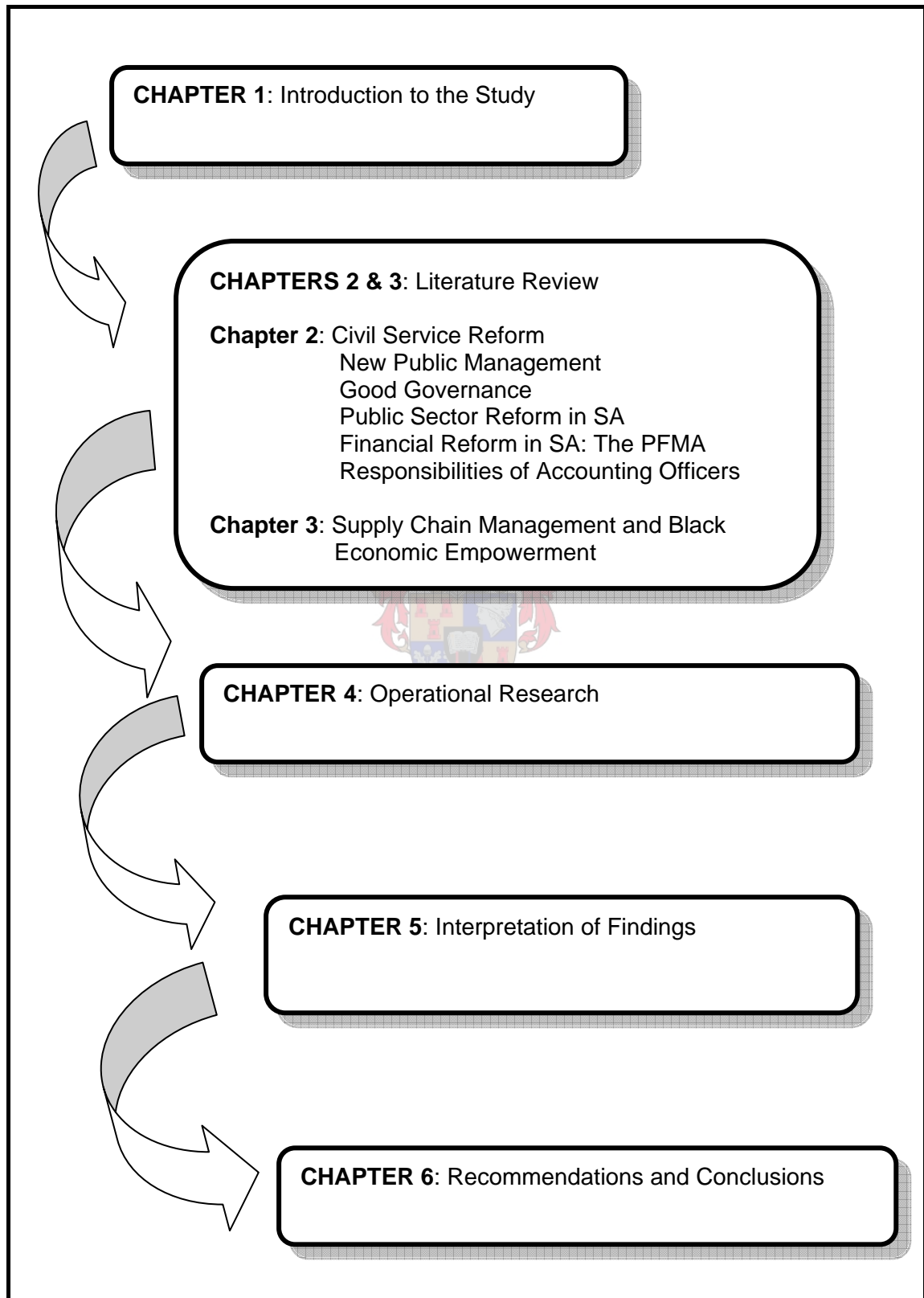
The Programme: Hospitals Services, which is contained in the annual provincial budget Vote: Health for the period 1997/98-2002/03, will be analysed. The budgets and spending trends at the three respective hospitals

will also be assessed. An evaluation between strategic planning documents and the actual budget spending will give an indication of patterns of compliance, under- or overspending, irregular and unauthorised spending. The audit reports for the said period will help to focus the research on those problematic areas identified by the AG and to establish whether, and to what extent, corrective measures were taken by the respective hospitals. Special focus will be placed on SCM and the effect of outside (upstream) service providers on the effectiveness, efficiency, economy and equity of health care service delivery at the three selected hospitals.

All interviews will be convened and conducted by the author. All information gathered through the analysis of budgets, planning documents and audit reports, as well as the information received through the interviews, will be compared, discussed for reliability and validity, interpreted and the results be contextualised within the framework of the research question.



1.7 Outline of Chapters



CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Pursuant to the socio-economic challenges that government faces, as highlighted by Manuel (2003) in Chapter 1, he places emphasis on the key elements necessary for development and growth in SA. Some of these key elements are “public administration reform, founded on respect for citizens’ rights, courteous and efficient service delivery, modernisation of systems and honest, accountable government” (Manuel, 2003: 23). This statement underwrites government’s intention that every piece of legislation that it promulgates, will have to contribute to public service reform and an improvement of service delivery to all South Africans.

The promulgation of the PFMA was intended to reform the public finance system and processes in SA. To understand the origin and value of the PFMA, an understanding of the history of international civil service reform is a prerequisite. SA’s exposure to globalisation and its effects after the birth of democracy in 1994 necessitated the reform of financial systems and processes in the country. Civil service reform (CSR) worldwide has searched for better measures to respond to the challenges of improved government efficiency and increased socio-economic needs of citizenry. New Public Management (NPM), one of the phases of CSR, had a significant influence on public administration. The PFMA can be viewed as an example of CSR in public finance developments in SA.

Chapters 2 and 3 deal with the literature review. These two chapters will endeavour to contextualise the development of CSR and financial reform within the following framework:


Chapter 2:

- Civil Service Reform;
- New Public Management;
- Good Governance;
- Public Sector Reform in SA;
- Financial Reform in SA: The PFMA; and
- The responsibilities of the accounting officer.

Chapter 3:

Supply chain management.

2.2 Civil Service Reform (CSR)



Governments worldwide are continuously seeking ways and means to address the dichotomy that exists in meeting the immense socio-economic needs with the limited resources at their disposal. Civil service reform (CSR) was initiated by governments and developed over years as a consequence of the attempt to bridge the gap between needs and resources. CSR was preceded by many other processes and changes regarding policy development that stretched over decades. The ultimate objective of CSR is to search for solutions that will help to meet the socio-economic needs of citizens in an effective, efficient and economic way. It further attempts to facilitate and sustain the realisation of government's policy objectives. CSR also appeals for responsible and accountable political leaders.

According to Kiggundu (1998:155-171) the motives, reasons and expectations for CSR vary from country to country. In the industrialised countries, CSR was

driven by ideology in response to the tension between citizen and taxpayer for improved public services. In developing countries, especially in Africa and South America, CSR was a direct consequence of the early experiences of structural adjustment programmes. Phenomena like globalisation, democratisation, aid conditionality, the rapid growth in technology, state collapse and constitutional decay all contributed to the necessity to expedite CSR.

One of the significant phases in CSR was New Public Management (NPM).

2.3 New Public Management (NPM)

New Public Management (NPM) is a phase in CSR that evolved during the seventies (De Leon & Overman, 1998). The overall objective of NPM is to achieve “value-for-money” by establishing a link between spending and performance. NPM is driven by competition and efficiency. The other side of the coin of efficiency is accountability. Schwella (1999: 339) emphasised the need for new approaches to the study of Public Administration, which should entail the promotion of values like “efficiency, effectiveness, productivity, accountability, responsibility and responsiveness.” NPM is thus not only calling for “value-for-money” outcomes, but it also appeals on the conduct, capacity and commitment of public officials entrusted with management functions. Even the concept of “good governance” refers to aspects like honesty, transparency and ethical behaviour in government (Minogue, 1998a: 1-15).

Osborn & Gaebler (as cited in Minogue, 1998b: 17-18) argued that public administration should be more than just efficiency – it also involves ideas of democratic participation, accountability and empowerment. The relationship between the state and its citizens should therefore be carefully defined.

Osborn & Gaebler (as cited in Minogue, 1998b: 18) developed the following 10 NPM policy principles:

- Steer the ship, rather than row it;
- Empower communities, rather than simply deliver services;
- Encourage competition rather than monopoly;
- Be mission-driven rather than rule-driven;
- Fund outcomes rather than inputs;
- Meet the needs of customers rather than the bureaucracy;
- Concentrate on earning resources, not just spending;
- Invest in prevention of problems rather than cure;
- Decentralise authority; and
- Solve problems by making use of the marketplace rather than by creating public programmes.

According to Osborn & Gaebler (as cited in Minogue, 1998b: 17-18) the above-mentioned principles had to be achieved via restructuring (privatisation) of the public sector, restructuring (down-sizing) of the civil services, competition in the internal markets and improving efficiency (performance auditing).

Minogue (1998b: 19-20) identified three areas of pressure that forced governments to apply the NPM model as a possible solution to yield certain results within their public administrations. These pressures were of a financial, qualitative and ideological nature. These pressures can also be interpreted as of a budget and spending, service delivery and political (policy objectives) nature.

Public sector reform that was implemented in New Zealand, Australia and the United Kingdom displayed the following elements of NPM: cost-cutting, creation of separate entities to replace bureaucracies, separating the purchaser of goods from the provider of those goods, decentralising

management authority, introducing performance management systems and the increased use of customer-focused quality improvement systems (Box et al., 2001: 612). The above tendency provides evidence that those countries who had undergone CSR shared common objectives.

The intention of NPM was to increase the level of service delivery and to spend state funds effectively and efficiently. South Africa has not escaped the influence of NPM. Before this research focuses on CSR in SA, it is important that the relationship between CSR and good and sustainable governance is discussed and contextualised within the CSR paradigm.

2.4 Good governance

The World Bank (as cited in Cloete, 1999a: 10) defines governance as “the manner in which power is exercised in the management of a country’s economic and social resources for development.” The World Bank puts a strong emphasis on the development of a free-market economy and accepted implicitly that it should be driven by elements of good governance. It, therefore, closely relates good governance with NPM. The concept of good governance has, however, changed over time. NPM’s conception of governance blurs the distinction between public and private sectors (Cloete, 1999a: 10-11). Whilst NPM philosophy was premised on principles that are closely bound to the profit-oriented private sector, some shortcomings were identified in the manner how these principles were applied in the public sector. Strong political and social institutions, supported by appropriately capacitated staff, together with appropriate social policies will eventually help government to achieve its objectives.

Cloete (1999b: 86) defines good governance as “a sustainable achievement of the developmental policy objectives of a participatory democratic government.” He argues that the success of government policy objectives

relies on access to resources and the creation of an environment that is conducive for policy implementation. According to Cloete (1999b: 86-87), some of the policy objectives that are necessary for good governance are:

- Political and financial accountability;
- Flexible, effective, efficient and affordable processes; and
- Creative, competitive and entrepreneurial practices.

Cloete (1999b: 91) further refers to the capacity that is necessary for sustainable government. An assessment of the experiences of the South-East Asian “tiger cubs” (Malaysia, Thailand, the Philippines and Indonesia) highlighted prerequisites for sustainable government success, such as:

- The availability of and the optimal creative, pragmatic, co-ordinated use of resources in the public, private and voluntary sectors of society;
- Effective strategic and operational managers; and
- A developmental social and organisational culture with a strong work ethic.

Efficiency alone is not a guarantee for better government (OECD, 2003). Improved efficiency is complicated by problems in governance, strategy, risk management, inability to adapt to change, collaborative action and the need to understand the impact of policy on society. Public management arrangements not only deliver public services, but enshrine deeper governance values and are therefore inseparable from the constitutional arrangements in which they are embedded. Public sector reform further depends on the strengthening of core capacity; to reflect on their public sector arrangements as a total system; and to have a deeper understanding of civil service culture and leadership and their respective places in public governance. The OECD (2003) mentions the importance of organisational culture as an aspect of public governance that is often underplayed. Organisational culture refers to staff commitment and the sense for joint purpose (own emphasis). In the absence of measuring instruments,

organisational culture becomes the prime means of direction, motivation, coordination and control.

Burger (2000) also alluded to the principles of good governance in his referral to high-performance organisations. According to him, high-performance organisations display certain characteristics which form the building blocks to ensure effectiveness and efficiency in the public sector. High-performance organisations are:

- Vision and customer-driven;
- Stakeholder and value-focused;
- Responsive and flexible;
- Horizontally or process-structured;
- Part of a network, interdependent and globally aligned; and
- Information-based centres of learning.

There seems to be agreement in the literature that NPM was, and still is, an important phase in CSR, with the emphasis on clear policy objectives, effective civil service, efficient public service delivery, a competitive and entrepreneurial economy and a responsive civil society. The concept of good governance serves as strategic support to management in order to ensure that the pursuance of NPM principles reap the expected benefits for the broad community. The 2004 election slogan of the African National Congress (ANC, 2004), viz. “A people’s contract to create jobs and fight poverty” contains elements of the principles and objectives of NPM (see pp. 24-26).

2.5 Public Sector Reform in South Africa

The birth of democracy in South Africa on 27 April 1994 opened the door to the global world of politics and economics, as well as to the principles of global civil service reform. Consequently, SA had to adapt to CSR and bought into the principles of NPM. However, it must be borne in mind that SA is a

complex country with a rich diversity in terms of race, ethnicity, culture, religion and language. Furthermore, the gap between the rich and the poor is complicated by the fact that the rich represent traditionally white South Africans, whilst black South Africans mostly represent the poor. Another perspective on SA's economy is that there exists a small percentage of very rich persons and a large number of very poor persons. After Brazil and Guatemala, SA has a huge unequal distribution of money (Makgetla, 2001). According to Motlanthe (2004:1), the "commanding heights of our economy remain in white hands, whether one looks at it from a point of management, control or ownership." He sees the deracialisation of the ownership of productive property in SA as a critical part of the challenge to societal reform.

The appointment of the Presidential Review Commission (PRC) in April 1996 by President Nelson Mandela signified government's commitment to develop and establish a culture of good governance in South Africa (PRC, 1998). Although the recommendations of the PRC contained most of the principles underscored by NPM, Minogue (1998a:15) suggested that NPM should be applied flexibly and should be adapted to the administrative and political context in SA. His caution is shared by Burger (2003a), who emphasised the challenges that reform in SA faces.

Burger (2003a) explored the context and content of the appropriateness of reform concepts within the SA landscape. Although Pollitt and Bouckaert (as cited in Burger, 2003a), view sector reform as a potential vehicle to multiple ends, Burger pointed out that insensitivity towards diversity of civil servants in the workplace in the SA context could jeopardise the attainment of developmental and equitable services. He proposed the necessity of state intervention in order to ensure that civil service reform is appropriate and that it contributes to real and meaningful change to the nature and quality of service delivery.

The drafting and promulgation of the PFMA, which was enabled by Section 216(1) of the Constitution, was another milestone in CSR in SA - especially with regard to the focus of this thesis.

2.6 Financial Reform in SA: The PFMA

According to Van der Linde (2000), then Accountant-General in the Department of State Expenditure, financial transformation in SA had to be achieved against the background of global visibility, tight fiscal constraints and immense social needs for service delivery. Some of the improved initiatives, especially on a strategic level, that have been undertaken by government since 1996 are:

- The introduction of the GEAR strategy;
- Lowering the deficit from borrowing;
- Introduction of performance management concepts in planning, budgeting and personnel management;
- Revised Public Service Regulations to improve delegation and accountability;
- The Medium Term Expenditure Framework (MTEF) in the planning and budgeting cycles;
- The Medium Term Budget Policy Statement;
- The National Expenditure Survey;
- The development and promulgation of the PFMA; and
- Improved empowerment of Small Medium and Micro Entities (SMMEs) and Previously Disadvantaged Individuals (PDIs).

According to Van der Linde (2000) the PFMA is regarded as a key instrument to facilitate financial management reform in the public sector. It gives effect to Sections 213, 215, 216, 217 and 218 of the Constitution. These sections require national legislation to:

- Establish a National Treasury;

- Introduce budgeting principles and standards, generally recognised accounting practices and uniform treasury norms and standards for all spheres of government;
- Prescribe measures to ensure transparency and expenditure control in all spheres of government; and
- Set the operational procedures for borrowing, guarantees, procurement and oversight over the various National and Provincial Revenue Funds.

The PFMA was promulgated in 1999, but only implemented on 1 April 2001. It introduced the concept of performance budgeting into the public sector. The PFMA shifted the focus on outputs and responsibilities, rather than the rule-driven approach of the old Exchequer Acts (PFMA, 1999; Van der Linde, 2000; Du Preez, 2000). The PFMA must be viewed as “part of a broader strategy on improving financial management in the public sector (PFMA, 1999).” The objective of the PFMA (1999: 14) is “to secure accountability and sound management of the revenue, expenditure, assets and liabilities of the institutions to which the Act applies.” Furthermore, Section 41(c) of the Constitution (1996) states that “all spheres of government and all organs of state within each sphere must provide effective, transparent, accountable and coherent government for the Republic as a whole.”

Finance is regarded as one of the “what” trajectories of reform (Pollitt & Bouckaert, as cited in Burger, 2000). The PFMA introduced performance budgeting and shifted the focus from inputs and rules to outputs and responsibilities. According to Burger (2000) the following reform elements are provided for in the PFMA:

- “Super budgeting” was introduced by linking the budget to performance indicators and individual performance contracts. This took the initial “frame budgeting” approach of the Medium Term Expenditure Framework from a sound financial management level to a level of sophistication where good governance is supported;

- Accrual accounting was introduced;
- Auditing by the Office of the Auditor-General has to comply with the Generally Accepted Governmental Audit Standards of the International Organisation of Supreme Audit Institutions;
- Internal auditing is provided for and defined so as to ensure not only regularity, but also the measurement of value-for-money; and
- Control and risk management is made the responsibility of the accounting officer (AO) and of each manager that receives delegation from the AO.

The PFMA has brought with it shorter reporting deadlines (see Sections 8, 19 & 40) and more regular reporting [see Section 40(4)]. The PFMA (1999: Chapters 5 & 7) identifies the persons directly responsible to account to the legislature and to the Provincial Treasury, viz. the executive authority (EA), the AO and the chief financial officer (CFO). The EA is either the national Minister or the provincial Member of the Executive (MEC) of the relevant department. The EA accounts politically to the legislature, whilst the AO accounts administratively and financially to the legislature. According to Gildenhuys (1997: 76) the AO is “obliged to submit a draft budget, the execution of which will realise the policies of the legislature and the executive authority, as well as comply with the instructions of the minister responsible for the administration of the department.” He further states that the AO has to account for the departmental budget as executed and is responsible for the funds appropriated to and spent by the department. The different responsibilities of the AO will now be discussed.

2.7 Responsibilities of accounting officers

The nature of the responsibilities of the AO is threefold, viz. general, budgetary and reporting. The general responsibilities are contained in Section

38; the budgetary responsibilities in Section 39 and the reporting responsibilities in Section 40 of the PFMA.

The prescriptions spelt out in Sections 47, 48 and 49 (PFMA, 1999) place an enormous responsibility on the shoulders of the AO – a responsibility that the AO will have to shoulder with his/her entire management team. The chief financial officer (CFO) assists and advises the AO.

2.8 The chief financial officer (CFO)

The CFO is in control of the financial administration and financial record keeping and is directly accountable to the AO. The CFO must have a sound knowledge of the theory and practice of public financial management and administration. He/she must also have a sound knowledge of public financial accounting systems and procedures (Burger, 2003c: 30).

The role of the CFO in supporting the accounting officer is further complemented by the establishment of the Audit Committee and an internal audit unit within the organisation. Du Preez (2000) regards the following as key responsibilities of the CFO:

- The evaluation of existing and development of new systems and procedures for financial and risk management and internal control;
- The initiation and co-ordination of strategic planning;
- Budgeting with an emphasis on its linking to planning; and
- Monthly and annual reporting on expenditure and performance as well as the annual report.

2.9 Conclusion

Chapter 2 has provided insight into the CSR process as it unfolded internationally, as well as how it influenced and affected South African politics,

the South African public administration and the SA public sector in general. The formulation and promulgation of the PFMA must be seen as a direct intervention in the public financial reform process in SA. Section 38(1)(a)(iii) pronounces government's responsibility about procurement and provisioning of goods and services (supply chain management) in the public domain. The following chapter (Chapter 3) will deal extensively with the concepts of supply chain management and black economic empowerment.



CHAPTER 3

SUPPLY CHAIN MANAGEMENT

3.1 Introduction

As mentioned in Chapter 2, the implementation and maintenance of supply chain management (SCM) is prescribed by Section 38(1)(a)(iii) of the PFMA. The results (successes and/or failures) of SCM can be used as criteria to assess whether the implementation of the PFMA, together with other pieces of legislation, have yielded some results with regard to BEE.

The principles of SCM dates back to 1958 when Forrester (as cited in Mentzer et al., 2001) introduced a theory of management that recognised the integrated nature of organisational relationships in distribution channels. The use of the term “supply chain management” is relatively new in the literature, first appearing in 1982 (Keith & Weber, as cited in Chivaka, 2003). The term “supply chain management” became prominent after 1990 (La Londe, 1997; Ross, 1998; as cited in Mentzer et al., 2001). Some of the reasons why companies (organisations) increasingly use SCM are, inter alia, that they have turned to global sources for their supply (globalisation) and that these companies and distribution channels compete on the basis of time and quality in order to satisfy customer needs.

The success of SCM depends largely on the nature and quality of organisational (institutional) structure. Civil service reform implicitly includes institutional reform. According to the Policy Strategy to Guide Uniformity in Procurement Reform Processes in Government (2003: 25), institutional reforms should assist government to achieve the ideals of good governance and to address the deficiencies in SCM. These reforms had to include efficient

and effective procurement and provisioning systems and practices that would enable government to deliver the required quality and quantity of services to its citizenry and to promote equity. Government, therefore, regards the development of SCM as a vehicle to continue with improved procurement and provisioning processes in terms of affordability, quality, enhanced competition amongst suppliers, value for money and equity (see Figure 1, p. 18).

Consequently, this chapter will focus on the following:

- Legislative framework for SCM in the public sector;
- Definition of SCM;
- BEE as objective of SCM;
- The value chain; and
- Benchmarking for strategic procurement.

3.2 The legislative framework for supply chain management (SCM)

Section 217(1) of the Constitution provides the basis for procurement, whilst Section 217(3) confers an obligation for the promulgation of national legislation to prescribe a framework to provide for preferential procurement that would assist in addressing the socio-economic imbalances of the past. Section 76(4)(c) of the PFMA makes provision for the determination of a regulatory framework for a provisioning and procurement system that is “fair, equitable, transparent, competitive and cost-effective.”

SCM, mandated by the Constitution and further entrenched by the PFMA, must be seen within the context of CSR and financial reform in SA.

3.3 Definition of supply chain management (SCM)

Turban, McLean & Wetherbe (2001: 242-247) define supply chain as follows:

“A supply chain refers to the flow of materials, information, payments and services from raw material suppliers, through factories and warehouses, to the end customer. A supply chain also includes the organisations and processes that create and deliver products, information, and services to the end customers.”

SCM is the management of processes and activities that are used to integrate and manage the activities and resources that impact on the supply chain (Hadley, 2004).

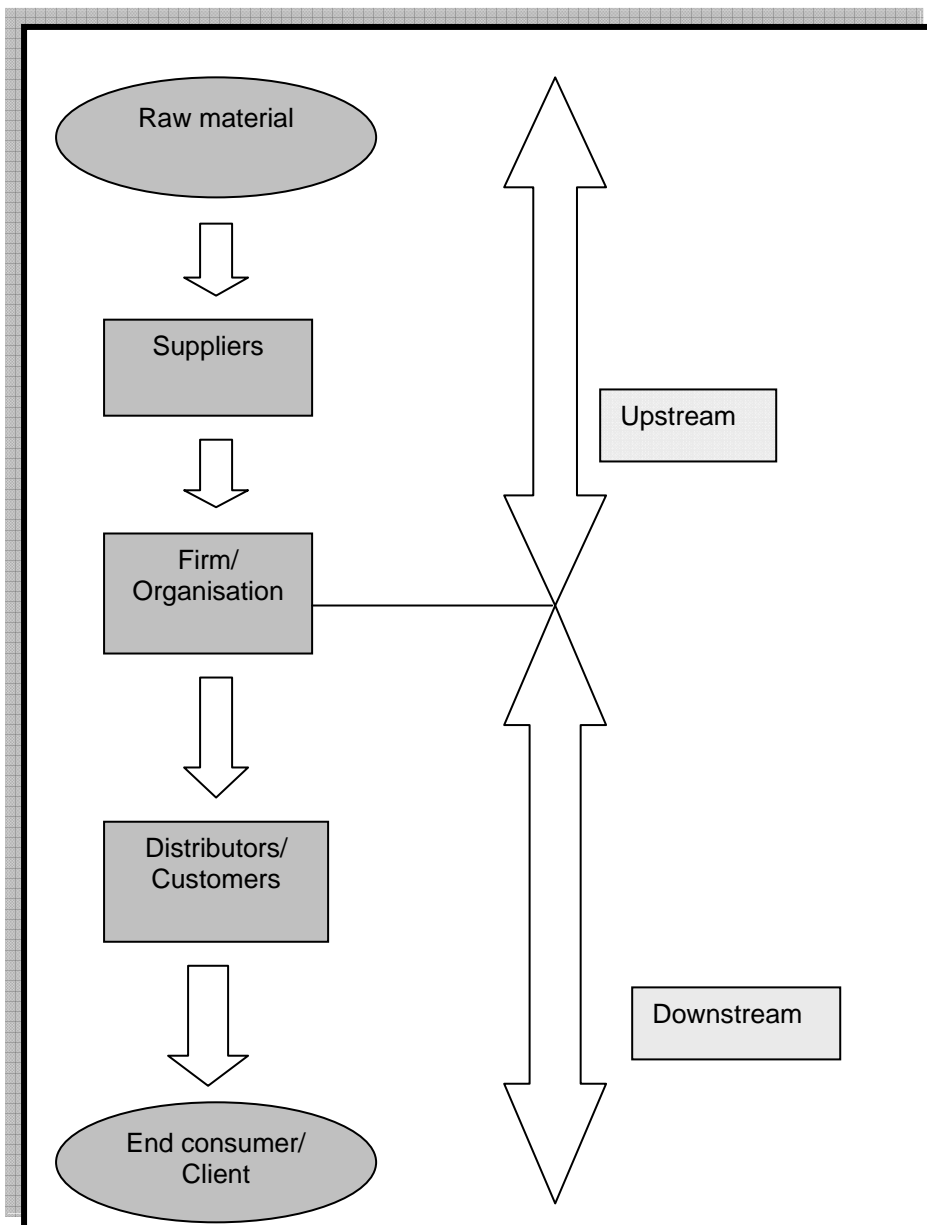
SCM involves “the management of flows between and amongst stages in a supply chain (SC) to maximise total profitability” (Chopra & Meindl, 2001: 6). Profitability in the private sector can be equated to economy, effectiveness, efficient and equity in the public sector.

SCM includes procurement, previously referred to as the state tendering processes. According to the Policy Strategy to Guide Uniformity in Procurement Reform Processes in Government (2003), procurement reform, as part of CSR in SA, started in 1995 and was directed at two areas, viz. the promotion of the principles of good governance and the introduction of a preference system to address certain socio-economic objectives. The procurement processes were supported by the promulgation of the PFMA and the Preferential Procurement Policy Framework Act (2000)[PPPFA]. The PPPFA (2000) provides a framework that allows government to give preference to previously disadvantaged individuals (PDIs) and groups in the adjudication of state tenders.

The supply chain can be broken down into two parts, viz. the downstream supply chain and the upstream supply chain (see Figure 2, p. 38). The downstream supply chain is the SC that goes from the firm (organisation) to

the customer. The upstream SC refers to the SC of raw materials to the organisation (Melnik, 2000).

Figure 2: The complete supply chain



Source: Melnyk (2000: 9)

According to Melnyk (2000) suppliers/providers form part of the upstream and customers/beneficiaries part of the downstream of the supply chain (SC). He further identified four major partners in the upstream supply chain, viz.

- The firm (organisation) and its operations management system;
- The supplier;
- Purchasing; and
- Logistics.

The demands and needs of the customer (a concept described later in this chapter, p. 40) drive the upstream supply chain. The supplier is held accountable to meet these demands and needs. The firm or organisation is responsible to deal with the purchasing or procurement element by effectively managing the interface between the firm and the supplier(-s). Logistics refer to the flow of materials and products between the various elements of the supply chain. Suppliers can be divided into tiers. The concept “tier” refers to the location of the supplier relative to the operations management, e.g. a first tier supplier provides goods and services directly to the organisation. Melnyk (2000) further emphasised the need and importance for an organisation to evaluate the supplier’s capabilities regarding:

- capacity levels;
- other customers demands on that capacity;
- bottlenecks in internal processes; and
- potential threats to supplier production.

The author agrees with this caution spelt out by Melnyk, because interference in the delivery of goods and services in certain spheres of the public sector, e.g. in a hospital, could eventually result in the sacrifice of lives.

Turban, McLean & Wetherbe (2001) regard the function of SCM to be the planning, organising and coordination of the above-mentioned supply chain activities. They further divide the supply chain into three parts: the upstream supply chain (those who deliver from outside the organisation), internal supply

chain (processes inside the organisation to get the products ready for distribution) and downstream supply chain (those processes that allow for the flow of products to the final end customer).

Jones and Riley (as cited in Mentzer et al., 2001) identify supply chain activities as part of the philosophy that must drive SCM in the organisation.

These activities include:

- Integrated behaviour;
- Mutually sharing of information;
- Mutually sharing channel risks and rewards;
- Cooperation;
- The same goal and the same focus of serving customers;
- Integration of processes; and
- Partners to build and maintain long-term relationships.

According to the Policy Strategy to Guide Uniformity in Procurement Reform Processes in Government (2003), SCM is an integral part of financial management that seeks to introduce internationally accepted best practice principles, whilst it addresses government's preferential procurement policy objectives. Further, SCM links with government's budgetary planning processes, with a strong focus on the outcomes of actual expenditure in respect of the sourcing of goods and services. SCM eventually ought to impact on the effectiveness and efficiency of the delivery of goods and services to all customers – the communities – and to influence the realisation of equitable socio-economic outcomes.

The referral to customer in the context of this research refers to the greater SA community/society. Customer in the public sector refers to all the potential beneficiaries (the public/communities) of government delivery processes. Customers in the private sector use their resources, e.g. money to procure the best quality goods and services possible. They can exercise a broad range of

choices in procuring goods and services that depend on their ability to pay for it. The majority of the beneficiaries of government services in SA do not have the luxury of many choices. Within the context of limited government resources, that place a consequential limitation on choices, the onus lies on the public sector to provide quality services and to uplift the standard of living of the disadvantaged. SCM (as process) and BEE (as vehicle) are intended to assist the public sector to achieve those government outcomes depicted in Figure 1 (p. 18).

How does SCM and BEE contribute to equity/empowerment of the SA community? Whilst the tension between demand, supply and affordability of private goods and services are minimal, the management of the demand on public goods and services are more complicated, especially within the SA context of huge socio-economic needs vis-à-vis budgetary constraints. SA is a representative democracy. According to Gildenhuys (1997: 32), a representative democracy places emphasis on political responsibility and accountability of elected political representatives, who undertake to govern in the interests of the individual citizen and not in the interest of some defined groups or in their own interest. The decision-making power of taxpayers has been taken over by political representatives. Government - representing voters (taxpayers included) - has taken a decision, after consultation through the NEDLAC process, but also through the constitutionally prescribed legislative process, to implement BEE as a mechanism to consciously attempt to change the uneven SA economic and social landscape into a more equitable one. BEE has a central role to play in helping to sustain SA's growth trajectory and improving the distribution of income and opportunities (Manuel, 2003: 7). While all taxpayers might not be in agreement of BEE, its implementation must be judged against the possible advantages to the majority of citizens in SA.

One of the criteria of the theory of the Wicksell's decision-making model is that priority is given to individual preferences (Gildenhuys, 1993: 63). The promulgation of the Broad-Based Black Economic Empowerment Act (Act 53 of 2003) seems to be diametrically opposite to this theory of Wicksell. The money that will be used by government to promote BEE comes from all taxpayers in SA. Whilst it is true that taxpayers want to benefit optimally from the taxes they pay, the following question can rightfully be posed: How does government ensure satisfaction amongst all taxpayers, including those who might not directly benefit from BEE? The answer to this question depends on the successful achievement of equity via BEE – social equity of the broader SA society, i.e. the realisation of the delivery of more and better public goods and services to all SA citizens, especially those previously disadvantaged by the Apartheid ideology. The deviation of the quid pro quo principle in relation to tax paid and public goods and services received in the SA context must be seen against our political history (past), but also within the context of SA's future political, economic and social stability where everyone in SA stands to benefit.

Gildenhuys (1993) draws a distinction between consensus and majority decision making. The larger the number of choices of public goods and service society has, the more easily it will be to reach decisions by consensus. However, the "Wicksellian" model cannot be afforded by SA, because of cost implications and the fact that its implementation would lead/contribute to a further polarisation of both race relations and the deepening of economic inequities in SA. BEE, as a vehicle in SCM, should be seen and judged against the dilemma expressed above.

The demands by interest groups on political decision-makers should never be underestimated. These demands help public representatives to ensure the "equitable and effective allocation of public financial resources" (Gildenhuys, 1993: 68). Mikesell (as cited in Gildenhuys, 1993) resolves that the welfare of

a community depends on the individuals in that community. This premise complicates the challenge of government that, despite the good intentions to take decisions on majority rule and in the interest of the larger society, a balance needs to be struck in terms of the manner in which minorities or smaller interest groups are dealt with. The onus is then placed squarely on the shoulders of government to monitor the progress and impact of a social action or decision on the welfare of society. The Pareto optimality principle refers to a condition where it is impossible to increase the welfare of one person without decreasing the welfare of another person. According to Mikesell (as cited in Gildenhuys, 1993) the morality of the Pareto optimality principle is questionable – is it fair to take public decisions in the interest of the broader society at the cost of decreasing the well-being of certain groups? The Pareto principle is further supported by the Kaldor criterion which holds that “a government policy or action improves the welfare of a community at large if those benefiting from the government policy or action could, hypothetically, compensate in full those experiencing a relative loss from that policy or action and still have gain over” (Gildenhuys, 1993: 70). The social gain must always be greater than the social cost. Burger (2003b:18), however, accedes that the determination of the nett gain to broader society remains problematic, because “societal benefits and costs may not be as easily quantified as benefits and costs considered by individuals in a business decision.”

The SA government's decision to embark on BEE must be seen and understood within the context of the Pareto and Kaldron criteria. Government uses the process of SCM, linked to the concept of BEE as vehicle, to realise the outcome of “a better life for all”. It is a matter of taking collected taxes to address the socio-economic status of the larger SA population. Both the Pareto and Kaldor criteria open up several choices for political decision-making on public finance. It is choices that a government will have to exercise

with care and with the intention and commitment to enhance the quality of life for the majority of SA citizenry.

Another important aspect of the delivery of goods and services is the quality of such goods and services. Kaplan & Norton (as cited in Burger, 2003c: 18-19) emphasise the fact that the mobilisation of intangible assets is more decisive than the management of physical assets. These intangibles include high-quality products and services, motivated and skilled employees, responsive and predictable internal processes and loyal and satisfied customers.

Except for the fact that SCM deals with the provisioning and procurement for public goods and services, it has been recognised by government as an ideal platform to promote Black Economic Empowerment.

3.4 Black Economic Empowerment (BEE)

The promulgation of a Broad-Based Black Economic Empowerment Act (2003) was an attempt by government to redress the economic imbalances caused by the pre-1994 political dispensation of Apartheid. Public-private partnerships (PPPs) should also be seen as vehicles to achieve BEE objectives (Code of good practice for BEE in PPPs: 2003). Some of the policy objectives for BEE in PPPs are as follows:

- To achieve meaningful and beneficial direct ownership of substantial equity interests in the Private Party (usually an entity from the private sector) to a PPP Agreement by black people, black women and black enterprises;
- To achieve effective participation in the management control of the Private Party and its subcontractors by black people and black women;

- To ensure that a substantive proportion of the Private Party's subcontracting and procurement is to black people, black women and black enterprises;
- To create jobs; and
- To ensure effective employment equity and skills development in the Private Party and its subcontractors throughout the PPP project.

The legal basis for BEE is vested in Section 217(2) of the Constitution that enables the state to implement a “procurement policy for (a) categories of preference in the allocation of contracts and (b) the protection or advancement of persons, or categories of persons, disadvantaged by unfair discrimination.” Further, Section 16.5.3(b) of Treasury Regulation (2004), issued in terms of the PFMA, states that the procurement procedure for a PPP “must include a preference for the protection or advancement of persons, or categories of persons, disadvantaged by unfair discrimination.” The SC should thus provide ideal opportunities for BEE and PPPs to be promoted in the procurement of goods and services at state institutions.

One of the objectives of BEE is to assist with processes of empowerment, development and equity in the SA society. The empowerment and development of black disadvantaged South Africans is an important objective of government. Conger and Kanunga (1988) regard empowerment as a relational matter that intends to spread power from one entity to the other and to decrease the rate of dependency from each other. Delegation of power and authority, qualitative participation and the sharing of resources construct some of the elements of empowerment. Development addresses both the needs of the individual and the community but the needs of the community supersede those of the individual. Stewart (1997) sees development as a process with the following elements:

- Two directional democratic and consultative practices;
- Identification of the needs of people;

- Act on what is good for the people;
- Identification of the constraints and opportunities;
- Greater social and material welfare should be the projected outcome;
and
- Ultimately to address poverty.

Empowerment further implies that the developing programme must be sustainable, i.e. it must continue to benefit the needs of the community long after the actual programme has come to an end. BEE must become a programme that will assist to sustain a “better life for all.”

3.5 The value chain

The supply chain and the value chain goes hand-in-hand. According to Turban, Mclean & Wetherbe (2001: 96) a firm's value chain is part of a larger stream of activities, called a value system. A value system includes the suppliers who provide the inputs necessary for the firm and its value chain. The firm creates products that also pass through the value chain of distributors, all the way to the buyers (customers). The value chain and value system concepts are applicable for products, goods and services within any organisation – private or public. The purpose of the value chain has been to evaluate the internal operations of a company, in order to increase its efficiency, effectiveness and competitiveness. Public sector institutions, e.g. hospitals should be mindful that the procurement of any goods and services should add value to the end-product or to beneficiaries.

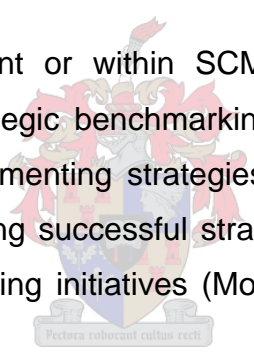
The supply chain as a whole can be considered a complete value system delivering products and services to the end customer. Value can be created or added at many points along the chain (Slater & Narver, as cited in Nix, 2001). An understanding of the entire supply chain is critical in identifying and

delivering value that would improve the competitiveness of the chain as a whole.

Customer satisfaction is an important aspect of the value chain. The satisfaction or dissatisfaction of customers is based on their evaluation or judgement of the difference between what was expected and what was received (Woodruff & Gardial, as cited in Nix, 2001). The unhappiness and dissatisfaction of the media-reported hospital patients (see Chapter 1, paragraph 1.2) must be understood within the context of the mismatch between expected and received services.

3.6 Benchmarking for strategic procurement

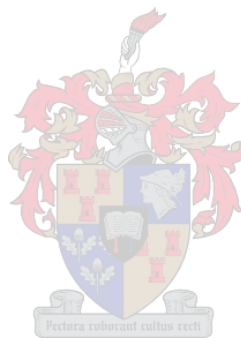
Benchmarking in procurement or within SCM is important. According to Kisperska-Moron (2001) strategic benchmarking is a systematic process of evaluating alternatives, implementing strategies and improving performance by understanding and adopting successful strategies from external partners. The following are benchmarking initiatives (Monszka, as cited in Kisperska-Moron, 2001):

- 
- Strategic supplier alliance/partnership;
 - Supplier integration into new product/process/service development;
 - Integrated SCM;
 - Supplier development and quality management; and
 - Human resource development.

These benchmarks imply that management should, in implementing SCM, be pro-actively searching for the best option or combination of options that would best serve both service delivery and empowerment. Without benchmarking the danger exists that SCM could become another mechanically and bureaucratic process – nothing better than the old tendering processes.

3.7 Conclusion

SCM is an important process for the procurement of goods and services in all government institutions. Consequently, the practical implementation, monitoring, evaluation and continuous adjustment will demand of civil servants a high level of commitment, skills, capacity and an understanding of and identification with the political objectives of SCM.



CHAPTER 4

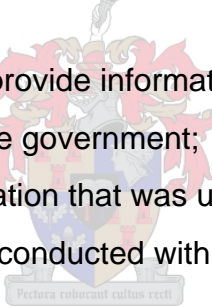
OPERATIONAL RESEARCH

4.1 Introduction

This chapter will provide details on the steps and processes that were followed to collect the necessary information for the research. The Audit and Annual Reports were used to gather information that would assist to appraise financial management in the WCHD in general, and at the three chosen hospitals specifically. Information regarding the provisioning and procurement of goods and services at hospitals was gathered by means of interviews.

Consequently, this chapter will provide information on the following matters:

- SCM in the Western Cape government;
- A list of all the documentation that was used; and
- The interviews that were conducted with health officials.



4.2 Supply chain management in the Western Cape government

The Preferential Procurement Policy for the Province of the Western Cape (undated) was drafted by the Provincial Treasury in conjunction with members of the Western Cape Tender Board. The Tender Board was dissolved in December 2003. The function of provisioning and procurement was decentralised to departments. The supply chain management section within each department is now expected to fulfil the function of the dissolved Tender Board. The Preferential Procurement Policy of the Western Cape (undated) was drafted in order to give effect to the Preferential Procurement Policy Framework Act [PPPFA] (Act 5 of 2000), and was also informed by the Preferential Procurement Regulations (2001), Section 217(3) of the

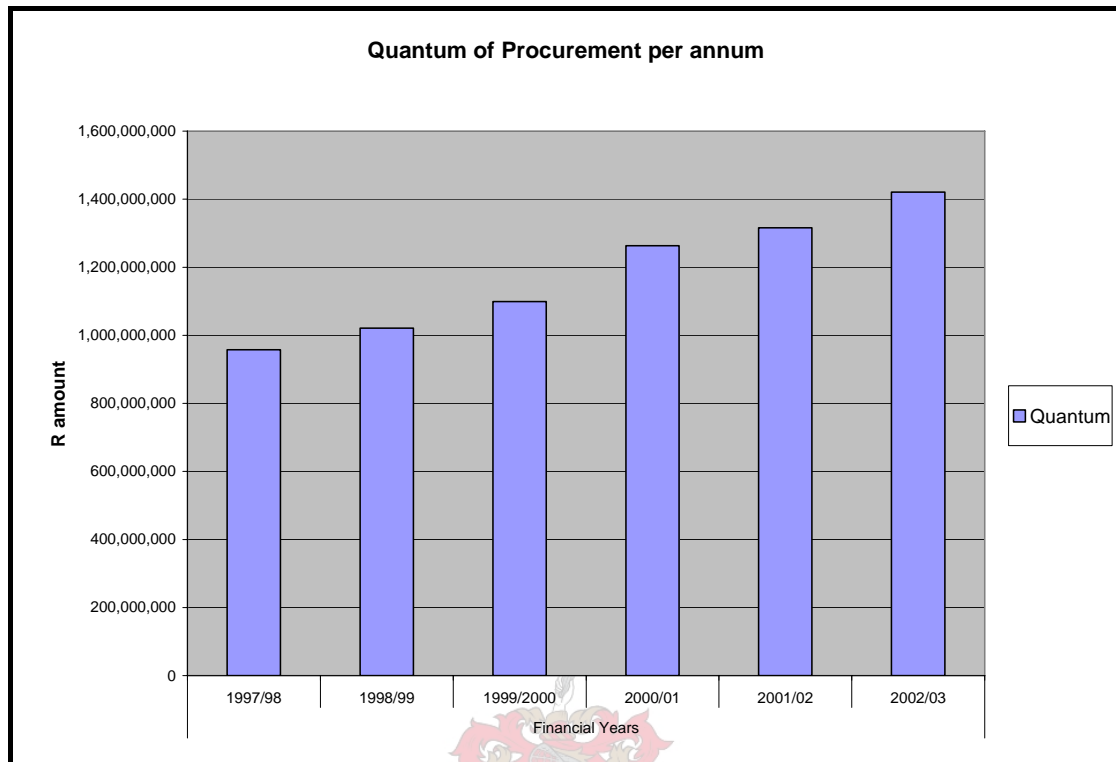
Constitution, as well as Section 62(2)(1) of the Constitution of the Western Cape (1997). The Preferential Procurement Policy of the Western Cape (undated) provides general principles which should serve as foundation to achieve the following objectives:

- Increase participation by the historically disadvantaged in provincial procurement opportunities;
- Increase participation by Small Medium Enterprises (SMEs);
- Promote local labour;
- Promote joint ventures and partnerships;
- Encourage linkages between small and large enterprises;
- Promote skills transfer and training of the historically disadvantaged;
- Promote job creation in the province; and
- Promote a uniform procurement approach in all provincial procurement substructures.

The policy will further be applied with a system that is fair, equitable, transparent, competitive and cost-effective. The application of the policy will be subjected to a robust performance management system.

Graph 1 (p. 51) indicates the amounts (in Rand) that the WCHD has spent on procurement between the financial years 1997/98 and 2002/03. The graph shows an annual increase in the budget spent on procurement and provisioning. According to Lynne Brown (MEC for Finance and Economic Development), the provincial government spends an average R4 billion per annum on contracts (Essop, 2004b: 8).

Graph 1: Amount of annual budget spent on SCM (1997/98-2002/03)



4.3 Audit and Annual Reports

The Audit and Annual Reports for the financial years 1997/98 to 2002/03 were assessed. Some of the elements or concerns raised by the AG regarding financial and supply chain management were extracted for the purpose of this thesis. These elements or concerns will now be highlighted separately in the different Audit and Annual Reports:

4.3.1 Auditor-General Report: 1997/98

The Report of the Auditor-General on the Financial Statements of Vote 6 – Health of the Provincial Administration: Western Cape for the year ended 31 March 1998 (PR 2/2000) revealed the following shortcomings:

4.3.1.1 Lack of internal control with pharmaceutical stock. Segregation of duties between ordering, receipting and issuing of medical stock did not exist at the Lentegeur hospital.

4.3.1.2 Shortcomings and deficiencies in the control of linen at various provincial hospitals and other institutions. Linen is sent to laundries and returned without being counted.

4.3.1.3 Annual stocktaking did not happen at Karl Bremer for this specific financial year. An audit showed that asset registers or inventory control sheets were not updated.

4.3.1.4 Audit reports and income statements of institutions receiving transfer payments have not been obtained in all cases.

4.3.1.5 Confirmation has not been obtained in all cases that the utilisation of funds is subject to internal auditing.

4.3.1.6 Regular progress reports have not been submitted in all cases by the relevant local authority or institution.

4.3.2 Auditor-General Report: 1998/99

The Report of the Auditor-General on the Financial Statements of Vote 7 – Health of the Provincial Administration: Western Cape for the year ended 31 March 1999 (PR 105/2000) revealed the following shortcomings:

4.3.2.1 Shortcomings in the internal control measures regarding stocktaking at Lentegeur and Karl Bremer hospitals were reported.

4.3.2.2 Inadequate control measures were identified in linen management at the Lentegeur hospital. Linen received at the laundry was not checked, nor was a written acknowledgement in this regard completed.

4.3.2.3 Improper measures were in place at certain hospitals to dispose of expired pharmaceutical stock, despite procedures laid down in Circular H36/1998 that provides guidelines to hospitals on how to deal with expired pharmaceutical stock.

4.3.3 Auditor-General Report: 1999/2000

The Report of the Auditor-General on the Financial Statements of Vote 7 – Health of the Provincial Administration: Western Cape for the year ended 31 March 2000 (PR 147/2001) revealed the following shortcomings:

4.3.3.1 A performance audit that was done on contract WKT 30200/98B for catering services at the Lentegeur hospital showed that it was awarded to the sixth lowest tenderer at an amount of R501 775 per month for five years that commenced on 1 July 1998. One of the tenderers objected and the department subsequently lodged an investigation into the adjudication of the said tender. The statement that a winter menu had not been submitted was a mistake and could possibly have been prevented if the adjudication committee had not simply relied on the dietician's summary, but scrutinised the original tender documentation. If this had been known, and the tender contract was awarded to the third lowest tenderer at R438 585 per month, the department could have saved approximately R3.8 million over the five year period.

4.3.3.2 Deficiencies were again cited at the Karl Bremer hospital where irreconcilable duties such as the ordering, receipt and issuing of pharmaceutical were performed by the same person. This phenomenon could increase the risk of error and/or unauthorised transactions.

4.3.3.3 An audit on the purchasing of medicine and laboratory items has shown that payments in some cases have been delayed for periods longer than 30 days, which is contrary to finance regulations.

4.3.3.4 Segregation of duties and delegation of powers at certain institutions was not clearly outlined – resulting in a range of financial irregularities at certain hospitals.

4.3.4 Annual Report: 2000/01

The Auditor-General report, contained in the Annual Report 2000/01 of the Department of Health, Provincial Administration: Western Cape elevated the following deficiencies in the department:

4.3.4.1 Documents on personnel files presented for audit were not filed in the proper order, i.e. date/year, whilst certain files did not contain all the appropriate documentation to substantiate the allowance paid.

4.3.4.2 It was found that Karl Bremer had no controls in place to properly dispose of expired medical stock.

4.3.4.3 No annual stocktaking of assets and equipment has taken place at most of the hospitals as per provincial treasury directives. Inventory lists at the Lentegeur hospital were not updated on a regular basis. Further, annual stock-take revealed equipment shortages valued at R152 930 at the institution.

4.3.4.4 Karl Bremer hospital used inventory lists instead of an asset register. The inventory lists did not comply with minimum requirements stipulated by the applicable Provincial Treasury directives. The inventory lists were not updated on a regular basis.

4.3.4.5 Lentegeur hospital registered an outstanding personnel debt of R296 653 during this financial year.

4.3.5 Annual Report: 2001/02

The Auditor-General report, contained in the Annual Report 2001/02 of the Department of Health, Provincial Administration: Western Cape emphasised the following deficiencies at state hospitals:

4.3.5.1 Hospital accounts between February 2001 and March 2002 have not been issued.

4.3.5.2 Some admission files could not be submitted for audit purposes.

4.3.5.3 Some admission files were not signed by patients admitted to hospital. The department could have been held liable should anything happen e.g. to a patient being operated on.

4.3.5.4 In some cases no records could be submitted for patients admitted to hospitals.

4.3.5.5 Monthly reconciliations between the hospital fees received on the hospital debtor system and the Financial Management System (FMS) has not been performed since October 2000.

4.3.5.6 Total revenue outstanding for hospital fees in the province was R122 571 592 as at March 2002. A further R23 247 843 had been written off during the financial year under review.

4.3.5.7 Although commuted overtime to the amount of R112,8 million was recorded, no system was in place to record the actual commuted overtime

hours or to monitor the commuted overtime payments with reference to actual overtime worked and vacation, sick or special leave taken. Double payments could have occurred.

4.3.5.8 Asset registers at certain hospitals were not properly maintained. No inventory lists could be produced in certain cases.

4.3.6 Annual Report: 2002/03

The Auditor-General report, contained in the Annual Report 2002/03 of the Department of Health, Provincial Administration: Western Cape emphasised the following deficiencies in the department:

4.3.6.1 Outstanding hospital fees to the amount of R95.5 million were reported. Approximately R61.2 million (87%) had been outstanding for more than 1 year.

4.3.6.2 An asset register at Lentegeur hospital has not been maintained. Inventory lists were used to control assets.

4.3.6.3 No formal maintenance plan was available at the Lentegeur hospital to ensure that equipment is properly maintained and fully functional at all times.

4.3.7 Governance Outcomes

The author wants to re-emphasise that financial management cannot be evaluated without a context. Financial management in the public sector must be assessed within the broader context of the realisation of government objectives regarding the delivery of public services. Government has committed itself to the provision of health care services to the poor and the destitute. In the case of public hospitals, financial management must

contribute to the achievement of the objectives set out in sections 27(1) & (2) and 28(1) of the Constitution (1996: 13), as well as in section 16 of the Health Act (Act 63 of 1977, as amended: 673-675). In his 2003 Budget Speech Trevor Manuel again reminded public servants about government's commitment and seriousness with health care service delivery when he said the following:

“We cannot and must not tolerate those ... who bring shame to their profession by treating patients and their families callously ... or those who could not be bothered to ensure that hospitals have medicines. We cannot tolerate the breakdown in elementary management that results in rundown facilities, ... slow-moving queues, festering bed-sores,”

Manuel (2003: 4) continued and linked the urgency for better service delivery directly with the Budget when he said:

“We (all public representatives) in this House, in provincial legislatures and in municipal councils, are charged with ensuring that the funds we vote to departmental programmes and government agencies are responsibly and effectively employed.”

It is against this background that this research attempts to assess how financial management contributes towards the realisation of health care delivery outcomes. The assessment of Auditor-General Reports, Annual Reports and Strategic Management Plans are necessary in order to evaluate health care service delivery at the three hospitals.

4.4 Strategic objectives as per Strategic Planning Documents (Effectiveness, efficiency and economy)

According to Section 5.1 and 5.2 of the Treasury Regulations (2000), departments and constitutional institutions must compile and submit a

Strategic Planning document to Treasury no later than 30 June of each year. Treasury submits this Strategic Planning document to the Legislature, who sends it to the relevant Standing Committee to deal with. This Strategic Planning document then informs the budget process for the specific department over the Medium Term Expenditure Framework (MTEF) period. Within five months after the close of the financial year departments must submit Annual Reports to Treasury and to the Legislature [see Section 40(1)(d) & (e) of the PFMA, 1999] in which they compare the objectives outlined in the Strategic Planning document with the actual achievements for that specific financial year.

Strategic Planning documents were presented for the first time during the 2000/01 financial year, because the PFMA was only implemented on 1 April 2001. With a special focus on hospitals, a comparison between the key measurable objectives (KMOs) contained in the Strategic Planning documents and the actual performance as contained in the Annual Reports for the financial years 2000/2001 to 2002/03 will be made and are presented in Table 3 (p. 59), Table 4 (p. 60) and Table 5 (p. 61).


Pectus roboret cultus recti

Table 3: Strategic Planning vs. Actual Output (2000/2001)

Strategic Planning Document (KMO)	Annual Report (Actual Performance)
Maintain level of services	<ul style="list-style-type: none"> ➤ Admissions: 126 117 ➤ Out-patients: 698 704 ➤ Casualties: 97 493 ➤ Average length of stay: 6,1 days
Increase day surgery	<ul style="list-style-type: none"> ➤ Number of day surgery patients: 6 307. ➤ Day surgery as % of surgery patients: 14%.
Decrease the waiting lists for cataract and hips and knee replacements.	<ul style="list-style-type: none"> ➤ Number of cataract operations: 2 275 (15% more than 1999/2000 year). ➤ Number of hip and knee replacements: 976
Upgrade radiological facilities.	<ul style="list-style-type: none"> ➤ New equipment was bought: ➤ Cardiac catheterisation laboratory at Groote Schuur Hospital. ➤ Gamma camera at Red Cross Hospital. ➤ CAT scanner at Tygerberg Hospital.
Increase own revenue.	Revenue increase on Budgeted Revenue: +13,6%.
Maintain training platform.	<p>Numbers trained:</p> <ul style="list-style-type: none"> ➤ Medical and Profession Allied to Medicine: <ul style="list-style-type: none"> Under-Graduate: 2 958 Post-Graduate: 673 ➤ Dental <ul style="list-style-type: none"> Under-Graduate: 373 Post-Graduate: 115

Table 4: Strategic Planning vs. Actual Outputs (2001/2002)

Strategic Planning Document (KMO)	Annual Report (Actual Performance)
Replacing obsolete equipment using medical equipment grant.	<ul style="list-style-type: none"> ➤ X-ray machine and a colour Ultrasound machine with Doppler facilities at Eben Donges Hospital. ➤ Anaesthetic machine and theatre tables in the Westcoast/Winelands region.
Extension and upgrading of George Hospital.	Phase 2B has been completed (80% of the target).
Outpatient Department (OPD) at Eben Donges to be relocated as Community Health Centre on the hospital grounds.	Project was successfully completed by November 2001.
Specialist Outpatient Department at GF Jooste Hospital was commissioned.	The specialist OPD was completed and is functioning.
Relocate Karl Bremer Rehabilitation Unit and similar units at academic hospitals to Conradie Hospital – which is to become a specialised rehabilitation hospital for the province.	<ul style="list-style-type: none"> ➤ Conradie Hospital was closed, but re-established as an institute for acute and chronic services. ➤ Patients at the closed Conradie were moved to Lentegeur Hospital. ➤ Eerste River Hospital was also purchased.
Commissioning of a 25 bed ward at Karl Bremer.	The ward was operational by April 2001.
To improve perinatal mortality rate.	An audit system, the Perinatal Problem Identification Programme (PPIP) has been implemented at the Peninsula Maternity Services and all district hospitals in the Boland/Overberg Region.
Re-opening of Brewelskloof Hospital after upgrading and closure of 136 beds for 9 months.	Brewelskloof Hospital wards were not opened due to delays in the renovation project, recruitment and management problems at hospital level.

Table 5: Strategic Planning vs. Actual Output (2002/2003)

Strategic Planning Document (KMO)	Annual Report (Actual Performance)
All hospitals must submit audited financial statements at end of financial year.	Fourteen (14) hospitals did not submit audited financial statements.
Regions have the responsibility to procure the services from service providers (e.g. NGOs, local authorities, etc.) for the rendering of Primary Health Care (PHC). These procurement agreements must be presented for audit purposes.	Contracts and agreements for the rendering of this service of 19 providers could not be found during the annual audit process.
Maintenance at any institution should be part of the overall year management plan of the institution.	NO formal maintenance plan was available at Lentegeur Hospital to ensure that equipment is properly maintained and is fully functional at all times.
Stocktaking of linen should happen annually.	No linen stock-take happens at some institutions. No spot checks of linen (as prescribed by the Linen Control Policy) at the Western Cape Laundry performed by staff.
Implement LOGIS to cost centres at all institutions	Only 20% institutions received Logis. And 40% staff was trained in the process.
Reduce the turnaround time for the processing of requisitions from 25 to 7 days,	A 72,5% improvement was recorded during the audit process.
To introduce Delta 9 Debtors' Module at all institutions to help with revenue collection.	<ul style="list-style-type: none"> ➤ This output was achieved and the AG reported an increase of 3.52% in debt collection. ➤ Accounts are issued 5 days after discharge of patients.

4.5 Interviews

Some of the information used in this research was gathered through questionnaires and interviews. The interviews were semi-structured (Welman & Kruger, 2001: 161). Information was also requested from Head Office and the three hospitals via questionnaires that were sent to the CFO of the WCHD and the three hospitals. Interviews (one-on-one and focus group) were conducted with a range of officials. The questions that were used during the interviews are attached as Appendices 1-4 (see pp. 113-116). The purpose of the interviews was, inter alia, to gather information on the following aspects:

- Staff experiences about the implementation of the PFMA;
- To assess what progress has been made with the implementation of the PFMA
- The sufficiency of allocated budgets;
- Capacity of staff to deal with processes and change in the hospital system;
- An assessment of shortcomings on internal control measures;
- An evaluation of staff's understanding of concepts like the PPPFA, SCM and BEE;
- An assessment of the delivery capacity of BEE companies; and
- An assessment of the collection of hospital fees at the three institutions.

Interviews were conducted at Head Office and at three hospitals, viz. Karl Bremer, Lenteguur and Swellendam hospitals. In total nineteen (19) officials were interviewed. All interviews were audio-taped. A summary of all interviews conducted is contained in Tables 6-9.

The questions used in the different questionnaires refer to the theoretical aspects contained in Chapters 2 & 3, and simultaneously try to shed some light on the challenges hospitals face as highlighted in Chapter 1.

The focus group interviews extended beyond the questions contained in the questionnaires. The focus group interviews provided the author with opportunities to expound further on issues like staff capacity, an understanding of the legal framework of health care service delivery, an understanding of the contents and intentions of BEE, the effectiveness and efficiency of organisational systems and its consequential impact on actual health care service delivery in the three hospitals.

The author believes that responses to questions in any questionnaire (structured or unstructured) are coloured with some subjectivity. Therefore, having interviewed nineteen (19) officials and having had the advantage of interviewing focus groups, the findings and interpretations arrived at are well founded. An open questionnaire (Appendix 5, p. 117) was sent to all institutions prior to the interviews. The feedback on this open questionnaire provided useful information that will be used in the interpretation of the findings. The feedback received on the open questionnaire also explains the absence of pertinent questions in the first four questionnaires (Appendix 1 to 4) because many of the questions were addressed in the open questionnaire.

4.5.1 Head Office

The Directorate: Supply Chain Management at Head Office is responsible for provisioning and procurement of transversal tenders for Head Office and all public health institutions in the province. The directorate has an approved staff establishment of 36 posts, of which 24 are filled with 12 vacancies. One person was interviewed at Head Office (see Table 6, p. 63). The interview was conducted on 28 October 2004.

Table 6: Interview - Western Cape Health Department (Head Office)

No.	Official	Gender	Capacity/ Responsibility	Type of interview
1.	Mr I Smith	Male	Director: SCM	Interview

Mr Smith has extended knowledge of procurement and provisioning. He previously served as secretary to the Western Cape Provincial Tender Board, until its dissolution in December 2003.

4.5.2 Karl Bremer Hospital

Karl Bremer Hospital is a regional hospital situated in Bellville. Its drainage area (the area from where its potential patients come from) is the Northern Suburbs and part of the Cape Flats, like Elsies River, Ravensmead, Belhar, Delft/Blue Downs area and even as far as Khayalitsha. The hospital has a capacity of 252 beds.

Five (5) officials were interviewed on the 27 July 2004 (see Table 7, p. 64).

Table 7: Interviews - Karl Bremer Hospital

No.	Official	Gender	Capacity/ Responsibility	Type of interview
1.	Dr L Naudé	Female	Superintendent	Interview
2..	Mrs E Louw	Female	Assistant Director	Interview
3.	Ms E D Van Tonder	Female	Finance (Income)	Cluster Interview
4.	Mr S Human	Male	Finance	
5.	Mrs A Stemmet	Female	Procurement	

4.5.3 Lentegeur Hospital

Lentegeur Hospital is a Psychiatric hospital. It is located in Mitchell's Plain and has a considerable large drainage area, mainly from the Southern Suburbs, Cape Flats and Khayalitsha. Lentegeur has a bed capacity of 814.

Six (6) officials were interviewed on the 28 July 2004 (see Table 8, p. 65).

Table 8: Interviews - Lentegour Hospital

No.	Official	Gender	Capacity/ Responsibility	Type of interview
1.	Mr V Gertze	Male	Deputy Director: Administration and Finance	Interview
2.	Mr M Gameldien	Male	Procurement	Cluster Interview
3.	Ms T Hendricks	Female	Procurement	
4.	Mr C V April	Male	Section Head: Finance	
5.	Mr D De Bruin	Male	Finance	
6.	Mr C Jacobs	Male	Finance	

4.5.4 Swellendam Hospital

Swellendam Hospital is a district hospital. The hospital is located in Swellendam. This hospital provides services to patients from farms in the Swellendam district, as well as from surrounding towns like Riversdal, Riviersonderend, Barrydale, Malgas, Heidelberg, Bonnievale and Slangrivier. The hospital has 75 beds. It also renders a service to any emergency situation that might occur on the N1 route.

Seven (7) officials at the hospital were interviewed on the 29 July 2004 (see Table 9, p. 65).

Table 9: Interviews - Swellendam Hospital

No	Official	Gender	Capacity/ Responsibility	Type of interview
1.	Mr B Abrahams	Male	Hospital Secretary	Interview
2..	Ms A Bokwana	Female	Procurement	Cluster Interview
3.	Ms G Kleynhans	Female	Procurement	
4.	Ms H Norman	Female	Procurement	
5.	Mr T Jeftha	Male	Finance	Cluster Interview
6.	Ms C Rhodes	Female	Finance	
7.	Ms L Hartszenberg	Female	Finance	

4.6 Conclusion

The co-operation received from all officials during the interviews is commendable. Every effort was made by all to be helpful and to provide complete information as far as possible.

The next chapter assesses and interprets the information extracted from available documentation and of the interview results.



CHAPTER 5

INTERPRETATION OF FINDINGS

5.1 Introduction

The interpretation of findings in this chapter is based on the information gathered from the audit reports, annual reports and the interviews. The interpretation of findings will be dealt with in relation to the following two categories, viz.

- Financial management; and
- Supply chain management.

5.2 Financial management

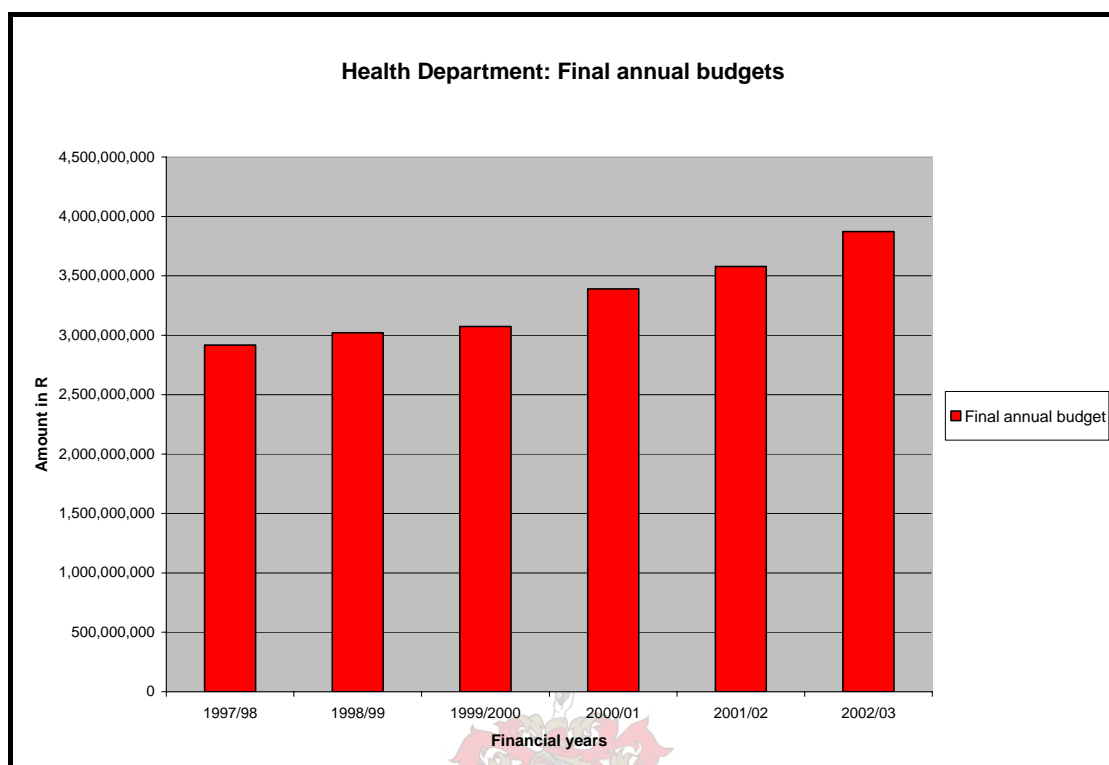
The information collected at Head Office and at the three hospitals, indicates that there has been an overall improvement in financial management at the institutions under discussion. The Health Department received four unqualified audit reports over the last four financial years (1999/2000–2002/03) [see Table 10, p. 68]. These unqualified audit reports are significant because they serve as an indication that the Health Department has improved in terms of compliance with the prescripts of the PFMA. No incidents of fruitless and wasteful expenditure were reported over the six financial years under discussion. Paragraphs 5.2.1 till 5.2.11 further substantiate the financial management outcomes in the different institutions. The audit and annual reports of the financial years 1997/98 to 2002/03 were evaluated and the findings are contained as summaries in the following tables: WCDH: Head Office (Table 10, p. 68); Karl Bremer Hospital (Table 11, p. 70); Lentegeur Hospital (Table 12, p. 71) and Swellendam Hospital (Table 13, p. 71). Graph 2

(p. 69) is a graphical representation of the budget allocation to the Health department for the 1998/99-2002/03 financial years.

Table 10: Financial position at Head Office (1997/98-2002/03)

Item	Financial Years					
	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03
Annual Budget	2,473,664,000	2,901,470,000	3,006,779,000	3,322,532,000	3,535,037,000	3,741,094,000
Adjustm. Est.	444,127,000	118,528,000	66,109,000	68,692,000	43,730,000	130,542,000
Final annual budget	2,917,791,000	3,019,998,000	3,072,888,000	3,391,224,000	3,578,767,000	3,871,636,000
% increase	17,95	4,09	2,20	2,07	1,24	3,49
Audit report						
Qualified		X				
Unqualified	X		X	X	X	X
Unauthorised expenditure (Y/N)	N	Y	Y	N	Y	
Underspending	11,402,000	NIL	NIL	24,535,000	NIL	NIL
Overspending	NIL	3,863,000	33,817,000	NIL	2,250,000	3,926,000
Staffing						
Posts filled	26 988	24 661	24 013	24 224	24 987	24 003
Vacancies	4 775	6 945	7 128	7 409	6 972	7 408
Procurement						
Quantum	957,980,000	1,020,978,000	1,099,435,000	1,263,303,000	1,315,809,000	1,420,962,000
As % of total budget	32,8	33,8	35,8	37,3	36,8	36,7

Graph 2: WCHD - Annual Budgets (1997/98-2002/03)



5.2.1 The PFMA

Officials admitted that the PFMA is a good financial management instrument, but that its implementation inhibited their creativity in terms of both revenue generation and expenditure. The inhibition and caution, according to them, is caused by the conscious focus that the PFMA is placing on accountability and the “value-for-money” principle.

5.2.2 Annual budget allocation

Hospitals regarded their budgets as inadequate. Although there was an annual increase in the overall budget of the Department (see Graph 2, p. 69), there was no real growth of the budget within the context of the total provincial

budget. The same argument holds for hospital budgets [see Tables 11 (p. 70); 12 (p. 71) and 13 (p. 71)].

Two of the hospitals suggested that Head Office should not manage and administer their allocated budgets. Hospital budgets should be transferred to the respective hospitals to allow them to manage and to account for their own funds. According to officials, the regular administration and finance meetings that are held on a regional level provide a valuable platform to hospital officials to discuss and share ideas and best practices.

Table 11: Annual budgets allocated to Karl Bremer Hospital

Item	Financial Years					
	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03
Budget received	41,178,000	43,222,000	45,413,514	53,363,782	66,323,438	69,496,438
Budget spent	42,205,014	43,137,791	45,429,214	48,562,344	63,880,000	70,475,000
Overspending (Y/N) If Y, quantum?	Y 1,027,014	N	Y 15,700	N	N	Y 987,562
Underspending (Y/N) If Y, quantum	N	Y N/A	N	Y 4,801,438	Y 2,443,438	N
Staffing						
Number of posts filled	555	504	509	522	626	565
Number of vacant posts	48	104	108	263	171	163
% Budget for Procurement	23,6	22,8	25,1	22,2	27,6	29,0
Y=Yes; N=No N/A= not available						

Table 12: Annual budgets allocated to Lentegeur Hospital

Item	Financial Years					
	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03
Budget received	73,359,000	71,490,000	73,390,000	80,239,000	83,729,000	85,588,000
Budget spent	75,553,242	73,425,821	71,919,597	77,156,503	83,066,696	87,409,570
Overspending (Y/N) If Y, quantum?	Y 194,242	Y 1,935,821	N	N	N	Y 1,821,570
Underspending (Y/N) If Y, quantum	N	N	Y 1,470,403	Y 3,082,497	Y 660,304	N
Staffing Number of posts filled Number of vacant posts	967 105	841 233	786 194	784 45	800 60	759 102
% Budget for Procurement	24,9	22,2	21,4	23,3	21,9	25,3
Y=Yes N=No						



Table 13: Annual budgets allocated to Swellendam Hospital

Item	Financial Years					
	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03
Budget received	4,512,000	5,429,000	5,367,000	6,729,000	7,149,000	7,554,000
Budget spent	5,368,928	5,626,245	5,788,088	6,749,228	7,172,163	7,621,446
Overspending (Y/N) If Y, quantum?	Y 856,928	Y 197,245	Y 421,088	N	Y 23,163	Y 67,446
Underspending (Y/N) If Y, quantum	N	N	N	Y 42,712	N	N
Staffing Number of posts filled Number of vacant posts	64 4	59 7	64 5	65 3	64 5	62 8
% Budget for Procurement	25,5	25,6	26,7	24,2	24,6	24,4
Y=Yes N=No						

5.2.3 Underspending

The reasons submitted for the underspending of the budgets [see Tables 10 (p. 68); 11 (p. 70); 12 (p. 71); 13 (p. 71) and Appendix 5 (p. 117)] are as follows:

- Savings due to the non-filling of posts;
- Granting of Voluntary Severance Packages (VSPs) to staff during the rationalisation process;
- Down-scaling of support services;
- Non-submission of government printer and IT claims;
- Delay in the delivering of medical equipment, caused by new tender procedures;
- Amalgamation of nursing colleges in the province, coupled with a lower intake of students;
- Surpluses carried over to the next financial year;
- Non-requisitioning of personnel equipment during the 2000/01 financial year at Swellendam Hospital; and
- Non-utilisation of the professional and special services budget at Lentegeur Hospital.

During the interviews, officials pointed to the fact that certain key positions at their respective institutions were not filled. The non-filling of vacancies influenced all three hospitals negatively in terms of their capacity to deliver on certain services. If the underspending was a result of savings made through the non-filling of posts as alluded to by the WCHD, whilst a need for administrative capacity was registered during the interviews, then it could be argued that it reflects poorly on management's ability to deal with human resource management within their available budgets. It could then be asked whether the incidents experienced and/or described by Lindsay Rall (p. 4), Jade Willemse (p. 5) and reporter Jo Breach's article on the corpse that was lying in the ward for almost five hours (p. 4) would have happened if hospitals

had their full complement of approved staff? It thus seems as if underspending during certain financial years under review came at a price, viz. a negative impact on service delivery to the general public.

5.2.4 Overspending

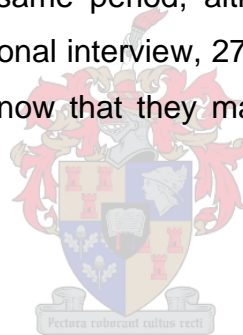
The reasons provided for overspending [see Tables 10 (p. 68); 11 (p. 70); 12 (p. 71); 13 (p. 71) and Appendix 5 (p. 117)] are as follows:

- Filling of vacant posts of medical staff to create a more secondary health service on a lower level than tertiary services;
- Purchasing of urgent medical care services;
- Price increases on medicines;
- Increased patient loads;
- Stock piling in readiness for Y2K contingency;
- The weakening of the rand, coupled with increased inflation on medical and surgical sundries and pharmaceuticals in general; and
- The use of agency staff due to a moratorium on the filling of posts in the 2002/03 financial year.

The average overspending on Programme 4 (Provincial Hospitals) and Programme 5 (Central Hospitals) over the last four financial years is 4% and 5,2% respectively (Annual Report 2003/04). Both over- and underspending, according to the author, reflects negatively on financial management capacity viewed against the Public Governance philosophy. Poor financial management could be the result of either ill-considered policy decisions or lack of close monitoring of budget expenditure, as prescribed by Section 39 (4) (b) [PFMA, 1999: 48]. However, the author agrees that the Department has no control over factors like rapid increase in prices or the fluctuation of the rand which could also contribute to either under- or overspending.

5.2.5 Trading account (Karl Bremer Hospital)

Karl Bremer Hospital was part of a national pilot programme where the institution's annual budget was transferred into a trading account managed by the respective hospital. Four hospitals country-wide were involved and the pilot project ran for four years. The pilot programme was terminated in March 2003 without providing reasons to the hospitals involved. Karl Bremer is of the opinion that they have managed their trading account reasonably well and that they were on the brink of generating meaningful revenue for the hospital when the programme was stopped. Information contained in Table 11 (p. 70), however, does not support the opinion of Karl Bremer. Significant amounts of underspending occurred between the 1999/2000 and 2002/03 financial years. The overspending over the same period, although relatively small, is also unacceptable. Ms Louw (personal interview, 27 July 2004) remarked that staff are more motivated if they know that they manage and generate their own funds.



5.2.6 Staffing

Personnel comprise the largest slice of the budget. Care should therefore be exercised with the management of personnel expenditure. Hospital management needs to strike a balance between personnel expenditure, i.e. the filling or non-filling of posts, and the maintenance of an acceptable level of service delivery in the hospital. Karl Bremer Hospital e.g. recorded an underspending of R 4 801 438 for the 2000/01 financial year, whilst for the same period 263 vacancies were not filled (see Table 11, p. 70). According to the hospital the underspending resulted from a surplus that was carried forward to the next financial year Appendix 5 (p. 117). Many experienced staff left the public health sector due to the national rationalisation process – a process to decrease the size of the public sector. Experienced nurses are poached by private hospitals or recruited, normally at better salaries, by other

countries. Officials interviewed at hospitals are, however, positive that their current staff is well trained, dedicated and do more than what is required of them. The staffing situation at the three hospitals is depicted in Graphs 3 (p.76); 4 (p. 77) and 5 (p. 77):

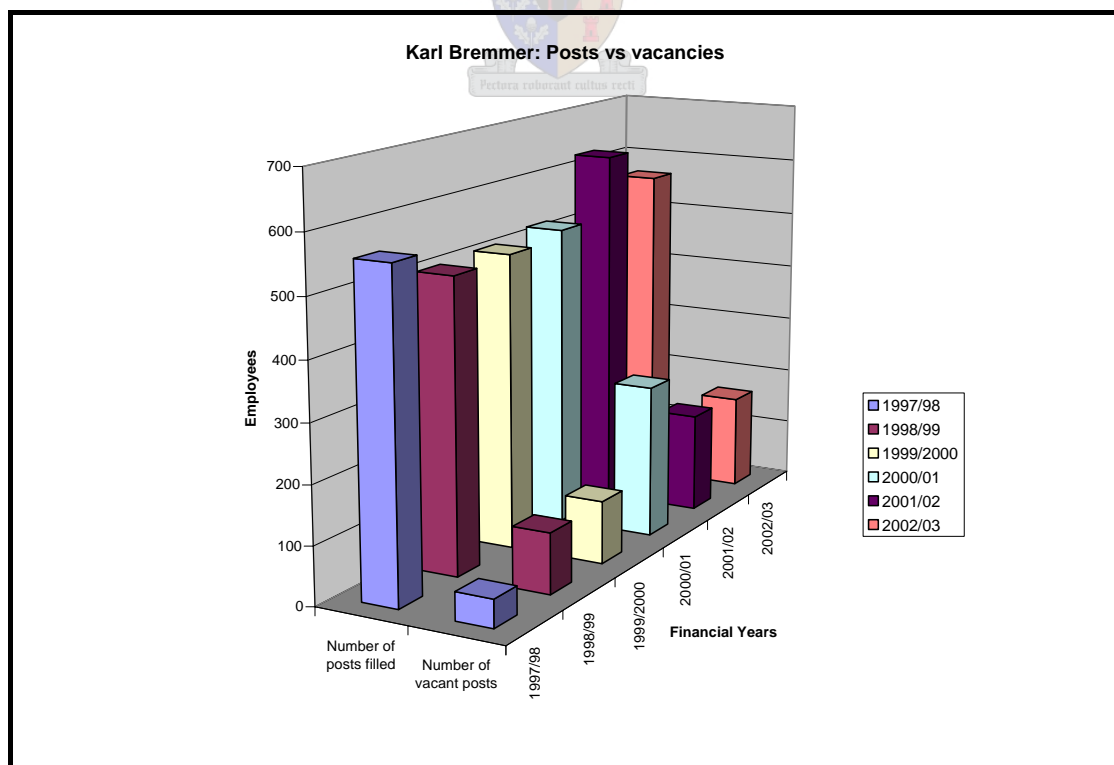
It could be argued that the underspending, caused by the non-filling of posts or surpluses that was carried forward, demonstrates sound financial management. The author however disagrees, because if underspending - which resulted from the non-filling of vacant posts – occurred, whilst at the same time the Health Department and or any public hospital failed to assist in the realisation of the government objectives of proper and decent health care service delivery to the general public [as is evident in examples depicted in Chapter 1 and from the analyses of the Audit and Annual Reports (paragraph 4.3, p. 51)], then indeed the underspending reflects negatively on sound financial management in such an institution. According to the PFMA, financial management must assist administrative institutions to add value to the services rendered by such institutions. The Health Department cannot accrue savings (via underspending) at the cost of health care service delivery to the public. This would go against the grain of public governance and good governance as described under paragraphs 1.4.4 (Chapter 1) and 2.4 (Chapter 2).

An assessment of the Audit and Annual Reports indicate that hospitals struggle to implement and maintain effective monitoring and control mechanisms mainly due to the non-filling of certain positions on their administrative establishments. Lentegur and Swellendam Hospitals registered some of the difficulties they have experienced with the non-filling of posts. Lentegur Hospital felt that it will make management sense to create a Deputy Director: Finance post. Such a step will alleviate the load of the current Deputy Director: Administration and Finance, in order to allow the incumbent to concentrate on administration. According to Mr April (personal

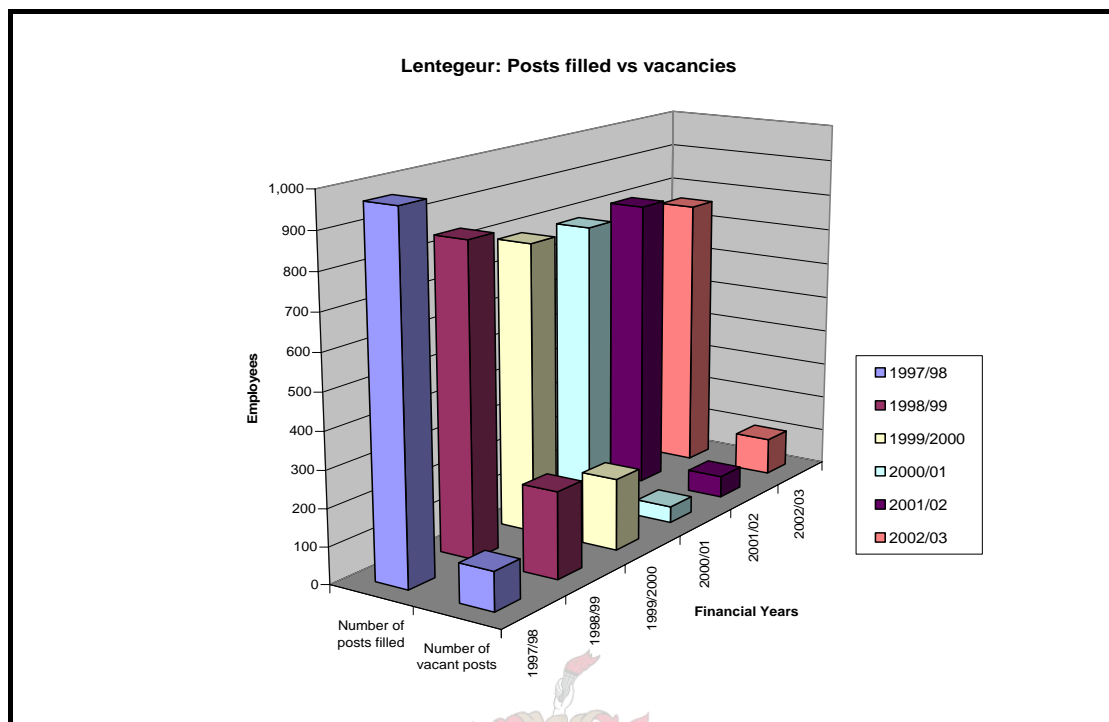
interview, 28 July 2004) two key vacancies in the finance department at Lentegur Hospital resulted in an increased workload on the remaining staff. Swellendam Hospital exercises a practice where patients receive their accounts immediately after they have been attended to. In this way they make sure that patients (especially those staying on farms) receive their accounts. This practice cannot continue at night because no administrative staff are on duty. The Hospital Secretary indicated that they are now in the process of appointing one or two persons who could assist with the administration at night.

At Karl Bremer Hospital a strategic vacancy could not be filled for 2-3 years due to requirements of their employment equity plan. A person was eventually appointed after two years of the post being vacant. However, the person left the hospital after a year because of a better career offer elsewhere.

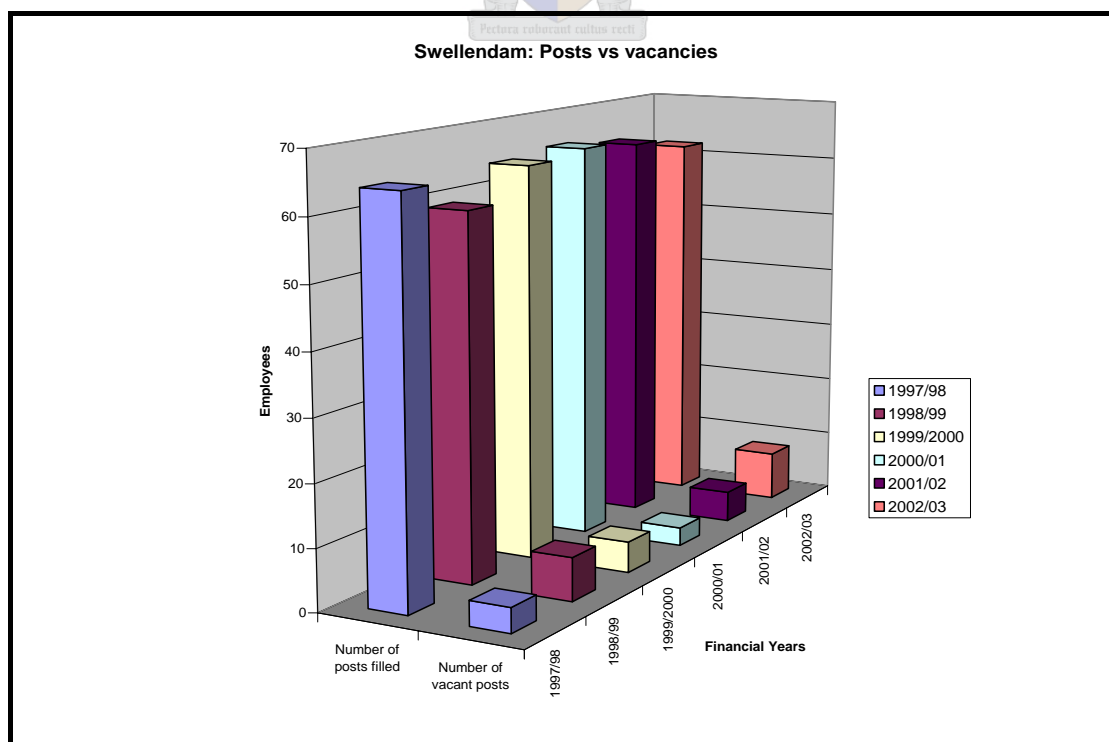
Graph 3: Staffing situation at Karl Bremer Hospital



Graph 4: Staffing position at Lentegeur Hospital



Graph 5 Staffing situation at Swellendam Hospital



5.2.7 Hospital fees

The collection of hospital fees remains a challenge. Each hospital gets a target for fee-collection per annum. All fees collected must be paid over to Head Office. Hospitals are, however, allowed to retain all fees that they collect in excess of the annual fee-target. Hospitals (like Lentegeur) argue that this policy does not serve as an incentive to them, because the majority of patients within their drainage area are unemployed and cannot settle outstanding accounts in any case.

The following are some of the difficulties that hospitals experience with the collection of outstanding fees:

5.2.7.1 Patients provide incorrect addresses which makes it difficult to present them with accounts via the post. Many accounts sent out are returned unopened or with an indication that the person does not reside at the specific address. Swellendam Hospital mentioned that many patients come from farms in the district and the migrating nature of some farm workers makes it difficult for the hospital to present them with accounts.

5.2.7.2 The majority of patients are unemployed or poorly paid workers. Category H1 patients refer to those patients who receive a social grant or pension, an individual earning less than R36 000 per annum or a family earning less than R50 000 per annum. Many patients who seek medical services at hospitals indicate that they are unemployed, but hospitals have to determine whether patients are indeed unemployed.

5.2.7.3 Many patients simply disappear after they have been helped and some are never traced, especially when they come from another province.

5.2.7.4 Two of the hospitals experienced late (up to four months) settling of accounts by medical aid schemes.

5.2.7.5 Lentegeur Hospital provides services to communities in a drainage area that is characterised by poor socio-economic circumstances, e.g. poverty and unemployment. The hospital is thus experiencing difficulties in collecting fees from most patients residing in its drainage area.

5.2.7.6 If all measures fail to collect outstanding fees, the accounts are then referred by the hospital to VERICRED for collection. VERICRED is the company which has been awarded the tender for fee collection by the Western Cape Health Department. Outstanding fees are being collected by VERICRED on a commission basis.

5.2.8 Information technology

Hospitals have functional systems in place. Dr Naudé, superintendent at Karl Bremer Hospital (personal interview, 27 July 2004), expressed concern that the public service in general will have to modernise its information technology communication at a faster rate than what is currently the case.

Over the years, accounts were managed by hand. Lentegeur Hospital changed over to Delta 9 (computerised programme) about a year ago to help officials in the accounts department. According to officials, the Delta 9 system is time-consuming and is not user-friendly. Officials have recently been trained in using a new programme called Basic Accounting System (BAS).

The Logistical Information System (LOGIS) is being used for procurement and provisioning purposes. Procurement officials at Swellendam Hospital complained that LOGIS is sometimes off-line for 2-3 hours per day. If the

programme/system goes off, their work output is negatively affected, because they cannot do anything meaningful during that time.

5.2.9 Audit and Annual Reports

The Audit and Annual Reports provided the researcher with useful information. Only those shortcomings that relate to the accounting officers responsibilities as contained in sections 38-40 (PFMA, 1999) are focussed on. An evaluation of the Audit and Annual Reports for the period 1997/98 to 2002/03 revealed the following:

5.2.9.1 The absence of an internal audit unit under the control of a dedicated audit committee, as prescribed by Section 38 (1)(a)(ii) of the PFMA, as well as Section 27.2.6 (Treasury Regulations, 2001), for a few years after its implementation, could have contributed to a range of irregular practices with concomitant service delivery implications (see paragraph 4.3.1.5, p. 52). The internal audit process and the purpose of the audit committee is to help management to pick up deficiencies and shortcomings in the systems and to put in place corrective measures.

5.2.9.2 The separation of functions is important. According to paragraphs 4.3.1.1, 4.3.3.2 and 4.3.3.4 (p. 52-54), the fact that one person was often responsible for ordering, receipting, issuing of stock and payment of requisitions could have contributed to irregularities, unauthorised expenditure or even corruption.

5.2.9.3 Paragraph 4.3.3.1 (p. 53) implies that Lentegour Hospital does not have a competent team to deal with high-value tenders. The managing and subsequent decision of acceptance of contract WKT 30200/98B resulted in an increase of R3,8 million more (over the five year period) for the same services

that another tenderer could have offered. The R3,8 million could have been used to provide other services, e.g. the provisioning of more medication.

5.2.9.4 Serious shortcomings have been identified in the internal control measures (see paragraphs 4.3.1.2, p. 51; 4.3.2.1, p. 52; 4.3.4.1 & 4.3.4.2, p. 54; 4.3.5.3, p. 55). Many of the shortcomings were attributed to the non-filling of vacancies.

5.2.9.5 Asset registers at certain hospitals were not properly maintained. It is the responsibility of the AO of the WCHD to maintain and safeguard the assets of the institution [Sections 38(1)(d) & 45(e) of the PFMA and Treasury Regulation 10.1 (2000)]. Annual stocktaking is one method to take care of this responsibility. Audit and Annual Reports, however, showed on the contrary (see 4.3.1.3, p. 52; 4.3.4.3 & 4.3.4.4, p. 54; 4.3.5.8, p. 56 & 4.3.6.1, p. 56).

5.2.10 Achievements of strategic objectives (Efficiency, effectiveness and economy)

Achieving effectiveness, efficiency and economy constitutes the overarching objective of management in public health delivery (Abedian, Strachan & Ajam, 1998: 82). An assessment of the comparisons in Tables 3-5 indicates that most of the visualised KMOs were indeed achieved, but it also shows that important KMOs were not achieved, which could have contributed to an under- or overspending of budget allocated to the specific items, e.g. the delay in the renovation project at Brewelskloof Hospital (Table 4, p. 60); the safekeeping of contracts and agreements regarding procurement and provisioning (Table 5, p. 61) and non-compliance with annual stocktaking of linen (Table 5, p. 61). The execution of performance audits by the office of the AG would assist a great deal in evaluating effectiveness, efficiency and economy of financial budget management.

5.2.11 Benchmarking

To effectively determine the effective, efficient and economic spending of public funds, it is important that the outputs are measured against certain benchmarks. It was unclear, in many cases of health delivery as contained in the Strategic Planning documentation, what the benchmark was, how it was determined and what the international norm for the delivery of a specific service is.

The author could not ascertain what the WCHD or the respective hospitals' benchmarks for linen losses were. The question is then raised: Against what is the linen loss measured? How many linen pieces can get lost during a year? It becomes complicated to evaluate, e.g. the linen losses of R 112 189,24 at Karl Bremer Hospital (see Table 1, p. 7), because against what benchmark is the loss measured? The commitment of the institution to implement corrective steps also becomes a futile exercise in the sense that the hospital management is vague as to the measures to be implemented and to indicate what improved results are expected after the implementation of the corrective steps.

It is indeed an achievement for the Health Department to have attained a 72,5% improvement in reducing the turnaround time for the processing of requisitions from 25 to 7 days (see Table 5, p. 61). However, what is not indicated in the Strategic Planning document is the expected norm/benchmark allowed for processing requisitions. The absence of this norm complicates an objective assessment of effective, efficient and economic expenditure of public funds.

5.3 Supply Chain Management (Procurement and provisioning)

As alluded to in Chapter 3, the success of SCM depends largely on the nature and quality of organisational (institutional) structure. Civil service reform implicitly includes institutional reform. According to the Policy Strategy to Guide Uniformity in Procurement Reform Processes in Government (2003: 25), institutional reforms should assist government to achieve the ideals of good governance and to address the deficiencies in SCM. These reforms had to include efficient and effective procurement and provisioning systems and practices that would enable government to deliver the required quality and quantity of services to its citizenry and to promote equity.

5.3.1 Procurement and provisioning processes

The procurement and provisioning processes at Head Office and at the hospitals will be evaluated separately.

5.3.1.1 Procurement and Provisioning at Head Office

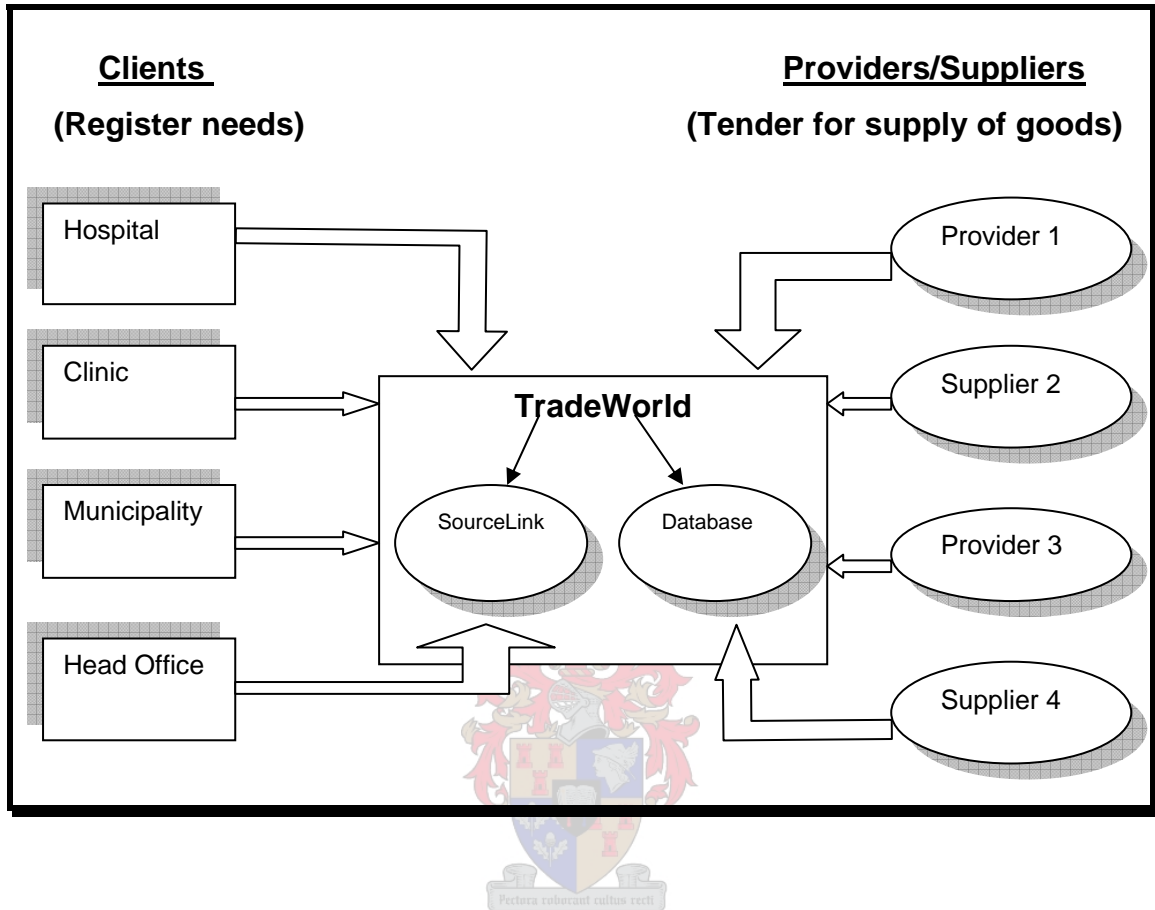
Certain items, e.g. information technology and communication (ITC) items, are procured by Head Office via the prescribed tender process. Once such a tender has been concluded, all hospitals and institutions under the jurisdiction of the WCHD are then obliged to procure such goods and services from the specific supplier. Head Office-secured tenders are referred to as transversal tenders. If a specific transversal tender supplier cannot provide the goods and services needed by a hospital, then the hospital is allowed to procure the required goods or services from other approved suppliers via three quotations. Such procurement must be effected through TradeWorld - a sourcelink electronic purchasing system - and within the limit of the financial delegation of the hospital.

5.3.1.2 Procurement and Provisioning by hospitals

Hospitals are allowed to do their own procurement and provisioning of goods and services. Each hospital has a team of employees who specifically deal with procurement. The procurement and provisioning of goods and services is done according to guidelines laid down by the WCHD. Hospitals procure some goods and services directly from suppliers of choice, some through TradeWorld and some via transversal tenders.

TradeWorld is a private company who won the tender from the WCHD to provide a facilitation function between clients (e.g. hospitals) and suppliers during the procurement and provisioning process. Hospitals then procure goods and services via TradeWorld. Hospitals submit tenders to TradeWorld, which sends it electronically to all the providers/suppliers affiliated to it. The hospital chooses a supplier from among those tender offers received by TradeWorld (see Figure 3, p. 85). Providers/companies pay an affiliation fee of R540 per month to belong to TradeWorld, which grants them access to tenders placed by hospitals (and all other government institutions). Figure 4 (p. 87) is a diagrammatical representation of the procurement and provisioning process followed by hospitals. The LOGIS system/programme is used to assist with the administration of the procurement and provisioning processes.

Figure 3: TradeWorld's facilitating function in terms of tenders



TradeWorld must provide quarterly summary reports to the WCHD (TradeWorld, 2004). These quarterly summary reports enable the WCHD to track all transactions that transpired between its clients and suppliers. Hospitals also have the right to list smaller companies directly onto SourceLink. This service is provided free of charge to smaller companies who cannot afford to affiliate to TradeWorld.

5.3.2 Delegation

Each hospital has a team that adjudicates tenders below R2 000. For purchases below R50 000, the team recommends the required provider/supplier to the Regional Office. The Regional Office can approve or reject (with reasons) the recommended provider.

Hospitals can buy emergency items to the value of R2 000, on the provision that they call for three quotations. They are then supposed to accept the lowest quotation. Should a hospital prefer a quotation other than the lowest, then it has to submit a motivation for its decision to the Regional Procurement Team.

The powers of procurement delegation, which is applicable to all departments, are prescribed in Annexure A of the document titled Supply Chain Management – The Accounting Officer's System (AOS) (2003).

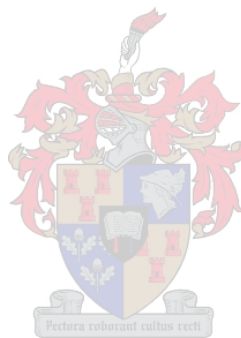
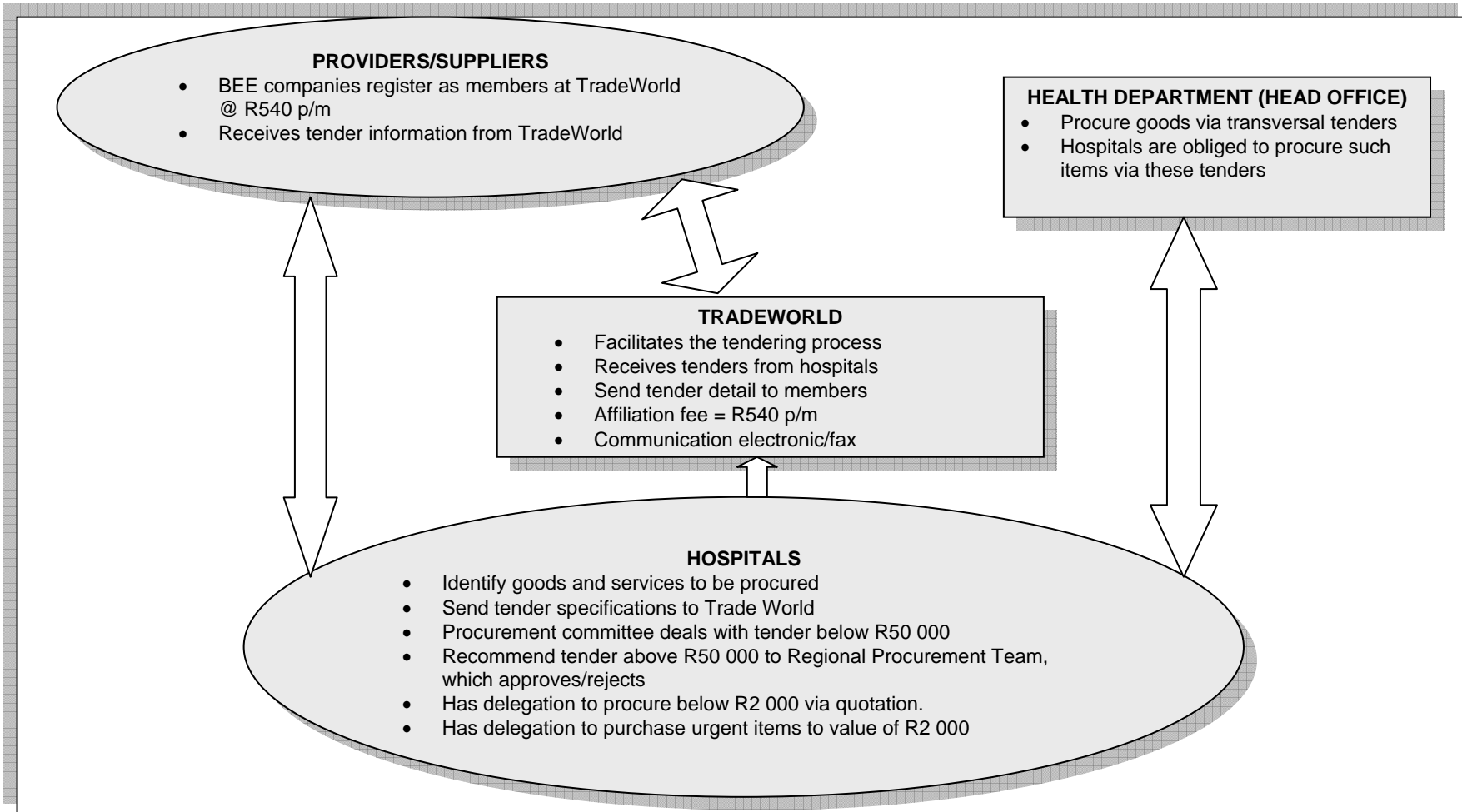


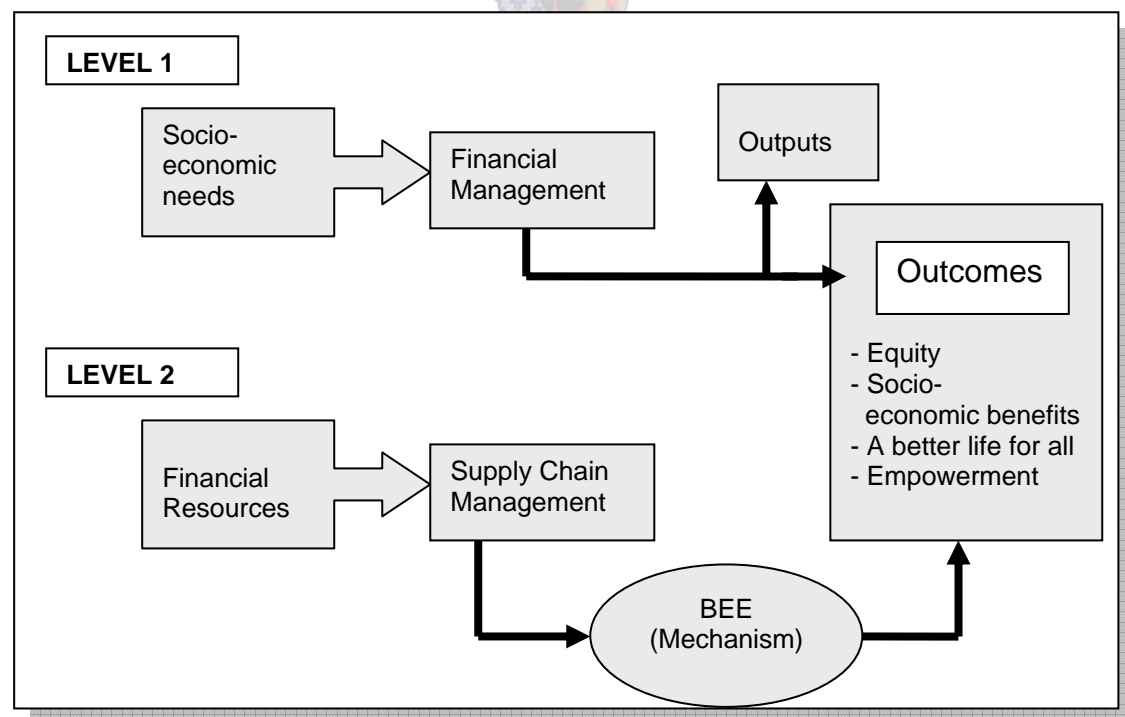
Figure 4: Procurement process at hospitals



5.3.3 Black Economic Empowerment (BEE)

As previously mentioned in Chapter 3 (Paragraph 3.4, p. 44), BEE should be seen as a vehicle in SCM to help government to transform the socio-economic face of communities in SA, especially those sections of the SA community who were consciously excluded from economic opportunities in government before 1994. BEE has no direct influence/effect on the output of hospitals, but BEE (as applied in the SCM of hospitals) is supposed to considerably contribute, over a period of time, towards the process of changing the face of the SA society. All South Africans should eventually reap the benefits of empowerment, equity and better quality services as illustrated in Figure 5 (p. 88) below:

Figure 5: SCM as process, together with BEE as strategy/mechanism should help to realise equitable societal outcomes



Hospital staff are fully aware of preferential procurement policy principles. They are legally bound to recognise and support BEE companies. The following information on BEE emerged from the interviews:

- The preferential procurement policy is strictly applied;
- Established black-owned companies generally deliver satisfactory services;
- Hospitals have encountered problems with some BEE companies where the quality of items delivered did not comply with standards, e.g. sutures that were not up to standard and the hospitals (Karl Bremer and Swellendam) had to procure the same items from another supplier;
- Karl Bremer, located in a predominantly white geographical area, has no PDI or HDI companies within its immediate vicinity. It uses BEE companies from other areas in the peninsula;
- The capacity of some BEE companies is limited – both in terms of human resources and finances. These shortcomings hamstring timeous supply of goods and services which, in turn, impact negatively on service delivery at hospitals;
- Services like cleaning and the provisioning of security are outsourced easily, because it does not require a high degree of expertise or sophistication;
- Lentegeur Hospital is taking extra measures to support BEE companies to whom they allocate work, e.g. it helped the company who cut their grass by allowing it to repair its broken equipment in their workshop;
- Lentegeur Hospital allocates 60-70% of its procurement budget to PDIs or HDIs;
- The processes (as outlined in paragraph 5.3.1.2, p. 84) whereby BEE companies access hospital tenders are too stringent and the process does not help small PDIs or HDIs to achieve the objectives of BEE. The processes determine that smaller providers of services should have, e.g. a fax number, telephone number, e-mail or a banking

account. These criteria, although necessary to prevent corruption, have unfortunately made it difficult for one person businesses in the Swellendam, Mitchell's Plain and Khayalitsha areas, which operate from a home/garage to access state tenders;

- One interviewee revealed that some BEE providers are so desperate in securing a job that they under-quote the tender. Such companies eventually land in financial difficulties, which results in the non-delivery of the required goods or services. Except for failing to provide the required goods or services, such companies often suffer severe financial losses in the process;
- At two hospitals, officials questioned the nature and scope of empowerment within certain BEE companies with whom they are dealing. According to them, some BEE companies are exactly the same white-owned companies that they have been dealing with since pre-1994. Their addresses and telephone numbers have remained unchanged; there has just been a name change. One hospital suspects "fronting" (the phenomenon where blacks are used or "abused" in the business make-up just to secure tenders) by some of the suppliers which regard themselves as BEE companies. The officials at one hospital felt that they do not have the power to question or investigate the nature of such suspicious BEE companies. Officials mentioned that they are powerless to legally assess the nature of these BEE companies that they suspect of fronting;
- Lack of technology and computer skills affects BEE companies negatively;
- It is too expensive for small BEE companies to affiliate to TradeWorld. Although small BEE companies can be listed by hospitals free of charge to Sourcelink, their non-affiliation to TradeWorld excludes them from meaningful tender opportunities in other government institutions;
- The specifications (requirements) of certain tenders make it impossible for smaller BEE companies to apply and qualify for such tenders;

- Transversal tenders bind hospitals to procure certain items via Head Office, even if it could be procured cheaper elsewhere;
- The prices of goods and services of BEE companies are often higher than what bigger established companies can offer. Economies of scale do not allow small BEE companies to compete with cheaper prices, nor do they have storage facilities to buy items in bulk. These factors limit their power to negotiate for better (cheaper) unit prices on items. Often BEE companies do not have enough capital to quickly grow and expand their business; and
- Swellendam is currently engaged in a Private-Public-Partnership (PPP) project. The hospital and Afrox - a petroleum and gas company – negotiated a partnership, whereby Afrox undertook to convert and equip one of their wards into a state-of-the-art men's ward for private use. It is a fifteen year agreement with benefits to both parties. Afrox will help the hospital to replace their theatre equipment where necessary. The two parties will share the theatre and kitchen facilities. Agreement has also been reached that should Swellendam hospital need beds, it will be allowed to utilise the beds in the private ward at normal public hospital rates.

5.4 Conclusion

The WCHD has a functional SCM directorate. Internal documentation has been developed to help with the institutionalisation of the SCM process. Despite staff vacancies at Head Office and the three hospitals, sincere dedication and commitment is detected in the staff's efforts to make the process work. With more training and functional ITC hospitals will be in a position to do justice to the SCM processes. Ongoing training and development of staff regarding the PFMA is necessary. With a full complement of approved posts institutions will eventually be in a position to beef up internal control measures.

CHAPTER 6

RECOMMENDATIONS AND CONCLUSION

6.1 Introduction

As mentioned in a Chapter 3, SCM as a decentralised function was only introduced in January 2004 into the provincial departments. Officials in the WCHD concede that the provisioning process will be refined as it gets implemented. The PFMA has been implemented in April 2001 and has been in operation now for almost four financial years. BEE as an empowerment vehicle/strategy is also a relatively new concept in SA. The author will attempt to suggest recommendations that will mainly fall into two categories, viz. those recommendations applicable to financial management and those applicable to supply chain management and BEE.

6.2 Recommendations regarding financial management

Based on the findings reported in Chapter 5, the author wants to make the following recommendations in regard to financial management:

6.2.1 The WCHD must continue to invest in the training and development of administrative staff regarding PFMA requirements, Treasury Regulations and BAS. Ongoing focussed training will assist to improve the effectiveness and efficiency of financial management procedures.

6.2.2 The WCHD and hospitals should accelerate the filling of key vacancies. The lack of internal checking, control and monitoring processes, as pointed out by audit reports, can be largely ascribed to

the non-filling of vacancies. If the filling of vacancies is governed by available budget, then management will have to take conscious priority decisions around those factors that will eventually contribute to efficiency in the workplace.

6.2.3 More concerted efforts must be made to assist some hospitals in their preparation of audited annual financial statements. This assistance from Head Office can simultaneously be used as a monitoring mechanism to assess financial management progress in such hospitals.

6.2.4 BAS should be rolled out as speedily as possible. BAS will put hospitals in a better position to comply with the PFMA and Treasury Regulations. BAS will enable hospitals to manage and report on their assets and liabilities as prescribed by Section 38(1)(d) of the PFMA.

6.2.5 In order to ensure effectiveness, efficiency and economy of the expenditure of public funds, at least one performance audit in the Health Department per annum needs to be commissioned. In this way the “value for money” principle can be tested. These performance audits should clearly spell out what corrective measures should be taken to ensure “value for money” spending in the WCHD. Performance management is concerned with measuring, monitoring and evaluating performance, and then initiating steps to improve performance where this is warranted (Abedian, Strachan & Ajam, 1998: 81). They further contemplate that a mixture of financial and non-financial measures are appropriate to measure the complexity of the public health services – health status, patient recovery rates and patient satisfaction are as important as cash figures.

6.2.6 The nature (socially and economically) of the drainage area of a hospital should become an important factor in the determination of the budget allocation to public hospitals. Hospitals servicing a drainage area comprising of historically disadvantaged communities – where poverty and unemployment is rampant - find it difficult to collect outstanding patient fees. Such hospitals must receive a more favourable budget allocation. Even the level of the target fee for collection of outstanding hospital fees at such hospitals should therefore be reasonably attainable.

6.2.7 The general public must be educated about public hospital services – the types of services available, the costs of services, the payment structures, etc. A well-informed patient can assist hospital officials with a quicker and more effective processing of certain information when visiting a public hospital. This education process can happen via the distribution of pamphlets and through media advertisements (radio, community newspapers and television). Well-informed patients can also help to relieve the frustration and stress that both officials and patients experience when patients report for health care services.

6.2.8 Hospital officials should be given a mechanism to establish the financial position of patients. This mechanism could assist in preventing middle income and affluent patients from utilising hospital services free of charge. Such mechanism could even include a physical visit to the home of the patient or assessing the financial ability of a “doubtful” patient. Spot checks should be made to ascertain whether addresses given to hospitals are indeed correct. A correct address assists to improve the fee collection process.

6.2.9 The Health Department should re-evaluate the fee structures at public hospitals. Although the collection of outstanding fees is necessary and important, cognisance should be taken that it is a time-consuming job. Hence the question: Can the person power that is currently used to deal with fee collection not be deployed usefully elsewhere in the hospital? A balance should be sought between the amount of fees that is collectable and the utilisation of the person power needed to collect such monies.

6.2.10 Fees charged for medical aid patients, who use the services of public hospitals, should be made more competitive in comparison to the fees at private hospitals. According to Ms Louw (personal interview, 27 July 2004), an operation that is regarded as one procedure in a private hospital is often split into two or three procedures in a public hospital, which often results that medical aid patients pay more for the same operation in a public hospital than in a private one. Fees charged for operations are costed at the amount of procedures during the operation. Competitive fee structures for medical aid patients may contribute to an increase in private patient usage of public hospitals. This could help to improve fee collection at public hospitals. It must be added that the services that public hospitals render should accordingly compete with those in private hospitals.

6.3 Recommendations for Supply Chain Management and BEE

Every effort is made by the SCM unit at Head Office and Procurement Teams at hospitals to execute their mandate as effectively and efficiently possible. The procurement and provisioning processes will hopefully be refined as its implementation is rolled out. It will take time before the benefits and results of BEE will become visible. The need for reliable mechanisms to evaluate and monitor the effectiveness and efficiency of BEE companies is of cardinal

importance. The following recommendations could help hospitals in specific and the department in general to achieve its BEE objectives via SCM:

6.3.1 The transversal tender process at Head Office needs to be re-evaluated. Responses recorded during interviews proved that certain items, e.g. Doom (insect repellent) can be procured cheaper locally by the hospital then by making use of the transversal tender process (see Table 14, p. 96).

Table 14: Price difference between transversal tenders and local providers

Item	Transversal tender price. It is fixed and hospitals must use the tender for the specific item.	Local price for which the hospital can buy the item	Price difference
Doom	R19.95	R10.95 (Pick & Pay)	R9.00

Head Office is in a position to secure better prices on tender items than individual hospitals. Head Office should use economies of scale to force down tender prices. If Head Office cannot secure better prices, then hospitals should be given the right to procure the specific tender items from other approved suppliers and on condition that such items are South African Bureau of Standards (SABS) approved. Hospitals' budgets are cut to the bone and they should be allowed space to negotiate better prices that will enable them to stretch their budgets.

6.3.2 Access to TradeWorld, especially for small PDIs and HDIs should be revised. The affiliation fee of R540 per month, including other criteria that are being used, currently excludes most of the PDIs or HDIs from government tenders in general. The current system benefits the bigger BEE companies more and the broader BEE objectives will be missed if the

large number of smaller BEE companies is excluded. The current situation could result in a skewed and unintended outcome of BEE. Tony Erhenreich, Western Cape Secretary of COSATU (e-TV, 8 November 2004), referred to the current moral dilemma of BEE during an interview with Judge Dennis Davis on the programme “Judge for Yourself”. According to Erhenreich, only certain Blacks (who normally have good political credentials or influence/contact) benefit from BEE, whilst the living circumstances of the majority potential beneficiaries of BEE are still appalling. He further suggested the necessity of a policy intervention to correct the above-mentioned phenomenon.

6.3.3 The WCHD must take care not to define and apply BEE too narrowly by limiting it to a set of transactions transferring corporate assets from white to black ownership. BEE, as defined and intended by government, must be understood as a coherent and integrated socio-economic process that directly contributes to the economic transformation of SA and brings about significant increases in the numbers of black people that manage, own and control the country's economy, as well as significant decreases in income inequalities (Buthelezi, 2003).

The BEE process must include elements of human resource development, preferential procurement, as well as investment, ownership and control of enterprises and economic assets. More so, BEE must, as its eventual goal, translate into the transformation of the socio-economic landscape of the disadvantaged and the destitute of the SA society.

6.3.4 BEE companies should receive adequate education and training about state procurement and provisioning policies, systems, and processes. Support must be provided to guide BEE companies, especially with the first few tender applications. BEE companies should also be educated that the process of BEE is not intended to be a “quick rich”

scheme. Rather, that it is intended to be a process of real empowerment and should serve as a mechanism for people of colour to get into the economy in order to help transform the face of the SA economy, to add value to the broader South African economy and to help with the social upliftment of all citizens. BEE companies need to learn to share the new wealth that they are creating. The Western Cape MEC for Finance and Economic Development, Lynne Brown, recently indicated that contracts to the value of R4 billion are awarded to companies and individuals annually. Forty percent (40%) of these contracts must be awarded to broad-based black economic empowerment companies (Essop, 2004b: 8).

6.3.5 Stringent application of legislation and regulations is necessary to prevent “fronting” and the accompanying exploitation of black people. If any company acquires a tender on a fraudulent basis, then the penalties as stipulated in section 15 (Preferential Procurement Regulations, 2001) must be invoked. Essop (2004b: 8) reports that Lynne Brown, Western Cape MEC for Finance and Economic Development, warned business companies that they would be dealt with harshly if found guilty of “fronting”. She said that “fronting ... does not allow us to transform the economy, and keeps the economy in the hands of a few.” Brown further suggested that a unit must be created for the Western Cape to monitor and investigate companies suspected of ‘fronting’. Such a step would, however, necessitate policy and legislative changes that could take up to two years to complete.

6.3.6 A study needs to be conducted amongst BEE companies to establish the following information:

- Adherence to the BEE Act by big companies and businesses;
- Experiences of real economic empowerment;
- The nature of such economic empowerment (quantified in terms of value);

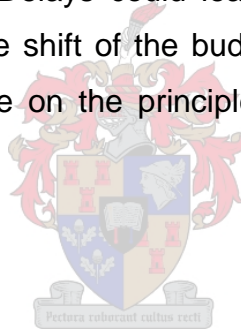
- An evaluation of continuous government support and guidance in the establishment of BEE companies;
- Expansion of BEE companies – the extent thereof;
- An assessment of the cash flow situation of BEE companies;
- The number of complaints lodged against the delivery of goods and services to health institutions, as well as the implications of the non-delivery;
- A determination of the overall growth of BEE companies; and
- An assessment of the difficulties and challenges experienced in the procurement process.

The information gathered through this survey could be useful in the development of a governance model that would assist in dealing with the procurement and provisioning processes, as well as the realisation of BEE objectives.

6.3.7 The Health Department must develop a highly effective cadre of officials in the SCM directorate. They should be knowledgeable about SCM, the legislative framework of BEE and should also comply with the criteria as contained in Section 3.6.6 of the Policy Strategy to Guide Uniformity in Procurement Reform Processes in Government (2003: 34). These officials must be subjected to regular ongoing training and development.

6.3.8 A risk management plan for procurement and provisioning must be drafted and distributed to all hospitals. This risk management plan will serve as a guiding and preventative management tool to assist hospital officials in administering procurement and provisioning tenders in hospitals.

6.3.9 The WCHD should be allowed to manage its own budget for maintenance work and building programmes. This budget currently lies with the Department of Transport and Public Works (DTPW). It is a contradicting phenomenon that the Health Department is held accountable for the delivery of the budget, whilst the budget and the execution thereof lie with DTPW. The WCHD should be granted the space to outsource its maintenance and building projects – even to the Department of Transport and Public Works. The Annual Reports make reference to projects that were planned and budgeted for, but were not completed as scheduled. The non-compliance of delivery dates of maintenance and building projects could possibly have financial implications, because building material increases at a rapid year-on-year basis. Delays could lead to an escalation on original budgeted prices. The shift of the budget from the DTPW to WCHD will assist to improve on the principles of effectiveness, efficiency, economy and equity.



6.4 Conclusion

The financial budget of the Health Department in the province, in comparison to other provinces, is relatively well-managed. Taking cognisance of all the pressing needs in the department, it will take some time before the financial position of the department stabilises. The filling of key vacancies will assist in addressing the concerns about the lack of internal control measures. The gradual role-out of information and technology communication should contribute to enhanced effectiveness, efficiency and economy in terms of financial processes.

BEE, as a vehicle within the context of supply chain management, is relatively new and in its infant stages. There is no doubt about the potential future for BEE companies through public procurement and provisioning. Stability in

SCM processes, the development of an effective and efficient governance model for SCM, coupled with well trained staff, a risk management plan, an efficient internal audit unit and the implementation of effective monitoring mechanisms, can form a good foundation to assist with the realisation of BEE objectives as spelt out in paragraph 3.4 (p. 44).

BEE will not change the outcomes of health care services directly. BEE will eventually contribute to meeting government's visualised outcomes, e.g. empowerment, equity and "a better life for all". BEE, as a vehicle to contribute to empowerment and equity within the SCM processes, are still in its infant stages. It is thus difficult at this point in the history of BEE to substantiate the gains or losses of BEE in relation to SCM. The continuous monitoring and measuring of these outcomes is important. Processes will have to be put in place which would enable the WCHD, and government in general, to measure the quality of life of citizens in society.



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<p style="text-align: center;">APPENDIX 1</p> <p style="text-align: center;">INTERVIEW WITH THE DIRECTOR: SUPPLY CHAIN MANAGEMENT AT HEAD OFFICE.</p>

1. What is your name?
2. What does your work entail?
3. What is the structure of the SCM unit at Head Office?
4. What is your staffing situation in the directorate?
5. Does the department have a procurement and provisioning policy?
6. What is a transversal tender? Why are hospitals compelled to use transversal tenders secured by your unit?
7. Are you satisfied with the use of LOGIS in the provisioning and procurement process?
8. What is the importance of TradeWorld in the provisioning and procurement processes?
9. How do you monitor the application of BEE within the PPPFA?
10. Are suppliers of goods and services paid on time as stipulated by Treasury Regulations?

<p style="text-align: center;">APPENDIX 2</p> <p style="text-align: center;">QUESTIONNAIRE FOR THE INTERVIEW WITH THE SUPERINTENDENT AND HEADS OF FINANCE AT THE RESPECTIVE HOSPITALS</p>

(NB. This questionnaire will be used in one-on-one interviews with the superintendent and Heads of the Finance departments at hospitals.)

1. What is your name?
2. What is your designation at the hospital?
3. Are you comfortable that I can mention your name in the research?
4. What is your view on the annual budget allocation to this hospital?
5. What is your function in the management of the annual budget of the hospital?
6. Is there enough skilled and capable staff in this institution to deal with the budget?
7. If yes, why do you say so? If not, why not and what is being done in the hospital/ Western Cape Health Department to remedy the situation?
8. Are you happy with the way in which the PFMA has been implemented in the hospital?
9. What are the difficulties that you have experienced with the implementation of the PFMA?
10. What is the current situation with hospital fee collection?
11. Are you comfortable with your hospital fee collection target as set by the WCHD?
12. Have you appointed an agency to help with hospital fee collection? If so, explain?
13. What other difficulties are you experiencing in general with service delivery at state hospitals?

APPENDIX 3

QUESTIONNAIRE FOR FOCUS GROUP INTERVIEW:

STAFF IN THE RESPECTIVE FINANCE

DEPARTMENTS OF PUBLIC HOSPITALS

(NB. This questionnaire will be used in focus group interviews with the respective staffs in the Finance departments of hospitals)

1. Are you comfortable that I can mention your names in the research?
2. What is your view on the annual budget allocation to this hospital?
3. What is your function in the management of the annual budget of the hospital?
4. Is there enough skilled and capable staff in this institution to deal with the budget?
5. If yes, why do you say so? If not, why not and what is being done at the hospital to remedy the situation?
6. Are you happy with the way in which the PFMA has been implemented in the hospital? If so, why; if not, why not?
7. What is the situation at the hospital with fee collection?
8. Are you comfortable with your hospital fee collection target as set by the Western Cape Health department?
9. What are the average outstanding hospital fees at the hospital?
10. Have you appointed an agency to help with hospital fee collection? If so, explain?
11. Are you happy with the internal control measures in the hospital? If so, why; if not, why not?

APPENDIX 4

QUESTIONNAIRE FOR FOCUS GROUP INTERVIEW: PROCUREMENT AND PROVISIONING STAFF

(NB. This questionnaire is to be used in the focus group interview with the staff that is responsible for procurement and provisioning at each hospital)

1. Are you comfortable that I mention your names in the research?
2. Do you manage your own procurement in the hospital?
3. Do you have one person or a team of people responsible for procurement of services in the hospital?
4. Can you name the types of procurement that you manage at this level?
5. What are the problems/risks that you are experiencing with suppliers?
6. How do you go about in addressing these problems/risks?
7. If you are not managing your own procurement, who is doing it?
8. Are you happy with this arrangement (in 6) that procurement of services happens at another place?
9. If you are not currently responsible for your own procurement, would you love to be in charge of this function and why?
10. What is your understanding of BEE and the PPPFA?
11. What percentage of procurement goes to Black Economic Empowerment (BEE) companies?
12. Are there specific problems that you experience in the delivery of goods or services by BEE companies?
13. Are you happy with the delegation of powers (regarding finances) that you have?
14. What are the problems that you have picked up with the procurement of goods and services from Black Economic Empowerment (BEE) companies and how do you go about to resolve them?

APPENDIX 5

RESPONSES RECEIVED FROM THE HEALTH DEPARTMENT AND HOSPITALS ON OPEN QUESTIONNAIRE

Western Cape Health Department

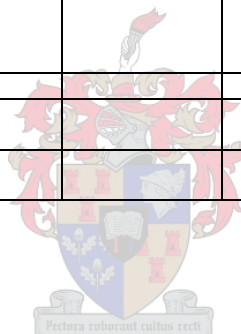
Item	Financial years					
	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03
Annual Budget	2,473,664,000	2,901,470,000	3,006,779,000	3,322,532,000	3,535,037,000	3,741,094,000
Adj. Estimates	444,127,000	118,528,000	66,109,000	68,692,000	43,730,000	130,542,000
Final Annual Budget	2,917,791,000	3,019,998,000	3,072,888,000	3,391,224,000	3,578,767,000	3,871,636,000
% Increase	17,95	4,09	2,20	2,07	1,24	3,49
Audit Report						
Qualified	X	X				
Unqualified			X	X	X	X
Any unauthorised spending (Y/N)	N	Y	Y	N	Y	-
If yes, nature of unauthorised spending						
Quantum of unauthorised spending						
Underspending						
Quantum	11,402,000			24,535,000		
Reasons for underspending	Saving mainly due to non-filling of vacant posts and the granting of VSPs, as well as down scaling of support services.			Savings mainly due to the non-filling of vacant posts, the non submission of government printer and IT claims, delays in delivering of medical equipment as a result of tender procedures. Lowe student intake and amalgamation of nursing colleges, cabling contract at college not completed.		

Overspending						
Quantum		3,863,000	33,817,000		2,250,000	3,962,000
Reasons for overspending		Overspending mainly due to filling of vacant posts of medical staff to create a more accessible secondary health service on a lower level than tertiary services where such a service as a result of personnel shortage cannot be rendered by the Department.	Overspending mainly due to price increase on medicine, increased medical stores to LA clinics and stock piling in readiness for Y2K contingency.		Overspending mainly due to increased patient loads, devaluation of the rand with increased inflation on medical and surgical sundries and pharmaceuticals in general.	Overspending mainly due to increased patient loads, devaluation of the rand with increased inflation on medical and surgical sundries and pharmaceuticals in general, as well as the utilisation of agency staff as a result of the moratorium on the filling of posts.
Fruitless and wasteful expenditure						
Quantum						
Reasons for fruitless and wasteful expenditure						
Staffing						
Number of funded posts						
Number of posts filled	26 988	24 661	24 013	24 224	24 987	24 003
Number of super-numery posts	3	295	13	0	0	0
Number of vacant posts	4 775	6 945	7 128	7 409	6 972	7 408
Procurement						
Quantum of procurement	957,980,000	1,020,978,000	1,009,435,000	1,263,303,000	1,315,809,000	1,420,962,000
As % of Budget	32,83	33,81	35,78	37,25	36,76	36,70
Hospital fees						
Amount outstanding						
Debt collection mechanism						

Karl Bremer Hospital

Item	Financial years					
	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03
Budget received	41,178,000	43,222,000	45,413,514	53,363,782	66,323,438	69,496,438
Budget spent	42,205,014	43,137,791	45,429,214	48,562,344	63,880,000	70,475,000
Overspending (Y/N)	Y	N	Y	N	N	Y
If Y, quantum?	1,027,014		15,700			987,562
If Y, Reasons?	Budget split between Karl Bremer Hospital and Karl Bremer Rehab Centre not correct. The over-expenditure of Karl Bremer Hospital was offset against an under-expenditure of R1,100,000 at Karl Bremer Rehab Centre.		Karl Bremer became a Trading Account w.e.f. 01.04.1999 and any deficit/surplus was carried forward to the next financial year.			A deficit on the Trading Account as a result of the weak Rand resulting in price increases in medicine and equipment.
Underspending (Y/N)	N	Y	N	Y	Y	N
If Y, quantum?				4,801,438	2,443,438	
If Y, reasons?				Surplus carried forward to next financial year.	An actual deficit for the year as a result of the weak Rand and the increase in medicine prices. However, as a result of the carried over surplus of the 2000/01 financial year there was still a Trade surplus of R2,443,438 to be carried over into the 2002/03 financial year.	
Unauthorised spending (Y/N)						
If yes, nature of unauthorised spending						
Quantum of unauthorised spending						

Staffing						
Number of funded posts						
Number of posts filled	555	504	509	522	626	565
Number of super-numery posts						
Number of vacant posts	48	104	108	263	171	163
Reasons for vacant posts						
Number of temporary posts	3	3	3	6	7	6
Procurement						
Budget % for procurement	23,57	22,77	25,11	22,24	27,63	28,96
Number of tenders awarded						
Nature and value of each tender						
Number of BEE tenders						
Rand-value of BEE tenders						
Problems experienced with suppliers						
Hospital fees						
Amount outstanding						
Debt collection mechanism						



Swellendam Hospital

Item	Financial years					
	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03
Budget received	4,512,000	5,429,000	5,367,000	6,792,000	7,149,000	7,554,000
Budget spent	5,368,928	5,626,245	5,788,088	6,749,228	7,172,163	7,621,446
Overspending (Y/N)	Y	Y	Y	N	Y	Y
If Y, quantum?	856,928	197,245	421,088		23,163	67,446
If Y, Reasons?	Personnel Admin Stores Prof & Spec	Personnel Admin Prof & Spec	Personnel Admin Stores Prof & Spec		Admin Prof & Spec	Personnel Admin Prof & Spec
Underspending (Y/N)	N	N	N	Y	N	N
If Y, quantum?				42,712		
If Y, reasons?				Personnel Equipment		
Unauthorised spending (Y/N)						
If yes, nature of unauthorised spending						
Quantum of unauthorised spending						
Staffing						
Number of funded posts						
Number of posts filled	64	59	64	65	64	62
Number of super-numery posts						
Number of vacant posts	4	7	5	3	5	8
Reasons for vacant posts						
Number of temporary posts	3	3	3	3	5	5
Procurement						
Budget % for procurement	25,49	25,57	26,68	24,25	24,59	24,36
Number of tenders awarded						
Nature and value of each tender						
Number of BEE tenders						
Rand-value of BEE tenders						
Problems experienced with suppliers						
Hospital fees						
Amount outstanding						
Debt collection mechanism						

Lentegueur Hospital

Item	Financial years					
	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03
Budget received	73,359,000	71,490,000	73,390,000	80,239,000	83,727,000	85,588,000
Budget spent	75,553,242	73,425,821	71,919,597	77,156,503	83,066,696	87,409,570
Overspending (Y/N)	Y	Y	N	N	N	Y
If Y, quantum?	194,242	1,935,821				1,821,570
If Y, Reasons?	Personnel	Personnel Admin Prof & Spec				Personnel Admin Prof & Spec
Underspending (Y/N)	N	N	Y	Y	Y	N
If Y, quantum?			1,470,403	3,082,497	660,304	
If Y, reasons?			Personnel Prof & Spec	Personnel Admin Stores Equipment Prof & Spec	Personnel Stores	
Unauthorised spending (Y/N)						
If yes, nature of unauthorised spending						
Quantum of unauthorised spending						
Staffing						
Number of funded posts						
Number of posts filled	967	841	786	784	800	759
Number of super-numery posts						
Number of vacant posts	105	233	194	45	60	102
Reasons for vacant posts						
Number of temporary posts	2	2	2	3	2	3
Procurement						
Budget % for procurement	24,89	22,20	21,35	23,26	21,92	25,93
Number of tenders awarded						
Nature and value of each tender						
Number of BEE tenders						
Rand-value of BEE tenders						
Problems experienced with suppliers						
Hospital fees						
Amount outstanding						
Debt collection mechanism						