



Managing Finances at Johannesburg Hospital

It was approaching the middle of the 2006/07 financial year. The Johannesburg Hospital finance director, Gumani Matodzi, had just completed another weekly run of the hospital's top 20 goods and services expenses. As always, National Health Laboratory Services (NHLS) expenses were at the top of the list and yet again they were over budget. The demands of the Public Finance Management Act (no 1 of 1999) (PFMA) made it important to ensure that the hospital did its best to stay within its budget, and Matodzi wondered how he could better manage NHLS expenditure.

Background on the SA Health Sector

In comparison with other middle income countries, South Africa spent a relatively high proportion of gross domestic product on health care. (See **Exhibit 1** for comparative figures of countries such as Botswana, Brazil, Mexico and Turkey.) Despite this, the country's health status ranked poorly in comparison with other similar countries that spent the same or less. (For example, in 2002, the human development index in Botswana, Brazil, Mexico and Turkey was higher than in South Africa.)¹

Responsibility for healthcare provision fell largely to the public sector, which had to serve about 84% of the population. Yet private sector health expenditure was higher than that of the public sector. For example, private sector health expenditure accounted for 59% of total health expenditure, and that of the public sector, only 41% in 2004.²

Provincial health departments were responsible for delivering public health services. These departments allocated budgets to the public health care facilities within their jurisdiction. In addition there were specific-purpose, conditional grants from the national budget for things like tertiary³ services and HIV/Aids.

In 2005, this public health sector was a product both of the system that the democratically elected government had inherited when it took power in 1994 and the reforms it had instituted to try to improve the system. The new government had inherited a fragmented, racially-segregated health system with inequitable distribution of health resources⁴, an emphasis on

¹ N Leon and R Mabope, 'The Private Health Sector', in *South African Health Review 2005*, available www.hst.org.za, South African Health Review link (accessed 22 November 2005).

² *Ibid.*

³ Tertiary services referred to teaching services offered by certain hospitals for the training of doctors and nurses.

⁴ Speech by the Minister of Health at the Official Opening of Colesberg Hospital Colesberg, Northern Cape, 1 April 2004, available www.doh.gov.za, speeches link (accessed 22 November 2005).

This case was prepared by research associate, Claire Gordon-Brown, with Dr Debashis Basu. The case is not intended to demonstrate effective or ineffective handling of an administrative situation. It is intended for classroom discussion only.

curative and hospital-based care and a neglect of preventative and primary health care (PHC).⁵ The *South African Health Review* described South Africa's health system in the 1990s as "a bureaucratic entanglement of racially and ethnically fragmented services; wasteful, inefficient and neglectful of the health of more than two thirds of the population."⁶

The first challenge that the new government identified was to move from a hospital-based system to a PHC system. The aim was to create a district health system based on PHC services (with clinics that would be more accessible to the population as a whole) and an effective referral system to secondary and tertiary services where necessary. In the process, the government wanted to move away from large hospitals as the primary place for healthcare provision towards PHC clinics fulfilling this role.⁷

In reality, however, the load on hospitals had not decreased. If anything, it had increased. By 2005, the national Department of Health had built 1 300 new primary health care clinics, but the dean of the Wits Medical School, Dr Max Price, remarked that because health problems were now being discovered that had previously been hidden, the load on hospitals had increased. In addition, patients still preferred to use larger hospitals. They trusted hospital staff more than clinic staff, and often basic services such as water were not continuously available at clinics.⁸

To give effect to its policy of improving the focus on primary health care, the NDoH had decided that there should be minimal growth in the budget for tertiary hospital services, slow growth for provincial and district hospitals and significant growth in PHC expenditure until PHC constituted 26% of the annual budget. Hospital budgets had therefore remained largely static in real terms since the institution of this new policy.⁹

Background on South African Public Health Finance

Public health specialist, Nicholas Crisp, had been scathing in his assessment of hospital budgeting in the apartheid era. "Until 1994, the health departments in South Africa never once came in on budget," he said. "A budget was a piece of paper and Chris Barnard was doing heart transplants. We were world famous... Nobody asked, 'Is this worth it, has it been budgeted, what are we getting from it?'"¹⁰

This changed in 1999 when the government introduced the PFMA. The PFMA's objective was to modernise financial management in public institutions and to enhance financial accountability in these institutions. The preamble of the Act stated that its purpose was "to regulate financial management in the national government and provincial governments; to ensure that all revenue, expenditure, assets and liabilities of those governments are managed efficiently and effectively, to provide for the responsibilities of persons entrusted with financial management in those governments; and to provide for matters connected therewith."¹¹

The Act applied to all national and provincial government institutions and departments, as well as to public entities under their ownership control. It held the accounting authority in public institutions accountable for managing the budget of that institution and for preventing any "wasteful" or "fruitless" expenditure in that institution. It made provision for anyone in a management position in a public entity to be regarded as an accounting officer. (See **Exhibit 2** for excerpts from the Act on the responsibilities of an accounting officer.) It provided, in the

⁵ T Murray and Prof G Stockport, *Johannesburg Hospital: Of Oaths and Opportunity Costs*, Wits Business School, WBS 2004-15.

⁶ HC van Rensburg, D Harrison, 'History of Health Policy', *South African Health Review 1995*, available www.hst.org.za/sahr (accessed 7 April 2004).

⁷ T Murray and Prof G Stockport, *op cit*.

⁸ J Pile, 'Hospitals: A Faltering Pulse', in *Financial Mail*, 21 October 2005.

⁹ T Murray and Prof G Stockport, *op cit*.

¹⁰ Interview by Tessar Murray with Nicholas Crisp, 27 May 2004.

¹¹ Public Finance Management Act No. 1 of 1999, p.1.

most extreme cases, for criminal prosecution of an accounting officer that willfully or in gross negligence did not comply with the provisions of the Act (see **Exhibit 3**).

Researchers worldwide had noted that reform and restructuring of health systems tended to focus on financing and accountability and not on the impact these changes would have on the staff having to implement them. According to researchers from the Centre of Health Policy at the University of the Witwatersrand, Loveday Penn-Kekana, Duane Blaauw and Helen Schneider, the situation in South Africa was no exception. Their study found that the PFMA had had the unintended consequence of causing the quality of maternal health services to deteriorate in the maternity wards that they studied.¹²

They cited one example of a rural hospital which used to admit women who came to the hospital at 40 weeks pregnant or more, even if they were not in labour. This was because the nurses knew that many patients in labour struggled to get to the hospital in time, because of the distance and cost of travel. The Department of Health also had a policy that all women should deliver their babies in medical institutions. With the introduction of the PFMA, however, the hospital was worried about overspending its budget, and decided to send away women who were not in active labour. The result, for one 17-year-old who came to the hospital complaining of pains but showing no signs of labour, was the inter-uterine death of her baby. Her waters had broken soon after she got home, but her grandmother had refused to give her money to go back to the hospital for fear that she would get sent home again. The matron of the hospital reported that they had not had any choice in the matter: that if the hospital management committee did not cut its budget, they could end up in jail.¹³

A further change that the new government set about realising was that of making the provincial health budgets more equitable. In the past, there had been large disparities in the per capita budget allocated to the various provinces, with Gauteng and the Western Cape receiving disproportionately more than the other provinces. In real terms this meant that per capita expenditure on public health in Gauteng, of which province Johannesburg Hospital formed a part, had dropped since 1995/96. Nevertheless, it still remained higher than in most other provinces; the only other province with a higher per capita expenditure being the Western Cape.¹⁴

Background on Johannesburg Hospital

Johannesburg Hospital's vision was, "Health for a better life for all the citizens of Gauteng Province".¹⁵ Its stated mission was to provide, promote and maintain a holistic health care service to the Gauteng community by implementing the principles of Batho Pele "People First", by engaging in dynamic leadership and appropriate community interaction, and by sharing responsibility for and information regarding health care maintenance. It aimed to use its allocated human and material resources cost effectively to provide a holistic service.¹⁶

The hospital was designated as a central hospital. It had 974 beds and served patients from across Gauteng and neighbouring provinces. It offered inpatient and specialist outpatient services – mainly at level 3 and level 2, although 20% of the services were rendered at level 1. It had outsourced the provision of level 1 services, because the outsource partner could provide these services more efficiently and cost-effectively than the hospital could.¹⁷ (See **Exhibit 4** for

¹² L Penn-Kekana, D Blaauw and H Schneider, 'It makes me want to run away to Saudi Arabia': management and implementation challenges for public financing reforms from a maternity ward perspective' in Health Policy and Planning, vol 19 (supplement 1).

¹³ *Ibid.*

¹⁴ C Day and A Gray, 'Health and Related Indicators', in *South African Health Review 2005*, available www.hst.org.za, South African Health Review link (accessed 22 November 2005).

¹⁵ www.johannesburghospital.org.za, about us link (accessed 13 May 2006).

¹⁶ *Ibid.*

¹⁷ Interview with Professor Jeff Wing, head of the department of medicine at Johannesburg Hospital, 7 June 2006.

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a list of the clinical and other departments in the hospital.) It was also the main teaching hospital for the University of the Witwatersrand's faculty of health sciences, providing the service base for under-graduate and post-graduate training in all health professions.

The hospital employed more than 4 000 professional and support staff and was headed up by Sagi Pillay. His immediate reports included Matodzi, the human resources and logistics director, the information technology deputy director and the clinical director. Four clinical executives reported to the clinical director and, in turn, they were responsible for overseeing the administrative activities of the clinical departments within their portfolio. (See **Exhibit 5** for a hospital organogram.)¹⁸

Clinical executives (termed medical managers in some other public health institutions) had to apply for their posts, and were mostly qualified general practitioners who wished to diversify into management. (See **Exhibit 6** for a job description of a clinical executive.) The heads of clinical department were specialists in their field, who applied for these positions with the understanding that 70% of their time would be spent between clinical and administrative activities at the hospital and the remaining 30% with teaching activities at the medical school. They had to work 65 hours a week at the hospital and could spend the rest of their time in private practice.

Originating from the old General Hospital in Hillbrow, Johannesburg Hospital had been built as a flagship facility of the Transvaal Provincial Administration in 1979. Initially, it had served the white community as both a community hospital and a referral hospital for patients needing specialised care.¹⁹ However, racial integration and the transition to democracy brought about significant changes, as desegregation, together with the hospital's reputation for offering specialist and high-quality care and the disparity in health services across provinces, led to a massive increase in patient numbers.

Before 1990, for example, 2 000 babies were born each year at Johannesburg Hospital.²⁰ Babies born at the clinic at Alexandra Clinic in the north of Johannesburg who needed medical attention were sent to Chris Hani Baragwanath hospital in Soweto. By 2004, however, more than 10 000 babies were being born in Johannesburg Hospital and it was handling all of the problems experienced at Alexandra. At the same time, the number of staff in the hospital had not increased.²¹ Professor Jeff Wing, the head of the hospital's department of medicine, noted that the number of beds in the level 1 in-patient facility had increased from 90 a few years previously to 200 by 2006. His entire department was seeing 13 000 patients per month.²²

Finances at Johannesburg Hospital²³

Matodzi had been finance director of Johannesburg Hospital since November 2003. Prior to this, he had held the same position at Chris Hani Baragwanath Hospital.

The hospital's funding came from the Gauteng provincial government and a tertiary services grant from national government. Its initial 2006/2007 budget allocation amounted to R860 million. This was actually a decrease on what it was finally allocated the previous year. Prior to this, the hospital's budget had increased by more than the rate of inflation for two years running – by almost 13% in 2005 and almost 16% in 2004 (see **Exhibit 7**). In the 2005/06 financial

¹⁸ www.johannesburghospital.org.za, about us link (accessed 13 May 2006).

¹⁹ J Myburgh, 'Johannesburg Hospital Nursing Services: A Case Study', Graduate School of Business Administration, Public and Development Management Programme, University of the Witwatersrand, September 1991.

²⁰ Interview with Peter Cooper, 24 May 2004.

²¹ *Ibid.*

²² Interview with Prof Jeff Wing, 7 June 2006.

²³ Unless otherwise specified, the information in this section comes from an interview with Gumani Matodzi on 15 May 2006.

year, the hospital had come in at a little more than 1% over its budget – not as good as the previous financial year, when it had come in 1% under budget, but an improvement on the two years before that, when expenses had been over budget by close to 10% and 6% respectively.

For Matodzi, the budget process involved two main phases. First, by July of each year he had to put together a medium budget for the next three years. He had to work within certain percentage increase guidelines that the province gave him, and if he thought that these guidelines were unrealistic, he had to justify his thoughts. He based this budget on past expenditure trends and estimates of future expenditure, according to the number of patients that the hospital's management committee thought it would treat.

Normally, the province would not give as much as Matodzi asked for the first time around. However, at the review period in the middle of the financial year, the province was happy to allocate additional funds, provided that Matodzi could illustrate clearly why the hospital needed these funds.

Once the province approved the initial budget, Matodzi then asked the heads of department to put together budgets for their departments, bearing in mind the constraints of the budget that the province had approved. He hoped to use these budgets to allocate funds accurately to each department and also to provide an early warning to the province if it looked like the hospital would exceed its budget. (See **Exhibit 8** for some slides from his presentation.) The response from heads of department was slow to non-existent. He made the presentation to heads of department for the 2006/07 budget in December 2005, for example, but by May 2006, only two clinical heads of department had submitted budgets.

For their part, the clinical heads of department didn't give the overall budgeting process, both within the province and within the hospital, much credibility. Professor Ken Boffard, the head of the surgery department, described the budget as "completely artificial".²⁴ He said that the budget was allocated by the provincial department based on historical criteria, and that there were two problems with this approach: firstly the hospital was not allowed to turn away patients, but yet the budget made no provision for the hospital to get more money if it saw more patients than it had the previous year. Secondly, it was often difficult to send in-patients to lower-level facilities when they no longer required the expensive care of a tertiary facility, because these lower-level facilities had collapsed. "It doesn't take into account that a budget needs to be variable according to workload," he said.²⁵

Wing echoed Boffard's concerns. "The budget is a historical thumbsuck," he said. "A productive hospital will overspend its budget, because it will see more patients and cure more people. Any hospital that stays within its budget is not doing anything. To stay within budget, we would have to shrink the number of patients we see, which we can't do; or shrink our staff numbers, which we can't afford to do," he said. "The only way around it is for the funding to follow the patient. Let the hospitals earn their budget."²⁶

He added that in real terms the hospital budget had not increased over the past few years, but yet the load on the hospital had. Hillbrow hospital had shut down, so its patients now came to Johannesburg. The hospital was the only tertiary referral hospital in Gauteng that provided sophisticated tertiary services, such as oncology, cardiac surgery and haemophilia treatment. As a result, it provided more complex and expensive surgery. The range of level 3 services on offer had increased as technology had improved, but this meant that there was a comensurate increase in the costs to the hospital. Added to this was the fact that the primary healthcare load on the hospital had not diminished.²⁷

²⁴ Interview with Professor Ken Boffard, 7 June 2006.

²⁵ *Ibid.*

²⁶ Interview with Professor Jeff Wing, 7 June 2006.

²⁷ *Ibid.*

Internally, Boffard believed that the budgeting process lacked transparency. “We get told what the province has allocated to us and then we are asked to come up with what we need within that. When we do this, they simply change things without letting us know,” he said.²⁸ He gave an example of the purchase of a gastroscope, which was initially approved. He got the lightbox, he got the gastroscope, but without consultation, the expenditure on the fibre optic cable that connected the two was suddenly not approved.

The result, noted Wing, was that the heads of department simply paid lip service to the budget and to trying to stay within it. “It’s a meaningless exercise,” he said, “and it’s not worth the unnecessary anguish of trying to meet it.”²⁹

For his part, because Matodzi didn’t get much input from heads of department, he simply split the overall budget between the various departments based on historical figures, and he said, “dealt with the management issues later.”

The NHLS Budget

This lack of input from the clinical heads was one of the reasons that Matodzi found it difficult to manage the NHLS budget. The SAP system that the hospital had installed provided Matodzi with sufficiently reliable information on the institution’s expenses. Each week, using figures from this system, he compiled a list of the top 20 cost drivers in each department and gave them to the department heads. (See **Exhibit 9** for a list of the top 20 drivers in the hospital for the first three months of the 2006/07 financial year.) These 20 cost drivers accounted for more than 70% of Matodzi’s goods and services budget and he knew that controlling these costs would go a long way towards controlling overall goods and services costs. NHLS costs were always at the top of the list and always exceeded the allocated budget.

Budgeting for NHLS costs was a difficult process in itself, because the NHLS negotiated cost increases for the next financial year with the national government after Matodzi was required to submit his budget for that financial year, yet these cost increases impacted directly on the hospital’s expenditure every year. In fact, pointed out Boffard and Wing, the NHLS negotiated a fixed rate that it would receive from each institution and if the number of tests that Johannesburg Hospital conducted went down, the price of the tests would simply go up to ensure that the NHLS received what it had negotiated. They pointed out that this made trying to reduce NHLS expenditure a futile endeavour.³⁰

Boffard added that the departments were not asked how many tests they thought they would need and what their NHLS budget should be before the NHLS budget was decided. It was a budgeting process in which they were completely uninvolved. He said, however, that if asked, and although the information system in the hospital was not entirely accurate, he could at least give a ballpark figure, which might go some way towards making the budget more accurate.³¹

Another reason that NHLS expenditure was higher than necessary, was that the test results of patients who were transferred from other hospitals to Johannesburg Hospital did not transfer with them. As a consequence, these tests then had to be performed again. “The province has no integrated management information system,” said Wing, “so the three levels work in isolation. The result is that we have to reinvestigate patients at enormous cost.”³²

Matodzi had also noticed that the number of tests requested spiked shortly after an intake of new doctors. Because these doctors were inexperienced, they often requested tests that were not

²⁸ Interview with Professor Ken Boffard, 7 June 2006.

²⁹ Interview with Professor Jeff Wing, 7 June 2006.

³⁰ Interviews with Professor Ken Boffard and Professor Jeff Wing, 7 June 2006.

³¹ Interview with Professor Ken Boffard, 7 June 2006.

³² Interview with Professor Jeff Wing, 7 June 2006.

necessary. “They are new. They don’t know what’s needed and they don’t get proper orientation,” he said.

The real issue for Matodzi, however, was whether all of the tests were necessary. The hospital did not practice evidence-based medicine, in terms of the application of newer tests and technology to improve diagnosis and reduce costs. This meant that some tests might not be necessary. In addition, over the past few months, he had analysed NHLS expenditure for a number of patients and found that some appeared to have had too many tests. He was told that this was because the test results got lost.

Until very recently the process of requesting tests and receiving test results had been entirely manual, where the doctor had to take a written request for the tests to the laboratory and pick up a hard copy of the results from the laboratory. This was because the internal information system, Medicom was, in Boffard’s terms “a flop” and no-one used it.³³ The system, which has been installed in several hospitals in the province in 2000, had never worked effectively, added Wing.³⁴

A new electronic system had now been introduced in terms of which test results would be captured on the computer. Matodzi hoped that this would eliminate the problem of lost results and duplicated tests.

Despite the factors over which the hospital had no control, Matodzi believed that he had insufficient control over the aspects of the NHLS budget that he could manage. He needed accurate information to be able to justify over-expenditure to the province, and this required the assistance of the clinical heads. Unfortunately, this was generally not forthcoming. “Up until now, I have not had proper feedback from the professionals to say how they would deal with NHLS over-expenditure,” he said.

This made his task much more difficult. He had proposed that the issue should be discussed at an NHLS committee meeting. The NHLS committee had been formally constituted and was supposed to consist of the clinical director, the finance director and representatives from the clinical executives and heads of department, but Matodzi was not sure if it had met yet. He was nevertheless sure that NHLS expenditure would not have come up for discussion, because the committee’s purpose was to discuss clinical issues.

Conclusion

Matodzi looked up from the Excel spreadsheet that listed the hospitals top 20 goods and services expenses and wondered again how he could contain NHLS expenditure. In the end, he believed that there was more to the issue than simply trying to get the clinical heads to co-operate. “We are dealing with issues of change here,” he said. “When I say, ‘Let the Prof be in charge,’ the clinical executive might ask, ‘What do I remain with?’”

³³ Interview with Professor Ken Boffard, 7 June 2006.

³⁴ Interview with Professor Jeff Wing, 7 June 2006.

Exhibit 1 Health Expenditure as a Proportion of GDP: 2001

Country	Private Sector	Public Sector	Total
South Africa	5.1%	3.6%	8.7%
Botswana	2.2%	4.4%	6.6%
Brazil	4.4%	3.2%	7.7%
Mexico	2.7%	3.4%	6.3%
Turkey	2.6%	1.5%	4.1%

Source: C Day and A Gray, 'Health and Related Indicators', in *South African Health Review 2005*, available www.hst.org.za, South African Health Review link (accessed 22 November 2005).

Exhibit 2 Excerpts from the Public Finance Management Act

50. Fiduciary duties of accounting authorities. – (1) The accounting authority for a public entity must –

- (a) exercise the duty of utmost care to ensure reasonable protection of the assets and records of the public entity;
 - (b) act with fidelity, honesty, integrity and in the best interests of the public entity in managing the financial affairs of the public entity;
 - (c) on request, disclose to the executive authority responsible for that public entity or the legislature to which the public entity is accountable, all material facts, including those reasonably discoverable, which in any way may influence the decisions or actions of the executive authority or that legislature; and
 - (d) seek, within the sphere of influence of that accounting authority, to prevent any prejudice to the financial interests of the state.
- (2) A member of an accounting authority or, if the accounting authority is not a board or other body, the individual who is the accounting authority, may not-
- (a) act in a way that is inconsistent with the responsibilities assigned to an accounting authority in terms of this Act; or
 - (b) use the position or privileges of, or confidential information obtained as, accounting authority or a member of an accounting authority, for personal gain or to improperly benefit another person.
- (3) A member of an accounting authority must-
- (a) disclose to the accounting authority any direct or indirect personal or private business interest that that member or any spouse, partner or close family member may have in any matter for the accounting authority; and
 - (b) withdraw from the proceedings of the accounting authority when that matter is considered, unless the accounting authority decides that the member's direct or indirect interest in the matter is trivial or irrelevant.

51. General responsibilities of accounting authorities. - (1) An accounting authority for a public entity –

- (a) must ensure that that public entity has and maintains-
 - (i) effective, efficient and transparent systems of financial and risk management and internal control;
 - (ii) a system of internal audit under the control and direction of an audit committee complying with and operating in accordance

- with regulations and instructions prescribed in terms of sections 76 and 77; and
 - (iii) an appropriate procurement and provisioning system which is fair, equitable, transparent, competitive and cost-effective;
 - (iv) a system for properly evaluating all major capital projects prior to a final decision on the project;
 - (b) must take effective and appropriate steps to-
 - (i) collect all revenue due to the public entity concerned; and
 - (ii) prevent irregular expenditure, fruitless and wasteful expenditure, losses resulting from criminal conduct, and expenditure not complying with the operational policies of the public entity; and
 - (iii) manage available working capital efficiently and economically;
 - (c) is responsible for the management, including the safeguarding, of the assets and for the management of the revenue, expenditure and liabilities of the public entity;
 - (d) must comply with any tax, levy, duty, pension and audit commitments as required by legislation;
 - (e) must take effective and appropriate disciplinary steps against any employee of the public entity who-
 - (i) contravenes or fails to comply with a provision of this Act;
 - (ii) commits an act which undermines the financial management and internal control system of the public entity; or
 - (iii) makes or permits an irregular expenditure or a fruitless and wasteful expenditure;
 - (f) is responsible for the submission by the public entity of all reports, returns, notices and other information to Parliament or the relevant provincial legislature and to the relevant executive authority or treasury, as may be required by this Act;
 - (g) must promptly inform the National Treasury on any new entity which that public entity intends to establish or in the establishment of which it takes the initiative, and allow the National Treasury a reasonable time to submit its decision prior to the formal establishment; and
 - (h) must comply, and ensure compliance by the public entity, with the provisions of this Act and any other legislation applicable to the public entity.
2. If an accounting authority is unable to comply with any of the responsibilities determined for an accounting authority in this Part, the accounting authority must promptly report the inability, together with the reasons, to the relevant executive authority and treasury.

Source: Public Finance Management Act No. 1 of 1999

Exhibit 3 PMFA Penalties

- 86. Offences and penalties-** (1) An accounting officer is guilty of an offence and liable on conviction to a fine, or to imprisonment for a period not exceeding five years, if that accounting officer wilfully or in a grossly negligent way fails to comply with a provision of section 38, 39 or 40.
- (2) An accounting authority is guilty of an offence and liable on conviction to a fine, or to imprisonment for a period not exceeding five years, if that accounting authority wilfully or in a grossly negligent way fails to comply with a provision of section 50, 51 or 55.
- (3) Any person, other than a person mentioned in section 66 (2) or (3), who purports to borrow money or to issue a guarantee, indemnity or security for or on behalf of a department, public entity or constitutional institution, or who enters into any other contract which purports to bind a department, public entity or constitutional institution to any future financial commitment, is guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding five years.

Source: Public Finance Management Act No. 1 of 1999

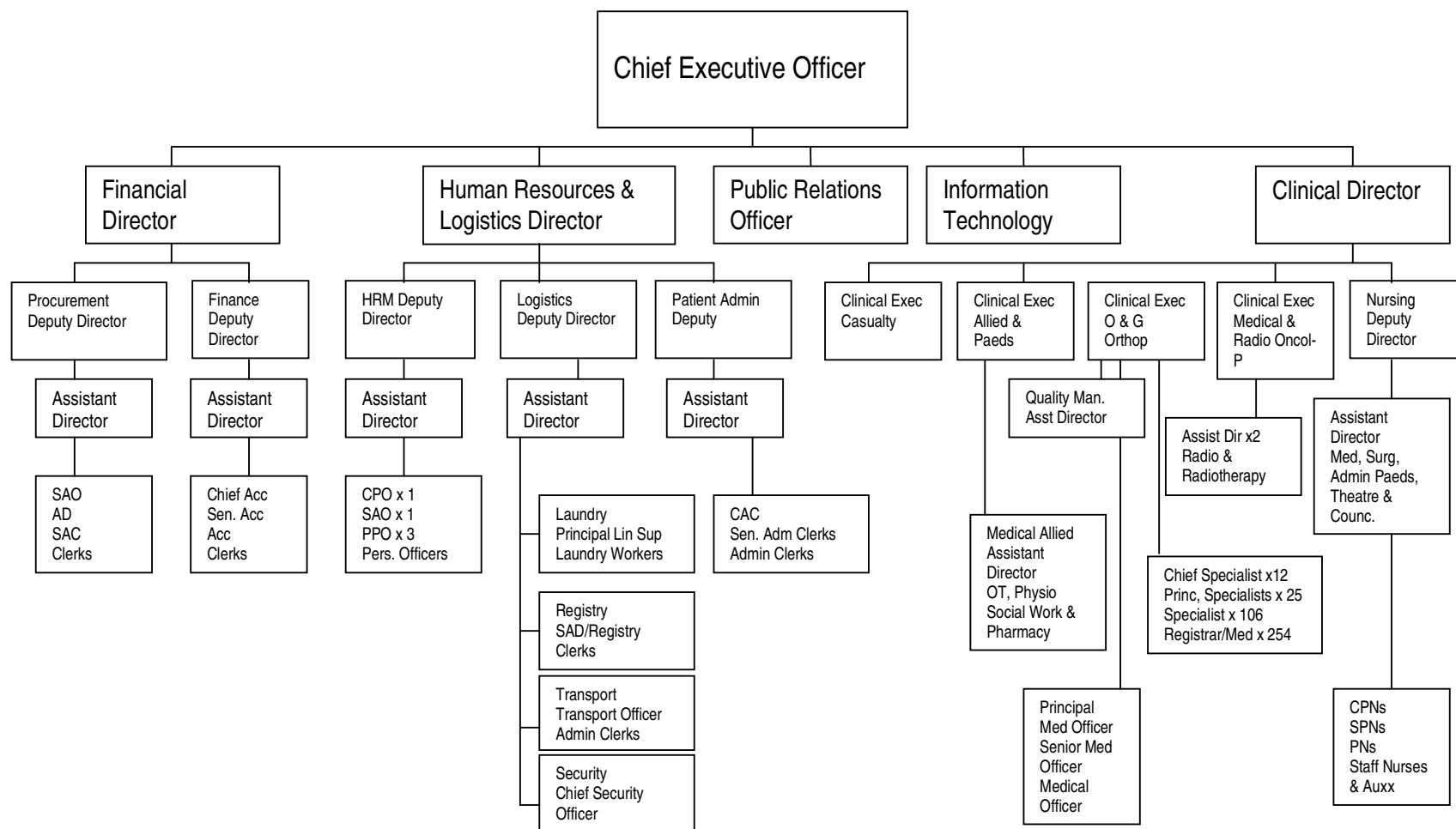
Exhibit 4 Johannesburg Hospital Departments

Clinical Departments	Allied Departments	Administrative Departments
Nursing Medicine Cardiology Neurology Pulmonology Haematology and Oncology Dermatology Geriatrics Family Health Nephrology Hepatology Endocrinology Department of Surgery Otorhinolaryngology Paediatric surgery Urology Trauma Unit Plastic and Reconstructive Surgery Cardio-thoracic surgery Maxillo-facial and Oral Surgery Neurosurgery Nuclear Medicine Orthopaedics Ophthalmology Anaesthesia Radiation Therapy Paediatrics and Child Health Radiology - Diagnostics Obstetrics and Gynaecology Psychiatry and Mental Hygiene	Dietary Services Occupational Therapy Physiotherapy Speech Therapy and Audiology Social Work Pharmacy	Human Resources and Logistics Finance and Procurement Public Relations Information Technology Telephone exchange and paging systems Patient affairs

Source: www.johannesburghospital.org.za, about us link (accessed 13 May 2006).

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Exhibit 5 Johannesburg Hospital Organogram



www.johannesburghospital.org.za, about us link (accessed 13 May 2006).

Exhibit 6 Job Description of a Clinical Executive

Clinical functions:

1. Manage all medical and allied disciplines;
2. Plan and control CPD programmes for doctors, medical services and medical support services;
3. Monitor core hours and overtime requirements;
4. Implement and monitor referral networks between PHC, district hospitals, and Level 3 Hospitals;
5. Develop and implement clinical protocols;
6. Manage the clinical governance strategy, policies and protocols;
7. Lead clinical audit process;
8. Co-ordinate and manage Medico-legal Research, Epidemiological Biostatistical services in the Hospital / Facilities;
9. Lead quality assurance processes; and
10. Cover the hospital after hours.

Financial management functions:

1. Management of cost-drivers;
2. Business plan for medical component regarding action plans; and
3. Budgeting.

Legislation function:

1. Adherence to the relevant health and public service legislations including Batho Pele Principles and Patients' rights Charter .

Human resources functions:

1. Management of staffing requirements of medical departments;
2. Performance management of medical and allied staff;
3. Staff development and training; and
4. Training to junior doctors.

Information management and part of the executive management team.

Source: Information provided by Dr Debashis Basu, clinical executive at Johannesburg Hospital, 6 June 2006.

Exhibit 7 Johannesburg Hospital Budget: 2002/2003 – 2005/2006

YEAR	BUDGET	INCREASE	EXPENDITURE	OVER (UNDER) SPEND
	(R Millions)	%	(R Millions)	%
2001/2002	705 468		681 405	(3.41)
2002/2003	736 977	4.47	806 961	9.50
2003/2004	764 342	3.71	799 975	4.66
2004/2005	883 225	15.55	869 253	(1.58)
2005/2006	995 303	12.69	1 010 764	1.55

Source: Figures provided by Mr Matodzi, 29 May 2006.

Exhibit 8 Slides from Matodzi's Budget Presentation

STRATEGIC OVERVIEW

- Budgeting is a vital part of the planning process
- It is the critical stage of translating policies and goals into actual implementation.
- The following policies are to affect our budget process
 - The priorities of the National Department of Health
 - The National and Provincial Cabinet vision for 2014
 - Gauteng Provincial Government Priorities
 - Key health and health problems and challenges in the province
 - Existing and proposed legislation

Key Points on Budgeting

- Budget must be driven by policy
 - Budget is not a bean-counting exercise
 - Budget is too important to leave to CFO or accountants
 - Do non-financial managers understand/participate in budget process?
- Budget is a POWERFUL instrument
- Good financial management will ensure maximize service delivery
- All government department have challenge to close the gap between policy, planning and budget

Exhibit 8 Slides from Matodzi's Budget Presentation (Contd)

CHANGING ROLES OF FINANCIAL & OPERATIONAL MANAGERS

- | | |
|---|---|
| ■ FINANCIAL MANAGER | ■ OPERATIONAL MANAGER |
| ➤ Gives financial information | ➤ Sets & achieve objectives |
| ➤ Uses systems & skills for costing | ➤ Ask what quality & quantity of service is needed |
| ➤ Provide support in monitoring expenditure | ➤ Checks expenditure, output & outcomes of delivery |
| ➤ Manages cash flow | ➤ Provides info on cash flow |
| ➤ Shows revenue & expenditure | ➤ Take corrective measures |
| ➤ Reports monthly & annually | ➤ Reports monthly & annually |

Budget Process

- **Key elements departments should consider when budgeting:**
 - Fiscal discipline – Constrain spending within the agreed 3 year expenditure envelope.
 - Allocate efficiency – Allocate and spend resources on prioritized objectives.
 - Operational efficiency – Promote efficiency in the use of resources.

Exhibit 8 Slides from Matodzi's Budget Presentation (Contd)

General information required for budgeting

- The strategic plan
- Operational plan(objectives,goals, activities, outcomes and performance measures
- Political review of provincial priorities
- Budget documents of the current and previous financial years
- Latest information regarding policy decisions that will have impact on activities
- List of all expenditure items applicable to the activities
- Latest price list

Recommended Approach When Budgeting

- Define the aim of activity
- Determine the deliverables(output)
- Evaluate these deliverables against the principles of economy, efficiency and effectiveness
- Do breakdown of deliverables and list all goods and services required to produce each of the deliverables
- Classify the goods and services necessary per standard item
- Determined the required quantity and quality specifications per item
- Use known cost implication per unit and calculate the cost of each activity
- The budget of the activity should be submitted by the responsibility manager to the programme manager

Source: Slides provided by Gumani Matodzi, 15 May 2006.

Managing Finances at Johannesburg Hospital

Exhibit 9 Johannesburg Hospital Top 20 Cost Drivers: March-May 2006 (need explanation of abbreviations)

Cost elements	Actual	Commitment	Assigned	Budget	Available
41001650 Med Ser:Laboratory	79 534 645.42		79 534 645.42	73 663 000.08	(5 871 645.34)
41001413 Med:Bld,Bldprod&P	37 649 189.96		37 649 189.96	34 074 424.20	(3 574 765.76)
41004155 Mun Services:City	30 608 717.48		30 608 717.48	30 999 999.96	391 282.48
41001358 Med:Solidosforms	29 323 778.83		29 323 778.83	30 411 999.96	1 088 221.13
41001395 Med:Cysto&Imm Su	28 911 351.63		28 911 351.63	28 443 999.96	(467 351.67)
41001410 Med:Large Vol Par	19 639 755.31	369 026.26	20 008 781.57	18 920 000.04	(1 088 781.53)
41001653 Medser:Nurs Prv	19 612 647.10		19 612 647.10	19 500 000.00	(112 647.10)
40001105 Empl:Medical(Res)	19 594 060.49		19 594 060.49	22 134 999.96	2 540 939.47
41001647 Medser:Hosp Cent	19 340 296.68		19 340 296.68	18 999 999.96	(340 296.72)
41001218 Eq<R5g:Med&Allied	1 981 014.77	14 640 634.76	16 621 649.53	3 000 000.00	(13 621 649.53)
41001404 Med:Fract Treatm I	14 763 159.04	197 318.31	14 960 477.35	17 184 000.00	2 223 522.65
41001357 Med:Sml Vol Pare	12 216 778.67		12 216 778.67	11 499 999.96	(716 778.71)
41002719 Mnt&Rep:Medical&Al	11 933 131.43		11 933 131.43	2 100 000.00	(9 833 131.43)
41001414 Med:Cardgic&Cons	10 798 481.07	477 897.63	11 276 378.70	8 850 000.00	(2 426 378.70)
41001388 Med:Refre Med Itms	10 367 330.72		10 367 330.72	10 665 075.96	297 745.24
41001416 Med:Antibiotics	8 215 027.99		8 215 027.99	11 900 000.04	3 684 972.05
41001411 Med:Caters,Tbs&Ur	7 848 583.48	315 507.85	8 164 091.33	9 300 000.00	1 135 908.67
41001300 Fs:Food Supplies	8 003 621.80		8 003 621.80	8 000 000.04	(3 621.76)
41001418 Med:Biological	7 805 383.04		7 805 383.04	9 000 000.00	1 194 616.96
41001417 Med:Bang&Dressin	6 617 488.07	103 710.65	6 721 198.72	7 200 000.00	478 801.28
Total	384 764 442.98	16 104 095.46	400 868 538.44	375 847 500.12	(25 021 038.32)

Source: Information provided by Gumani Matodzi, 15 May 2006.