The effectiveness of revenue management in South African public hospitals: The case of the Tshwane District Hospital.

THE EFFECTIVENESS OF REVENUE MANAGEMENT IN SOUTH AFRICAN PUBLIC HOSPITALS – THE CASE OF THE TSHWANE DISTRICT HOSPITAL

By

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DECLARATION

I hereby declare that the dissertation submitted for the degree M Tech: Cost and Management Accounting at Tshwane University of Technology is my own work and has not previously been submitted to any other institution of higher education. I further declare that all sources cited or quoted are indicated and acknowledged in a comprehensive list of references.

_____

J. P. Maila

DEDICATION

This study is dedicated to
my mother, Maila Mathilda,
my sister Maila Eunice and
Masemola Suzan for their love and support.

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I would like to express my gratitude and appreciation to:

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ABSTRACT

The Department of Health levies substantial amounts of user-fees (fees paid for hospital services) for various services. The accounting officer of the Provincial Department of Health is required by the Public Finance Management Act No 1 of 1999, to take effective and appropriate steps to collect all money due to the department. Most public hospitals are still depending on payment methods at a cashier office, with limited debt follow up.

This study focused on the revenue management at the Tshwane District Hospital (TDH). Revenue management receives little attention and as a result methods of revenue collection are weak. The aim of this study was to evaluate the effectiveness of the revenue management system at the TDH.

Case study research was conducted consisting of a literature study of revenue collection systems in public hospitals internationally compared with the current system being employed at the TDH. Research methods included observing operations in the revenue management process and conducting interviews with the officials in the revenue management section of TDH and Gauteng Provincial Department of Health (GPDoH).

The study found that not all revenue management procedures in TDH are effective. Key findings included a lack of adequate measures to collect outstanding debt. The enhancement of debt management policy, classification income and implementation of electronic payment methods were included in the recommendations.

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CHAPTER 1
INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

The South African government has the responsibility to provide public goods and services to its citizens. To render these services, it needs funds (revenue) to finance the cost thereof. Government revenue consists of taxes, donations, user-fees and levies. Tax is administered by the South African Revenue Services (SARS) while donations, user-fees, and other levies are administered by public revenue collecting institutions. To collect the revenue, these public institutions need effective revenue collection systems.

Hospital managers and the provincial departments of Health face challenges to improve their revenue management systems to deal with changes in the health system, economy and community growth. Public hospitals are responsible for collecting revenue in the form of user-fees. Mudau (2010:12) is of the opinion that national government revenue will be improved if all hospitals in South Africa implement an effective revenue collection system. The words ‘user-fees’ and ‘user-charges’ are used interchangeably throughout the study. Further, reference to the Department of Health refers to the National Department of Health.

The *White Paper for Transformation of the Health System in South Africa* (Department of Health, 1997:online) presented the objectives upon which a unified health system of South Africa are based. In restructuring the health system of South Africa, there had been a decentralisation of the management of health services with emphasis on the District Health System. The District Health System has been adopted as a means to deliver primary health care services, and thus includes the district hospitals.

In the reclassification of public hospitals, district hospitals were classified as Level 1 hospitals (Department of Health, 2012:34). The district hospitals are defined as first-level non-specialist hospitals to which patients from clinics or health centres may be referred (Department of Health, 1997:online). According to the *Policy on the*

Management of Public Hospitals, this restructuring of public hospitals in South Africa was done to address the issue of equity, affordability, efficiency, and effectiveness (Department of Health, 2012:online).

Where the National Department of Health sets the policy framework, the provincial departments of Health are responsible for the implementation of policies through district health care services. District hospitals report to the health district management while still being accountable to provincial head offices in terms of budgets and service delivery. The functions of the provincial Departments of Health include co-ordinating funding and financial management of District Health Services (SA, 2004:online).

The health district's financial management is guided by specific rules and regulations. The most applicable legislation is the Public Finance Management Act, No 1 of 1999 (PFMA) and its supporting Treasury Regulations. The implementation of Treasury Regulations should enhance accountability and effectiveness within health district financial management (Engelbrecht, Jooste, Muller, Chababa & Muirhead, 2002:online).

Financial management in the public sector consists of planning, budgeting, resources allocation, evaluation, and reporting (Graham, 2011:online). Managers are required to draft a budget and measure the attainment of targets. In this sense, managers in the district need to budget for the revenue that will be collected. Each cost centre and district management team has to project the revenue to be generated during the financial year. The revenue targets are monitored to determine any deviation from the budget, and are reported on together with the cash management performance, on a monthly basis (Engelbrecht, et al*.* 2002:online).

Although revenue management is an integral part of financial management, public hospitals have a tendency to collect revenue below their budget estimates. The Gauteng Department of Health and Social Development (GDoHSD) experienced an under-collection of R11 million in patient fees in the 2010/11 financial year (GDoHSD, 2011:online). During 2015/16 the GDoHSD had a decline of R44 million in revenue collection and an under-collection (against the budget) of R76 million (GDoHSD, 2016:online).

During the 2010/11 financial year, the annual targeted revenue of the GDoHSD was adjusted due to the negative impacts caused by the industrial actions, where few staff members were available to bill the patients (GDoHSD, 2011:online). The decline and under-collection in the 2015/16 financial year were attributed to the late implementation of Uniform Patient Fee Schedule (UPFS). The 2010/11 annual report of the GDoHSD also indicated that other organs of the state were reluctant to pay for services provided to patients who were referred to public hospitals in Gauteng (GDoHSD, 2011:online). Even though it is accepted that actual revenue collected may never be precisely as estimated, the size of the deviance is still a grave concern. The PFMA states that the under-collection of revenue will result in a reduction in the approved budget of a provincial government department (SA, 2000:online), at a time when public hospitals are already struggling to make ends meet.

The recurrence of a short-fall in collected revenue leads to questions on the effectiveness of revenue management in public hospitals. During the financial year 2011/12, the GDoHSD was owed R2.1 billion in patient-fees (GDoHSD, 2012:online). After massive debt write-offs, at the end of the 2015/16 financial year, the GDoHSD was owed R434 million, with an increase from R228 million in patients' debts written off to R336 million (GDoHSD, 2016:online).

Since the 2011/12 financial year, the amount of patient debts written off has been steadily increasing. In the 2011/12 financial year, patient debts written off increased from R124 million to R127 million. Besides debts written off, there was no clear indication of the cause of a decrease in patient debts in the 2015/16 financial year.

User-charges and tariffs relieve the pressure on tax revenue because if consumer tariffs and user-charges are not imposed, the cost of all particular and quasi-collective services has to be met from taxation (Gildenhuys, 1993:362). User-charges are amounts of money charged for the use of specific public services (Gildenhuys, 1993:362). These charges are levied to recover a portion of the direct costs incurred on behalf of the user.

Apart from taking the importance of revenue collection for the state into consideration, public hospitals do not have an effective incentive to collect fees because all revenue generated is deposited into the National or Provincial Revenue Fund (McIntyre,

Dolterty & Gilson, 2003:55). The PFMA Section 22 states that all money received by the provincial government must be paid into the province's Revenue Fund (SA, 2000:online).

There seems to be little research done in this area of revenue management at public hospitals, specifically with regard to the proposed introduction of a National Health Insurance (NHI) scheme. The South African community, both users of hospitals and officials at hospitals, appear to have little knowledge of the importance of user-charges.

1.2 RESEARCH PROBLEM

The Department of Health is responsible for the patient fees collected by public hospitals. Public hospitals charge user-fees for hospital services according to the UPFS that has three categories: fully paying patients, fully subsidised patients, and partially subsidised patients (Wadee & Gilson, 2007:11). These fees are charged at the point of service using a means test to determine the ability of the user to pay for the service. According to Kahn (2012:online), the government has neglected to adjust the means test for patients using public hospitals for over 10 years, resulting in poor people without medical aid being charged for services received.

This system may be ineffective considering the fact that the hospital does not have the right to turn away patients (Department of Health, 2002:online). Patients are unlikely to instantly pay for the services at the point of service, thus leaving the hospital with the responsibility to collect the money at a later stage. Bloom (in Kahn, 2012:online) is of the opinion that Gauteng Province public hospitals hardly take action to recover outstanding patient fees. The aforementioned statement is also supported by Mudau (2010:13) that the Gauteng Province has no intention to improve debt collection.

Internationally, researchers have identified challenges in the system of user-fees paid at the point of service, especially where the hospitals are using a manual system (Nyonator & Kutzin, 1999:333; Naomi, Rebecca, John, Junior & Razak, 2012:12). As a result, the collection systems in most South African public hospitals may have weak controls that ensure revenue is actually collected.

McIntyre, et al. (2003:53) supported this assumption by stating that user-fee collection systems are ineffective at South African public hospitals and still need improvements to ensure increased revenue under an NHI. The National Treasury (2000:online) at the time echoed the sentiment that revenue management has become a low priority in many government departments, including the Department of Health. The research problem is, therefore, formulated as the ineffective management of revenue collection by public hospitals under provincial Departments of Health.

The following aspects were identified in support of the research problem:

- **Weakness in revenue collection methods** – most public hospitals still depend on payments at the cashier's office, where methods used to receive revenue are ineffective and inefficient. According to Molefi Mosenogi, the former coordinator for the NHI task team in Gauteng, public hospitals rely on a manual system to bill patients (Monama, 2012:online). The patient administration system makes it impossible to interface with medical aid schemes; as a result, claims are submitted in batches (GDoHSD, 2011:online).

- **Lack of technical skills in financial management –** according to Engelbrecht, et al*.* (2002:online), financial management is often seen as a difficult skill that few people have.

- **Means test system to determine the ability to pay at point of service is dysfunctional and inequitable** – according to the *Inquiry into the various social security aspects of the South African health system review* (Department of Health, 2002:online)*,* the means test used by hospitals is impractical given the inability to turn patients away.

1.3 RESEARCH QUESTIONS

The research questions formulated in this study were:

- Is the system of revenue management effective?
- What are the processes followed to ensure effective management of revenue?
- What actions can be taken to enhance the revenue management system?
- What payment methods will be most effective?

1.4 DELIMITATION OF THE STUDY

The TDH is a public hospital situated in the central Tshwane sub-district with a 200-bed capacity according to the latest statistics (TDH, 2011:online). This hospital, formerly known as the HF Verwoerd Hospital, was changed into a community hospital following the transformation of the health system in South Africa.

The study was conducted at TDH within the GPDoH. This study was limited to revenue management, i.e. ***user-fees*** levied on services provided by public hospitals.

1.5 OBJECTIVES OF THE STUDY

The primary objective of this study was:

- To evaluate the effectiveness of revenue management in South African public hospitals through a case study of the TDH.

The secondary objectives of this study were:

- To conduct a literature review on financial management in public hospitals.
- To explain the revenue collection system by reviewing the hospital revenue management cycle implemented internationally in public and private hospitals.
- To explain revenue management in terms of the PFMA and the Basic Accounting System (BAS) receipt process.

- To determine the current state of revenue management at the TDH.
- To make recommendations on the improvement of revenue management at the TDH.

1.6 ASSUMPTIONS

Assumptions are propositions that a researcher assert based on his/her intuition and experience but which have not been scientifically proven. Leedy and Ormrod (2010:6) define assumptions as “conditions taken for granted which without them the study would be pointless”. For this study, the assumptions were tested using data from interviews and observation.

The assumptions for this study were:

- Poor health service delivery discourages payment of user-charges by self-paying patients.
- Users of public hospitals include both employed and unemployed individuals.
- Payments are made either out-of-pocket or through medical insurance.
- Lack of skills leads to poor capturing of patients’ information and medical insurance schemes not being billed.
- Patients from referring provinces find it difficult and uneconomical to settle their small debts.

1.7 SIGNIFICANCE OF THE STUDY

The significance of this study contributes to an area of financial management in TDH and adds value to existing knowledge of revenue management in South African public hospitals. By evaluating revenue management in TDH, the study provided recommendations on the identified problems.

1.8 METHODS OF DATA COLLECTION

1.8.1 Observation

Observation is regarded as the most objective method of obtaining information. Observation is defined as a research method that enables the researcher to systematically observe and record people's behaviour, actions and interactions (Hennink, Hutter & Bailey, 2011:170).

The primary purpose of the observation was to determine the current state of revenue management in TDH. The researcher observed the processes of revenue management in the hospital, and this included the functions carried out by the finance officials. By observing the cashier's office, the researcher collected data regarding actions taken when user-fees are paid. The researcher also observed how the means test was conducted. The procedures that are followed in the collection of revenue, such as the receipt and the issuing of invoices, were also observed.

Observation has its own drawbacks. A commonly identified shortcoming in observation is the Hawthorne effect. According to Bracht and Glass (1968:online), the Hawthorne effect implies that participants are likely to improve or change their behaviour if they are aware that they are being observed. In the case of employees, this means that participants being observed can improve their production or perform a process accurately where otherwise they would not, if they are aware that they are being observed.

The Hawthorne effect had little impact on the data collected for this study. Although the Hawthorne effect cannot be eliminated, the researcher was able to mitigate the possible risk of this effect by discarding the first days of observations. The researcher did not investigate the behaviour of employees but rather the processes involved in the revenue management of the hospital. Prior to undertaking the observation procedures, the participants were informed about the procedures both, verbally and in the form of a written information leaflet. The researcher explained to the participants that the data collected will only be used for the purpose of this study. The informed

consent forms were signed by the participants. Clarity on the ethical aspects of the study is provided under the section on ethical issues.

An essential activity in conducting an observation is the recording of observation activities. In this study, this was in the form of field notes. Leedy and Ormrod (2005:146) advise that when a researcher opts to take field notes he/she should consider having a notebook with two columns, one to record observations and the other to write interpretations. This helps the researcher to avoid being biased.

In this study, video or audio recordings were not used for observation purposes as these instruments might reveal the identity of participants. Leedy and Ormrod (2005:145) state that a video recording can only manage to capture activities in a particular direction.

The results of the observation assisted the researcher in formulating the interview questions.

1.8.2 Interviews

In an effort to collect data for the purpose of the study, interviews were conducted. Conducting interviews allowed the researcher to interact with individuals responsible for revenue management at TDH. The interviews conducted were in-depth. Hennink, et al. (2011:109) describe in-depth interviews as a one-on-one method of data collection that involves an interviewer and interviewee to discuss specific topics in depth. The authors (Hennink, et al. 2011:109) further state that this type of interview can also be conducted with two interviewees. It can also take the form of a semi-structured interview.

The selection of participants was based on the area of study, which is financial management. The researcher was interested in those officials directly responsible for revenue activities in the hospital, including, but not limited to clerks/cashiers, supervisors, and officials at management level responsible for the hospital's revenue management.

A qualitative research approach affords the researcher an opportunity to evaluate people's experience. Therefore, when seeking information from people, the in-depth interview is an appropriate data collection method to use. This approach assisted the researcher to gather information from individuals regarding the application of the PFMA and other revenue management policies and procedures within public hospitals. The interviewees consisted of officials responsible for financial management at TDH and the Gauteng Provincial Department of Health (GPDoH). The GPDoH and GDoHSD refer to the same Provincial Department of Health.

To ensure the objectivity of data collected, the researcher aligned the interview questions with the observation outcomes. Further, tables were used for the analysis and interpretation of research findings.

The researcher considered these methods suitable for this study. The summarised methods are further discussed in Chapter 4, and includes the definitions, advantages and disadvantages of each method.

1.9 ETHICAL ISSUES

Ethics are defined as "moral rules or principles of behaviour for deciding what is right and wrong" (Longman Dictionary of Contemprary English, 2003:533). Msweli (2011:79) suggests that a researcher needs to anticipate the ethical issues involved in the proposed study. Ethical considerations take the protection of information acquired during the course of the study into account by not disclosing it to other persons without the authority of the parties concerned.

The anticipated issues for this study comprise of confidentiality of the data gathered through the research methodologies indicated above, anonymity, informed consent, and permission to access facilities and approach officials. Any risk involved, including the risk of officials losing jobs, exposing the officials' integrity, et cetera, was taken into consideration and was dealt with accordingly.

To protect the participants from any risk or harm the researcher did not use positions, names, or professions as a means of identification. The anonymity of the participants was protected as no personal information was required in the study. According to the Institutional Review Board (2013), study labels are an effective means of protecting the confidentiality and anonymity of participants. Therefore, the researcher used narrative labels in making reference to the information acquired from the participants. Throughout the study the researcher used "*int"* as a label in sequence to identify the interviewees. A separate document that links the participants' identity to their labels was not included in the study, but is kept in a safe place with limited access.

Wisker (2008:87) states that regardless of which research a person is involved in, ethics still need to be taken into account. The participants in this study were free to take part and had the right to withdraw at any stage. The interview guide accompanying the consent form provided participants with participation details. This included details informing the participants that their participation would be voluntary and that there would be no financial benefits offered. Where participants found it inappropriate to provide the researcher with certain information, and felt that it should not be used in the study, they could withhold such information (Wisker, 2008:87).

With regard to the informed consent, Wisker (2008:87) advises that the participants should give their full consent before taking part in the study. The participants were provided with consent forms to sign in order to indicate that they gave consent for the information to be acquired for this study. Prior to signing the consent forms the researcher explained the details of the interview guide and attended to any questions from potential participants. The consent forms were structured in simple language and format to avoid misunderstanding. By referring to the interview guide that accompanied the consent forms, it provided an area where the potential participant could write a name, signature and date to indicate that he/she had read the interview guide and agreed to take part in the study.

1.10 LAYOUT OF THE STUDY

CHAPTER 1 – INTRODUCTION AND BACKGROUND

The background of the study was discussed in this chapter, indicating the area of technicality from which the researcher was working. It included the problem statement, research questions, and delimitation of the study, the purpose, objectives, assumptions, and the significance of the study. Overall, this chapter provided an overview of the entire study.

CHAPTER 2 – LITERATURE REVIEW: FINANCIAL MANAGEMENT AND REVENUE COLLECTION SYSTEMS

As an integral part of the study, financial management is reviewed within the context of the study. After the examination of financial management is a review of the concepts of management, economy, effectiveness, efficiency, and revenue collection systems. The literature review of each item evaluated is discussed as a subsection within the chapter.

CHAPTER 3 – PROCEDURES AND FUNCTIONS IN REVENUE MANAGEMENT

In this chapter, the researcher expands on the procedures and functions within the revenue collection process. Sources of revenue, role players and their functions are explained. Furthermore, the revenue collection process as undertaken through BAS is discussed. In essence, Chapter 3 provides a conceptual framework indicating how revenue is actually managed in the public sector following Treasury guidelines and recommendations.

CHAPTER 4 – RESEARCH METHODOLOGY

The research methodology for this study is discussed in Chapter 4. This includes the research design and data collection methods. The rationale for each chosen method is justified, highlighting the advantages and disadvantages thereof.

CHAPTER 5 – ANALYSIS AND INTERPRETATION OF RESEARCH FINDINGS

This chapter provides the analysis and interpretation of data collected during the course of the study. It includes the findings of interviews and observations. The

analysis and interpretation are done according to the identified categories, namely the means test, billing, debtors management, and the cashier office.

CHAPTER 6 – CONCLUSION AND RECOMMENDATIONS

The final chapter of this study concludes on the objectives of the study and provides recommendations. A general conclusion is made of revenue management, followed by specific variables that formed an integral part of this study.

1.11 CHAPTER SUMMARY

The current chapter provided an introduction to the entire study with a discussion of its background. The sources of government revenue were considered, with user-fees identified as one of these revenue sources. Further, a brief review of administration user-fees within the South African healthcare sector took place.

Subsequent to the background of the study, the problem statement was discussed followed by the research question, objectives and delimitation, and the significance of the study. The problem statement, together with the research objectives, gave rise to the investigation of identified challenges.

This chapter also provided a brief discussion of the methods of data collection used in this study, which are observation and interviews. Based on the nature of the study, ethical issues affecting data collection methods were also reviewed. The following chapter covers the literature review.

CHAPTER 2
LITERATURE REVIEW: FINANCIAL MANAGEMENT AND REVENUE COLLECTION SYSTEMS

2.1 INTRODUCTION

The literature review of this study includes the review of financial management as applied in the South African public sector and its revenue collection system. Although revenue management is part of financial management, it is imperative to have a separate discussion on financial management for the purposes of this study. The Auditor General South Africa's (AGSA) audit report for the year 2003/04 indicated that poor revenue management in public hospitals was caused by poor financial management (SA, 2004:1-5). Patient billing is one area that has always been regarded by the AGSA as ineffective in most public hospitals (SA, 2004:1-5). Subsequent to the review of financial management, the researcher extended the effort to indicate what constitutes performance in terms of public financial management by discussing the concepts of *effectiveness, efficiency,* and *economy* (3Es).

Revenue collection systems are examined later in the chapter. The hospital revenue management cycle forms the basis of this revenue collection discussion. The different concepts reviewed in this chapter are brought together in summary at the end.

2.2 FINANCIAL MANAGEMENT IN DISTRICT HEALTH MANAGEMENT

Financial management is a pillar in managing the scarce resources of any private and public sector organisations, ensuring that ultimate objectives are reached. In order to provide the public with the best healthcare services, public managers need to have a thorough knowledge of financial management. Therefore, for one to understand financial management in the public sector, it needs to be broken down into components. These components can be subdivided into the management of finances in an organisational (departmental) unit or the whole entity (own emphasis). For the purposes of this study, organisational units refer to the cost centres of the Provincial Department of Health (PDoH) such as district offices, hospitals, clinics, et cetera.

In the private sector, financial management is concerned with the analysis of financial issues faced by the business, and the decision making processes on the source of funding and the effective use of such funds and other assets to maximise profit, while still staying liquid (Bowlin, Martin & Scott, 1990:1; Van Horne & Wachowicz, 2001:20; Matschke, Hering & Klingelhöfer, 2002:1). Profitability refers to the ability of the company to maximise profit, while liquidity relates to the ability of the company to pay its long-term and short-term liabilities (Van Horne & Wachowicz, 2001:20).

Although state operated hospitals are not profit orientated, cost minimisation is still one of their objectives in order to provide healthcare services. Therefore, profitability could be seen as the ability to provide desired services at the lowest costs. Based on “batho pele” principles, to meet the value-for-money principle, government institutions should achieve maximum benefit from goods and services with the amount of financial resources available.

Liquidity also forms an integral part of financial management. Although hospitals are not directly responsible for paying suppliers, when the provincial health department experiences a financial crisis it affects the hospitals at an operational level. In relation to the study, the GPDoH has been identified as one of the provinces that follow a system that delays payments to suppliers. The *“Unsettled settlement”* is a report by Public Protector South Africa (SA, 2014:55), that also indicated in its findings that the GPDoH has failed to settle some of its debts within 30 days as required by the Treasury Regulations.

Although securities are part of financial management, this study does not cover securities, such as common stock and debentures, in financial management because the public hospitals do not issue shares to raise capital. Therefore, the focus in this study remained within the public sector’s financial management.

In addition to the aforementioned variables of financial management, various observers (Rosenberg, 2003:online; CIPFA, 2010:online; Graham, 2011:online) in the field of public sector financial management define financial management in reference to planning, budgeting, and fund allocation. In support, McKinney (2004:2) and the Chartered Institute of Public Finance and Accountancy (CIPFA, 2010:online) view

financial management in the public sector as the process that is employed by a governmental unit or agency as the means to obtain and allocate resources based on implied or articulated priorities, and utilise methods and controls to effectively achieve publicly determined ends.

Therefore, effective financial management in government is achieved through financial planning, monitoring, and evaluation and reporting. Numerous government publications address these key elements of financial management. Part 3 of the Treasury Regulations (National Treasury, 2005:online) provides guidelines on planning and budgeting for departments, constitutional institutions, public entities, parliament, and provincial legislatures. The *Guide for accounting officers in terms of the Public Finance Management Act* also strives to address these elements (National Treasury, 2000:online). When this guide was prepared, it supported the vision of the PFMA in linking planning, budgeting, monitoring and reporting (National Treasury, 2000:online).

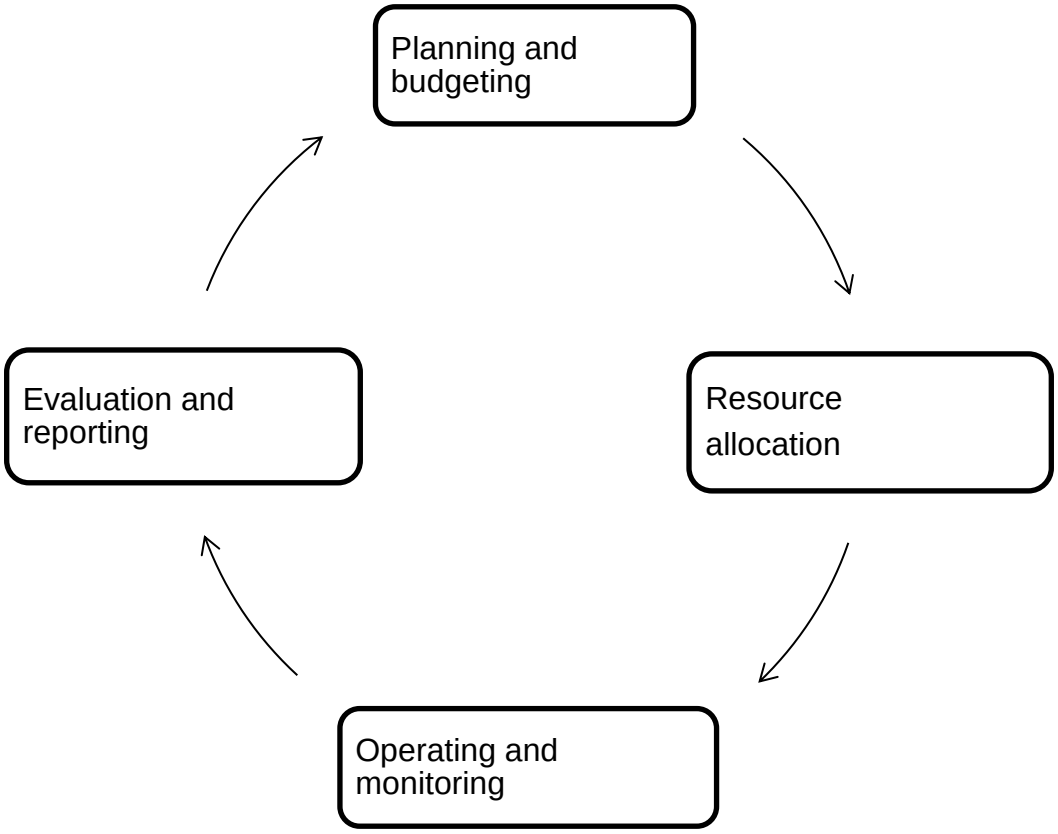
Ramos (National Treasury, 2000:online) stated in the *Guide for accounting officers in terms of the Public Finance Management Act* that financial management in the public sector ensures effective stewardship of public money. Public money refers to the funds that government has control of and all the revenue that is due. Thus, financial management is not only concerned with the spending of public funds but also with the collection of revenue.

Graham (2011:3) and McKinney (2004:2) agree that effective financial management is essential for the collection of money. The ability to collect revenue effectively at minimum costs enhances profitability that can be read for the public sector as “cost-effectiveness”.

The ability to collect user-fees and other revenue improves the financial sustainability of government and subsequently improves the conditions of public facilities. As a result, it is concerning that South African government departments are generally negligent towards revenue collection and do not allocate enough resources to the revenue collection system as compared to the expenditure control system (Kuye, Thornhill, Fourie, Brynard, Crous, Mafunisa, Roux, Van Dijk & Van Rooyen, 2002:107).

Collecting user-fees can be improved if the public sector implements correct policies, plans, processes, and ensures that monitoring and evaluation are in place. Treasury Regulations, Section 7.2.1 (National Treasury, 2005:online) requires the accounting officer of an institution to manage revenue effectively and efficiently by developing and implementing appropriate processes that provide for identification, collection, recording, reconciliation, and safeguarding of information about revenue. Further, financial management assists the managers to assess the financial health, i.e. liquidity, profitability and security of the organisation by way of financial analysis. This is achieved by using the financial statements. In the public sector, the financial ratios used to assess the financial health of a public institution have less importance because profitability is not the objective of pursuing the business. However, these instruments can still assist the GPDoH to ensure the effectiveness and efficiency in the use of resources in order to deliver services. The purpose of financial analysis in the public institutions is to find options to fund new programmes and strategies (Steiss & Nwangu, 2001:15).

Public financial management can also be viewed as a process that enables delivery of goods and services. The Oxford Business English Dictionary (2008:427) defines a process as “a series of things that are done in order to achieve a particular result”. The following is an illustration of financial management processes with a discussion of financial management components:



(Source: Engelbrecht, et al. 2002:online)

Figure 2.1: Financial management cycle

2.2.1 Planning and budgeting

The purpose of planning is to determine what will be done, how it will be done, and what the end results in future should be. Steiss and Nwagwu (2001:5) support this view by defining planning as the process whereby decisions are made beforehand regarding what is to be done and how. According to Nickols (2016:online), planning should put emphasis on future goals. Hence, government departments are required to have a strategic plan that will cover a three-year period (National Treasury, 2005:online).

Different activities take place during planning to allow a comparison of available options. With regard to the healthcare sector, planning activities include identifying analyses of current states of healthcare activities and trends, setting the specific

objectives, developing policies and programmes, identifying and selecting the best options for attaining the objectives, estimating input requirements, and preparing the budget (Steiss & Nwagwu, 2001:5).

Planning in financial management refers to financial planning. Castellina and Hatch (2011:online) define financial planning as the process which articulates the strategic objectives of an organisation in financial terms. According to Van der Heever (2009:37), financial planning varies according to the levels within the organisation and the organisational objectives. At the district health level, the financial planning process includes setting targets for revenue and expenditure while considering the concepts of effectiveness, efficiency, and equity (Engelbrecht, et al. 2002:online).

Pauw, Woods, Van der Linde, Fourie and Visser (2002:92) categorised public sector planning into strategic planning and operational planning. Strategy should inform the tactical plan and operational plan. A tactical plan is developed to attain certain goals of the strategic plan, including short-term goals (Griffin, 2013:68).

2.2.1.1 Strategic planning

According to Scott (2007:15), the word "strategy" comes from the Greek word "*strategos"* referring to the military rank of General. Thus, according to the Oxford South African Concise Dictionary (2006:1173), strategy is the art of planning and directing military operations. Many businesses have adopted the planning style of military strategy by setting objectives, identifying strengths and weakness, organising resources, and evaluating the results (Scott, 2007:15).

In the public sector, strategic planning is therefore defined as "the process of identifying public goals and objectives, determining needed changes in those objectives and deciding on resources to be used to attain them" (Steiss & Nwagwu, 2001:5). Goals and objectives set by the strategic plan should be well defined, measurable, comprehensive, and time-specific (Pauw, et al. 2002:94). This is well known as the SMART method, which is specific, measurable, attainable, realistic, and time-specific. A strategic plan should be a long-term plan (Pauw, et al. 2002:101).

Further, it should be in line with a medium-term expenditure framework to cover a three-year period (National Treasury, 2000:online).

Referring to the purpose of planning, strategies give direction on how the set objectives will be achieved. These objectives include securing value-for-money through improvement of financial management (Gauteng Department of Health, 2002:online). According to David (2011:41), strategies are channels through which the organisational objectives can be achieved. Failure to have a strategic plan can result in poor service delivery. Further, David (2011:41) states that the drawback of strategic planning is that there is less involvement of lower level employees in the planning. Engelbrecht, et al. (2002:online) recommend that even though strategic planning involves top and middle management, all employees should be engaged.

District health should develop the district health plan (strategic plan) that will provide a basis for operational activities (Engelbrecht, et al. 2002:online). This plan offers a framework for delivering services and incurring expenses. Subsequent to the strategic plan, the organisational unit must indicate day-to-day activities in order to execute the set plan (Kuye, et al. 2002:106).

2.2.1.2 Operational planning

The operational plan, also referred to as the business plan or annual performance plan, is a service plan prepared annually to provide information with regard to resource requirement and operations of the organisation in pursuit of the strategic plan (Kuye, et al. 2002:106). A business plan is required where funds need to be approved by the Ministry while the operational plan aims to put the business plan into action. Kirigia, Sambo, Agu and Lambo (2001:14-15) view the operational plan as a plan of actions to solve identified problems and achieve goals. Kirigia, et al. (2001:14-15) further state that goals can be efficiently achieved if managers can link budget allocations to expected results during the formulation of the operational plan.

The operational plan of an organisational unit contributes to the attainment of strategic plans which are in line with the objectives of the National Department of Health. Each

organisational unit should have an operational plan which will guide the spending and revenue collection.

Moreover, the operational plan provides a basis for budgeting and it indicates the costs required, including nurses, vehicles and equipment to deliver services (Engelbrecht, et al. 2002:online). Kuye, et al. (2002:105) view the operational plan as a budget that estimates the revenue to be collected, the funds to be spent, and the service to be delivered. The following section focuses on the budget as a primary tool for financial management in the public sector.

2.2.1.3 Budget

Public hospitals are entrusted with the duties to collect revenue (user-fees). Therefore, it is crucial to estimate the amount of revenue to be collected. In addressing the crux of this study, the researcher found a need to discuss the budget concept ahead of the discussion of revenue collection.

A budget should depict the principles of sound financial planning and management. According to Pintea, Lacatuş and Deceanur (2013:online), a budget is defined as a plan with predictable revenue and expenditure of an organisation for a particular period. Klerk (2000:2) and Gildenhuys (1993:392) define a budget as a financial statement of income and expenditure, indicating how much will be earned and how much will be spent within a specific period. The meaning of financial statement in the aforementioned assertion does not refer to the statement of financial performance that shows a surplus or deficit, but rather the presentation of receipts and payments in detailed tables in terms of the Economic Reporting Format.

Klerk (2000:2) further highlights that there are two types of budgets: the revenue budget, and the expenditure budget. Herkimer (1986:203) is of the opinion that the revenue budget predicts the amount of revenue the department can expect from each cost centre. The revenue budget of a hospital provides the projected revenue the hospital will collect for the PDoH. Herkimer (1986:205) further indicates that the budget determines the reimbursement the department can expect for the services rendered, and incorporates a provision for third-party contractual allowance, free work and bad

debts, to arrive at the net amount the facility may expect. Third-party contractual allowance is the difference between the amount billed to the third-party payer, such as medical aid institutions, and the actual amount to be received from the third-party payer as a result of contract negotiations (Cleverley & Cameron, 2003:126).

Budgeting in most non-profit organisations (such as churches, hospitals, and charities) is initiated by managers at the lowest level by calculating the expected expenditure and revenue to maintain the operations. A common budgeting technique for these non-profit organisations is line item budgeting (Drury, 2012:380). The researcher reviewed common methods used for budgeting that can by applied to estimate revenue.

There are numerous budgeting methods that include, among others:

- Line item budgeting – in which amounts are based on historical information. With this budgeting technique expenditure and revenue are expressed in detail. Drury (2012:381) argues that line item budgeting does not identify costs of activities and there is no guarantee that resources will be used effectively and efficiently. In support, critics of line item budgeting further argue that, although it is straightforward, it does not provide for the output and the outcome for related costs (Seer, 2000:187-188). Line item budgeting is commonly implemented by government organisations (Shane, 2005:online).

- Zero-based budgeting – this budgeting method requires managers to construct the budget from the ground starting with zero (Government Finance Officers Association, 2011:online).

- Activity based budgeting – according to Shane (2005:online), activity based budgeting indicates how costs and revenue are allocated to specific activities. In comparison to line item budgeting, an activity based budget enables managers to see the link between costs, resources, and services provided.

The line item budgeting technique within the current performance budgeting system is used by public hospitals to compile a budget. Items that are commonly budgeted for

include personnel, administration, vehicles, laundry, et cetera. In addition to the expenditure budget, there should also be a revenue budget. The revenue for public hospitals consists of funds from PDoH, donors, municipal revenue systems, and user-fees. In relation to the study, the implementation of a line item budgeting technique does not have as adverse an effect on revenue items compared to expenditure items. Compiling a revenue budget of a hospital requires the estimation of patients treated.

One typical example of compiling a revenue budget, not taking factors that might influence the projections into account, is to take the number of patients treated annually from previous records and multiply it by the nominal fee. This method of estimating revenue is considered a shortcut for constructing a budget (Blair, Keagy & Thomas, 2004:20). This technique ensures that realistic targets are provided of revenue to be collected.

According to Blair, et al. (2004:6), the revenue budget is compiled by using the estimates of patient volume at different levels of payments, i.e. classification categories according to UPFS. Because estimates of revenue to be collected are based on the previous records, prior years' records are adjusted for seasonal fluctuations and population growth. These are considered the factors that influence the projections.

Based on the fact that budgets consist of projections, there are possibilities that revenue collected may not be consistent with the estimations thereof. The estimations are not 100% accurate. In some instances, varying from the budget is due to the fact that hospitals are often under-resourced, with no operational incentive to collect revenue.

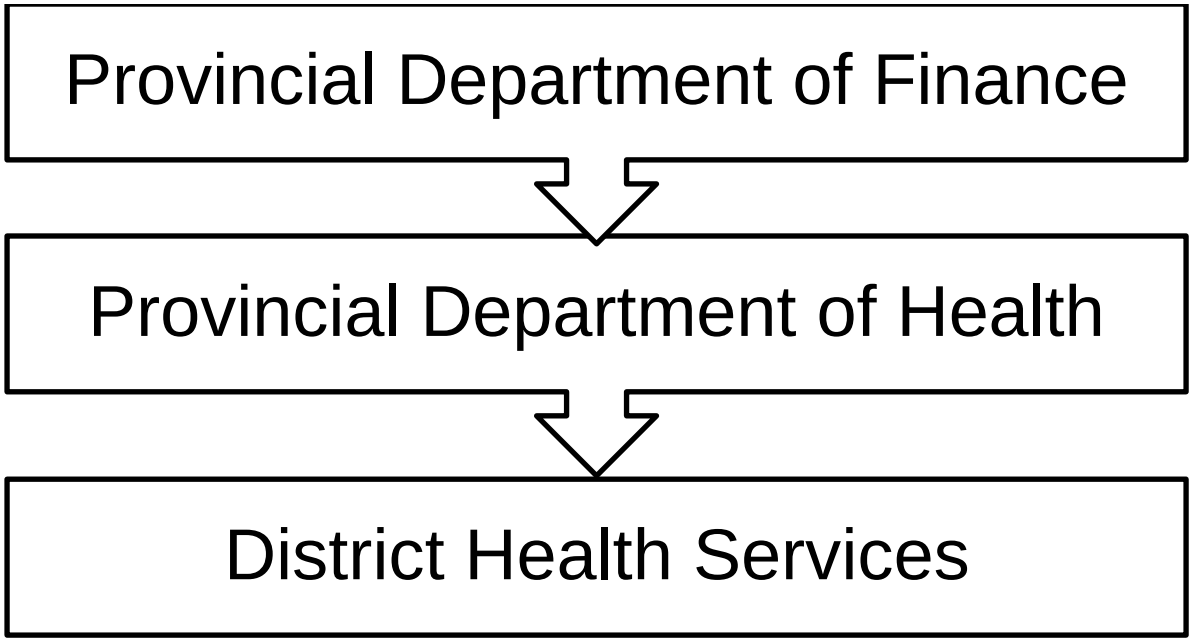
Sound planning and budgeting will ensure that funds are consistently collected and allocated for operational purposes. In the following section, resource allocation is discussed.

2.2.2 Resources allocation

A healthcare system requires a process that will make a division of total resources in a number of components possible (Knox, 1978:3). The allocation of resources refers to the distribution of funds, staff, equipment, buildings, et cetera, being allocated to lower administrative levels, geographic regions, clients groups, or institutions (Knox, 1978:3). Green, Ali, Naeem and Ross (2000:1025) refer to resource allocation as the distribution of financial resources to the decentralised areas of a national health system. In a nutshell, an effective financial management process within the PDoH should ensure that financial resources are appropriately distributed to the District Health Services (DHS).

The PDoH receives an annual appropriation from the Provincial Revenue Fund in terms of the annual provincial Appropriation Act (SA, 2017:online). The annual appropriation is revenue received by departments divided among the departmental programmes (SA, 2017:online). The GPDoH consists of ten programmes including DHS (GDoHSD, 2011:online). Funds allocated to the programme are further distributed to sub-programmes within (Engelbrecht, et al. 2002:online). Sub-programmes refer to cost centres, and for the DHS this includes district management, community health service, community health centres, community based services, HIV/Aids, nutrition, coroner services, and district hospitals (GDoHSD, 2011:online).

In a district hospital, funds are further allocated among different sections (Engelbrecht, et al. 2002:online). The aim of this process is to allocate the resources to the lower administrative levels in the health services to ensure possible access to healthcare for those in need of the healthcare services. Funds are allocated vertically and this vertical allocation of resources can be depicted in the following manner (refer to Figure 2.2).



(Source: own)

Figure 2.2: Vertical allocations of funds

According to Green, et al. (2000:1024), when resources are allocated, different needs have to be considered. Further, the authors claim that "...previous budget allocation (incrementalism), current service or facility patterns, capital developments or political factors heavily influence resources allocation, and such approaches fail to address efficiency and equity objectives" (Green, et al. 2000:1024). Based on previous budget allocations, failure to address efficiency and equity objectives is due to the fact that resources are allocated according to historic data to address current problems.

In this view, resource allocation requires policy that will address the 12 principles of development of DHS, namely, overcoming fragmentation, equity, comprehensive services, effectiveness, efficiency, quality, access to services, local accountability, community participation, decentralisation, developmental and intersectoral approach, and sustainability (SA, 1997:online).

In the process of decentralising resources, different factors are taken into account to address the earlier principle. For example, Hennell (2009:online) indicated that in England the Resources Allocation Working Party (RAWP) was used as an allocation formula. The advantage of RAWP is that it takes population, age and socio-demographic characteristics into account (Hennell, 2009:online). It ensures equal

access to healthcare services. On the same note, in Pakistan the same factors, including local needs differences and socio-economic factors, are considered to affect resource allocation (Green, et al. 2000:1024). However, one of the issues identified with this method of allocating resources is that some areas are under-resourced due to their economic conditions and as a result those areas need to utilise the revenue collected through user-fees for operations. South Africa does not allow public hospitals to utilise the user-fees collected.

In South Africa, the National Treasury stated that components of the formula used for resource allocation comprise of economic activity, social welfare, education, population, and health (McIntyre, 2012:3). Due to its drawback, this formula had to be adjusted to address the equity principle by removing or adjusting the weighting of economic factors because of the fact that it redirects the resources to provinces with better economic productivity (McIntyre, 2012:3).

In support, the Department of Health emphasises that the purpose of resource allocation is to promote equity in the provision of health services (Department of Health, 1997:online). In addition to equity, Van der Heever (2009:73) states that resources at the public hospitals are used for the purpose of ensuring efficiency in providing healthcare service.

Besides prioritising healthcare service, Bayley, Calkins and Machana-Pariere (2013:online) suggest that resources be allocated to enhance efficiency and effectiveness within all functions of the hospital, including financial management areas. However, the focus is on the provision of healthcare services to the citizens as a primary reason for the existence of public hospitals that are mostly visited by underprivileged and senior citizens who cannot afford medical aid schemes. Allocated funds should be spent in a manner that will allow equity.

Although funds received by cost centres are further distributed within the units of each cost centre, in the studied literature there was no indication of how cost centres allocate funds to the revenue collection activities. Revenue collection activities are often under-resourced. Besides the salaries of officials directly involved in revenue collection activities, most resources are allocated to administration costs, the purchase

of equipment, transport, catering, laundry, stores, maintenance, radiology, dental, theatre, and pharmacy (McCoy, Thomas, Makan & Chimfwembe, S.a:online).

As mentioned, in South Africa user-fees are not utilised to defray operational expenditure, hence, revenue collection activities are not prioritised by officials as it lacks incentive. It was, therefore, proposed by the *White Paper for Transformation of Health System in South Africa* that a certain amount of revenue collected should be retained by the hospital (SA, 1997:online). This revenue was meant to supplement the funds allocated to the hospital.

The retained revenue will provide incentives to improve the collection of user-fees and the quality of services from public hospitals that may eventually result in attracting paying patients. However, the PFMA (Section 22(1)) requires that all revenue collected by public institutions and entities be deposited into the appropriate revenue fund and no money should be withdrawn from such a fund except in terms of an Appropriation Act (SA, 2017:online). As a result, the GDoHSD has previously been able to enter into an agreement with the National Treasury to have 20% of the revenue collected to be used to improve revenue collection processes and systems (GDoHSD, 2010:online).

In addition to the budget allocation received by hospitals, the revenue collected by hospitals, according to the *White paper on the transformation of the health system in South Africa* (SA, 1997:online), should serve as the new source of public health finance. This revenue needs to be split between the collecting hospital and PDoH (SA,online). The accounting officer of the PDoH, among other authorities, must delegate powers to the managers of the hospital to shift funds for certain items and to utilise a specific amount of revenue collected (SA, 1997:online).

An international experience indicated both positive and negative effects of collecting and retaining user-fees. In a study conducted by Akortsu and Abor (2011:134), it was suggested that user-fees also served as a source of funding for public hospitals in Ghana, in addition to a budget allocation from government. This source of financing for public hospitals resulted in the allocated funds from the government budget being reduced in Cambodia (Akashi, Yamada, Huot, Kanal, & Sugimoto, 2003:562). In

Kenya, hospitals retained 75% of the revenue collected from user-fees and surrendered 25% to the government account (Mwabu & Wang'ombe, 1997:282).

Based on these experiences it can be assumed that if a hospital is directly benefiting from the collected user-fees, such benefit will stimulate the collection of revenue. Among other benefits, Wilkson, Gouws, Sach and Karim (2001:665) state that the benefits of user-fees include injection of revenue, improvement of health services, and preventing the misuse of health services. In Ghana, where the allocated funds from government are often below the required amount to run hospital operations, user-fees are utilised to supplement the available resources (Witter, Arhinful, Kusi & Zakariak-Akoto, 2007:64).

From the reviewed literature, it is apparent that the South African health system places more attention on the provision of health service and less focus on revenue collection. In South Africa, hospital managers are mainly concerned with receiving funds from the government budget, while in other countries the provision of better healthcare is dependent on the resources raised by the providing hospital.

These managers, however, have the onus to manage the allocated funds of their respective hospitals. To ensure health service delivery, managers need to be certain that information on the funds spent and what is remaining in their budget is accurate. This is vital for a hospital to avoid overspending or being under-resourced. If managers are aware of how much the hospital has spent and how much is available, they will be able to reduce unnecessary activities such as entertainment, in order to remain within the budget and ensure convenient healthcare service delivery.

2.2.3 Operating and monitoring

The system of in-year management, monitoring, and reporting was implemented by the National Treasury to monitor departments' spending (Kuye, et al. 2002:120). Besides determining spending trends, the purpose of monitoring is also to check the revenue collected against the targets (Engelbrecht, et al. 2002:online). With this process, managers are able to determine possible future overspending or underspending and under-collection of revenue (Wang, 2010:79).

The PFMA requires the accounting officers to make an effective system of in-year resource management available (National Treasury, 2000:online). According to Ramos (National Treasury, 2000:online), the in-year management system must monitor the progress of the department's operational plan, which includes the budget.

Wang (2010:79) views the role of monitoring as improving ongoing checks on the budget by comparing actual results against the plan, revealing inefficiency of operations, and consistency against the plan, such as a revenue surplus that may indicate effectiveness in operations. In order to achieve this, managers need to raise the following questions during monitoring (National Treasury, 2000:online):

- What has happened so far?
- What do we think will happen to our plan for the rest of the year?
- What (if any) actions do we need to take to achieve our plan?

Engelbrecht, et al. (2002:online) state that hospitals have budget cash-flow committees that meet regularly to discuss expenditure and revenue management. Among other reports and records, revenue collection records or ledger reports are requested to determine whether targets are met as projected. This information is requested on a monthly basis.

According to Wang (2010:80), to develop an effective system of monitoring, indicators to assess the financial performance of an organisation are needed. Through these indicators, one can state whether or not the system is effective and efficient. Indicators are used for determining progress towards the set targets in monitoring.

The district hospitals monitor revenue collection in terms of the following indicators (Engelbrecht, et al. 2002:online):

- Revenue collection targets – this indicator shows the extent to which set targets have been achieved.
- Revenue collection rate – it measures the rate at which revenue was collected.

- Revenue as a percentage total of expenditure – this is the revenue collected expressed as a percentage of total expenditure. It measures sustainability.
- Debtors collection period – this is the number of days it takes for a hospital to collect revenue. This is regarded as a measure of efficiency, effectiveness, and sustainability.

The revenue management process should enable effective monitoring of revenue collection (National Treasury, 2000:online). Normative measures for financial management comprises of the following as measures and indicators relevant for revenue management monitoring (refer to Table 2.1):

Table 2.1: Normative measures for financial management

Critical performance area	Basic evaluation	Performance indicator/ measure requirement	Performance	
			Norm	Actual
Revenue management	Is the collection of revenue monitored on a regular basis and reported to the executive authority [sec 39 (290(b)) of the PFMA]	Frequency Timeliness Quality	Monthly 15 days after month end All variances explained and followed up	Actual performance compared to normal

(Adapted from: National Treasury, 2003:online)

The PFMA stipulations as applicable to government departments must also apply to their respective cost centres (GDoHSD, 2011:online). As mentioned in this chapter, the accounting officer of a department should ensure that there is an effective system of monitoring within the department. The PFMA further requires that officials take effective and appropriate steps to prevent under-collection of revenue due (SA, 2000:online). Monitoring systems will alert public hospital managers of any possible under-collection of revenue.

According to Mudau (2010:42), the monitoring system assesses the rate at which payments are made. Managers are able to determine the age of accounts receivable through this process. The monitoring system prompts corrective actions where deviations are detected from the set targets. Thus, an effective system of financial management for public hospitals should have a system of monitoring in place to ensure that the revenue collection is monitored and monthly reports are available.

2.2.4 Evaluation and reporting

“The setting of aims, missions, strategic plans, objectives, functions, outcomes, output, performance measures, and preparation of a budget to deliver the services mean nothing if they are not followed by a reporting process that provides information to be used for evaluation, scrutiny and instituting corrective steps” (Kuye, et al. 2002:120). The Longman Dictionary of Contemporary English (2003:534) defines evaluation as “a judgement about how good, useful or successful something is”. The public sector, unlike the private sector, does not measure success in terms of profit but it measures success in terms of economy, efficiency, and effectiveness (Pauw, et al. 2002:137).

In this view, success is met if the organisational unit implements a system of financial management that is effective, efficient and economical as required by the Act. At the end of each financial year, managers need to evaluate how the hospitals have performed against the operational plan, and whether the resources were effectively, efficiently and economically used. Evaluation is concerned with the attainment of pre-set targets or goals.

Evaluation is essential where one has to report on performance, and this can only be achieved if the operational plan is compared with the actual results. Therefore, when evaluating the effectiveness of the financial management system, one is assessing the performance of an organisation in financial terms. In relation to financial management, this study aimed to evaluate the effectiveness of revenue management. The vision of the *Guide for accounting officers in terms of the Public Finance Management* Act was to ensure that the public sector has an effective revenue management system (National Treasury, 2000:online).

Although the study aimed to evaluate the effectiveness of the revenue management system, to assess a system in terms of effectiveness only may not provide enough data to draw a conclusion. As Kreitner (2009:7) says, "[e]ffectiveness alone in not enough". The PFMA states that accounting officers should ensure that an effective and efficient system of financial and risk management, and internal control, is in place (SA, 2000:online). According to the *Guide for accounting officers in terms of the Public Finance Management Act*, a report should specify how the department has performed in terms of effectiveness, efficiency and economy (National Treasury, 2000:online). Questions to ask when evaluating these "3Es" are (Engelbrecht, et al. 2002:online):

- "Have we done the right thing?
- Have we done it in a right way?
- Did we receive a good value for our rands?"

What constitutes effectiveness, efficiency and economy in the public financial management field, with emphasis on revenue, can therefore be explained as follows:

2.2.4.1 Effectiveness

The Longman Dictionary of Contemporary English (2003:502) defines *"effective*" as successful and working in a way that was intended. Van der Waldt (2004:70) concludes that a public sector institution is effective if it renders services as expected. For example, if the programme aims to train 5000 candidates in revenue collection functions, the programme will be considered effective if it properly trains 5000 candidates to perform revenue collection functions.

In relation to the study, Kuye, et al*.* (2002:107) state that a department needs to have a system of revenue collection that is effective, and that regularly reviews the tariff structure. In terms of South African public hospitals, a tariff structure refers to the UPFS. Section 7(7.3)(7.3.1) of the Treasury Regulations (National Treasury, 2005:online) states that the accounting officer of an institution must review at least annually, when finalising the budget, all fees, charges or rates, scale or tariffs of fees, and charges that are not or cannot be fixed by any law, and relate it to the revenue

accruing to a revenue fund. Therefore, a system which is effective will ensure that all revenue due to the state is collected to meet the revenue projections. Where there are fees owed to the state as a result of one receiving a service from the hospital and not paying instantly, a system of revenue collection should have credit policies to ensure timely collection of such fees at a later stage.

According to Mihaiu, Opreana and Cristescu (2010:online), measuring effectiveness demands estimating costs and resources involved. Thus, by concluding that a system is effective, one needs to look into the costs involved to achieve the end results. For this purpose, the researcher explored efficiency and economy concepts.

2.2.4.2 Efficiency

Efficiency is defined as the “ability to do something well without wasting money or energy” (Oxford Business English Dictionary, 2008:185). Van der Waldt (2004:181) states that a system is efficient to the extent that it renders services with the least amount of resources available. In relation to this study, efficiency is achieved if the hospital is able to collect budgeted revenue with the amount of resources allocated. Efficiency is best understood when the output is related to the input consumed.

Various authors have defined efficiency in terms of technical and economic efficiency. Ouattara (2012:38) states that technical efficiency occurs when the input possessed is able to produce the maximum possible output. According to Otrusinova and Pastuszkova (2012:174), efficiency assesses the relationship between input and output.

Grandy (2008:8) claims that the public sector applies the Pareto principle of economic efficiency in allocating resources. In terms of economic efficiency, resources are allocated in a way that one person cannot become better off without making the other person worse off (Grandy, 2008:online). Although the primary objective of public hospitals is to provide health services, when allocating resources to the hospital all the divisions (supporting functions as well) within the hospital should receive sufficient resources.

2.2.4.3 Economy

Van der Waldt (2004:70) defines economy as the minimisation of resource consumption. According to Otrusinova and Pastuszkova (2012:174), economy is interpreted as the use of the lowest possible expenditure to achieve high quality. The concept of economy in this context refers to the costs of resources, such as revenue staff, equipment, computer software, and the usage thereof.

The relationship among these three concepts can be explained as producing expected results – **effectiveness** – by using resources without wasting them – **efficiency** – at minimum cost – **economy**. The system implemented should ensure the timely collection of revenue without unnecessary costs.

In relation to this study, these terms can be better explained in terms of input, output, and outcome. In support, Aubyn, Pina, Garcia and Pais (2009:online) state that efficiency is determined through a comparison between input and output. A system which is efficient should be able to translate into effectiveness, i.e. when resources are utilised efficiently they should achieve envisaged results.

In the case of revenue collection, input refers to the effort, resources and the cost of collecting revenue, while the output relates to the actual revenue collected during a particular period. The outcome is the final results of revenue collected during the period.

Since government departments do not operate with the profit motive, the outputs available are the means to assess the performance against predetermined targets. Where a department is required to submit monthly reports on revenue, the submitted reports will serve as the output to assess the financial reporting of such a department. The financial report will provide information with regard to the financial performance of departments and their respective cost centres.

The revenue collected throughout the financial year should be reported to the PDoH on a monthly basis in the form of monitoring reports. The monitoring reports help to evaluate the level at which objectives have been met against performance indicators

set in the budget. Treasury Regulations, Section 5(5.3)(5.3.1) (National Treasury, 2005:online), states that the accounting officer must establish procedures for quarterly reporting to the executive authority to facilitate performance monitoring, evaluation, and corrective actions.

These reports also facilitate the compilation of financial statements which will be included in the annual report of a provincial department to be submitted to the relevant Treasury (National Treasury, 2000:online). Reporting and evaluation ensure the accountability of financial managers in the public sector. It enables managers to plan, allocate resources, collect revenue, and ensure that public funds are spent in a manner that will meet the common needs of the population.

The hospital managers are responsible for an effective financial management system. These managers, together with district management teams, compile a budget for their respective hospitals. The budget will provide a basis for subsequent procedures in financial management.

It is, therefore, concluded that financial management in the public sector focuses on budget implementation. Revenue collection is one of the objectives incorporated in the budget. How revenue is collected by hospitals is discussed in the subsequent section.

2.3 REVENUE COLLECTION SYSTEM

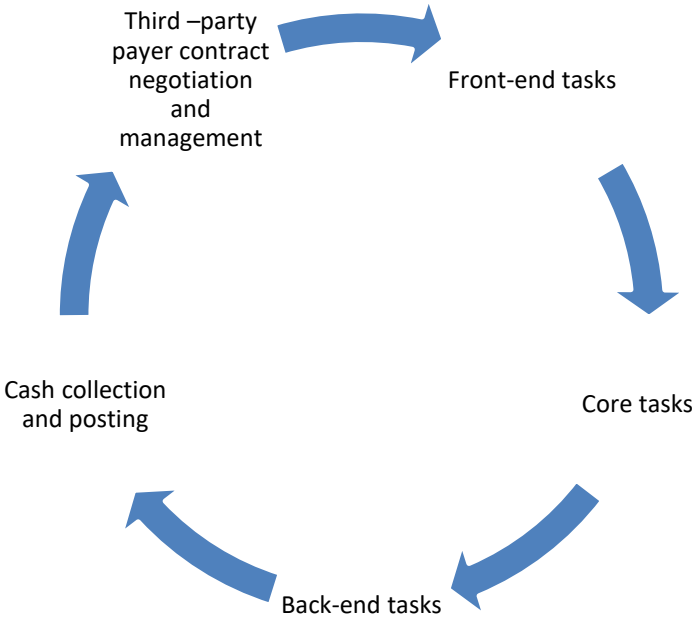
Revenue collection refers to the manner in which financial resources are mobilised or raised to pay for health system costs (Department of Health, 2011:online). Among others, the PDoH raises revenue through user-fees charged for services rendered. The system to manage revenue collection includes billing the patients using the hospital information system, and managing patient account payments, which are maintained by the BAS – the application accounting software of the South African government.

Luhmann (2013:online) briefly describes a system as a relationship between components, or a relationship of structures and processes. Matthies (2012:630) states that based on Luhmann’s system theory, there are various systems with different

functions and these systems are independent. In essence, a political system can solve political problems while financial systems can only address financial matters.

The Oxford Dictionary (2009:1189) defines a system as a set of principles or procedures according to which something is done; an organised scheme or method. From these definitions, the revenue collection system can be understood as the related process, methods, procedures, and routine to collect revenue. The characteristics of a system, as explained by Matthies (2012:630) are reflected in revenue collection procedures or processes which are specifically designed to collect revenue.

The revenue management of a hospital is portrayed as a cycle with various activities, and is regarded as a method that helps to trace and improve revenue generation (Rauscher 2010:11; SEHA Corporate, 2013:online). The revenue management cycle is well defined as a "…process of collecting money for services rendered by the provider" (Blair, et al. 2004:34). There are various procedures undertaken from patient scheduling to the point of revenue collection. According to the study of Rauscher (2010:12), a revenue management cycle consists of various elements (refer to Figure 2.3).



(Source: Rauscher, 2010:13)

Figure 2.3: Hospital revenue cycle

2.3.1 Revenue management cycle

The hospital revenue processes actually begin with the service provider signing a contract with the payer (Martin, 2011:online). Berger, Eldenburg, Schafer and Zulauf (in Rauscher, 2010:12; Martin, 2011:online) point out that the initial stage of the revenue cycle is negotiating contracts with the third-party payers. The hospital and the third-party enter into an agreement regarding pricing, timing, payment terms, et cetera. However, Blair, et al. (2004:34) are of the opinion that the revenue cycle starts when a patient seeks health service from the hospital. Both views attempt to explain one point which is the initial stage of the revenue cycle, which in fact includes seeking medical services and contract negotiation.

Although setting a contract with payers is viewed as the first phase in the process according to Martin (2011:online), Rauscher (2010:12) regards front-end, core and back-end tasks as essential elements in the cycle. From the statement of the author (Rauscher, 2010:12), according to the order in which these elements are arranged, the front-end is seen as the first stage of the revenue cycle. A patient's first contact with

the hospital occurs at front-end when scheduling an appointment. These elements help the hospital to achieve its objectives (Rauscher, 2010:12). Various authors indicated common explanations of these processes:

2.3.1.1 Front-end

According to Cleverley and Cameron (in Rauscher, 2010:14), at this stage of the appointment, scheduling and registration take place with a hospital staff member registering and collecting the patient's demographic, clinical and insurance information. Scheduling occurs once a patient decides to visit a hospital. Besides walk-ins, scheduling can also be done telephonically, by e-mail, or web self-service. In public hospitals scheduling is mostly done in person, whereby the patient walks in and makes an appointment prior to consultation.

The information technology industry is striving to bring in a system that will improve these processes by means of a self-help system whereby a patient can schedule an appointment and register online (Triple Tree, 2006:online). According to Rauscher (2010:14), registration accelerates the collection of revenue. Transformation is therefore needed to meet the high demand for health services at this point. Subsequent to scheduling is the financial status of patients that is also assessed for payment purpose.

The means test to determine how much a patient is supposed to pay out-of-pocket, is carried out at this stage. The hospital officials verify the eligibility of the individual in order to determine the services covered by the medical insurance plan (Martin, 2011:28). It is imperative to provide the patient with the information regarding financial responsibility before being presented for treatment. Financial counselling is offered to a patient in order to inform him/her about the financial implication of the service received. In a nutshell, the purpose of financial counselling is to determine whether the person is liable for payments (Blair, et al. 2004:35). Front-end activities ensure that patient information is available for correct billing and collection of related fees.

2.3.1.2 Core

The primary role of hospitals is to provide health services. This is a stage where actual revenue is generated. The medical record of a patient documented is used in the billing process and communicated to the third-party payers (Rauscher, 2010:15). The amount owed by the insurer is for medical services provided (Martin, 2011:online). The services provided to the patient should be clearly recorded to avoid disputes between the payer and the hospital. Rauscher (2010:15) highlights the significance of capturing the information related to services provided on the hospital system by stating that, if the services are rendered but not entered on the system, such service will not be billed.

It also needs to be mentioned that if the information is incorrectly entered on the system and corrected at a later stage, it prolongs the billing and the collection process. Mudau (2010:39) indicates that record keeping in public hospitals is still done manually. The risk of keeping information in manual form is that such information can be lost, which may result in revenue not being claimed where claims are submitted in batches. However, there are systems which are used to capture these medical records/notes. CLINICOM, a hospital electronic database, is the patient administration system used for both state and private ward patients in Tygerberg Academic Hospital (Wadee & Gilson, 2007:14). The charges made are only available on the system once the patient has seen a doctor and the notes are entered into the system. However, this system is not linked directly to the billing system (Wadee & Gilson, 2007:14).

In addition to CLINICOM, public hospitals have the option to use different systems that integrate with the main financial system. Most public hospitals in the Gauteng Province implement the Patient Administration and Billing system (PAAB) that supports revenue collection, patient administration, and clinical functionality (GDoH, 2012). This system is linked with other sub-systems within the hospitals. For revenue purposes, a system that PAAB is linked to, is the Invoicing, Receipting and Engineering system (IRE) (GDoH, 2012). This system (PAAB) matches other systems that are implemented internationally.

According to Martin's (2011:online) study that focused on the United States of America's (USA) health sector, order-entry forms used to order tests, medication and

other related medical services, are the basis for charges. Cleverley and Cameron (in Rauscher, 2010:15) state that each medical procedure and diagnosis is given a code. Martin points out that regardless of which method is used to record medical information by the hospital, Chargemaster is still the focal point as it harbours the population of all items that are billed to the payer. Chargemaster is an electronic system that keeps record of all the medical services billed. This system is arranged in a manner that codes and information entered on the system can be linked to its specific code (Martin, 2011:online).

In reference to South African systems, UPFS is linked to PAAB for the purpose of revenue collection. These systems communicate in terms of codes. International Classification Diseases-10th revision coding (ICD-10) has been implemented to meet international standards in collecting, processing, classifying, and presenting mortality statistics.

This system also reports on the procedures relating to billing. It has been a requirement for hospitals to have this system in order to be able to submit claims to the medical aid institutions (Wadee & Gilson, 2007:14). A research report by Triple Tree (2006:online), an independent investment banking firm, indicates that prior to ICD-10, ICD-9 was used in the USA's health sector for coding claims. Medical aid institutions also have such systems in use. According to Cleverley, Song and Cleverley (2011:17), ICD-9 also included codes used for diagnosis reporting. The purpose of implementing this system was to improve billing and communication between systems.

2.3.1.3 Back-end

At this stage billing and revenue collection are performed using the information contained in the medical records of the patient. The cycle ends with the collection and posting of the cash received (Rauscher, 2010:16). Wadee and Gilson (2007:vii) are of the opinion that public hospitals experience difficulties in billing patients for services rendered, and recovering bad debts. This opinion will be verified in the data collection stage of this study.

Rauscher (2010:15) states that one of the factors affecting billing and revenue collection is the time taken from the point of service to charge entry. In certain hospitals, the cashier's office is separated from the nurse stations or reception where files are actually collected by patients before consultation. Patients are not constantly reminded to pay their fees after seeing a doctor. Therefore, it becomes difficult for a finance official to bill a patient while a file, which contains the doctor's notes, is left at the nurse's station to be taken back to the filing room at a later stage. To overcome this challenge, the American Hospital Association (AHA) (2012:online) suggests that hospitals should ensure that all staff members working closely with patients, including officials in admission and registration, social workers, receptionists and nurses, have knowledge of billing and collection policies.

Cleverley, et al. (2011:20) view the capturing of charges for services performed, incorrect billing, and billing late charges as challenges faced in billing. According to the authors (Cleverley, et al. 2011:20), the business of private hospitals is to provide health services and if services are not billed this may result in losses with no revenue generated. Billing, for both private and public hospitals, is vital regardless of which motive a sector pursues.

Once the service has been billed, a claim is prepared to be submitted to payers. This task also includes the editing of a claim. Cleverly, et al. (2011:15) state that in the process of editing a claim, the most critical areas are reviewed to determine if sufficient information is available for the insurer to pay.

The AHA and other parties in the health sector formed a National Uniform Billing Committee (NUBC) which implemented a standard hospital billing form for claim submission (Martin, 2011:24). In the case of electronic claim submission, such submissions are based on that form (Martin, 2011:online). The standard hospital billing form provides a basis for forms that are used to claim.

In reference to the South African health system, there are still parts of the patient administration system that make it impossible to interface with medical aid schemes; as a result, claims are still submitted in batches (GDoHSD, 2011:online). The process of submitting claims manually to medical aid schemes prolongs the collection of

revenue. Reforms, such as the introduction of electronic interchange systems, took place in 14 public hospitals to ensure that the collection process functions effectively (GDoHSD, 2011:online).

The last process of this stage comprises of collecting cash, medical aid payment, and posting on the patient's account. This involves receiving payments from the payers and updating patient accounts by posting the payments (Vein Specialists of America, 2012:online). The objective of posting is to ensure that daily deposits are balanced accurately and the amounts disputed are resolved in time.

In relation to the public hospitals in South Africa, accounts are maintained on the BAS. The functions of revenue management on BAS will be discussed in Chapter 3.

2.3.2 Revenue collection systems used in other countries

In many countries payments for user-fees are still made at the point of service with the system being susceptible to maladministration. The responsibility to implement an effective system of revenue collection lies with the policy makers and hospitals. The collection, administration and the use of hospital user-fees are implemented differently in many countries. The study conducted by Nyonator and Kutzin (1999:333) at Volta Region on the effects of user-charges, revealed that hospital clients make payments at the point of service. In the researchers' findings, the drawback of this system was that there were demands for bribes by officials from users. Naomi, Rebecca, John and Razak (2012:12) also highlighted the weakness in this system by stating, in the case study conducted at Suntreso Government Hospitals, that medical officers often collect money illegally.

Many undeveloped and developing countries are still making use of manual systems to administer user-fees (Dupas, Stanford & Nber, 2012:online). This creates an opportunity for officials to manipulate the system for their own benefit. The hospitals with no financial systems or weak computerised financial systems are most vulnerable. In Kenya, hospital officials were able to place revenue collected into their own pockets due to the fact that the revenue collection system that was implemented was not computerised (Vian, 2005:online). Poor internal controls are another reason hospital

officials are able to illegally benefit from the revenue collected. Providing higher remuneration, as suggested by Dupas, et al. (2012:online), is unlikely to prevent the theft of collected cash.

The use of handwritten books for accounting of cost-sharing funds proved to be ineffective in other countries. In Kenya, to combat such a situation, network cash registers were installed to collect and account for payments (Management Science for Health, 2008:online). One of the measures taken by the hospitals in Kenya to collect outstanding revenue was to lock the patients in a guarded room until the payment was received (Mudau, 2010:33). This measure illustrates that user-fees can create obstacles for people to receive health services from hospitals. It was observed in Sudan that underprivileged people hardly seek health care due to their inability to pay for the services (Kurian, Wagle & Raymus, 2011:online).

The lack of policies to deal with user-fees result in patients being afraid to use hospital services. The hospitals should have a policy on actions to be taken for non-payment (AHA, 2012:online). With systems such as locking patients in guarded rooms, user-fees will not achieve the objectives of levying such charges, which is to improve health service delivery within the country. It is accepted that the main business of public hospitals is not to raise profit. However, in order to ensure sustainable provision of health and other public services, it is vital to have effective systems for revenue collection in place.

The South African government can learn from these poor policies. The government should ensure that patients are protected from abuse as a result of outstanding user-fees. Government should also ensure that systems are in place to reduce the risk of bribery and theft.

2.3.3 Revenue collection system in South African public hospitals

Private hospitals in South Africa differ significantly from public hospitals. The private hospitals are not reliant on any manual revenue collection system. The statement of the former coordinator of the Gauteng NHI task team, Molefi Mosenogi, as quoted in the Sowetan newspaper points out that "...private hospitals have more effective systems for billing patients, the details of the patients are punched on the computer and patients are billed, whereas at public hospitals they rely more on manual systems and end up losing money" (Monama, 2012:online).

Most public hospitals in South Africa have not improved their revenue collection systems to keep up with the changes in the healthcare system, technology, economy, and population growth. The Department of Health admitted that it is experiencing an increase in debts and officials working in financial departments are failing to collect such debts (Mudau, 2010:33).

2.3.3.1 Collecting revenue from medical aid schemes

Collecting revenue from medical aid schemes has always been problematic in the South African healthcare sector. The problem is often associated with the information system implemented by the hospitals. In the Gauteng Province, AGSA also identified the computerised information system as ineffective (GDoHSD, 2011:online).

The former health MEC in the Western Cape Province, Theuns Botha, quoted in Cape Argus (Sipokazi, 2011:online) indicated that the department of Health in the Western Cape Province has been making use of MediKredit to collect revenue from medical aid schemes. Since 2005, 89% of claims were successfully collected. It was internationally proven that the use of service providers to collect revenue in public hospitals could improve revenue collection. The number of hospitals outsourcing revenue collection activities in the USA to improve revenue management has increased from 20.4% to 40% between 2015 and 2016 (Murphy, 2017:online).

Research conducted in all small non-profit and rural hospitals in Georgia, USA, indicated that activities such as billing and collecting revenue from self-paying patients

had been outsourced (Singh, 2011:35). Further, the study revealed that the billing system in the hospitals is linked to various medical aid institutions and government departments (Singh, 2011:35).

2.3.3.2 Collecting revenue at the point of services

The public hospitals charge fees at the point of service for healthcare services rendered. Patients without medical aids are obliged to settle their payments out-of-pocket. Out-of-pocket payments are made by patients without medical aid and also the members of medical aid schemes that do not cover the full costs of service provided (McIntyre, 2009:online).

The amount a patient has to pay out-of-pocket is determined according to the means test (Department of Health, 2009:online). Grosh and Baker (1995:online) describe the means test as a process of determining a person's eligibility for health services. Further, Qungyue, Beibei and Liying (2010:online) indicate that there are different methods of means tests that can be performed, and these include:

- Verified means test – with this method data on the household's income is collected and verified against an independent source such as tax records, pay rolls, and assets.

- Simple means test – it involves the means test administrators visiting the household to verify the consistency with information provided by the applicant in a qualitative manner.

- Proxy means testing – it looks into an individual's location, ownership of durable goods, demographic structure of household, education, and occupation of family members.

- Mix approach test – in terms of this method, a simple means test or proxy means test is combined with other methods.

Although many African countries, specifically developing countries, use a proxy means test, in South Africa the simple means test is used to determine the eligibility of the individual for health service based on family income through an interview with the patient (Qungyue, et al. 2010:online). For payment purposes, patients are classified according to three categories. According to the *UPFS for paying patients attending public hospital,* a patient fee manual, the classification consists of fully paying patients classified as H3, partially subsidised patients classified as H1 or H2, and fully subsidised patients classified as H0 (Department of Health, 2009:online).

Inquiry into the various social security aspects of the South African health system review identified payment at the point of service as an ineffective system due to the fact that patients will not be denied service because payment cannot be made at that point (Department of Health, 2002:online). According to McKesson (2010:online), patients hardly pay the outstanding fees once they leave the hospital facilities. In the aforementioned research, to solve the problem it was indicated that hospitals should employ consumer techniques of collecting payments such as deposits, payment contracts, and card-on-file which can improve collection at the point of service in future (McKesson, 2010:online).

When a patient leaves the hospital without paying the fees, a debt should be initiated against such a person. The *Guide for accounting officers in terms of Public Finance Management Act* defines a debtor as a person who received a service from the department but did not pay for it (National Treasury, 2000:online). Collecting revenue from debtors involves sending a monthly statement, making personal contact, and sending reminders (National Treasury, 2000:online). For public hospitals, it is difficult to follow such a procedure. The majority of the public hospital users are classified as partially and fully subsidised patients. These individuals may hardly act upon reminders, and in some cases, letters may not even reach the addressee.

The means test only determines what the patient can afford but does not provide a guarantee that the outstanding fees will be recovered. South African public hospitals can learn from practices highlighted in the study of Rubenstein (2008:online). According to Rubenstein (2008:online), certain hospitals in the USA screen patients' credit records to determine if a patient has the potential to settle the resulting medical

bills. For this purpose, credit checks are done. Credit checks on patients are also used to identify those patients the hospital will need to follow up with. The information provided by credit records includes obligations such as a credit card, mortgage debt, payment history, and information on previous services providers (Nielsen & Kuhn, 2009:116).

From the reviewed literature on revenue collection practices, it is evident that certain practices or measures discourage less privileged citizens from using public hospitals. Where the collection of revenue is feasible, the information systems appear to be ineffective to manage the information.

2.4 CHAPTER SUMMARY

This chapter was aimed at reviewing literature on financial management with an emphasis on revenue collection. It is evident that financial management systems in South Africa play an important role in the health sector, especially in delivering healthcare services. However, it also appears that the revenue collection system as required by the prescript is given less attention within public hospitals.

Improvements in public hospitals' financial policies, including credit policies, are needed to cater for patients with low income to ensure that a minimum pre-set fee is received. The current system still needs to be transformed in order to accommodate any changes in the healthcare sector such as the introduction of the NHI. According to the reviewed literature, the computerised financial system of public hospitals in South Africa does not appear effective in collecting revenue from medical aid schemes.

Although user-fees appear to be obstacles to access healthcare services in some countries, lessons can still be learnt from countries with effective financial systems. Chapter 3 of this study will present revenue management by discussing its functions and procedures.

CHAPTER 3
PROCEDURES AND FUNCTIONS IN REVENUE MANAGEMENT

3.1 INTRODUCTION

Chapter 2 of this study discussed financial management and the revenue collection system in hospitals. Although revenue collection is part of revenue management, Chapter 2 did not provide a vivid review of revenue management processes in government organisations. It has been deduced from Chapter 2 that cost centres cannot be independent from their respective provincial departments. In this chapter the researcher provides a comprehensive review of revenue management from a provincial department's perspective, specifically the PDoH.

The intent of this chapter is to explain the revenue management process in terms of applicable legislations, regulations, accounting systems, and other publications from National Treasury. The aim is also to discuss revenue collection procedures in order to address the research problem. Although the focus of this chapter is revenue management, revenue collection is still the focal area of the entire study. Therefore, revenue management is discussed with the emphasis on the revenue collection procedure in public hospitals.

According to Chiang, Chen and Xu (2007:98), the concept of revenue management emerged from the airline industry in 1978 and was later implemented in the hospitality industry. When revenue management was introduced in the airline industry, it was aimed at saving companies from a declining market and increased competition. Presently, revenue management is used to maximise revenue from the available capacity in all industries (Stanciu, 2009:8; Chiang, et al. 2007:98). Different industries such as car rental agencies, hotels, resorts, and railways started adopting revenue management techniques for various reasons. Most importantly, in these industries revenue management focuses on the pricing of services and/or goods (Wirtz & Kimes, 2007:230).

Compared to other industries, revenue management was previously not effective in the healthcare sector (Stanciu, 2009:9). This was because healthcare institutions were operating as non-profit organisations. However, these institutions needed resources to continue operating on a daily basis.

From this background, it is apparent that revenue management has developed from the private sector which is highly profit orientated. The private sector is concerned with raising revenue for profit reasons. However, it cannot be excluded from the public sector as effective revenue management mechanisms are essential for sustainable service provision.

The purpose of this study was to evaluate the effectiveness of revenue management in South African public hospitals through a case study of the TDH. Therefore, this chapter reviews the management process of revenue collection in a South African context. Revenue management has been identified in Chapter 2 as an area that was previously of low priority in government financial management (National Treasury, 2000:online).

The contexts covered within the subsequent sections of this chapter comprise of the definitions of revenue management, the objectives of collecting revenue, the classification of paying patients and non-paying patients, prescripts regulating revenue in the South African public sector, role players, accounting systems, and accounting for revenue collected.

3.2 WHAT IS REVENUE MANAGEMENT?

Wang and Bowie (2009:32) state that there is no standard definition of revenue management, but definitions vary according to industries and sectors. To establish a common definition of revenue management for the purpose of this study, various definitions were synthesised.

Piersma and Pak (2002:online) define revenue management as "...the art of maximising profit generated from a limited capacity of a product over a finite horizon by selling each product to the customers at the right time for the right price".

Karaesmen (2001:2) defines revenue as the application of techniques that determine customer reaction at the market and improve the product availability and the price to maximise revenue. However, the applicable definition of revenue management in this study is that of the National Treasury (2010:online) as outlined in its explanatory note. In this note, revenue management is defined as those procedures and processes that are vital to ensure the planning and accountability of departments' revenue, including cash management.

According to the aforementioned note, the focal area of revenue management includes legislative requirements, sources of revenue, cash management, **revenue collection**, management of debt, and accounting for revenue (National Treasury, 2010:online). In this study, revenue refers to the income received by the PDoH. Besides the annual appropriation of funds, a department collects revenue from different sources. The money collected from other sources is considered as revenue if it meets the definition of revenue stated as: "...the inflow of cash arising in the course of ordinary activities, normally from the sale of goods, the rendering of services and the earning of interest, taxes and dividends" (National Treasury, 2010:online). The common sources of revenue are explained next.

3.2.1 User-fees

The user-fees, being the focal area of the study, are payments which are directly made by individuals to the hospital at point of service. According to Mclntyre (2009:online), these payments were equivalent to 14% of funds allocated to the South African health system in the 2005\06 financial year.

The user-fees are paid according to the rates set by the PDoH. The PDoH issues a guideline that outlines the amount payable by the individual for healthcare services based on the assessment of income. The correct classification of patients depends on the effectiveness of a means test that, for the purpose of this study, has been identified as part of the problem in collecting user-fees. According to the UPFS applied by the DoH (2009:online) and the *Hospital Fee Manual* issued by the Mpumalanga Provincial Department of Health (MPDoH, 2013:online), the classifications of user-fees constitute of the following categories:

3.2.1.1 Fully paying patients

This category is classified as the H3 group. The H3 consists of, but is not limited to, externally-funded patients, patient being treated by their private practitioners, and other non-South African citizens. The externally-funded patients are funded in terms of the Compensation for Occupational Injuries and Diseases Act No. 130 of 1993, the Road Accident Fund Act No. 56 of 1996, and the Medical Scheme Act No. 131 of 1998. This category also refers to patients being treated on the accounts of other government departments, local authority, foreign governments, and any employers.

Any patient treated by his/her private practitioner in a public healthcare facility is liable for the full payment of the facility fee for the services rendered by the practitioner at the facility, and the total user-fee for any other services received.

The non-South African citizens exclude immigrants who are permanent residents in the country but without citizenship, immigrants with temporary residence or work permits, and persons from the South African Development Community countries who enter South Africa illegally.

3.2.1.2 Subsidised patients (MPDoH, 2013:online)

These patients are further sub-categorised into three categories, i.e. H0, H1, and H2, based on the patient's ability to pay, and comprise of:

a) Partially subsidised patients

This is a default classification. The patients in this group pay user-fees based on their level of income determined by the means test. These patients are classified in terms of the H1 and H2 group. Patients earning above pre-set income levels are responsible for full payment and are classified under H3.

H1 and H2 groups include patients earning equal to or more than a pre-set annual income. These patients pay a specific percentage of tariffs stated in UPFS based on their income.

b) Patients qualifying for a full subsidy

This group is classified as H0. The patients classified under H0 receive free services. Among other patients receiving free services in this group are patients referred from primary healthcare services (local and mobile clinics). Besides the patients referred from primary healthcare services, other patients receiving free services should produce proof in order to be classified under H0. The patient should prove to be a social pensioner, a person with disability, previously formally employed, and needing to be reclassified because he/she can no longer afford the service as a result of previous classification.

The recipients of social grants are regarded as social pensioners in terms of the UPFS and include old age recipients, child support recipients, military veterans' pension recipients, care dependency grant recipients, pension for the blind, family allowance, maintenance grant recipients, disability grant, and single-care grant recipients. However, if the social pensioner is a member of any medical scheme, he/she will be responsible for full payment.

Unemployed patients classified under the H0 category are required to produce proof of unemployment in the form of an affidavit. The individuals who are supported by the Unemployment Insurance Fund should present evidence of unemployment, i.e. the contributor's record card.

The classification of patients according to the level of income does not imply that patients with higher income will receive healthcare service different to the patients without income. The purpose of this classification is to provide cost-sharing for services rendered by public hospitals and equal treatment.

3.2.1.3 Revenue from ancillary services

The public hospitals generate revenue internally from different sources. Naomi, et al. (2012:31) indicated other sources that can generate revenue internally comprise of consultation, laboratory services, X-ray services, in-patient feeding and

accommodation, car park toll, sales auctions, et cetera. In most public hospitals, there is additional space for kiosks that is leased out to generate revenue for the hospital.

3.2.1.4 General tax funds\ Government revenue

This refers to the money collected by government such as direct and indirect taxation to finance healthcare services through a budget allocation. The government revenue that is used to finance public health is not paid directly to a particular hospital but collected by SARS on behalf of the government. The revenue collected is allocated to the relevant department before it reaches the hospital by means of a budget. The PDoH is responsible for allocating the revenue received from the Provincial Treasury to its respective public hospitals.

3.3 THE OBJECTIVES OF COLLECTING USER-FEES

Different individuals and organisations hold different views on the objectives of user-fees collected through government facilities. According to Lagarde and Palmer (2011:online), the collection of user-fees was recommended by UNICEF and the World Bank. The literature was reviewed to determine the purpose of collecting user-fees. According to Gilson (1998:online), national policymakers state their main objective of collecting user-fees as raising revenue. This was identified in many low-income and middle-income countries as a source of finance for health systems (Lagarde & Palmer, 2011:online). Gilson (1998:online) and the World Bank (in Lagarde & Palmer, 2011:online) emphasise that the revenue raised through user-fees will improve and ensure sustainability in the healthcare system within a country.

In South Africa, public services rendered by the central government are financed through revenue collected by SARS. However, South Africa is in a position where official taxpayers have to finance a majority of unemployed and poor citizens. The motive of financing public services by taxation is to ensure that these services are available to the general public, rich or poor, employed or unemployed (Gildenhuys, 1993:364).

Although tax is a primary mechanism for financing public services, the responsibility still needs to be spread among the citizens by means of user-fees. The user-fees are charged to relieve the taxpayers of the burden of paying public service costs (Gildenhuys, 1993:364). These charges do not cover the total costs of the services; however, they ensure that users take responsibility in using the public services.

The World Bank indicated three objectives of charging user-fees: to improve efficiency in the use of public services; to raise revenue; and to enhance the equal distribution of financial resources within the health sector in the country (Lagarde & Palmer, 2011:online). Ataguba and McIntyre (2009:online) state that there is inequality in terms of income in South Africa, hence, user-fees should be utilised to finance the healthcare system. Gildenhuys (1993:364-365) claims that charging user-fees is a means to assist the government keep record of the demands of services, prevent the misuse of services, and ensure equity in sharing the costs of services. It can, therefore, be said that user-fees prevent patients from seeking unnecessary healthcare services. They ensure that healthcare services are used efficiently.

3.4 ROLE PLAYERS AND THEIR FUNCTIONS IN REVENUE MANAGEMENT

“Revenue management processes must ensure adequate separation of duties and provide effective supervision and monitoring of revenue collected” (National Treasury, 2000:online). The segregation of duties reduces the risk of errors and fraudulent actions where money is involved. The procedures, from collecting debts, receipting cash at the point of service, to banking the cash, should be executed by different officials.

These officials need to be equipped with the necessary financial management skills and knowledge to ensure effective and efficient revenue management. As a result of changes in policies, standards and systems, financial management skills will always have to be enhanced. Due to a lack of sufficient skills in the public sector, it is necessary for government departments to provide training to officials in order to enhance their knowledge and skills.

Van der Heever (2009:23) points out that role players in financial management need to be competent in terms of knowledge and skills, and be familiar with the legislative framework and policy structures in order to execute their responsibilities effectively. The responsibilities of the role players, i.e. cashiers, supervisor, responsibility manager, chief financial officer, and accounting officer, are discussed next.

3.4.1 Cashiers

Cashiers are well described by the U.S Department of Treasury as officials in the employment of a department within the finance division designated to carry out cash operations (U.S Department of Treasury, 2001:online). They receive the money at the point of collection and issue manual or electronic receipts (National Treasury, 2010:online). These officials are also responsible for the safe custody and depositing of all monies collected (National Treasury, 2012:online). As part of good internal control, such officials should not be the same person responsible for receiving money and capturing receipts.

The general Notice of National Treasury (2012:online), Notice 1005 of 2012, states the following:

a) The accounting officer or accounting authority of an institution must ensure that employees responsible for collection, receipting or banking the institution's money are assigned such tasks in writing.
b) Employees whose duties include the receipt or disbursement of institutional money are responsible for the safety and custody of all the money under their control.
c) Institutions' accounting officers or accounting authorities must ensure that employees entrusted with receipting or handling the institution's money are granted leave or a change of duties at regular intervals of not more than 12 months.
d) In public hospitals, the main duties of cashiers include billing of services rendered, capturing of revenue transactions in the financial and hospital system, banking of revenue collected, performing daily revenue reconciliation, reconciliation of debtor accounts, recovery of patient fees debts, among others.
e) With proper segregation of duties there should be more than one cashier with different duties. One cashier will be responsible for capturing all receipts issued by

the other cashier. The capturer can also be the same cashier who collected money from the hospital users at the point of service.

3.4.2 Supervisor

A supervisor is defined as an official with subordinates and the responsibility to ensure that the work is done effectively (Asgar, 2008:1). This is an official who oversees the work of cashiers within the finance office. This official is also responsible for closing shifts. The supervisor reconciles cash collections against a day-end cash collection (GDoH, 2012:online).

3.4.3 Responsibility manager

The responsibility manager, being the head of the institution, is responsible for submitting the projected revenue to be collected by the organisational unit to PDoH (GDoH, 2012:online). There are numerous responsibilities delegated to this official, including the responsibility to collect money that is due to the PDoH. In the public hospital sector, the responsibility manager refers to a Chief Executive Officer or the Superintendent of a particular hospital. This manager reports to the chief financial officer (CFO) of the PDoH (Van der Heever, 2009:21).

3.4.4 Chief Financial Officer

The CFO's responsibility is to assist the accounting officer in discharging his/her financial duties. The accounting officer is required to identify sources of revenue within the PDoH. To be able to identify the sources of revenue, the CFO must gather the information with the potential sources of revenue, as well as analyse revenue collection trends. The CFO is directly accountable to the accounting officer (Director General) of the PDoH (SA, 2000:online).

3.4.5 Accounting officer

The accounting officer must take effective and appropriate steps to collect all the money due to the PDoH with support from finance officials, specifically the CFO. In relation to user-fees, the accounting officer is required to review the tariffs related to the provision of healthcare services.

3.5 LEGISLATIONS REGULATING REVENUE MANAGEMENT

The responsibilities for managers of government revenue are outlined in legislation. The PFMA, Magistrate Courts Act, Prescription Act, Hospital Ordinance Act, Department of Health Gauteng Administration Procedure Manual and Treasury Regulations form the basis of revenue management and debt management in state operated hospitals (GDoH, 2012:online).

The PFMA is a financial management legislation that regulates financial management in the national and provincial governments. It ensures 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 of those governments, and to provide for the matters connected therewith (SA, 2000:online). The PFMA entrusts the responsibilities of revenue management to the role players in financial management of government institutions.

Section 38(1)(c)(i) of PFMA states that the accounting officer of a department, trading entity, or constitutional institution must take effective and appropriate steps to collect all the money due to the department, trading entity, or constitutional institution. With regard to PDoH, this includes the money due to public hospitals. Section 45 of the Act entrusts the responsibilities to other officials employed by the government departments (SA, 2000:online). This includes a responsibility to take effective and appropriate steps to prevent, within that official's area of responsibility, any unauthorised expenditure, irregular expenditure, and fruitless and wasteful expenditure, and any under-collection of revenue due (SA, 2000:online).

Section 39(2)(b) of PFMA states that an accounting officer should report to executive authority and the relevant Treasury (SA, 2000:online):

i. Under-collection of revenue
ii. Shortfalls in the revenue budget

The role players in the financial management of a government department are responsible for managing departmental revenue. Revenue includes cash and debts accrued by the department. It is imperative for government departments to convert their debtors into cash to ensure that government at large does not experience cash-flow problems with excessive outstanding debtors. The PFMA, Treasury Regulations and National Credit Act make provision for the management of debtors.

3.6 DEBTORS AND CASH MANAGEMENT

3.6.1 Management of debts

The Treasury Regulations defines debt as an amount due to the department (National Treasury, 2005:online). In terms of the Prescription Act, 68 of 1969, a debt is due when the creditor has knowledge of the identity of the debtor and of the facts from which the debt has arisen (SA, 1970:online). In this context, debts refer to the amounts owed to the PDoH resulting from services received by hospital users without paying for it.

To ensure that debtors are managed properly and monies owed are collected, PDoH needs to have a debt management policy. According to the guide entitled *Managing Departmental Debt,* the debt management policy should cover the following procedures (National Treasury, 2010:online):

- The department must keep a register of all debts, in electronic or any other format. The register should include the name of the debtor, type of the debt, age analysis, any amounts already collected and paid over to the relevant Revenue Fund, and the details regarding the procedures followed to collect the debt.

- The register should be inspected and signed-off on a monthly basis by the CFO or his/her delegated official, and must be available for audit.
- The register should contain system generated information and manual documentation such as debtors' letters, attorney referrals, et cetera.
- A monthly reconciliation should be performed on all outstanding debtors to determine the status of the debt.
- The investigation of debtors must be segregated from the collection, banking and reconciliation responsibility of debtors.
- A separate file must be kept for each debtor for safekeeping of documentation.
- A debtor must be placed in default before collection processes are affected.
- Interest charged should only start to accrue after 30 days' default period.
- Interest should be calculated on the decreasing balance of the capital amount of the debt, and must not be capitalised.
- Accounting officers must assure that interest is calculated and recovered together with the capital amount.

3.6.2 Debt collection strategy implemented by Gauteng Department of Health

Debt management is an essential aspect of revenue management and often public hospitals are faced with considerable patient debts to collect. The healthcare service received by public hospital users is likely to result in debts, except for members of medical aid schemes. The knowledge that public hospital users are individuals with disadvantaged financial backgrounds who will possibly ignore debts related to health services, creates a need for effective strategies to collect user-fees.

The patient debts are classified into two categories: self-funded and externally-funded debts (GDoH, 2012:16). The self-funded patients refer to those patients paying their own medical expenses. This category is further classified into two types of patient debts, i.e. patients owing an amount less than R195, and patients owing an amount more than R195.

The classifications allow different procedures to be followed when pursuing debtors to settle their accounts. When applying debt collection procedures, it is imperative to

consider the costs involved and the financial status of the debtor. This allows the creditor to make a sound financial decision to recover the debt. According to Section 35(g) of National Credit Act No. 34 of 2005, collection costs incurred during the period in which attempts are made to remind or inform the debtor about the outstanding payments should be recovered from the debtor concerned (SA, 2005:online).

In terms of the aforementioned categories, each category has recommended procedures to be followed when collecting the money owed to the hospital. The study identified collection procedures as one of the weaknesses in the revenue management of public hospitals. In order to achieve the objectives of this study, the collection procedures are discussed next. For self-funded individuals owing less than R195, the following procedures are recommended (GDoH, 2012:16-18):

- Based on the fact that these are not substantial amounts of money, telephone calls and written communications should not be made to communicate with these debtors.
- These debtors should be verbally reminded of their debts on subsequent visits to the hospital.
- These debts should be written off if they are not settled within 90 days from the period of treatment.
- However, an attempt should be made to recover accounts which have been written off.

For individuals owing more than R195, the following procedures are recommended (GDoH, 2012:16-18):

- Should a debtor not respond to his/her account, a reminder should be sent one month after the treatment was sought.
- Telephone calls should also be made to remind the debtor of the debt.
- Where a debtor does not respond due to changed circumstances, different procedures will have to be followed. In the case where the debtor is insolvent or has passed away, the name of the executor should be established to submit the debtor's account for settlement. If the name of the executor cannot be established, the local

magistrate's office or the Master of the High Court may be approached in this regard.

- Where a debtor cannot be found due to certain reasons, such as change of address, incorrect information, et cetera, an effort should be made to determine his/her whereabouts. The South African Police Services, Post Office, Telkom, and the Department of Home Affairs are among other institutions which can be consulted to ascertain the current location of the debtor. It is further recommended that all measures be taken to trace the debtor if the abovementioned processes are not effective.
- Should the account not be settled within 14 days of the date stated on the last reminder, a letter of demand must be sent to the debtor. In the case where a debtor does not respond to the letter of demand, the debt must be considered irrecoverable and treated accordingly.
- Where it is determined that the debt is recoverable, it should be recovered by means of legal processes.
- In the case where the debtor claims an inability to settle the debt, he/she should submit evidence to substantiate his/her claim.
- When patient fees are recovered by means of legal action by the State Attorney, the details of the debt and debtor should be submitted, measures already taken to recover the debt, the name of the debtor's employer, and any movable asset owned by the debtor of which the debtor is aware.

The procedures to collect money from external-funders are more convenient compared to those mentioned earlier. The nature of these institutions allows the hospital to use the following procedures (GDoH, 2012:18):

- The government departments and other countries are dealt with in terms of written communications and telephone calls. Further, meetings are arranged by senior officials to negotiate terms of payments.
- In the case of the medical aid schemes, follow up is done on rejected claims. All the rejection reports should be acquired from the medical aid schemes. The medical aid scheme rejections can result from various reasons, such as termination of the medical aid before the patient visits the hospital, the medical aid funds could be

exhausted, medical aid plans might not cover the treatment, et cetera. Therefore, should a rejection result from the aforementioned circumstances, the individual should take responsibility for the liability.

Although public hospitals have measures in place to collect outstanding debts, certain measures are not available to effectively encourage debtors to pay their outstanding debts. Given that public hospitals are not required to charge interest on user-fees, debtors are likely to ignore their debts. The individuals owing public hospitals are not at risk of being blacklisted. The current procedures in place also provide an opportunity for debtors who are able to pay to manipulate the process and avoid the debt.

In the absence of these drastic measures, Mudau (2010:61) suggests that debt collectors should also be considered when drawing debt collection policies. According to the author (Mudau, 2010:61), debt collectors should be appointed to assist hospitals in collecting their outstanding debts. A debt collector refers to a person, other than an attorney or his/her employee, who collects debts owed to another for a reward (SA, 1999:1).

The Debt Collector Act No. 114 of 1998, has been enacted to provide for the establishment of the Council of Debt Collectors. This council exercises control over debt collectors. According to the debt collectors' code of conduct (SA, 2003:online), debt collectors should conduct their services in a good manner. In an effort to collect the debt, the debt collector should, among others, not:

- collect or attempt to collect an amount in excess of the money owed to the creditor, except for interest and legal costs;
- misrepresent the nature of his/her business, or threaten to institute a legal proceeding, civic or criminal, where there is no intention to carry out such a threat;
- use communication that portrays legal or judicial processes;
- threaten violence or harm to the debtor, those related to the debtor, or his/her property;
- use threatening or violent language when communicating with the debtor;

- communicate with the debtor while the legal adviser has notified the debt collector in writing to communicate with the legal adviser;
- abuse or intimidate the debtor in any manner, whether orally or in writing, in order to persuade the debtor to pay; or
- make telephone calls that might constitute excessive harassment to the debtor or his/her spouse.

Communication plays a vital role in collecting debts. It has been noted that public hospitals have ineffective communication systems in place (Mudau, 2010:69). An electronic format can be a useful medium of communication with the debtor as it also conforms to global initiatives of going green. The electronic process of collecting debts comprise of sending SMSs, e-mails, and faxes. The development of technology around the globe calls for departments and hospitals to review their policies and consider other electronic mediums of communication for collecting debts. Where written communications are ineffective, electronic communications will be appropriate to use as an alternative.

The PDoH finance policies are drawn in line with financial legislations. Mudau (2010:41) views the significance of a debt management policy as ensuring efficient and effective debtors' management.

In the South African government, the PFMA and Treasury Regulations form the basis of departmental finance policies. With regard to managing debts, PFMA and Treasury Regulations are applied concurrently. An example is Section 11(11.2) of Treasury Regulations that complement Section 38(1) (c) (i) and (d) of the PFMA. According to this regulation, the effective and appropriate steps to collect all the money due to government include maintaining proper accounts and records of all debtors, including amounts received in part payment, and referral of a matter to the State Attorney, where economical, to consider a legal demand and possible legal proceedings in a court of law.

Mudau (2010:28) indicates how this regulation applies to the public hospital as a government institution. According to the author (Mudau, 2010:28), Section 11 of

Treasury Regulation is applied where hospital users are unable to pay the user-fees at the point of services or where debts arise as a result of hospital services being utilised without compensation thereof. Treasury Regulation 11, which deals with the management of debtors, applies to all debts accruing to an institution and includes any amount receivable by the institution, such as invoices for goods, services, or outstanding fines (National Treasury, 2005:online). Although this regulation indicates how the amounts owed to the state should be recovered, it needs to be applied in conjunction with the National Credit Act No. 34 of 2005.

Among its objectives, the National Credit Act aims to provide for debt re-organisation in case of over-indebtedness and to regulate credit information to provide for debt counselling service (SA, 2005:3). Section 85 of this Act states that where a consumer is over-indebted the court may:

a) refer him/her directly to a debt counsellor with a request that the debt counsellor evaluate the consumer's circumstances and make recommendations to the court; or
b) declare the consumer over-indebted, as determined in terms of this section, and make an order to relieve the consumer's over-indebtedness.

This Act makes provision in cases where a person is unable to settle his/her debt due to excessive debts. From Chapter 2 a lesson was learnt on accruing fees at public hospitals and the inability of individuals to pay hospital fees. According to Kahn (2012:online), certain patients struggle to settle their fees since the means test was introduced. In an interview with cancer patients from Groote Schuur, the author discovered that it takes more than two years to settle some debts (Khan, 2012:online). The availability of debt management policies within the PDoH and public hospitals should ensure that conditions exist to enable patients to settle their debts.

3.6.3 Cash management procedures

This chapter will be incomplete if cash management procedures are not discussed. It is therefore imperative to mention cash management procedures available in state owned facilities. Section 7(1) of PFMA requires the National Treasury to prescribe a framework within which departments can conduct their cash management (SA, 2000:online). Treasury Regulation 15.10 states the following as sound cash management procedures (National Treasury, 2005:online):

- collect revenue when is due and bank it promptly; and
- pursue debtors with appropriate sensitivity and rigour to ensure that amounts receivable are collected and promptly banked.

The establishment of cash management processes and training is the accounting officer's responsibility. The *Basic Accounting Handbook for Departments* guides departments to implement effective controls to manage revenue (National Treasury, 2010:online). According to the aforementioned handbook (National Treasury, 2010:online), the internal controls for revenue should consist of:

- monitoring and consistency in deposit dates;
- segregation of duties related to cash management;
- internal verification process for recording receipts;
- correct classification of revenue accounts;
- reconciliation of bank deposits with departmental books;
- reconciliation of collection system and money collected to deposit books used by the collecting entity; and
- the reconciliation process should ensure that all the money received is captured on the system.

All the cash collected should be banked promptly as required. According to the revenue process manual issued by GDoH (GDoH, 2012:4), banking should be done on a daily basis. Banking of cash collected should take place through collecting

companies, with the collecting company acknowledging receipt of the money when it is collected.

3.7 BASIC ACCOUNTING SYSTEM FUNCTIONS FOR REVENUE MANAGEMENT

Chapter 2 indicated that the accounting officer of a PDoH should ensure that the department has an effective and efficient system of financial management. In addition, Section 45 (a) of the PFMA requires that officials in the employ of the department ensure that this system is implemented (SA, 2000:online). The South African public hospitals utilise BAS as a financial system to manage, among others, revenue, debts and payments.

BAS is an integrated financial system used by the South African government. According to Van der Heever (2009:8), this financial system was introduced to improve financial control. Ismay, et al. (in Van der Heever, 2009:7) indicated some of the objectives of BAS as to:

- provide high levels of financial controls;
- adapt to changing government structure;
- monitor the age of debts; and
- be as flexible as possible.

BAS provides functions for revenue management in most government departments. The officials mentioned earlier in the chapter process financial data on this financial system according to their allocated functions and responsibilities. The revenue process within this system is divided into particular main functions, namely, capturing of receipts, day-end, deposit close-off, and deposits confirmation (National Treasury, 2010:online).

3.7.1 Receipt and capture

In this function, the cashier receives money for services provided by the hospital on behalf of the PDoH and issues receipts to be captured. The capturer/cashier captures the receipt on BAS for all the money received by the department for services charged. This function allows different receipts to be captured, such as manual receipts, manual deposited receipts, and online receipts. In most hospitals payment at the cashier's office is still preferable. The cashier receiving the payment must issue a receipt in duplicate. One receipt should be given to the paying patient and the other copy kept in the file (GDoH, 2012:3).

3.7.2 Deposit close-off

Once all the receipts have been captured, a cashier does the deposit close-off to verify the amount of money received against the deposit slip for banking.

3.7.3 Day-end

Within this function the supervisor receives copies of the receipts and printouts of deposit close-off. The supervisor being the overseer of cashiers' work verifies the information captured on the system with the actual amounts received for a specific receipts batch. The next section describes the functions undertaken by the supervisor before and after receipts are deposited.

3.7.4 Deposit confirmation

In this function, the supervisor does the deposit confirmation. He/she compares the deposit made with the day-end balance. The cash collecting companies are required to return the deposit slip within three days to be filed. The deposit slip, together with a bank statement, is reconciled with the receipts issued.

The financial system caters for various payment methods, namely, cash, cheque, card, postal order, and traveller's cheque (National Treasury, 2010:online). Public hospitals

charge small amounts of money for certain services, and as a result cash payments are most convenient for hospital users.

The significance of a financial management system is to improve accounting in the organisation. BAS ensures that financial information is available to account for all the monies received and due to government. The financial system in government is designed in a manner that can produce information that conforms to certain accounting requirements. Accounting for money in government requires following certain accounting standards and principles. Every government and its institutions conform to certain accounting standards and principles for accounting purposes. In this study, the focus is on South African government departments, specifically PDoH.

3.8 ACCOUNTING FOR REVENUE COLLECTED BY DEPARTMENT

The purpose of accounting in government is to protect and manage the money collected (Chan, 2003:14). Without accounting systems in place, the organisation might not be able to indicate how revenue was raised and how the money was spent (Chan, 2003:13). As part of the accounting process, PDoH is responsible for reporting on the financial matters of public hospitals within its jurisdiction. This includes the monies collected by public hospitals.

The revenue collected by public hospitals is included in the departmental revenue collected by the PDoH and accounted for in the statement of financial performance. The departmental revenue on financial reports refers to all the money received by the PDoH which arise from its daily activities (National Treasury, 2010:online). This revenue is divided into taxes, sales, transfers, fines, penalties and forfeits, interest, dividends, and rent on land.

When accounting for departmental revenue, the PDoH needs to indicate the basis of accounting in use (National Treasury, 2014:online). The basis of accounting used in government departments varies from that used in the private sector. The basis of accounting refers to the method used to record and measure transactions. This consists of a cash basis of accounting and an accrual basis of accounting. The government departments use a cash basis while private sector uses an accrual basis

of accounting. The difference between the two methods lies in the timing of the recognition of transactions (Tudor & Mutiu, 2010:online).

The South African government is in a process to move from a cash basis of accounting to an accrual basis of accounting. All government departments are currently required to prepare their financial statements on a modified cash basis of accounting (National Treasury, 2014:online). According to the *Accounting Manual* issued by the National Treasury (2014:online), the modified cash basis of accounting is a cash basis of accounting supplemented by an accrual basis of accounting. Parry (2010:95) defines a modified cash basis of accounting as an intermediate stage to move to an accrual basis of accounting. The transition to an accrual basis of accounting can be achieved when there is full compliance with International Public Sector Accounting Standards (Ouda, 2010:65).

The last phase of the revenue management processes is reporting. This study can only highlight the accounting part of revenue collected, while the pros and cons of the transition remain a future topic for investigation.

3.9 CHAPTER SUMMARY

The PDoH does not directly utilise the revenue collected for its operation. However, the reality is, the channel to utilise the revenue collected is prolonged by legislation and other requirements. The PDoH receives voted funds from the Provincial Treasury to finance its operations. The voted funds received from the relevant Treasury are funded through various sources including the revenues collected by the department and paid into the relevant Revenue Fund. Therefore, it is essential for every department, specifically provincial Departments of Health as they collect large user-fees, to ensure that there are adequate systems and processes in place to effectively collect revenue due.

The means test and UPFS provide guidance in charging user-fees for services rendered by the public hospitals. The tariffs stated in the UPFS ensure that the payment for healthcare services does not cause undue hardship to hospital users. This

guideline allows public hospital users to pay the amount they can afford based on their level of income, regardless of the value of the service rendered.

The purpose of collecting user-fees has been outlined as to raise revenue and control the use of healthcare service. The user-fees collected through healthcare services have considerably contributed to government revenue and the healthcare system.

The systems and processes required to collect such revenue include people, financial management systems, and accounting principles and standards. The effective management of revenue could then be achieved if all role players execute their responsibilities as required by legislation and policies.

This chapter was aimed at explaining these processes to offer an understanding of revenue management procedures in government departments and their respective cost centres.

The following chapter will explain data collection procedures and instruments.

CHAPTER 4
RESEARCH METHODOLOGY

4.1 INTRODUCTION

The literature review discussed financial management and revenue management procedures. It also included a discussion of revenue collection practices and policies.

This chapter aims to elaborate on the primary collection of data to be analysed. The chapter begins by revisiting the objectives of the study. Later in the chapter a research approach/design and data collection methods are discussed.

4.2 PRIMARY OBJECTIVE OF THE STUDY

The primary objective of the study was to evaluate the effectiveness of revenue management in South African public hospitals through a case study of the TDH.

4.3 SECONDARY OBJECTIVES OF THE STUDY

The secondary objectives of this study were the following:

- To conduct a literature review on financial management in public hospitals.
- To explain the revenue collection system reviewing the hospital revenue management cycle implemented in public and private hospitals internationally.
- To explain revenue management in terms of the PFMA and the BAS receipt process.
- To determine the current state of revenue management at the TDH.
- To make recommendation on the improvement of revenue management at the TDH.

4.4 RESEARCH APPROACH

Qualitative research was applied in this study. This approach was the most appropriate due to the fact that it is viewed by other researchers (Hennink, et al. 2011:8-9) as an approach that allows the researcher to examine people's experiences in detail. This takes place by using a set of research methods such as in-depth interviews, focus group discussions, observation, content analysis, visual methods, and life histories or biographies. Social scientists have made wide use of the qualitative research method to examine contemporary real-life situations and provide the basis for the application of ideas and the extension of methods (Soy, 1997:online).

To attain the objectives of this research, a case study was utilised. The case study was also regarded as an appropriate approach due to its common use in this field. It has been used by researchers across different disciplines, including by Naomi, et al. (2012) who conducted case study research at Suntreso Government Hospital Kumasi in Ghana. These researchers assessed revenue mobilisation and expenditure in district hospitals.

Yin (in Soy, 1997:online) defines case study research as an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomena and context are not clearly evident. One advantage of the case study method is that the researcher may find new key factors emerging during data collection.

Revenue management is still a burning issue in the financial management of the public sector. After more than 23 years of full democracy in South Africa and the possible introduction of an NHI, the current state of public hospital revenue management still needs to be evaluated.

Critics of case study research argue that it may not be possible to generalise the findings thereof to broader populations. However, the findings may be susceptible to the concept of transferability, where it is considered that the situation and conditions are sufficiently similar to another environment (Krueger, 1998:69-70). The researcher

found it to be appropriate to apply the case study method in this study due to the following reasons:

- The financial management of all public hospitals in South Africa is regulated by PFMA.
- Time and funds placed constrains on access to all public hospitals in South Africa.
- The public hospitals in South African have the same client concerns.

4.5 RESEARCH LOCATION

This study was conducted at TDH within the GDoHSD in South Africa, located in Pretoria. The hospital was chosen due to its locality and being one of the first hospitals piloted to implement the NHI.

4.6 METHODS OF DATA COLLECTION

Data collection instruments in this study were designed to investigate the level of revenue management in terms of policies, process and systems in place, and the effectiveness thereof. The literature review served as a basis from which the data collection instruments were developed.

4.6.1 Observation

Observations are regarded as the most objective method for obtaining information. According to Swanborn (2010:74), observation forms an important part of research and cannot be excluded. Observation is defined as a research method that enables a researcher to systematically observe and record people's behaviour, actions, and interactions (Hennink, et al. 2011:170).

There are two common methods of undertaking observation. The researcher can conduct participant observation or direct observation, also known as unobtrusive observation. With regard to participant observation, the researcher interacts with the participants, while in terms of unobtrusive observation, the researcher does not

interact with the participant but instead records the activities as they unfold (Driscoll, 2011:online). In this study, the researcher did not take part in the activities, thus unobtrusive observation was conducted.

The researcher observed the revenue management process. Observations at the cashier office assisted the researcher to collect data regarding actions taken when user-fees are paid. The researcher also observed the means test conducted to determine the ability of patients to pay for health services. The procedures which are followed in the collection of revenue, such as sending letters to debtors and telephonically contacting debtors to remind them about the debt, receipt of cash, and the issuing of invoices were expected to occur during the observation. However, this did not take place; perhaps because they are performed on particular days that fell outside the observation.

One advantage of the case study method is that the researcher may find new key factors emerging during data collection. This study aimed to accommodate new information that might come to light concerning revenue of public hospitals. The NHI was expected to be a new factor that impacts on public hospitals' revenue management. Leedy and Ormrod (2010:147) assert that through observation the researcher can take advantage of unforeseen data sources as they surface.

Observation as a data collection method also has disadvantages. Swanborn (2010:74) states that observations can be time-consuming and expensive. In addition, Walliman (2011:196) states that observations can be difficult when the activity observed is not consistent and the researcher has to wait for an activity to happen. In a traditional ethnography study, the study of culture, observations can take a year or more, while in applied research this is impossible as it requires a shorter period of data collection. Fox (1998:online) advises that observation should not be too long or too short, but the researcher needs to decide on the time scale and/or when the data acquired are enough. Since this study is classified as applied research, it was appropriate to implement the advice of Fox (1998:online). Thus, the observations were done for a short period of time.

Applied research intends to provide solutions to an identified problem (Swanborn, 2010:35). Leedy and Ormrod (2005:43) define applied research as research that aims to address current problems related to current practices, policies, and procedures. Since there is no indication on the specific length, and no clear definition of how long is too long and how short is too short, the researcher relies on the experience of past researchers in this field (Naomi, et al. 2012; Rauscher, 2010). Observation time allowed by management in this study was ten working days.

Besides time as a disadvantage when conducting observation, participants being aware that they are studied or observed can influence the results of observation. This is referred to as the Hawthorne effect. According to Bracht and Glass (1968:online), the Hawthorne effect implies that participants are likely to improve or change their behaviour if they are aware that they are being observed.

In assessing the purpose of observation in this study, it was determined that the Hawthorne effect should have a limited impact on the data collected. The researcher did not primarily investigate the behaviour of employees but rather the processes involved in revenue management at the hospital. However, to manage the Hawthorne effect, the researcher did not consider the first days of observations in each office. Thus, information collected on the first day of the observation in each office was withdrawn to reduce the risk of Hawthorne effect. This was to ensure that the results of this study are not biased or influenced to create the envisaged results.

Prior to undertaking the observation procedures, the participants were informed about the procedures verbally and in the form of a written information leaflet. The researcher explained to the participants that the data collected will only be used for the purpose of this study. The clarity on ethical issues is covered in subsequent sections.

A critical activity in conducting observation is recording activities. The recording of observations in this study was done in the form of field notes in order to ensure the participants' anonymity. Leedy and Ormrod (2005:146) advise that when a researcher opts to take field notes, he or she should consider having a notebook with two columns; one to record observations and the other to write interpretations. This helps the researcher to avoid being biased. The researcher took notes in a personal note

book. These notes were later transferred into electronic format using Microsoft Word. This allowed the researcher to analyse the information and navigate around the documents. Video and audio recordings were not used for observation purposes as these instruments might reveal the identity of participants.

4.6.2 Interviews

To collect further data for the purpose of the study, interviews were conducted in TDH and GPDoH. Conducting interviews allowed the researcher to interact with individuals responsible for revenue management in TDH and GPDoH to gain reasonable knowledge about the phenomenon under study. The interviews conducted were in-depth interviews. In-depth interviews can also take the form of a semi-structured interview. However, for this study, one-on-one interviews were conducted with designed questions. Hennink, et al. (2011:109) describe in-depth interviews as a one-on-one method of data collection that involves an interviewer and interviewee to discuss specific topics in depth. Hennink, et al. (2011:109) further state that this type of interview can also be conducted with two interviewees.

The qualitative research approach afforded the researcher an opportunity to evaluate people's experience. Therefore, when seeking information from people, an in-depth interview is an appropriate data collection method to use. This assisted the researcher to gain information from individuals regarding the application of PFMA and other revenue management policies and procedures within public hospitals. The interviewees constituted the officials responsible for financial management at TDH, including their supervisors. When the researcher first met with the officials from TDH, the acting financial manager served as a coordinator and assisted with prior arrangements.

Efforts to get the CFO of the GPDoH to participate in an interview were in vain. However, one senior official from GPDoH agreed to participate. This official was a relevant participant due to the position held in the Revenue Management Directorate of the GPDoH. All the sections of financial management were represented. Chapter 5 will further provide a detailed structure of participation.

4.7 DATA ANALYSIS

Data analysis informs the reader about the steps taken to analyse the data collected and to make sense of it. There are various ways in which data can be analysed to allow interpretation thereof. These include the use of tables, line graphs, bar graphs, pie charts, et cetera. Kawulich (2008:online) related the approach to data analysis as using matrix and tables. Walliman (2011:180) identified coding and tabulation of results as methods of analysing data. The researcher opted to use tables to analyse the data, due to its simple form and ease of understanding. Furthermore tables are considered to be an acceptable and conventional method to convey information in research.

Prior to the data being presented in a table, the researcher should do the coding, i.e., labelling of data. This is the first step in analysing collected data from observational field notes and interview transcripts. Coding or labelling is also referred to as categorisation of data (Taylor-Powel & Renner, 2003:online). The researcher should thoroughly read through observational field notes and interview transcripts to generate categories and themes to help identify patterns and relationships between the data. Codes can be in the form of words or phrases (Walliman, 2011:181). The researcher analysed the data according to four categories, i.e. means test, billing, debtor's management, and cashiers. Chapter 5 of this study will provide the detailed analysis of the research results.

4.8 ETHICAL ISSUES

Wisker (2008:87) states that regardless of what research a person is involved in, ethics still need to be taken into account. Ethics are defined as "moral rules or principles of behaviour for deciding what is right and wrong" (Longman Dictionary of Contemporary English, 2003:533). Msweli (2011:79) suggests that a researcher needs to anticipate the ethical issues involved in the proposed study. Ethical considerations take the protection of information acquired during the course of the study into account by not disclosing it to other persons without the authority of parties concerned.

The anticipated issues for this study comprised of confidentiality of the data gained through research methodologies indicated earlier, anonymity, informed consent, and permission to access facilities and approach officials. Any risk involved, including the risk of officials losing their jobs, exposing the officials' integrity, et cetera, were taken into consideration and was dealt with accordingly.

The permission to conduct the study at TDH was obtained from the Tshwane Research Committee. Ethical clearance certificates were also obtained from the Research Ethics Committees of TUT and GPDoH (Annexures D and E).

To protect the participants from any risk or harm the researcher did not use positions, names, or professions as a means of identification. The anonymity of the participants was protected as no personal information was required in the study. The researcher used narrative labels in making reference to the information acquired from the participants. Throughout the study the researcher used "*int"* as a label in sequence to identify the interviewees. A separate document that links the participants' identity to their labels is not included in the study, but is kept in a safe place with limited access. According to the Institutional Review Board (2013:online), labels are an effective means of protecting the confidentiality and anonymity of participants.

The participants in this study were free to take part and had the right to withdraw from the study at any stage. This could be the reason not all the targeted officials participated. However, the researcher used the available participants within the same responsibility area to ensure that the study remained within its objectives.

The information leaflet accompanying the consent form provided participants with the details of participation. This included the details informing the participants that their participation would be voluntary and that there would be no financial benefits offered. Where participants found it inappropriate to provide the researcher with certain information and felt that it should not be used in the study, they could deny the use of such information (Wisker, 2008:87).

With regard to informed consent, Wisker (2008:87) advises that the participants should give their full consent before taking part in the study. The participants were

provided with consent forms to sign in order to indicate that they gave consent for the information to be acquired from them. Prior to signing the consent forms the researcher explained the details of the information leaflet (Annexure C) and attended to all questions from participants. The consent form was structured in a simple language and format to avoid misunderstandings. The information leaflet that accompanied the consent form provided an area where the participant could put a name, signature, and date to indicate that he/she had read the information and agreed to take part in the study.

4.9 CHAPTER SUMMARY

This chapter was aimed at discussing the research methods applied in this study and data collection instruments. The researcher justified why these methods were considered as appropriate instruments to collect data for this study. The justification was made by comparing advantages and disadvantages. The researcher indicated how the study dealt with disadvantages to ensure that the study produced credible results. The data collected is analysed and interpreted in the next chapter.

CHAPTER 5
ANALYSIS AND INTERPRETATION OF RESEARCH FINDINGS

5.1 INTRODUCTION

In the previous chapter, the steps taken to analyse the data collected by means of research instruments were discussed. The purpose of the current chapter is to make sense of and gain meaning from the data collected. In this chapter the researcher presents and analyses the data to add meaning to the results, in order to achieve the research objective.

Chapter 2 indicated that revenue management of hospitals consists of five stages namely, frond-end, core, back-end, cash collection and posting, and third-party payer. However, cash collection and posting is done within the same function in the hospital. As a result, collected data is presented according to the following main categories:

- Means test – this is performed at the front-end stage within the administration office. The patient's financial status is assessed.
- Billing and invoicing – patients are billed for medical services received (core stage).
- Debtors management – pursuing patients to pay for medical services received (cash collection stage).
- Cashier – receipting cash from the patients and capturing of revenue on the system (cash collection stage).

This study involved two stages of primary data collection, namely observations and interviews. Interview results are analysed by comparing them to the literature review and the researcher's observations. The results are also continuously interpreted and commented on.

The observations were conducted in each office which forms an integral part of the revenue management cycle at the public hospital. The following was revealed by the observations conducted in TDH.

5.2 ANALYSIS OF OBSERVATION RESULTS

5.2.1 Means test

The researcher conducted two days of observation in the administration office of TDH. The purpose of this observation was to enable the researcher to document the processes for undertaking the means test and to determine the documents/ information needed to undertake patients' affordability checks.

The patients' personal and demographic information is gathered in this office. The information required by the registration clerk include a referral letter, identity document, payslip/pension card, proof of address such as municipality/telephone account, and medical scheme card if the patient is a member. This information is used to open a file or register patients on the hospital PAAB system.

The required information, specifically the payslip, indicate how much a person would be able to afford. During the process of conducting the means test, the patient's monthly expenses were also taken into consideration. The researcher noted that the clerks requested the patients to give information about their monthly travelling expenses, food, airtime, clothes (clothing account instalments), and other expenses. Although the aforementioned expenses are basic, no proof was required to support the claim that the patient indeed travels to work and, if so, whether the patient uses a train or a private vehicle. Neither was evidence required of whether the patient has a clothing account or buys food for a specific amount.

In other instances, patients were assisted without the required documents. The officials relied only on the information provided orally. This means patients can easily provide incorrect information to avoid the liability but still receive the service. In such cases the hospital could be losing revenue if the patient cannot be traced or located. The patient is only advised to submit the documents during their next visitation. In Chapter 2 it was indicated that patients seldom pay the hospital after leaving the hospital premises. In these cases, it may be assumed that patients will not return to the hospital to make a payment after receiving the service.

Further, the researcher noted that the administration office is not only responsible for the means test but also assumes the duties of cashier, referred to as *sub-cashier.* Once the file has been opened and the patient is registered on the system, a minimal fee is paid to the clerk. The patients without cash on hand are requested to pay during their next visit.

5.2.2 Billing

This section of the hospital ensures that all the patients provided with medical services by the hospital are billed. The researcher observed the activities in this office for two days. Among other details, the researcher noted that officials in this section receive files from the ward to be able to bill discharged patients. Once the officials have completed the billing process, the files are sent to the record keeping department. The observations indicated a lack of interaction between the discharged patients and the billing officials.

Because patients do not collect their files following billing, the researcher is of the view that the patients leave the hospital without knowing how much they are supposed to pay on discharge. This means that there is no invoice or statement handed to the patient from the billing section on discharge. The patient will only be able to view the statement during the next visitation. Due to the nature of this office, most of the activities are performed on the PAAB system. Therefore, the researcher relied on the interviews guided by the observation to obtain more reasonable data. Interview analyses will follow later in the chapter.

5.2.3 Debtors management

During observation the researcher aimed to establish if debt collection procedures indicated in the previous chapters, such as telephone calls, are actually executed. The observation in this office was conducted at the time the officials from the Auditor General of South Africa were conducting the annual audit. The researcher noted that during the observation period the officials' effort was directed at getting the files to be audited ready rather than performing routine duties. It needs to be indicated that observation also includes listening. In their conversations, the officials suggested

working during the weekend to ensure that all the files required by the auditors are ready.

It is, therefore, noted that normal procedure is suspended during cyclical occurrences such as the annual audit due to the limited number of personnel in this section. This may also imply that where one staff member is absent from work, debt collection procedures will be affected. However, the researcher noted that debtors management was further subdivided into collection and tracing. Managing the workload and division of duties and responsibilities may need consideration in this section.

5.2.4 Cashier office

During the two days observation, the researcher learnt that only two officials who were appointed as interns were responsible for the main cashier office. These officials were performing the normal activities of cashier, and therefore sufficient information was gathered for observation purposes. Further information will be offered by the interview results. The researcher also noted that the clerks in the administration office are regarded as *sub-cashiers* and are responsible for collecting user-fees on a daily basis. The cash collected during the day by *sub-cashiers* is handed over to the main cashier for reconciliation and banking purposes.

During the observation, every time cash was received, the cashier in the main cashier office issued a manual source document to the payer. In this office the researcher noted that the cashier issues a receipt once cash is received. Although the researcher did not inspect all the documents used in this office in detail, it was noted that a Z1512 receipt book was in use. The Z1512 receipt book is a pre-numbered receipt book used in government institutions.

The main cashier is situated in a separate office from the administration, debtors management, and billing offices. The cashier office's door is locked with limited access. It appeared that the safe is not kept in the same room as the cashiers.

The observation revealed that patients could only pay with cash. This method of payment does not seem to be convenient for a person using a credit or debit card to

make a payment. There is only one ATM where cash can be withdrawn, thus, in cases where the ATM is out of order the hospital will not be able to collect cash. Eventually, this impacts negatively on the hospital's cash collection.

5.3 ANALYSIS OF INTERVIEW RESULTS

The researcher conducted interviews with TDH staff members to obtain raw data regarding revenue management. The literature review indicated that the revenue management cycle at a public hospital commences with the registration of patients and ends with the collection of cash. The researcher, therefore, followed all these processes and divisions involved in the revenue management of a public hospital. All the offices or divisions were represented by at least one participant.

It should be noted from Table 5.1 that the label "int" refers to the interviewee. For example, the label "int1" indicates that interviewee number 1 represented the administration section. All the questions regarding administration, including the means test, were asked within this section.

The researcher targeted four offices involved in revenue management in TDH. The intention was to at least get one representative from each office. Although only 5 planned interviews were conducted in this study, the researcher managed to obtain full participation from all the offices that are directly responsible for revenue management, starting with the administration office, and ending with the collection offices.

Table 5.1: Interview Schedule

Section	Location	Date	Time	Label	Tick/ Cross
Administration section	TDH	06/07/2016	13:15-13:33	Int1	√
Billing section	TDH	23/06/2016 & 12/07/2016	13:24-13:31 & 12:05-12:24	Int2	√
Cashier	TDH	09/07/2016	12:00-12:26	Int3	√
Debtors section	TDH	09/07/2016	12:30-12:47	Int3	√
Finance section	TDH	-	-	Int4	X
Revenue management	GPDoH	02/08/2016	13:30-13:50	Int5	√
Revenue management	GPDoH	-	-	Int6	X

“Int4” is not involved in the daily operations of revenue management, thus, “int4’s” lack of participation in this study did not negatively impact on the data gathered. This official’s section plays a central role in the entire financial management of the hospital. As a result, officials working within revenue management were preferable for interviews over “int4”. However, the researcher decided to target this participant on the schedule in case one of the officials withdrew. “Int6” was also targeted for the same reason.

On the 6th of June 2016, a 15 to 20 minute interview was held with “int1”. The interview guide consisted of five areas of enquiry. The researcher guided the participant in answering the questions to ensure that there was a common understanding and perception.

The experience with the first interview prompted the researcher to rephrase the questions where necessary to allow the remaining participants to “demonstrate”, “elaborate” and “explain further” on certain questions in order to give detailed responses.

On the 23rd of June and 12th of July 2016 the researcher interviewed “int2”. The initial interview had to be cancelled because the environment under which this interview was conducted was not conducive. There was a physical noise which caused a communication barrier and it was leading to a poor quality recording. The second interview with the “int2” from the billing section was successful and yielded a substantial amount of reasonable data. The researcher briefly reminded the participant about the objectives of the study and indicated conditions of participation ahead of the interview.

On the 9th of July 2016 the researcher met with “int3”. This participant was supposed to be interviewed for debtors’ management only. Due to the researcher’s experience with “int1”, the researcher was compelled to interview “int3” for two sessions to also cover the interview guide addressing cashiers’ duties and processes. This decision was taken owing to the participant’s role in the cashier office as an overseer.

Since “int3” is familiar with cashier office duties, the researcher took it as appropriate to interview “int3” regarding cashier office’s processes. This decision earned the researcher quality information to allow the study to produce concrete results.

The researcher concluded the interviews with the last participant, “int5”, from GPDoH. This participant represented the revenue management directorate. The interview was held on the 2nd of August 2016 following a stream of e-mails sent to the participant’s office requesting a meeting.

Although this study focused on TDH, the researcher saw a need to interview an official from the GPDoH to gain an oversight perspective on revenue management in public hospitals. Among other reasons, the following prompted the invitation:

- TDH operates under the GPDoH.
- TDH receives directives from the GPDoH.
- The revenue budget of TDH is determined by the GPDoH.
- User-fees rates are set by the GPDoH.
- TDH implements policies set by GPDoH.

- The literature review throughout the study indicated the link between the TDH and the GPDoH.

This interview was beneficial to the study as some of the data could not be gathered from the hospital. Besides the questions related to the identified categories, “int5” indicated that the revenue budget is indeed a responsibility of GPDoH and instead of budget committees in public hospitals, there are revenue forums that assume the same responsibilities as budget committees (Section 2.2.3). The results of this interview are not discussed separately but according to the presentation categories.

Because the PDoH has oversight over the entire revenue management of public hospitals, specific questions were selected from the interview guides used to conduct interviews at TDH. The PFMA requires that the department collects all the revenue due to government. The public hospital, therefore, collects revenue on behalf of the department. In a nutshell, the department and the hospital share the same responsibility.

The first part of the interview data analysis presents biographic information. Due to the generic nature of the question, the researcher consolidated the responses and presented them under one section. Subsequent questions were analysed according to the main categories and identical responses were also synthesised. In some cases participants provided more than sufficient information to the extent that, unexpectedly, responses or answers to other questions emerged. This is because these categories or sections are linked in terms of the duties and responsibilities. The literature review stated that revenue management of a hospital can be viewed as a cycle. Hence, the participants were responding to the questions relating to activities beyond their responsibilities.

5.3.1 Biographic information

The literature review of this study stated that the role players need to have the skills and knowledge of financial management. A lack of financial management skills was also identified by the researcher as a part of the research problem. The question

focused on qualifications to assess participants' possible financial management skills and knowledge.

5.3.1.1 What financial management qualification do you possess?

The qualification indicates the knowledge and understanding possessed by the participants in the financial management environment. Although one participant does not hold a qualification in the field of financial management, the participant's major responsibility is focused on administrative duties. It, therefore, seems that the officials are adequately qualified to perform their duties.

Table 5.2: Qualifications

Interviewee reference	Qualification and training course	Literature review reference
Int1	National Certificate: Legal Secretariat	Section 3.4
Int2	National Diploma: Financial Management, Bcom Accounting (in progress)	Section 3.4
Int3	National Diploma: Financial Management	Section 3.4
Int5	Master's Degree: Public Administration	Section 3.4

5.3.1.2 What does your institution do to improve your skills and competency?

Chapter 3 of the study required that skills development programmes should be in line with the functions performed by the officials. From the total number of participants, half indicated that the hospital allows the officials to attend BAS training courses. BAS is the official accounting software application system of the South African government.

Table 5.3 indicates that "int5" stated that there is a PFMA training course, however, this course could possibly only be attended by the officials at managerial level. This

study indicates that although it might be possible that not all officials working within revenue management of TDH attended the PFMA training, these officials are familiar with the PFMA, and its contents. However, this knowledge may not be sufficient. It emerged during the interview with "int3" that *"according to PFMA, they say if the patient has not paid within 90 days, then it is whereby you can write it off".*

Table 5.3: Skills and competency

Interviewee reference	Training course	Literature review reference
Int1	No training course attended.	Section 3.4
Int2	BAS training, SAP training.	Section 3.4
Int3	BAS training; PERSAL training and SAP training.	Section 3.4
Int5	Public Finance Management Act training course, Management Development Programs and Microsoft package.	Section 3.4

Section 76(1)(e) of PFMA requires the Treasury to make regulations regarding writing off money owed to the state. In terms of Treasury Regulations, an accounting officer of a department may write off a debt if all reasonable steps have been taken to recover the money, and it should be in accordance with the policy determined by the accounting officer (SA, 2000). In compliance with the Treasury Regulations, the GPDoH policy allows the hospital to write off debts of small amounts after 90 days from consultation.

"Int3" also mentioned that officials are trained on the Systems, Applications and Products (SAP) that links with BAS. SAP is implemented as a financial management system within the hospital. The purpose of the training is to help officials improve their skills. Due to the fact that not all the participants indicated SAP training when responding to the questions, it is possible that the system is only effectively being used by the billing and debtors management section. According to "int3", in addition to BAS, the hospital also uses the SAP system to administer receipts and banking transactions.

5.3.2 Means test

The literature review regards the means test as a dysfunctional system but still stated that it is an important phase of the revenue management cycle in a public hospital. Thus, it prompted the researcher to further investigate this aspect of revenue management. The following questions were asked:

5.3.2.1 What documents are required as a proof of income for individuals without formal employment to determine the amount payable for healthcare services?

The purpose of the means test is to assess the patient's affordability. According to the literature review, patients can be classified into different categories of payment based on their means of income. This can only be possible if the proof exists of how much income the patient is earning. However, not all hospital users are employed or earn income by means of employment. The literature review stated that an affidavit or contributor's fund for individuals, supported by evidence of collection from the Unemployment Insurance Fund (UIF), serves as proof of unemployment. The observation also revealed that a pension card is required where the patient is a pensioner receiving a social pension.

Table 5.4: Proof of payment

Interviewee reference	Documents	Literature review reference	Observation
Int1	Declaration form is completed by the patient.	Section 3.2.1	Ob 5.2

"Int1" indicated that the hospital has a standard document, a declaration form, which is used in the case where the patient is an unemployed citizen. This document does not provide exclusion to unemployed patients for payment purposes. However, it helps the officials to classify the patients correctly. These documents indicate that the patient cannot afford the full payment and therefore needs to be subsidised.

The aforementioned procedure does not appear to be effective. The hospital only relies on the information provided by the hospital users whom, hypothetically, are not prepared to pay for any service provided by the state hospitals. Considering the public hospitals' mandate, patients are certain that they will receive proper health care services regardless of the information they provide.

5.3.2.2 How does the hospital deal with patients who are not in possession of valid documents seeking medical service?

From the observation it was noted that patients from foreign countries were assisted without valid documents. As highlighted by "int1", the hospital cannot turn patients away. During the interview the participant indicated that these individuals are assisted and advised to submit valid documents in the future. These patients will also be liable for full payment of medical services received. Chapter 3 of this study stated that non-South Africans are responsible for full payment of medical services received. Invalid documents may make it impossible for hospitals to collect the debt relating to the services provided.

In the case of non-South Africans, invalid documentation could be in the form of expired passports, while in some cases illegal immigrants may produce fake passports. The patients may also submit invalid medical aid documents. The literature review indicated that medical aid scheme institutions often reject claims for various reasons, including terminated medical aid schemes. These circumstances impact negatively on revenue collection. These challenges were highlighted as common in public hospitals. The researcher sought to identify the reasons for providing invalid documents and a means to reduce claims' rejection by medical aid institutions. The literature review identified information systems used by the hospitals as one of the reasons claims are rejected by the medical aid institutions. Further, it indicated that the use of third parties could improve revenue collection.

Table 5.5: Invalid documents

Interviewee reference	Patients without valid documents	Literature review reference	Observation
Int1	Patients are assisted and advised to bring valid documents.	Section 3.2.1	Ob 5.2

5.3.2.3 Does the hospital do background checks on patients before placing them into an income category?

The implementation of the means test allows the hospital users to pay an amount that they can afford. During the observation it was noted that the hospital does not have any effective system that can be used to perform background checks on the credit record of patients. The officials only assess the patient based on their current income and basic expenses. This was identified as the only means of background check. However, it does not allow investigation of patients' previous and current records, such as credit and employment status.

Table 5.6: Background checks

Interviewee reference	Background checks	Literature review reference
Int1	Yes, background check is performed.	Section 2.3.3

"Int1" stated that the hospital does perform background checks. According to the researcher, this is not enough to verify one's eligibility, i.e. to further determine if the patient qualifies for certain charges or classification. This view is supported by literature in Chapter 2. During the interview with "int3" it was mentioned that the classification is based on the remaining income once all basic expenses have been deducted. The patients will often inflate their expenses with the intention of being classified within a lower category.

5.3.2.4 In the case where the patient is a minor, does the parent sign any document to acknowledge the debt?

The legislation section in Chapter 3 of this study states that the hospital, as the creditor, should have the identity of the debtor. According to the researcher, this requirement extends not only to the name of the debtor, but all the details of the debtor, including signature, identity number, et cetera. It therefore warranted the decision of the researcher to gain knowledge on this aspect regarding the responsible person for medical bills, whether the hospital does differentiate between patients and the person responsible for the account.

Table 5.7: Debt acknowledgement

Interviewee reference	Acknowledgement of debt	Literature review reference
Int1	Responsible persons agree to accept the liability by signing declaration form.	Section 2.3.1 & Section 3.6.1

Determining the responsible person to pay for the medical bill of a minor patient is a sound procedure to enhance chances of collecting revenue. Although the patient is a minor, the account/liability is created in the name of the parent. The literature review does not explicitly state how individuals under the age of 18 years should be classified. However, it does state that individuals getting a child support grant should be classified under H0. According to the literature review, the H0 category includes patients who qualify for a full subsidy. It is therefore reasonable for parents without child support grants to acknowledge the costs related to the healthcare services received by their children. The provision to allow the parents to sign debt acknowledgement documents, improves the opportunities to recover user-fees from the responsible persons.

5.3.2.5 Is the hospital system able to identify or detect false information submitted by patients?

Often patients provide false details to avoid the responsibilities of paying the hospital for medical services received. According to “int1”, the system is unable to detect false

information. Although the system is able to reject incomplete information, the researcher is of the view that the system cannot indicate if the patient's identity number exists in home affairs' database, or confirm the employment status of the patient at the Department of Labour or SARS. The literature review states that incorrect information can result in the loss of revenue. The researcher, therefore, sought to determine if there are means to limit processing incorrect information.

Table 5.8: Detection of false information

Interviewee reference	False information	Literature review reference
Int1	No, the system cannot indicate if the information is not correct.	Section 2.3.1

The system's inability to confirm the vital information allows the patients to avoid paying for hospital services. There is always a risk that patients can provide incorrect information about their employment status, and the available means test system does not mitigate this risk.

5.3.3 Billing

5.3.3.1 What information is required to bill the patients?

Often public hospital users spend hours waiting to consult a doctor or for medical procedures to be performed. The revenue is generated when a medical procedure is performed. It should be highlighted that the administration office is not responsible for the billing of major procedures. Major procedures, including X-rays and consultations, can only be billed by the billing section.

Table 5.9: Patient billing

Interviewee reference	Information required for billing	Literature review reference
Int2	Visitation dates, consultation form, X-ray forms and doctor`s notes	Section 2.3.1

According to “int2”, consultation schedules, consultation forms, and X-ray forms are used to bill patients. This procedure is standard in the healthcare industry. Chapter 2 of this study stated that patients’ medical records are essential for billing patients. This requires the hospital to have a proper filing system to ensure effective billing.

The hospital could be losing revenue where files cannot be retrieved or located. According to “int2”, the billing clerks only receive files twice a week for billing. The literature review indicated that it is important for hospital staff dealing with patients to understand the financial implications of healthcare services received by the patients. This knowledge can ensure that nurses from the wards and ward clerks submit files to the billing section in time.

The consultation forms, doctors’ notes, X-ray forms, and other documents used for medical procedures are important for billing purpose. Without these documents or having incorrect information recorded on them could result in a patient being wrongly billed. Accurately billing patients depends on proper filing and handling of files used to record the medical procedures.

The use of the documents stated by the interviewees ensures that the hospital charges patients for services actually received. However, the credibility of these documents depends on the accuracy of the information, such as the dates of services received.

5.3.3.2 Does the hospital charge patients administrative fees?

The study was aimed at investigating the collection of user-fees charged for healthcare services received by hospital users. It has emerged that these were not the only fees charged regarding the use of public healthcare services. The researcher focused on the effect of administrative fees on revenue collected and debts written off. The observation results indicated that administrative clerks inform every patient about the charge when patients are registered on the hospital system. This fee is charged before the patient consults a doctor. This appears to be the minimum amount payable by all the patients seeking medical services from the hospital.

Table 5.10: Administrative fees

Interviewee reference	Administrative fees	Observation
Int2	Yes, the hospital does charge administrative fees.	Ob 5.2

As a small amount, the administrative fees could be contributing to large debts being written off if they are not collected. It is logical to argue that most public hospital users do not have medical aid and often ignore medical bills. According to the researcher, administrative fees potentially have a high revenue generating ability for the hospital. The researcher took into account the fact that these are minimum amounts charged at the point of service to every patient registered on the system. Therefore, every patient opening a file or registering on a public hospital system are required to pay an administration fee.

5.3.3.3 In the case of out-patients, are these patient billed before they consult or after they have consulted a doctor?

According to the participant, patients are billed once they have consulted a doctor. It is a norm in the healthcare industry to charge patients once they have received a service. The literature review and the analysis of the previous interview questions indicated that medical records are used to bill patients.

Table 5.11: Billing out-patients

Interviewee reference	Patient billing	Literature review reference
Int2	After the consultation, the charge sheet or file is used to determine the procedures performed.	Section 2.3.1

From the literature review it was stated that if the service is rendered but not captured on the system, such service will not be billed. In this regard, the researcher maintains the opinion that patient files should be properly administered since public hospitals

rely on a doctor's handwritten notes to bill patients. The hospital might be losing revenue where consultation dates are not properly noted.

5.3.3.4 How do you ensure that all patients are billed in time once their files are received from the ward?

Table 5.12: Billing in-patients

Interviewee reference	Patient billing	Literature review reference
Int2	Receive files two times a week on particular days.	Section 2.3.1

The literature review noted activities that prolong billing and revenue collection as a concern, such as the time taken from the point of service to charge entry. According to "int2", all files should be submitted to the billing section once patients have been discharged. When files are kept in the ward for a long period after the patient has been discharged, the revenue collection process gets delayed. This can be the reason the patients leave the hospital without knowing the outstanding payment that still needs to be settled. Allowing the patients to depart the hospital premises without a statement or invoice creates an opportunity for the hospital to incur collection costs at a later stage.

To have standardised days on which files should be received ensures that all patients are billed before their files can be returned to the records keeping department. Although this procedure appears to be effective, it does not allow the billing official to inform the patient about their outstanding balance before leaving the hospital.

Chapter 2's literature review stated that it is often difficult to bill patients on time when the file that should be billed is still in the ward. This could be because the patients' files need to first be discharged on the system before they can be taken to the billing section. This procedure is performed by the ward clerk. It appeared to be a standard procedure to allow ward clerks to discharge files on the system before they could be submitted to the billing section.

5.3.3.5 According to what procedure does the hospital submit medical aid claims to medical aid institutions?

Table 5.13: Submission of claims

Interviewee reference	Claims submission	Literature review reference
Int2	E-mail or hand delivery	Section 2.3.1 & Section 2.3.3

The patients who are members of medical aid schemes have the potential of settling their medical bills. The onus, therefore, lies with the hospital to claim the payment from the medical aid institutions. The collection of revenue from the medical aid institutions can only be effective if there are sound procedures in place.

“Int2” indicated that claims could be submitted online via e-mail or in manual form to the medical aid institutions. In this case, the researcher holds the view that e-mail addresses in some cases may be rejected and there might not be acknowledgement that the claims have been received. Nevertheless, this remains the current method of claiming from medical aid institutions. The literature review indicated that medical aid scheme institutions often reject claims that are submitted late and dispute claims with incorrect discharge dates. Although late submission was identified as a challenge which can lead to a loss of revenue, the hospital uses e-mails that send instant communications. This allows the hospital to submit the claims on time after the service was provided.

For these claims to be successfully accepted by the medical aid scheme institutions for payment, it depends on the accuracy of information used to bill the patient. Hence, the researcher is of the view that more controls are needed to improve the timely submission of files to the billing section within the hospital.

5.3.3.6 How are patients informed of the balance of their debts once discharged?

Table 5.14: Informing patients

Interviewee reference	Informing patients about the debt	Literature review reference
Int2 & int3	The hospital sends letters and invoices to the patients. The case manager should visit the patient in the ward to communicate the debt to the patient. Tracing clerk should remind the patients about the debts once they left the hospital.	Section 3.6.2

The literature review indicated that telephone calls and letters should be used to remind debtors of their outstanding payments. Informing patients of their outstanding balance by letters, e-mails, or SMSs could be a standard procedure which is hardly being implemented. During the interview with “int3”, the impression was that some debts are small amounts and it is not economical to call or send e-mails to all patients with outstanding amounts. The researcher, however, maintains the view that a debt analysis report can be used to select those debtors who are not responding to their debts.

According “int2”, e-mails, letters, and SMSs should be sent by the tracing clerk. “Int2” also indicated that under normal circumstances a case manager would be appointed to inform and provide financial counselling to the patients. The use of letters and e-mails cannot be effective if they are only used to notify or remind the patients about the outstanding balances, but do not contain persuasive measures to encourage the patients to settle their outstanding balances.

5.3.3.7 Are statements or invoices handed to the patients once they are billed for medical services?

Table 5.15: Invoices

Interviewee reference	Invoices/statements	Observation
Int2 & int3	Invoices/statements are normally put inside the patient file.	Ob 5.2

Through observation it was noted that discharged patients' files are submitted to the billing section. Once the patient is billed, the invoice is put inside the file. According to "int2", the reason for placing invoices/statements inside the file is to ensure that the patients are able to see the outstanding balances during the next visitation.

The researcher holds the view that the hospital could be writing off numerous small debts before the debtors gain knowledge of the outstanding balances. The patient is likely to take more than three months to visit the hospital again. Although the patient will still be responsible for payment, the hospital will ignore collection of such amounts.

The hospital is prolonging the revenue collection procedures by not informing the patient of the debt before they leave the hospital. The decision to place invoices in the patients' files makes it difficult, if not impossible, for hospital users to know the actual amount owing before leaving the hospital.

5.3.3.8 Are statements or invoices of patients filed for future recovery?

Table 5.16: Filing

Interviewee reference	Record keeping	Literature review reference	Observation
Int2	The administrative system provides for statements of patients' accounts. Thus statements are filed electronically and manually	Section 2.3.1	Ob 5.2

Besides the manual filing system that exists within the hospital, there is an online system that keeps record of patients' accounts. The PAAB system allows clerks to view the statement online. According to the literature review, patients can be reminded verbally about their outstanding balances during the visitation. The ability of the administrative system to provide statements ensures that administrative clerks do not have to retrieve manual files or send the patient to the billing or cashier office to check their balance. This can easily be viewed on the system and communicated to the patient at the point of services.

It appears that in terms of keeping patient accounts, the system is effective. It prevents a loss of patient information and patient accounts are readily available at all points. Therefore, it is convenient to remind patients of the balances verbally as suggested by the literature review.

5.3.3.9 How do you ensure that all patient files are processed for billing?

While the literature review suggests that all the hospital staff working with patients should have knowledge of billing and collection policies to ensure that patients' files are submitted for billing, TDH has the ward clerks responsible for discharging and submitting files to the billing section at least twice a week for that purpose.

Table 5.17: Submission of files

Interviewee reference	Submission of files	Literature review reference
Int2	Ward clerks bring the files twice a week.	Section 2.3.1

A delay in submission to the billing section may prolong the actual collection of revenue. The hospital only bills patients once they are discharged and have left the hospital. This is a sound procedure for billing discharged patients. Although the procedure to submit files to the billing section twice a week is the reason the patients leave the hospital before billing takes place, it appears to be the only effective procedure to ensure that all the files are billed.

5.3.3.10 What system is used to bill patients?

Table 5.18: Information system

Interviewee reference	Information system	Literature review reference
Int2 & int3	Patient Administration and Billing system.	Section 2.3.1

According to the literature review, most of the hospitals in the Gauteng Province use the PAAB system to bill patients. This system provides for registering patients, and the patient information is stored on the database of this system. The information stored on the system includes demographic information and account details of the patient. “Int3” stated that the patient records can also be accessed on this system.

The PAAB system is linked to other systems, such as SAP and BAS. It appears that the hospital has sound online systems in place to manage revenue.

5.3.3.11 How does Patient Administration and Billing system link with BAS?

The literature review stated that the PAAB system interfaces with BAS. It feeds BAS with revenue related information.

Table 5.19: Financial system interface

Interviewee reference	Interfaces with the financial system	Literature review reference
Int2	It interfaces with BAS. The information captured on Patient Administration and Billing system can be requested through BAS reports.	Section 2.3.1

This allows the hospital to account for revenue collected and to properly record debtors. The online record keeping and accounting for revenue does not appear to be a challenge for the hospital. The link between financial systems and administrative systems ensures that all the revenue recorded is accounted for.

Considering the preceding two questions, the researcher maintains the opinion that the hospital systems in place are effective for managing revenue. The information processed by the hospital will also be available to the GPDoH. The use of online systems improve reporting on revenue management.

5.3.4 Debtors management

5.3.4.1 What methods are used to remind debtors of their outstanding debts?

Table 5.20: Reminders

Interviewee reference	Methods	Literature review reference
Int3	SMSs, e-mails, mailed letters, printing invoices and attaching it to the patient file.	Section 3.6.2

According to the participant, there are numerous options to remind the patients of their outstanding payments. SMSs, e-mails, mailed letters, and printed invoices to be attached to the patient file are methods at the disposal of the hospital. “Int3” highlighted

that the use of telephone calls is ineffective and inefficient. This is because the hospital often has a large number of debtors to remind and therefore the use of a telephone results in unnecessary costs.

It is evident that the verbal method of reminding patients about the payment is not applied as it should be. According to the literature review, patients should be constantly reminded to pay their debts. It is therefore possible that returning patients are not reacting to their debts, not because they are unable to, but because they are not encouraged to pay and no interest is charged.

The researcher concludes that all the methods could be effective depending on how they are used. E-mails can be useful where the debtor is an institution, such as a medical aid institution or the Department of Correctional Services. An SMS can be effective to communicate with a literate person who has a mobile phone. The posting of letters cannot be regarded as an effective method because patients may change their residential addresses time and again, whereas e-mail addresses and phone numbers can always be kept when the place of residence is changed.

5.3.4.2 How many days or months are patients given to settle their debts after they leave the hospital?

Table 5.21: Collection period

Interviewee reference	Collection period	Literature review reference
Int3 & int5	The hospital expects to receive payments from the patients in three months from the date the service was provided.	Section 2.2.3 & Section 3.6.2

The hospital does not have any set standard period to collect debts. However, the hospital relies on the policy set by the department. Without the standard period to collect debts, the methods of reminding debtors cannot be effective. These methods should be in place together with the period the debts should be settled in. The three

months period to collect debts is based on the policy to write off debts, but it is not necessarily the recommended collection period.

This is deemed appropriate according to the policy which allows the hospital to collect user-fees within a three month period. It, therefore, appears that the hospital writes off debts older than three months not only to apply the policy but also to reduce the balance of debtors at the end of every quarter. However, “int5” argued that the sole reason to write off such debts is to comply with the requirements of Treasury Regulations and the GPDoH’s policy. The purpose of writing off debts of small amounts may be seen as assisting the hospital and department to determine the actual revenue that can be collected. Writing off small debts can also ensure that financial statements, specifically statements of financial position, are not poorly presented.

5.3.4.3 What are the measures taken against the patients who do not pay their outstanding debts?

Table 5.22: Measures

Interviewee reference	Measures	Literature review reference
Int3 & int5	Patients are verbally reminded to pay their outstanding balances. The hospital does not hand over patients to attorneys. There are no drastic measures against patients who are not paying their debts.	Section 3.6.2

From the interviews, it is clear that the hospital does not have punitive measures in place to encourage patients to settle their debts. The patients are neither charged interest nor blacklisted. As a result, patients will become reluctant to pay the hospital because there are no penalties. Further, patients know that they will not be denied a service if they do not pay their previous debts.

Although the literature review indicated that interest should be charged and recovered together with the capital amount, the hospital does not seem to be implementing this recommendation. The departmental policy does not state the reasons for not charging interest.

However, the policy allows the use of legal means such as state attorneys to recover patient debts. Besides charging interest on outstanding debts to encourage patients to pay, the literature review emphasises that where it is possible to recover the debt, it should be recovered by means of legal processes. This requires the hospital to submit debtors, who are able but unwilling to pay their outstanding balances, to legal processes. The patients could be reluctant to respond to the reminders due to a lack of legal processes within the hospital to collect revenue.

A lack of drastic measures will further result in debt collection agencies being ineffective at the hospital. However, at the GPDoH level these collection agencies are effectively implemented to collect revenue from institutions such as medical aid institutions.

Although it has been highlighted by the literature review that debt collection agencies can increase debt collection in the health sector, the hospital still relies on traditional ways of collecting debts. However, “int5” indicated that third parties are used in some cases to assist in collecting user-fees, especially from institutions. Among others, the interviewees highlighted that MediKredit is used to submit claims to medical aid institutions. Based on the literature review, the use of MediKredit can assist in improving revenue collection.

It appears that the use of revenue collection agencies is centralised within the GPDoH to collect user-fees from the other institutions. According to “int5”, the use of revenue collection agencies at provincial (GPDoH) level is because the hospital or GPDoH systems do not link with the medical aid institutions’ systems. One participant’s response was *“we are using MediKredit, but the reason we are using a third-party is to have that link to submit electronic claims to medical aids because the department, at the moment doesn’t have that link”.*

The hospital might not plan to appoint debt collectors because often the agreements are not honoured by the patients, eventually resulting in no payments received. The hospital is relying on internal procedures which seem to be ineffective to collect debt. However, the results indicate that the procedure to use collecting agencies at the departmental level could be effective.

5.3.4.4 What procedures are in place to prevent under-collection of revenue?

Table 5.23: Under-collection of revenue

Interviewee reference	Prevention of under-collection of revenue	Literature review reference
Int5	Engaging with various stakeholders, appointment of external service providers to assist in revenue collection and regular communication with the paying institutions, such as Road Accident Fund (RAF).	Section 2.3.3, Section 3.5 & Section 3.6.2

The legislation, as quoted in the literature review, requires that the GPDoH take the necessary steps to prevent under-collection of revenue. “Int5” indicated that the GPDoH engages with stakeholders, such as the RAF and Department of Correctional Services, to ensure that all the revenue due from these institutions is collected.

Thus, it is reasonable to state that the major responsibility of collecting revenue from paying institutions still lies with the GPDoH. The following analysis clearly indicates the rationale behind the inability of hospitals to effectively collect revenue.

5.3.4.5 Does the GPDoH provide incentives to the hospital to collect revenue?

The literature review proposed that the hospitals be allowed to retain a portion of user-fees, referred to as incentives, to improve revenue collection. According to “int5”, the hospitals are not allowed to retain any of the revenue collected.

Table 5.24: Incentives

Interviewee reference	Debt collection agencies	Literature review reference
Int5	At this stage there are no incentives provided to the hospitals.	Section 2.2.2

However, the interviewee also indicated that the National Department of Health, Provincial Treasury together with the Financial Fiscal Commission are attempting to reintroduce a Revenue Retention Model at the hospital level. The retention of a portion of the revenue collected should assist the hospital to improve revenue collection systems used to collect user-fees from self-paying patients.

The researcher is of the view that an inability to collect revenue effectively at the hospital can also be caused by the lack of sufficient financial resources; perhaps because the supplementary resources, such as revenue incentives, were removed. The literature review indicated that 20% of revenue collected that was withheld by the hospitals was used to improve revenue collection. The decision to phase out this incentive might also have contributed to under-collection of user-fees over the years.

5.3.4.6 Does the hospital have a written policy on the management of debts?

Table 5.25: Debt management policy

Interviewee reference	Debt management policy	Literature review reference
Int3	Yes, there is debt management policy	Section 3.6.1

The hospital does have a policy on debt management. From the literature review the absence of a debt management policy was identified as a contributing factor to poor debt collection. Although the hospital has a debt management policy, the analysis clearly indicates that this policy needs to be improved in order to ensure that procedures are followed to collect debts. The aforementioned statement is based on the following weaknesses.

The policy does not enforce the use of third parties such as debt collection agencies and attorneys to collect user-fees. The recovery of debts below R1 000 by means of legal processes is optional. The absence of these third parties at the hospital indicates a lack of punitive measures. The policy does not provide any consequences for patients who are able but unwilling to settle their outstanding fees. According to the researcher, the hospital policy on debt management might be limited by the Treasury Regulations and the GPDoH's policy on debt management. The latter do not recommend any drastic measures against debts of small amounts, which are to be written off.

The availability of a debt management policy indicates that the hospital does give debt management the attention it needs. However, the procedures included in the policy are limited to a certain extent, as mentioned. As a result, these procedures cannot be effective if they are limited.

5.3.4.7 What is the reason for writing off small amount of debts after a 90 days period has passed?

Table 5.26: Debts write off period

Interviewee reference	Reason for writing off debts after three months	Literature review reference
Int3 & int5	It is uneconomical to write a letter, refer the matter to State Attorney or make a phone call to a debtor owing a small amount Trace the patient/debtor. If the patient cannot be found and 90 days period has passed consider writing the debt off.	Section 3.6.2

According to the literature review, the hospital has to be economical in collecting revenue from the patients. Thus, the hospital has to ensure that revenue is collected at minimum costs. Further, debts of small amounts should be written off after 90 days following the date the patient received the treatment.

From the conducted interviews with the participants, the researcher identified that the sole reason to write off debts after three months has lapsed, is because it would be uneconomical to recover such amounts by means of legal processes or telephone calls. As a result, many hospital users could be taking advantage of the policies in place. The researcher has also indicated that it appears that debts are written off just to implement the requirement of the policy.

According to “int3”, before writing off a debt it must have been proven that the cost of collecting the debt is more than the amount to be recovered. The tracing officer must have exhausted all the available options to recover the debt. The literature review stated that a debt should be written off within 14 days of the last date stated on the letter.

The debts of small amounts may, in aggregate, present considerable amounts to be written off. A substantial amount of debts written off or any increases in debts written off shows that the hospital systems used to collect debts are not effective.

5.3.4.8 How many staff members are working in revenue management section within the hospital?

Table 5.27: Staff members

Interviewee reference	Human resource	Literature review reference	Observation
Int3	Three in main cashier office, there must also be specific officials responsible for tracing patients.	Section 3.4 & Section 3.6.1	Ob 5.2

Segregating duties is vital for revenue management purposes. “Int3” indicated that there is a proper segregation of duties within this section. Besides sub-cashiers, the main cashier office is being managed by three cashiers. The literature review stated that there should be segregation between the investigation of debtors, and the responsibility to collect and bank the money. The observation revealed that TDH

revenue management offices and responsibilities are separated from the administration office and cash collection point. The interviewee also mentioned that the hospital should have a tracing official appointed to track the debtors and ensure that reminders are sent out.

The researcher believes that duties have been segregated, regardless of the fact that the hospital did not have a tracing official during the time the study was conducted. The officials responsible for managing debtors are not the same individuals responsible for cash management.

5.3.4.9 Does the hospital have formal payment arrangements as an option for patients to enter into?

Table 5.28: Payment arrangements

Interviewee reference	Payment arrangements	Literature review reference
Int3	Yes, the hospital does make arrangements for payment.	Section 3.5

Treasury regulations stipulate that a debt can be recovered in instalments. The researcher was concerned with the convenience for patients to pay user-fees. “Int3” agreed that the hospital is allowed to get into payment arrangements with the patients, which is in line with Treasury Regulations that require the hospitals not to cause financial hardship on debtors when collecting debts.

The hospital does not have a stipulated/fixed instalment rate for user-fees to be paid. This procedure is flexible and should encourage debtors to commit to their payments. However, in a case where the medical bill has accumulated to a large amount, agreement or arrangement can be made to allow the patient to settle the debt.

5.3.5 Cashier office

5.3.5.1 What controls are implemented to ensure that all the cash received is actually banked?

Table 5.29: Controls

Interviewee reference	Banking	Literature review reference
Int3	Reconciliation of cash received with the receipts as well as deposit book. Using cash collection agencies for banking.	Section 3.4.1, Section 3.6.3 & Section 3.7

The Patient Administrative and Billing system and BAS are two systems used to manage revenue. All the revenue billed on the administrative system should reflect on the financial system. Where the Patient Administrative and Billing system cannot link with BAS, all the cash receipts recorded on the Patient Administrative and Billing system should also be captured on BAS to ensure that all cash received is recorded. Additionally, reconciliation procedures are used to ensure that cash banked agrees with the receipts recorded.

The legislation requires that all cash received should be banked promptly. The literature review stated that cashiers are responsible for safe custody and depositing of state money. In order to ensure this, “int3” indicated that the hospital does not carry cash to the bank itself but implements controls to minimise the risk of theft.

The interviewee explained that the hospital employs cash collection agencies for banking purposes. Based on the interviews, the hospital banking procedures appear to be effective. According to the literature review, cash collected should be reconciled with deposits made to the bank by collections agencies.

5.3.5.2 What controls are in place to safeguard cash and departmental source document books?

Table 5.30: Safeguarding of source documents

Interviewee reference	Controls	Literature review reference	Observation
Int3	There is a safe where all important items and cash are kept.	Section 3.4.1	Ob 5.2

The literature review indicated that a lack of resources leads to loss of cash due to theft. The available controls to safeguard source documents and cash show that the hospital has low risk of losing cash as a result of theft. “Int3” indicated that the hospital does have a safe room to keep all the cash received, source documents, and valuable items.

Cash management is also an essential part of revenue management. Cash received should be kept safe and banked promptly. According to this study, the procedures for managing cash and all important finance books appears to be effective. Due to the limited access to the safe, it is clear that accountability is also exercised. This is maintained by signing hand-over documents. This form is signed every time a cashier takes over the duties.

5.3.5.3 Would you say payment methods available at the hospital are effective and efficient for hospital users from remote areas to settle their outstanding balances?

Table 5.31: Payment methods

Interviewee reference	Payment methods	Literature review reference	Observation
Int1, int3 & int5	Yes, the hospital has cash method and Electronic Fund Transfer (EFT) method. Patients are required to settle their payments where they have received the service The hospital cannot recover user-fees through debit orders. The hospital use cash payment method and cheque payment method	Section 2.3.2 & Section 3.7	Ob 5.2

The literature review showed several methods of payment that can be used by public institutions, including public hospitals. These methods consisted of cash payments, cheques, traveller's cheques, and postal orders. The interview results indicated that the cash method is used effectively in public hospitals.

Although the cash payment method is a preferred method in public hospitals for self-paying patients, it still has its own drawbacks. Among others, "int5" stated that hospital users have to settle their bills at the hospital where the service was received. This is because hospital administrative systems are not linked within the province.

According to "int3", the available methods at TDH allow the patients to settle their balances from distant areas. However, the current procedure prolongs the process of

collecting such revenue and often discourages patients to settle the outstanding balances. In responding to the question, “int3” stated that *“the patient will call me in order to give the information as to how they are going to pay. The things that are going to be needed from me, the information needed from me, to give to the patient will be the right information for the bank. I am going to tell the patient he/she must write the name, surname, and the reference number – we call it the patient ID number* [*sic*]”. Following this process, the patient will have to confirm with the hospital if the payment was received.
According to the interviewee, cash paid through EFT or as a deposit directly into the department’s bank account, will have to be manually cleared from the system by the hospital. This is only possible if the patient can submit the copy of the deposit slip via e-mail, fax, or hand delivery.

It also emerged that the hospital is not receiving payments by means of debit orders. According to “int1”, the hospital revenue collection system does not provide for collection of user-fees by means of debit orders. The literature review stated that patients seldom pay users-fees once they leave the hospital premises. The research problem also indicates that individuals from remote areas find it discouraging to settle small amounts of user-fees by travelling to the hospital that provided the service.

The results of this study indicate that the only means of receiving user-fees from self-paying patients from distant areas is through deposits or EFTs. Although this procedure is viable, the researcher is concerned with the process to finally clear the debt. The patients might not find this process convenient. It also appeared that cheques and postal orders are not effectively used by the hospital.

User-fees are often small amounts of payments that should be made at the point of service. Paying user-fees at the hospital could also have its challenges. “Int3” indicated that the hospital often fails to collect cash because the payment method at the point of service does not make provision for hospital users with credit/debit cards. The participant viewed this as a disadvantage to the hospital.

The researcher is of the opinion that the absence of electronic methods of payment at the point of service negatively affects hospital revenue. “Int3” indicated a need to have

electronic methods of payment to improve revenue collection. According to the participant, the cashiers are frequently unable to assist the patients using credit/debit cards to settle their user-fees. It should be noted that the inability of the hospital to collect revenue due to a lack of resources could lead to under-collection of revenue.

5.4 CHAPTER SUMMARY

The objective of this chapter was to analyse and interpret the findings of the study in order to provide meaning to collected data. The researcher thoroughly analysed the findings to allow the study to reach its conclusion and provide recommendations where necessary.

The identified variables of revenue management in public hospitals were used as a basis throughout the chapter to analyse the data. These variables are the means test, billing, debtors management, and cash collection.

The study employed two methods of data collection – observations and interviews – to collect data. The interviews were designed based on the results of the observations and the literature review. The observation and interview results were analysed separately, although the interview analysis included reference to literature reviewed and observations made.

This chapter sought to answer the research question. The following chapter provides a conclusion and recommendations based on the available data.

CHAPTER 6
CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

The previous chapter provided an analysis and interpretation of the research findings. The current chapter will present the conclusion on the study and offer recommendations. The study sought to explain revenue collection systems and revenue management in terms of legislation, and to determine the current state of revenue management at TDH.

A considerable amount of data was collected and thoroughly analysed to reach a conclusion and make recommendations. The aim of the conclusion is to state what the researcher has achieved in each phase of the study, and to provide recommendations where necessary.

To have clear recommendations, this chapter will be divided according to the following subheadings: skills and competency, means test, billing, debtors management, and cashier office. The researcher viewed the aforementioned subsets as the important variables of revenue management processes of a public hospital. The problem statement highlighted financial management skills, cash collection, and means test processes as part of the research problem. Because the investigation was directed by these variables, it is necessary to provide recommendations where required for the identified challenges in the aforementioned areas.

The purpose of this study was to evaluate the effectiveness of revenue management in South African public hospitals by conducting a case study at TDH. The primary objective of this study was achieved with a conclusion on whether the revenue management systems are effective or not, as stated in the subsequent sections. However, the study revealed that certain revenue management processes are not effective.

6.2 REVENUE MANAGEMENT

To get to the root of the problem and be able to conclude on the findings and provide recommendations, the researcher commenced the literature review of this study with financial management, which could be perceived as the landscape on which revenue management exists. The literature review suggested the cause of challenges in revenue management as poor financial management (Section 2.1).

Additionally, specific variables of revenue management that form an integral part of revenue collection where isolated from the data collection and data analysis stages. Figure 6.1 portrays the phases followed to address the problem that prompted the study.

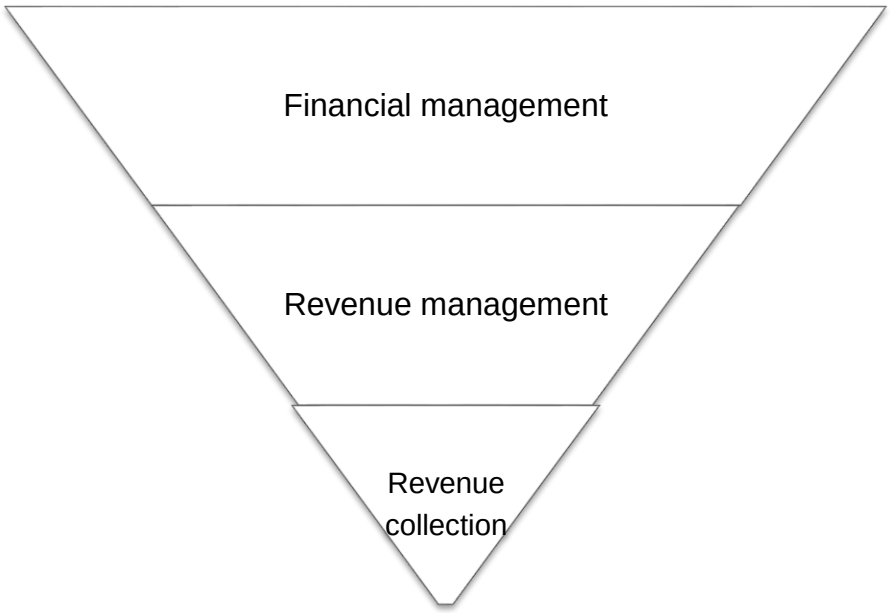


Figure 6.1: Summary

The data collection of this study was informed by two parts of the literature review, i.e. an overview of financial management and procedures, and functions in revenue management. The focal area of this research was on revenue collection with an emphasis on collecting user-fees.

In the literature review, financial management proved to be an important aspect of running public hospitals and contributes to government's objective to collect revenue.

The financial management processes and systems implemented by various governments internationally and in the private sector provided numerous lessons on revenue management. The literature review from Chapter 2 covered an overview of financial management. Financial management was discussed in terms of its components which included planning and budgeting, resource allocation, operating and monitoring, and evaluation and monitoring (Section 2.2).

In terms of budgeting, Chapter 2 indicated that the revenue budget of public hospitals provides the projected revenue the hospitals aim to collect on behalf of the PDoH (Section 2.2). The study also showed that there are less financial resources allocated to the hospital to collect the budgeted revenue (Section 2.2.2). A lack of financial resource could be the reason not all the revenue management systems are effective (Section 2.2).

In terms of effectiveness, efficiency, and economy principles (Section 2.2.4), Chapter 2 stated that a system would be effective if it can collect the revenue as projected. To assess the effectiveness of revenue collection systems, efficiency and economy had to be considered. The revenue collection systems of TDH appeared to be efficient for collecting revenue because even though the hospital is often under-resourced, it is still able to collect revenue from medical aid institutions. However, collecting revenue from individuals is still a challenge. Achieving the principle of economy requires the hospital to collect the budgeted revenue at minimum cost (Section 2.2.4). In order for the hospital to improve revenue collection, the GPDoH will have to increase the resources allocated for revenue collection purposes.

The hospital policies on debt management are not effective because of their inability to encourage debtors to settle their debts. There is no interest charged on individuals ignoring their debts, and due to limited resources, the hospital writes off outstanding debts after 90 days of service where the patients cannot be traced. Based on the results of this study, it will be uneconomical to keep sending letters and calling patients who are not responding.

Chapter 3 was specifically dedicated to the procedures and processes of revenue management within South African public institutions with reference to the public

hospitals. From Chapter 3 the definition of revenue management was stipulated as those procedures and processes which are vital to ensure the planning and accountability of PDoH revenue, including the cash management (Section 3.2).

The aforementioned chapter provided a guideline for revenue management by discussing the duties and responsibilities of the role players working within revenue management offices (Section 3.4), the legislations regulating revenue management (Section 3.5), as well as the main financial system (BAS) used to record and report on revenue information.

In terms of the legislation, it was learnt that the hospital does adhere to most of the requirements of the PFMA. However, there was no clear reason for the hospital's debt management policies to deviate from a requirement to charge interest on outstanding patient debts as required by Treasury Regulation 11.5.1.

To achieve the aim of this research, Chapter 4 provided a design of the instruments that were used to collect the data. The research instruments, observation, and interviews were accepted as appropriate based on the justification in the mentioned chapter and approved by the ethics committees of TUT and GPDoH. Eventually, a considerable amount of raw data was collected through field notes and recording devices. The available data were analysed and interpreted to give meaning to it.

Prior to a discussion of hospital operations, Chapter 5 of this study also indicated that the revenue budget of public hospitals in Gauteng is set by the GPDoH. Further, the results showed that instead of revenue budget committees, there are revenue forums involved in the discussions of revenue targets (Section 2.2.3). It may be a challenge for the hospital to meet the revenue targets if these targets are set by the GPDoH. However, the participation of revenue forums in revenue budget processes should ensure that the GPDoH provides reasonable targets for each hospital. To offer a clear conclusion on the subject matter at the centre of this study, the conclusions of Chapters 4 and 5 are synthesised as follows.

6.2.1 Skills and knowledge

It was determined that the interviewed staff members working within financial management, more specifically involved in revenue management, have relevant qualifications. Chapter 5 also indicated that both TDH and the GPDoH allow the officials to take training courses. However, the results revealed that it is possible for officials to work for a period of a year without attending a training course.

The findings also indicated that the officials' qualifications are relevant to their responsibilities and duties. The official with the highest rank from the interviewed participants holds a Master's Degree in Public Administration, specialising in debt management, while the lowest ranked official holds an administrative qualification. When considering the total group interviewed, the researcher was satisfied with the qualifications and skills development systems in place. However, recommendations will later be made for the areas that still need improvement.

6.2.2 Means test

The means test was viewed as the first stage in public hospitals' revenue management. The personal information gathered from the patients were considered to be important for assessing patients' affordability status. According to the study, proof of income such as a payslip proved to be the vital document in classifying patients on the system in term UPFS for payment purposes. The study revealed drawbacks within this aspect of revenue management.

The findings indicated that the hospital does not seem to have a sound, if not standard, procedure to deal with patients who cannot produce the required documentation before receiving medical services. Also, the verification process of information provided by the patients appeared to be ineffective if not reliable. The researcher was concerned about the misclassification of patients where incorrect information is provided.

6.2.3 Billing

The purpose of billing was established as to ensure that all patients are billed for medical services received. The process for billing patients appeared not only to be the responsibility of billing officials, but all the hospital officials working with patients. According to the results of this study, patients' files containing necessary billing information are submitted by the ward clerks to the billing office on a weekly basis.

It emerged in Chapter 5 that discharged patients often leave the hospital without statements or invoices. The cause for this was established as the difference between the discharge date and the billing date. The researcher concluded that this could result in hospitals incurring more fees in debt collection costs. The rationale behind this conclusion was based on the fact that the patient will later have to be informed of the debt, either by telephone call or letter, or any other means of communication available.

However, this weakness did not appear to be a challenge when submitting invoices to the medical aid institutions or other government institutions such as the Department of Correctional Services; perhaps because the hospital has the opportunity to be in direct contact with the mentioned institutions.

This study was conducted based on the assumption, mentioned in Chapter 1, that hospital user-fees can be paid out-of-pocket or by means of medical aid institutions. Therefore, the collection of revenue from user-fees was investigated based on both methods of payment. According to the research results, it can be concluded that billing patients on medical aid schemes, and patients paying out-of-pocket have different challenges, more specifically when invoices or statement are submitted.

Further, it is possible to have challenges in sending claims to the medical aid institutions, however the system appeared to be effective in this regard. The recommendation on the existing challenges and anticipated challenges in this regard are provided later in the chapter.

6.2.4 Debtors management

Managing debtors in any government institutions is of paramount importance. Substantial revenue is often in the hands of the debtors. This leaves the concerned institution to collect such revenue from their debtors. The results of the study indicated that TDH is also faced with the challenge of collecting revenue from the patients. The study proved that not all the methods used to collect the revenue from patients are effective. In fact, some of the methods, such as sending letters or telephone calls, often result in fruitless expenditure. In addition to the procedures mentioned in Chapter 3 (Section 3.6.2), the findings indicated that e-mails and SMSs could also be used to remind patients about their outstanding debts. Most of the procedures outlined in Chapter 3 appeared to be implemented by the hospital.

However, the results showed that the hospital is failing to pursue patients who are paying out-of-pocket to settle their outstanding balances. It appeared that the hospital rather relies on writing off debts of small amounts after the three months period has passed. There was no indication of persuasive measures in place to encourage patients to settle their debts on time.

It also became apparent that the hospital does not utilise debt collection agencies. According to the researcher, this could be because the use of debt collection agencies is centralised within the GPDoH. The use of agencies at departmental level appeared to be effective.

In addition, it emerged in Chapter 5 that the incentives from the GPDoH to improve revenue collection systems were phased out. However, the results also indicated that the incentives are still proposed to be reintroduced. The rationale behind the withdrawal of incentives can be an attempt by the Provincial Treasury to cut costs. Figure 2.2 in Chapter 2 clearly illustrates how resources are allocated from Provincial Treasury to the departments within the province.

Apart from the highlighted areas, the hospital appears to have sound procedures in place to manage debtors. The nature of this study required the researcher to draw

conclusions on the effectiveness of revenue management. As a result, it was learnt that not all procedures, such as use of letters as a reminder, are effective.

6.2.5 Cashier office

Based on the results of the study it appeared that the hospital is implementing sound cash management procedures regarding the recording and banking of cash. Chapter 5 of this study clearly highlighted how cash is managed within the hospital, and procedures applied by the hospital to manage cash was reflected in the literature review (Section 3.6.3). From the findings in Chapter 5, the researcher noted there is proper segregation of duties and handling of cash receipts in the cashier office as stated in Chapter 3 (Section 3.4.2).

The identified challenges in the literature review chapter did not emerge from the findings in Chapter 5. The literature review (Section 2.3.2) indicated that where hospitals are applying a manual system of managing cash at the point of service, the hospital officials illegally benefit from the cash collected. Although the TDH did not completely phase out the manual system, it relies more on online systems, such as PAAB and BAS. The manual system is only implemented in the case of power failure or where the online system is not working.

The findings of this study indicated that the hospital relies primarily on a cash method of payment. Although it appears to be an effective method of payment that does not need a substitute, the researcher made a conclusion that it may not be convenient for all hospital users. A complementary method of payment is suggested under the recommendations.

6.3 RECOMMENDATIONS

This study will not be complete if it does not fulfil all of its objectives, including the provision of recommendations for identified challenges. From the research question, the study sought solutions that can be implemented to enhance revenue management in TDH and possibly be generalised to South African public hospitals.

To ensure consistency in presenting this study, the researcher maintained the order in which the analysis and conclusion were presented. Therefore, the following recommendations are presented according to the identified categories or variables of revenue management.

6.3.1 Skills and competency

Although the findings indicated that the interviewed staff members have relevant qualifications and went for formal training in their respective duties, the hospital should consider providing newly appointed officials within revenue management sections with financial management training in the first year of employment to equip them with skills and knowledge (Section 3.4).

All officials working within the revenue management cycle should possess a common understanding and knowledge of financial management, and more specifically, about revenue management. This includes the knowledge of legislation and the policies regulating revenue management.

6.3.2 Means test

The accuracy of information gathered from patients for registration purposes was also perceived to be significant for revenue purposes. To avoid classifying patients incorrectly on the system as a result of false information, this research suggests the verification of employment information with SARS or the Department of Labour. This could be achieved by linking hospital administration systems with the external institution systems for verification purposes.

This research also recommends that the hospital considers applying fixed amounts of expenses for deduction purposes from patient incomes, rather than allowing the patients to list their monthly expenses without proof. The findings revealed that net income is used for classification purposes according to UPFS. The net income used to classify patients is determined by deducting all their monthly basic expenses from their gross income. The researcher suggests that the fixed amount be informed by the consumer price index. The consumer price index represents the cost of the *“shopping*

basket" of goods and services of a typical or average South African household during the specific period.

To enhance consistency in conducting a means test, the following method (refer to Table 6.1) could be applied.

Table 6.1: Classification income

Current method	Recommended method
Gross income – monthly expenses= Income used for classification	Net income – Fixed amount = Income used for classification

The researcher strongly criticises the current method as gross income includes tax, UIF, and other mandatory deductions that are deducted from the patient's income (payslip). The recommended method considers income after mandatory deductions. The fixed amount could be informed by the *"shopping basket"* as outlined in "*The South African CPI sources and methods manual*".

The goods and services that are considered to be household or individual consumption expenditure according to the aforementioned manual, include food and non-alcoholic beverages, alcoholic beverages and tobacco, clothing and footwear, housing, water, electricity, gas and other fuels, furnishings, household equipment and routine maintenance, health, transport, communication, recreation and culture, education, restaurants, miscellaneous goods and services. These items could be used to determine the fixed amount.

6.3.3 Billing

The literature review indicated different reasons for medical aid institutions to reject or dispute claims. Among these reasons was the computerised information system which was regarded as ineffective because of its inaccuracy in recording information. Improvements to the hospital administrative system can be made by implementing the latest version of International Classification Diseases (ICD) revision coding as recommended by the literature review (Section 2.3.1). This system ensures that patients are billed accurately for services received.

The findings indicated that discharged patients depart hospital premises without knowing the outstanding fees to be settled. The time difference between the discharge date and the date on which billing is performed appeared to be the reason invoices cannot be handed over to patients before leaving the hospital. To overcome this challenge, the study recommends that an SMS system be implemented to promptly send invoices to the patients.

The findings, as well as the literature review (Section 3.6.2), strongly criticised the use of telephone calls to remind patients about their outstanding user-fees. However, the recommendation promotes the use of an SMS method to send invoices/statements while the original copy of the invoice is attached to the patient file (Section 3.6.2). The hospital should also consider printing two invoices where possible, especially at the administration office, where one invoice can be handed over to the patient while the duplicate will remain inside the patient's file.

Besides normal medical service charges, patients are also billed for the administrative services at the point of service. The findings indicated that these fees are seldom paid once the patient is registered on the system. The researcher recommends that the hospital, together with the PDoH, makes it known to the public that the administrative fee is a compulsory payment when patients visit public hospitals. This information can be disseminated during healthcare campaigns and conferences. Notices can also be displayed at hospital facilities to provide information about hospital charges, including administrative fees.

6.3.4 Debtors management

Debt collection featured prominently in this study. The study indicated that the hospital could be writing off considerable amounts of debt based on the 90-day policy. Further, the findings showed that debts are written off after the tracing clerk has exhausted all means to recover the debts. The existing debt collection procedures limit the tracing clerk to only issue written communication for debts larger than R195. To reduce the debts written off by the hospital, the following recommendations can be applied.

Debt collection agencies should also be employed at the hospital level to improve revenue collection. Reviewed literature (Section 2.3.3) indicated that outsourcing revenue management functions could improve revenue collection.

The hospital should also engage with patients before leaving the hospital premises to make arrangements to settle their user-fees. The researcher recommends that a payment plan be drawn up between the hospital and patients paying out-of-pocket. The Treasury Regulation, Section 11.3.1 states that the accounting officer may allow the debts to be recovered in the form of instalments.

Improvements to the hospital debt management policy are needed to create more convenient channels to allow and encourage patients to pay for medical bills. Also, the researcher suggests that the difference between the debt collection period and the period allowed to write off debts should be amended. A debtor's collection period was identified as one of the revenue collection indicators that can be used for monitoring revenue collection (Section 2.2.3). This study recommends that a 30-day collection period be used as standard to monitor revenue collection.

The study also recommends that the hospital charge interest on outstanding fees to comply with the requirement of the legislation (Section 3.6.1). Charging interest on debts could encourage patients to pay the outstanding balances on time. This could eventually result in a decrease in the amount of debts written off.

6.3.5 Cashier office

Although the procedures within the cashier office appeared to be sound in terms of the findings in comparison with internal controls as outlined in Chapter 3 (Section 3.4.1), the researcher is of the opinion that improvements are still needed with regard to payment methods. An advanced development in technology and the economic environment will reduce the use of cheque methods of payment.

To improve cash collection within the hospital, the researcher recommends electronic methods of payments at the point of service. The literature review (Section 3.7) indicated that financial systems could also cater for electronic payment methods, while

the results of the study revealed that the hospital is not actually using this method of payment.

6.4 FUTURE RESEARCH

Although the study was limited to the investigation of revenue collection with emphasis on user-fees, the results of this study draw a guideline for future research within revenue management of public hospital settings. Further research could be conducted to investigate:

- resource allocation for the public hospitals to enhance revenue collection systems; and
- the public hospitals' policy on debt management.

6.5 CHAPTER SUMMARY

This chapter concludes the entire research by stating the achievements of each phase of this study. The conclusion summarises the process followed by the researcher to achieve the outcome of this study (refer to Figure 6.1).

Based on the results of this study, it was concluded that not all processes are effective within TDH revenue management, for example, sending letters of reminder to the patients. However, most of the systems or processes of revenue management in place are effective and can still be improved, for example, the process of receiving, recording, and banking the cash received. The ineffectiveness identified within revenue management systems appeared to be caused by a lack of resources. Further, there was no proof that poor health service delivery discourages patients from paying user-fees.

Subsequent to the conclusion, recommendations were provided. To avoid being vague, the researcher ensured that recommendations were aligned to a specific challenge identified from the findings and also as highlighted by the conclusion. The categories that were identified from data analysis were used to design the conclusions

and recommendations in this chapter. Annexure A contains the design that was used to derive at these categories.

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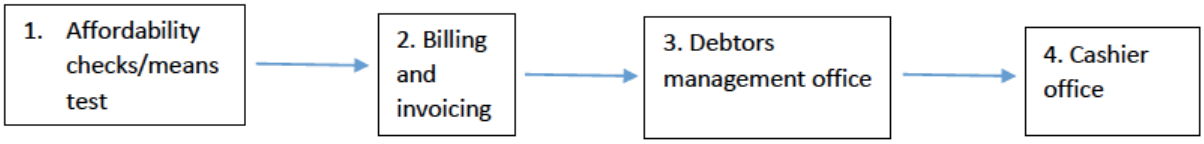
ANNEXTURE A: OBSERVATION PLAN AND NOTES

Observation Plan



1.1 Means Test

In this area the researcher should be able to see the process for undertaking the means test, and which documents are actually required for payment classification. Are patient turned away where there`s no supporting documents?

2.1 Billing and invoicing

In this area the researcher will observe the activities and the environment within billing section. Are patients actually billed for service? Does the patient administrator/billing cashier issue an invoice for billed services? Are patients advised to pay their balance? Are there enough resources to bill, i.e. computers and staff?

3.1 Debtors Management

Are letters of reminder prepared to collect revenue? Are telephone calls made to remind the debtor if the debt? NB. This might not be possible to observe, however, interview will be conducted to cover this content at the later stage.

4.1 Cashier office

In cashier office, the focus will be on the process of payment. The researcher will determine if the required procedures are followed when payment is made. Whether the segregation of duties is being implement.

WHAT TO OBSERVE

Category	Includes	Researcher`s attention/what to note
Means test	Supporting documents	Whether there are any documents provided for payment classification purpose. In the problem

		statement it was stated that hospitals do not turn back the patients who cannot afford to pay.
Billing	Invoices and communication	Determine if invoice are issued, when billing patients, to ensure that patients are informed of their balance they need to settle. Are patients advised to pay?
Debtors Management	Communication	Determine if there are any telephone calls to hospital clients. The researcher is aware that clients could be called in a specific period which falls outside the observation period. However, this should also be covered by interview questions.
Cashier office	Cash receipts	Are receipts issued for cash received to ensure that all the cash received is recorded? Are there enough equipment resources? In the literature review lack of resources in public hospitals has been identified as one of the contributing factors to ineffective revenue management.

Observation Notes

Objective: Determining the current state of revenue management at the TDH.

"In observation, we confirm what is already known and unearth new truth"

Researcher: Maila Jan

Location: Tshwane District Hospital: Administration office. Date: 12/02/2016

Start Time: 12:10

End Time: 15:25

The purpose of this observation is to enable the researcher to see the processes for undertaking means test. Determine the documents/information needed to assess the affordability

Each and Every department has its own administration office. The researcher is conducting observation in two offices, i.e. Casualties and Out Patient Department. Casualties' administration office has 6 computer desks *(sufficient resources)*. At the time of registration, each registration clerk had manual folders with him/her.

When the patient arrives the clerk asks for personal information and documents (*this could be used to open an account for patient and register the patient on the system)*. Besides the documents provided the clerk requires contact details of the patient including residential address and family members *(this information can be used to trace the patient at the later stage for collection purpose)*.

On the notice board next to registration desks there's poster with the following information. (*Reminder of important information needed to assist both patient and clerk and avoid returning patients away due to lack of document. However; the poster does not state that patients need to have cash to open file/account or for consultation).*

Heading: "documents needed when visiting a state health facility":-

- Appointment card/ referral letter.
- Identity document
- Payslip/unemployment card / pension card *(it assists the clerk in classifying the patient)*
- Proof of address, such municipality/telephone account *(location where the patient can be found or where the letter of collection can be sent)*
- Medical Scheme card if you belong to a scheme card (*this is required to claim from medical aid scheme organization the payment for service)*
- You are responsible for paying for services according to your income (*the onus lies with the patient to settle the amount due for service provided)*
- Services are free to certain categories of patients. (*which categories and why)*

Using the abovementioned information the clerk opens the file using a brown file for the patient and transfers the information into the system. *(The information is kept both in manual and electronic format)*

Private patients are required to make a deposit on admission equivalent to 5 days In-patient tariffs for specific financial classifications. *(What happens to those who do not deposit?)*

In the case of admission, the nurse brings the files to registration for admission. *(The charge for consultation and boarding vary, hence the files are brought back to clerks for admission.)*

Observation Notes

Researcher: Maila Jan

Location: Tshwane District Hospital: Administration office. Date: 14/02/2016

Start Time: 12:35

End Time: 16:12

The purpose of this observation is to enable the researcher to see the processes for undertaking means test. Determine the documents/information needed to assess the affordability

From the observations inside the administrative office, the registration clerk asked the following questions: (*To conduct means test/ affordability checks, below questions are asked)*

- Where do you stay?
- Are you working, if yes, where are you working?
- What are your work contacts?
- How much is your monthly income? *(this should indicate how much can one afford to pay, however supporting document could more accurate)*
- Which language do you speak
- What is your reason for visiting *(consultations rates differ, so are the charges for consultations. This assists the clerk in charging the correct amount for consultation.*

Before the clerks could ask the patient to pay, they ask the patients to list their monthly expenses. This includes Food, Airtime, Clothes, Travelling expenses etc. (*although user-fee schedule guides classification according level of income, clerk determine the amount one can afford as an installment after deducting basic expenses from the income) There`s no proof demanded, i.e. bank statement for debit orders*

The registration clerk informs the patient of the consultation fee payable after asking the above-mentioned questions?

Not all patients are able to pay minimum consultation fee immediately. In these instances the clerks does not turn away the patient, however, they tell them to proceed with the consultation. *(Patients are only informed to pay the outstanding balance during their next consultations, which can possibly be after 5-10 years. Patients are expected to voluntarily take responsibility to settle their fees at the later stage. In the real world, when one receive service from state chances are he/she might not to come back to pay unless necessary measures are taken.*

The clerk collects cash from the patients who can immediately pay their consultation fees. The clerk prints invoice together with the statement for the patients. These are put inside the brown file. (*Will the patient know how much is outstanding if the statement is put inside the folder?*

Some of the first time consulting patients do not have all the necessary documents. In this case, patients are still assisted and advised to bring the relevant documents during their next visit. *(How do you classify a person without a proof of income?)*

The clerk demands the details of the parent to open the account where the child is a minor and cannot pay for himself/herself.

Observation Notes

Researcher: Maila Jan

Location: Tshwane District Hospital: Billing Office Date: 11/03/2016

Start Time: 13:30

End Time: 15:00

The purpose of this observation is to enable the researcher to see the processes for billing patients once the service has been provided by the hospital.

Billing section is situated separate from administration section (*it appears that there`s sound segregation of responsibilities/duties*). This section has four desks and each desk has a computer and the telephone. There`s one printer in the room, *(invoices are not printed from this office, however patients, specifically boarding patients, are billed in this office.*

There are three cabinets in the room, including one big cabinet containing brown folders. *(How long do official keep the file before it could be billed).* The other cabinets were containing black folders. Some of the black folders are placed in a disorganized manner on top of the cabinet.

There is no personal interaction between patients and billing official. *(Patients might not know of their outstanding debt if they are only billed once discharged and departed hospital premises).* The officials only receive files for billing.

This observation is conducted during the time auditors from Auditor General are auditing the hospital, revenue section. Due to the audit only few activities are taking

place. Only few files are placed on one desk. Some of the officials are idling. (This could mean there was less work to do because audit was taking place). *(During the audit less revenue could be recorded)*

It appears that billing section does not issue invoices after billing the patients. It is noted that the files which were billed are returned to records management.

Observation Notes

Researcher: Maila Jan

Location: Tshwane District Hospital: Finance Control/Debtors Management office.

Date: 14/03/2016

Start Time: 11:00

End Time: 12:40

The purpose of this observation is to enable the researcher to see the processes for undertaking debtors' management.

This office is run by one individual, who`s also a supervisor to billing officials and Cashiers. During the observation the official spent most of the time concentrating on getting the files and other work ready for audit. Some of the expected activities are not taking placing nor have a chance to transpire during this period.

The researcher relies on listening as part of the observation. During the observation, it was noted that not all debts were registered on the system. Officials made arrangements to work overtime and during weekends to bill and register all the debts that were outstanding from previously.

During the observation, there was no telephone communication made regarding debt collection. Is the hospital utilizing debt collection agencies to collect the debts? If not, does one official manage to handle the volume of debts created daily?

It is not clear from the observation how debt collection is handled.

Does the hospital send letters to patients to inform them of the outstanding balance?

Observation Notes

Researcher: Maila Jan

Location: Tshwane District Hospital: Cashier Office Date: 14/03/2016

Start Time: 14:05

End Time: 15:40

The purpose of this observation is to enable the researcher to see the processes for administration of payments from patients.

The observation is conducted in main cashier office. Cashier offices are divided to into sub-cashier s. Each department, i.e. OPD and Causalities, receive cash from patients on a daily basis. Cash collected is handed over to Main cashier for banking.

The main cashier office consists of two officials, with two desks and computers. The entrance door is always locked and the safe is not kept in the same office. It was not seen where the safe is kept.

Besides administering cash from sub-cashiers, main cashiers also receive payments from patients directly. This includes payments for medical record, eye operations etc. The cashier issues receipt when the cash is received.

Are patients able to pay their debts or outstanding balances from outside the hospital, using EFT and deposits at the bank?

ANNEXTURE B: INTERVIEW GUIDES AND TRANSCRIPTS

Interview Guide

On

THE EFFECTIVENESS OF REVENUE MANAGEMENT IN SOUTH AFRICAN PUBLIC HOSPITALS – THE CASE OF TSHWANE DISTRICT HOSPITAL

By

MAILA JAN PHASODI

Primary data for a study towards the following degree:

MAGISTER TECHNOLOGIAE: COST AND MANAGEMENT ACCOUNTING

in the

Department of Managerial Accounting and Finance

FACULTY OF ECONOMICS AND FINANCE

at the

TSHWANE UNIVERSITY OF TECHNOLOGY

Supervisor: Prof LJ Erasmus

Co - Supervisor: Prof HE Klingelhöefer

1. **Skills and competency**

   1.1 What financial management qualification do you possess?

   1.2 What does your institution do to improve skills and competency of financial management staff?

2. **Means - test**

   2.1 What documents are required as a proof of income for individuals without formal employment to determine the amount payable for healthcare services

   2.2 How does the hospital deal with patients who are not in possession of valid documents seeking medical service?

   2.3 Does the hospital do background checks on patients before placing them into an income category?

3. **Acknowledgement of debt**

   3.1 In the case where the patient is a minor, does the parent sign any document to acknowledge the debt?

4. **Debit orders**

   4.1 Is it possible for the hospital to recover payment directly from a patient`s bank account on a monthly basis in the form of a debit order?

5. **Validation of information**

   5.1 Is the hospital system able to identify or detect false information submitted by patients?

   5.2 How does the hospital handle a patient without valid documentation?

CERTIFICATE OF VERACITY

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(NAME OF AUDIO: MEANS TEST)

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INTERVIEWER: The first one, we are assessing skills and competency, what financial management qualification do you possess? Which qualification do you have?

INTERVIEWEE: [Inaudible 0:00:34.0] National Certificate for legal secretary.

INTERVIEWER: What does your institution do to improve your skills and competency of financial management staff? Do they take you to any training?

INTERVIEWEE: [Inaudible 0:01:02.1] For me?

INTERVIEWER: All I'm asking here is I just want to find out if the hospital does send their staff for training.

INTERVIEWEE: Yes, they did.

INTERVIEWER: What sort of training?

INTERVIEWEE: [Inaudible 0:01:20.6] started last year.

INTERVIEWER: You started working last year [inaudible 0:01:24.8]

INTERVIEWEE: I don't have much experience and that's the problem [inaudible 0:01:32.8].

INTERVIEWER: The second one we are assessing the means test – what documents are required as a proof of income for individuals without formal employment to determine the amount payable for healthcare services?

INTERVIEWEE: Repeat the question.

INTERVIEWER: Which documents are required as proof of income for individuals without formal employment?

INTERVIEWEE: A pay slip.

INTERVIEWER: You can only have a pay slip if you're...

INTERVIEWEE: If you are not working then [inaudible 0:02:25.2]. It's only a pay slip and a bank statement.

INTERVIEWER: In the case where you have got someone who is unemployed, an affidavit or anything?

INTERVIEWEE: No, they complete a declaration form.

INTERVIEWER: Oh, you've got declaration form, thank you. How does the hospital deal with patients who are not in possession of valid documents, seeking medical services, if somebody doesn't have, in terms of...?

INTERVIEWEE: Like the foreigners?

INTERVIEWER: Yes.

INTERVIEWEE: We do classify them. If they do have a valid document then we charge them as a patient [inaudible 0:03:10.2].

INTERVIEWER: If they don't have documents?

INTERVIEWEE: It's also the same [inaudible 0:03:15.5].

INTERVIEWER: Does the hospital do background checks on patients before placing them into income categories? Do you check if the person was previously owing any institution or was blacklisted before?

INTERVIEWEE: We do check and we do bring the invoice for them to remind them to come and pay.

INTERVIEWER: Third one. In the case where the patient is a minor, does the parent sign any document to acknowledge the debt?

INTERVIEWEE: Yes, they do sign.

INTERVIEWER: Fourth one. Is it possible for the hospital to recover payments directly from the patient's bank account on a monthly basis, in the form of debit orders?

INTERVIEWEE: No.

INTERVIEWER: Okay, last one. Is the hospital system able to identify or to check false information submitted by the patient? Will the system notify you if there is any incorrect, let's say the ID number, or names?

INTERVIEWEE: No, they don't.

INTERVIEWER: How does the hospital handle a patient without valid documentation, do you turn the patient away or do you assist them?

INTERVIEWEE: We assist them. But we tell them that they don't have the valid documents, but we do help them but they must pay.

INTERVIEWER: Thank you very much for your time, I really appreciate it. I think we are done, it was short.

Interview Guide

On

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Supervisor: Prof LJ Erasmus

Co - Supervisor: Prof HE Klingelhöefer

1. **Skills and competency**

1.1 Which financial management qualification do you possess?

1.2 What does your institution do to improve skills and competency of financial management staff?

2. **Billing**

2.1 What information is required to bill the patient?

2.2 Does the hospital charge patients administrative fees?

2.3 In the case of out-patients, are these patient billed before they see the doctor or after they have consulted a doctor?

2.4 According to what procedure does the hospital submit medical aid claims to medical aid institutions?

3. **Invoice and Statements**

3.1 How are patients informed of the balance of their debts once discharged?

3.2 Are statements or invoices handed to patients once they are billed for medical services?

3.3 Are statements or invoices of patients filed for future recovery?

4. **Filing**

4.1 How do you ensure that all patients are billed in time once their files are received from the ward?

4.2 How do you ensure that all patient files are processed for billing?

5. **Information and Billing system**

5.1 What system is used to bill patients?

5.2 How does it link with BAS – Basic Accounting System?

CERTIFICATE OF VERACITY

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(NAME OF AUDIO: BILLING)

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MALE SPEAKER: Yes, I'll start with the first one. It's easy, this one.

FEMALE SPEAKER: Qualifications?

MALE SPEAKER: Close and competence, yes.

FEMALE SPEAKER: Qualifications, I have a national diploma in financial management.

MALE SPEAKER: You have a national diploma in financial management.

FEMALE SPEAKER: Yes, in management.

MALE SPEAKER: Are you busy studying now?

FEMALE SPEAKER: Yes, I'm currently studying with UNISA. I'm doing a BCom Accounting.

MALE SPEAKER: All right.

FEMALE SPEAKER: A BCom degree in Accounting.

MALE SPEAKER: What does your institution do to improve your skills and competency?

FEMALE SPEAKER: They usually take us for training, training such as Pastel, and BAS. Those are the systems and SAP, there are other systems which we are also using but usually the basic one that we have to know is BAS.

MALE SPEAKER: BAS only?

FEMALE SPEAKER: BAS and Pastel.

MALE SPEAKER: With regards to the billing, what information is required to bill a patient?

FEMALE SPEAKER: The only thing that you need to remember, you have to have a patient file, and you have to check whether the patient is billed correctly. Remember we classify patients according to their incomes, so we check on the things. That when you have to register the patient, so the patient has to have a registration form, just to check on a certain date, and a new patient has to have a consultation form, an x-ray form, nursing notes and other things, like prescriptions.

MALE SPEAKER: Does the hospital charge patients administrative fees?

FEMALE SPEAKER: Yes they do. Remember when you get to the hospital, it depends on whether you're working or not, but if you're working then remember, we classify a patient according to their income. That's how we charge our patients.

MALE SPEAKER: In the case of outpatients. Are these patients billed before they see the doctor or after they have consulted the doctor?

FEMALE SPEAKER: After they've consulted the doctor.

MALE SPEAKER: What do you use then to bill the patient?

FEMALE SPEAKER: We usually use a charge sheet or the file itself, looking at the things that I've mentioned before that we look at – the requirements to bill the patient.

MALE SPEAKER: In the case of this one, where the patient has seen the doctor already. Do you look into the doctor's notes or...?

FEMALE SPEAKER: We do. Remember, you have to check what procedures they've performed on a patient.

MALE SPEAKER: According to what procedures does the hospital submit medical aid claims, to medical aid institutions?

FEMALE SPEAKER: We usually bill the patient. After making an invoice, that's when we email the invoice to the medical aid. Some of the medical aid schemes we don't have their email addresses and others. They prefer us to bring it manually, to deliver it by hand.

MALE SPEAKER: With regards to invoice and statements. How are the patients informed of the balance of their debt once discharged?

FEMALE SPEAKER: We send letters, so there's a letterhead that we've drafted. So we send patient invoices and that letter, to remind the patient that he or she is still owing the hospital.

MALE SPEAKER: I want you to clarify me on this one.

FEMALE SPEAKER: Okay.

MALE SPEAKER: Would you say a patient would leave the ward without knowing how much he or she is owing?

FEMALE SPEAKER: Now that we don't have a case manager. Usually those things are performed by a case manager, and the case manager would go to the wards and speak to the patients, and advise the patients how much they are owing and how much they can pay on the hospital bills. Now that we don't have a case manager, but we're still working on that, as soon as we have a case manager then the case manager has to perform those duties. Then do the updates of the hospital.

MALE SPEAKER: Are statements or invoices handed to patients once they are billed for medical services?

FEMALE SPEAKER: For medical services – depending on which classification it is but usually we put it in a file, inside the folder. When the patient wants to come again then the patient has to be reminded how much she or he is owing the hospital.

MALE SPEAKER: Regardless of race or...?

FEMALE SPEAKER: No, we don't look at race. Remember we look at how much you are earning.

MALE SPEAKER: Literacy?

FEMALE SPEAKER: No, we don't look at that. We check on how much you are earning or making an income of how much.

MALE SPEAKER: Are statements or invoices patients filed for future [inaudible 0:04:53.8]?

FEMALE SPEAKER: Yes, we do that. We've got a system, remember, in place. We're using a PUB system and on that PUB system, when a patient comes every day we register the visit date. On that day, remember, we bill the file. After billing, the file that's when we've got to know that every time on this day, the patient came and be billed this much. On this day, the patient came, and we billed this much, so we have a system that we're using and we check on how much the patient is paying, and how much the patient is owing.

MALE SPEAKER: Regarding the filing again. How do you ensure that all patients are billed in time once their files are received from the ward?

FEMALE SPEAKER: The thing is, the ward clerks have to bring it. Usually they have to bring it twice, on Mondays and on Fridays. The ones that we get on weekends, the billing clerks bring it on Monday, and the ones that were discharged from Monday until Thursday, then they bring that on Friday. We make sure that we bill it and we send it to records. Then the

patient has to remember. We also don't have a tracing clerk. A tracking clerk is the one that traces and reminds the patients. She has to call every time to remind the patient that they are owing and whatever. We don't have that but sometimes if we don't have a lot of [inaudible 0:06:13.5] then we remind the patient. We call to try to contact them and remind them about the bill and stuff.

MALE SPEAKER: How do you ensure that all patients' files are processed for billing? I think you've already answered in the previous question. With regards to information and billing system, what system is used to bill patients?

FEMALE SPEAKER: We have a PUB system. The PUB system is the one that we use to capture, to do everything on it. We actually use it also to make payments.

MALE SPEAKER: Is it an admin system?

FEMALE SPEAKER: Yes, it's something like that, but on billing, we also use it.

MALE SPEAKER: How does it link with BAS?

FEMALE SPEAKER: Usually, remember at the end of the month, so whatever happened during the course of the month it interfaces with BAS. At the end of the month, we get the BAS report. When we request the report, everything that we have captured on PUB it reflects on BAS, so that's how it is linked.

MALE SPEAKER: All right, I think we have covered all of our questions, it was very short. Thank you very much for your time, we really appreciate it.

FEMALE SPEAKER: You are welcome.

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1. **Skills and competency**

   1.1 What financial management qualification do you possess?

   1.2 What does your institution do to improve skills and competency of financial management staff?

2. **Informing debtors of their outstanding balance**

   2.1 What methods are used to remind debtors of their outstanding debts?

3. **Debt collection period**

   3.1 How many days or months are patients given to settle their debts after they left the hospital?

4. **Encouraging and pursuing debtors**

   4.1 What are the measures taken against those who do not pay their outstanding debts?

5. **Debt collection agency and attorneys**

   5.1 Does the hospital use debt collection agencies to collect the debts?

   5.2 Are patients who are ignoring their debts handed over to attorneys?

6. **Debt Management Policy**

   6.1 Does the hospital have a written policy on the management of debts?

   6.2 What factors are considered before writing off a debt?

7. **Number of staff working in debtors management**

   7.1 How many staff members are working in debtors' management section within the hospital?

8. **Payment arrangements**

   8.1 Does the hospital have formal payment arrangements as a option for patients to enter into?

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(NAME OF AUDIO: DEBTORS MANAGEMENT)

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INTERVIEWER: The first stage is skills and competency. The first question – what financial management qualification do you possess?

INTERVIEWEE: My financial qualification that I have, I have a Financial Management National Diploma.

INTERVIEWER: Second one, what does your institution do to improve skills and competency of financial management staff?

INTERVIEWEE: Firstly, you, as an accounting officer, must make sure that you must know your responsibilities, as an accounting officer, which is to manage and revenue efficiently and effectively, always. By developing and implementing appropriate processes to provide for identification, collection, reconciliation, and safeguarding of information about the revenue. Secondly, what they do – in Government, we do allow them to go to training for their transversal systems.

INTERVIEWER: What kind of systems?

INTERVIEWEE: The kind of systems that we have, in accounting, we have BAS, which is a basic accounting system, and the basic accounting system is a financial system that it installs all the information from the other systems. The other systems we are speaking about, BAS, Pastel, which is also a financial system because we use it for the composition of the employee and extra. Again, we do have it manually, E-Receipt. The E-Receipt is the system those we E-Receipt for SAP. We use the system for our daily banking, to receive money from our patients, to the accounting system, and then at the end of the day we're going to bank, using the same system. The way we bank – the money it just corresponds or it just goes through to bank. It gives the bank information, and the information that we give to the bank, all the transactions that were recorded for that day, they are going to appear at the bank. In Government, we only use one bank. It's a contract we have with FNB.

INTERVIEWER: What you are saying to me is that you are taking your staff to BAS training and E-receipt training.

INTERVIEWEE: Yes, but for debtors for [inaudible 0:02:58.5] – let me say account receivable. For account receivable the system that we use is BAS and we use SAP E-receipt and previously, and even now, some of the hospitals use IRB.

INTERVIEWER: Are you also using SAP?

INTERVIEWEE: Yes, SAP E-Receipt.

INTERVIEWER: Informing debtors of their outstanding balances – what methods are used to remind debtors of their outstanding balances?

INTERVIEWEE: The method that we use is done from the tracing department. It also falls under the receivables. We use cell phones. I can use the cell phone to write a message. I can use emails to send an invoice. I can use post to post a letter and again, I can print invoices daily, after the account was billed, so that I take the invoice and I attach it into the patient's file.

INTERVIEWER: You don't use telephone calls.

INTERVIEWEE: Telephone calls – yes, I can say we can use it but again, it is a disadvantage because now what they're going to do is you find out you are tracing R500, but you are going to use a R200 bill. This is a disadvantage but it's a source you can use.

INTERVIEWER: Debt collection period – how many days or months are patients given to settle their debts, after they have left the hospital?

INTERVIEWEE: Usually what I can say, and according to the PFMA, they say if the patient has not paid within 90 days, then it is whereby you can write it off. Ninety-days, which is three months, but again we only making a write off from the amount of R195, and from there you don't make a write off. The rest is whereby you are going to perform tracing, until the patient comes back and pays that money.

INTERVIEWER: So what you are saying to me is patients are given three months to settle their debts.

INTERVIEWEE: Yes.

INTERVIEWER: From there the hospital is supposed to take necessary measures.

INTERVIEWEE: Yes.

INTERVIEWER: Fourth one. Now I want to know how do we encourage and pursue our debtors. What are the measures taken against those who do not pay their outstanding debts?

INTERVIEWEE: The measures, again, if the patient is not paying we are going to look at the figure or the balance. Then again, if that balance is more than R200, you don't have power

or anything to do because you can't write it off. Secondly, remember this is a public hospital, so you can't deny patients a service because they owing the hospital. Again, you can't take the matter to legal services because remember, like now okay the patient is owing R500, and we take it to the legal services. Again, it is still another expense, so it's going to lead us to wasteful expenditure. Remember, in finance we have a fruitless and wasteful expenditure. When we're speaking about fruitless and wasteful expenditure, it's like we're saying you buy something... Okay, you spend money on something that is not going to give you profit.

INTERVIEWER: Or benefit the institution.

INTERVIEWEE: That is wasteful expenditure because you are going to do it at your own interest or you try to improve revenue in your institution. At the end of the day, you spend more and you gain less.

INTERVIEWER: What if the hospital does charge the interest on the outstanding balances of debts.

INTERVIEWEE: No, we don't charge interest.

INTERVIEWER: The hospital doesn't charge interest.

INTERVIEWEE: No, we don't charge interest at all.

INTERVIEWER: The next one is debt collection. I want to know, does the hospital use debt collection agencies to collect debts.

INTERVIEWEE: No, for our institution we've never done that.

INTERVIEWER: It was never implemented in this institution. You collect the revenue and outstanding debts on your own.

INTERVIEWEE: Yes, because what we do is we only do tracing, and then from there its [inaudible 0:07:56.7].

INTERVIEWER: Are patients who are ignoring their debts handed over to attorneys? You've just mentioned the legal services. I think this one you've already answered it. You said to me that if the person is owing less than R500 then you don't take the person to legal services.

INTERVIEWEE: Yes, R500 again, it was just an estimated amount but in reality you can't spend more to claim something that is less.

INTERVIEWER: I just want to find out if the hospital does hand over the patients who are not paying to attorneys.

INTERVIEWEE: No, it doesn't.

INTERVIEWER: All right, the next one, which is debt management policy – does the hospital have a written policy on the management of debts?

INTERVIEWEE: Yes, we do.

INTERVIEWER: What factors are considered before writing off a debt, or what steps, before you can write off a debt, which steps do you consider first?

INTERVIEWEE: Take us back again.

INTERVIEWER: Hence, I was saying you shouldn't answer that one before we came to it.

INTERVIEWEE: Actually, it's a question because [inaudible 0:09:19.8], so we have to be directed because I can say it's the one and the same thing. Steps that will be taken to write off – still again, you take us back. You must follow all the relevant steps to trace the outstanding debts. I've already explained what is tracing and after all the reasonable steps have been taken to recover the debt, and that is when you can write it off. When you write off, you only write off a month or more, from R195.

INTERVIEWER: You can only write off up to R195.

INTERVIEWEE: Yes, and from there you can't write off.

INTERVIEWER: The next one is the number of staff working in debtor's management.

INTERVIEWEE: Again, to answer it, the previous one, you must make sure that before you write off the account it must be until 90 days. If the account is less than 90 days, you can't write it off. It means that you still have a chance to recover the debt.

INTERVIEWER: Okay, I get you. The next one is the number of staff working in the task management. How many staff members are working in the task management section, within the hospital?

INTERVIEWEE: For now, in the institution we do have three in medications – let me say why we have three is, the first one is for daily capturing the transactions from the patients. The second one is for banking. Remember, at the end of the day that money must be banked. In order to minimise fraud you can't capture and authorise at the same time. This third one is just there to replace if one of those people are not there. Again, for medication we do have billing, which also falls under the debtors. In our billing, we have four staff. The first one deals with the MVA. Remember, in our institution or in health, we have the external factors, which is our main focus. The reason why I'm saying it's our main focus is that these people already have budgeted for these accidents. Actually, let me say like the prisons those people already have a budget to pay us. Those people are not working but, at the end of the day, they will get sick. Then what they do is they bring the patient here and then from there, we provide the service to the patient. After providing the service to the patient, us as the Department of Health, we are going to take directly to Correctional Services. We are not going to take that directly to the patient. The one is for SAPS, the other one is for Correctional Services, the other one is for medical aid, and the other one is for H3, H2, and H1.

INTERVIEWER: You are saying that the task management is divided in this hospital.

INTERVIEWEE: Yes, it's very divided. Actually, when you're speaking about debtors section – we speak about accounts, whereby we create accounts for the patients. We're talking about tracing, which is where they trace accounts. Then we're speaking about...

INTERVIEWER: If I may ask, are there specific people responsible for tracing?

INTERVIEWEE: Yes, there must be specific people responsible for tracing because remember, tracing itself, is a section whereby you must actually have a telephone pin, they must make sure they check their emails every day. The telephone pin – they must make sure we give them the telephone pin, in order for them to conduct [inaudible 0:13:49.6], to use the government phone to contact the patients. The emails to check whether there is no respond. That's all I can say for now.

INTERVIEWER: The last one, which is payment arrangements. Does the hospital have formal payment arrangements, as an option for patients to enter into? Let's say that in a case where you find that a person is owing a large amount. Do you make an arrangement with the person to pay this of, let's say R100 or R50 per month?

INTERVIEWEE: Yes, we do because remember as an accounting officer it is my responsibility to get money from patients and to make sure [inaudible 0:14:33.6] but only in legal ways, to advise the patient or to make an arrangement with a patient, how can he or she settle the payment. Now, let me make an issue – like now the patient is earning R20.000. If he's earning R20.000, before they register him in administration they will give you a form, whereby you must fill in all your expenses. Then you find out from that R20.000, the monthly expenses for that patient is R18.000, so we are only going to focus on the R2.000. Then with that R2.000 – we are going to use it to classify you. Remember the reason why we have H3 – H3 are the patients that pay 100% for their services. If the quantity of Panado is R1.00, that means you are going to pay the full R1.00. Then H2 – it's another classification. Let me say that H2 does not pay 100%. H2 is perhaps paying 75%. If the Panado is R1.00, that means this patient is going to pay 75 cents. Then again, we have H1. H1 – we don't charge. H1 we only charge for consultation, and usually consultation is R20.00. These people are either not working or the amount that they are earning is just a living wage. That's the difference.

INTERVIEWER: This leads us to the end of our first session, and I'd like to stop here.

Interview Guide

On

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1. **Skills and competency**

   1.1 Which financial management qualification do you possess?

   1.2 What does your institution do to improve skills and competency of financial management staff?

2. **Cash management**

   2.1 What controls are implemented to ensure that all cash received is actually banked?

   2.2 What controls are in place to safeguard cash and departmental source document books?

3. **Payment methods**

   3.1 Would you say payment methods available at the hospital are effective and efficient for hospital users from remote areas to settle their outstanding balance?

   3.2 What payment methods are available for hospital users?

   3.3 What method of payment would you advise the hospital to implement?

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(NAME OF AUDIO: CASHIER)

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INTERVIEWER: Let's start with the questions. What controls are implemented to ensure that all cash received is actually banked?

INTERVIEWEE: The controls that we use, firstly, as I've said before, we have a [inaudible 0:00:23.7] system, which is a financial system. That is [inaudible 0:00:31.0]. We have that system and that system we use to capture the daily transactions, or daily cash that we receive from patients. Then remember we receive cash directly from the patients that come directly to us, as a cashier office, to pay directly to us. Again, we have the cash that we receive from OPD and Casualty. Let me say that OPD again, is a clinic where people come daily there and pay their money for their medicine and everything. Then casualty is where they deal with emergencies. It's where patients, like now when we're open, we file for emergency patients, and they pay R20.00 for that consultation. At the end of the day those people must bring that money to medication for [inaudible 0:01:35.9] for banking. Again, that money, we have a capturer in [inaudible 0:01:44.1]. It's a person who captures those transactions, and again, at the end of the day the supervisor must come to check the receipts. To check whether the receipts are corresponding with the money that is in the system. If the money is corresponding, it's whereby the approval can bank the money.

INTERVIEWER: If I may ask, the medication is the one who is capturing the receipts on the BAS system. Then those ones from OPD and Casualty division, I think you're referring them to as [inaudible 0:02:17.9]. Do they have a BAS system?

INTERVIEWEE: Okay, let me do it like this. Our [inaudible 0:02:27.0] because they deal direct with the patients. The system that they use is PUB. Then PUB is the system that they use to register patients, and the patient's information. At the end of the day, those people they pay for consultation and everything. Then at the end of the day, that person must bank that money from PUB but again, PUB is the system on its own. It doesn't interface with BAS automatically. It means that we must feed BAS with information that is from PUB.

INTERVIEWER: All right, manually?

INTERVIEWEE: Manually – it doesn't interface automatically and that is the reason why they must bring the money to us because as we are going to take that money, as a [inaudible 0:03:19.6]. We capture it from that system of [inaudible 0:03:22.0]. Now [inaudible 0:03:25.2] is connecting with BAS. In a simple way I can say [inaudible 0:03:33.2] or [inaudible 0:03:36.6] it links automatically with BAS, and BAS is our main system that we can request a monthly report from. After that what's going to happen... Me, as a

supervisor, I check the receipts from the capturer and from there, I correspond with the actual cash. If it corresponds with the actual cash is whereby I can bank. Again, when the system is down I have two books that I must use. The book that is going to be used by the capturer, from medication, we call it a Z15-12, which is our manual receipt book. As we know any financial book has a source document number, so that those source document numbers must be in sequence. If they are in sequence – the reason why we're checking it's in sequence is to avoid fraud. Like now, maybe the patient came to pay and from there I take that receipt out. It's my responsibility as a supervisor to make sure that book and those source documents corresponds.

INTERVIEWER: Okay, I get you.

INTERVIEWEE: From there, what I'm going to do I'm going to calculate manually, with my calculator. Let me say the capturer has recorded from receipt number 1 to 20. That means I must take that 1 to 20, I must write it down, and then from there I must write the total from 1 to 20 again. From there I'm going to do the calculations. If that Z15-12 it gives me, let's say R2.000. I must take that R2.000 from the manual book and then it must correspond with the actual cash, when it corresponds with the actual cash then its fine. I'm going to take another book, which is a deposit book. The deposit book is from FNB because the Department of Health has a contract with FNB. I'm going to take that R2.000 and I'm going to record it in the deposit book. That deposit book has four slips, and then it must be signed by a capturer and a supervisor, or their approval. That means that it must have two signatures and then again it must have a date stamp, and it's not just a date stamp. It's a medication date stamp because it's written Tshwane District Hospital – medication cash office. We don't just use any stamp. Then on that book, what I'm going to do is you must stamp the deposit, the four of them, and then we must append our signatures, both of us. The first page is the original receipt and then the second three all those receipts are duplicates. What we are going to do when we do banking, we are going to take out two receipts from those four receipts. The first one is the original one. The second one is a duplicate. Those receipts we put it in an envelope. Then again, there's a separate envelope for actual cash. That means we use two envelopes. The one is for deposit slips and the other one is for actual cash. We are going to take those two receipts in that envelope and then that means we have remained with two duplicates. We are going to tear out another one, and that one - we are going to attach it to our file for the audit purpose. That's the proof that they were banked.

INTERVIEWER: Okay, I get you.

INTERVIEWEE: Remember we've submitted two and then this one, I take it out and then I'm going to attach it in my file. That one is mine as proof that I've banked for that day. Those two receipts are going to be taken to FNB. Then again us, as [inaudible 0:08:45.0] we do not take that money directly to the bank. Health does has a contract with G4S Company, it's a collection company.

INTERVIEWER: That is a cash collection company.

INTERVIEWEE: Yes, a cash collection company, if I say health I put it wrong because some hospital they use Coin but we, Tshwane District, we use G4S.

INTERVIEWER: Okay.

INTERVIEWEE: That means I'm going to take that cash. I give it to the G4S Company and again, what I must do, when the G4S guy or the cash collector guy comes to my office, he or she must produce a card as proof that I'm from G4S. In that way we minimise fraud. You must make sure that you know that person who comes that day to collect the cash.

INTERVIEWER: Is actually from that company.

INTERVIEWEE: Yes, is actually from that company and again, each and every year, or any time they can send an email to that company. That company comes to us to collect cash to send you anything that it can help you to reduce fraud or prevent fraud. Remember they can create cards for them. People who steal and they can have their own cards, claiming that they're from the original company and meanwhile they're not from the original company. That one again is a duty as a [inaudible 0:10:15.5]. What is going to happen, let me say now that the cash is gone, it's gone with the G4S Company. Those people they must bring one receipt from those two receipts you have submitted to them but remember they stay with the original one. They're going to bring back the duplicate. Again, remember you have one receipt in your file. That means you are going to take that receipt from G4S. You are going to attach it again, into your file.

INTERVIEWER: For audit purpose.

INTERVIEWEE: For audit purpose and as the proof that that money was already banked or it is from the bank because that receipt from G4S, the difference is going to be one. The one

that I have in my file only has the Tshwane District Hospital stamp and that one is having a FNB stamp. That's the difference.

INTERVIEWER: Okay, to prove that the money was actually banked.

INTERVIEWEE: Yes, that one is only placed on a manual side and again systemically, as I've mentioned before, you only check the system. Let me say that the capturer already captured R2.000. I check the system and again, I check the actual amount, and what is corresponding, and from there I approve.

INTERVIEWER: Then this one is all about the safety – what controls are in place to safeguard cash and departmental source document books. How do you make sure that your books and your cash is safe?

INTERVIEWEE: Firstly, when they appoint you as a [inaudible 0:12:02.8] they're going to give you a form whereby you sign that it will be my duty to make sure that the statement is safe always. After that form, you take that form and can put it anywhere because obviously, HR are going to have that form as proof that you've signed and they're going to give you a copy.

INTERVIEWER: How do we feel that the cash is safe and the departmental books are safe?

INTERVIEWEE: As I've mentioned before, you sign a form. Always a cashier office, always and everywhere we do have our own safe.

INTERVIEWER: Okay, you have your own safe.

INTERVIEWEE: We have our own safe, and then that safe only has one key. If you want to make a copy, you must get an approval from the CEO or from your CFO. Always the key is one and that means that you are responsible for that key. In that safe you must always make sure that all your books are there. The important books that we have in the venue or in medication – we have the Z15-12, which is the one that we use for time down (when the system is down). Then again, we have the TP208, again, but that TP208 is used by our [inaudible 0:13:51.4] but always those books must stay in the safe. If the PUB system is down they must come to you to collect that book and again, you must have your spreadsheet whereby your record time says that this book was taken by this accounting officer at this time. The receipt number, the receipt numbers that are not used is 1 – 20 as an example. Then again, when that person is coming back to bring that book for banking you must make sure that you must check that book again, as approval. You check the book

– as a capturer. Remember that one is from [inaudible 0:14:39.2]. The capturer must check that book. The receipt number is 1 – 10. You must use a red pen at the last receipt. You must put a line.

INTERVIEWER: To indicate where they end?

INTERVIEWEE: Yes, and then from there you sign that I agree that this one is used.

INTERVIEWER: I get you.

INTERVIEWEE: You must make sure that that book must always be in the safe. The books that we use are TP861. The TP861 is the book that we use to record the account number two. The account number two let me say like now the patient is submitted and maybe the nurses they found cell phones, wallets, keys or maybe the car key or a house keys.

INTERVIEWER: Okay, and you put it in there.

INTERVIEWEE: Yes, so those sisters will bring those things to medication and then we must record it in the TP861. Then that book must always be in the safe and the bottom line the [inaudible 0:15:59.6] must always [inaudible 0:16:02.0]. That's how we put our...

INTERVIEWER: I get you, and that's enough. Now, the last section talks about payment methods. Would you say payment methods available at the hospital are effective and efficient, for hospital users in remote areas to settle their outstanding balances? Would you say someone from, let's say you had a patient from Limpopo. Would you say the methods of payment here are very effective for the person from Limpopo to pay?

INTERVIEWEE: Yes, I can say that. The payment methods that we have in our institution – I can say we only have two methods. We have the cash method and then we have an EFT method.

INTERVIEWER: Are you saying the hospital does allow patients to pay from a distance through EFTs?

INTERVIEWEE: Yes, through EFTs. Let me say for the patient from Limpopo. Then I've already sent her or him the reminder that they owing us this much. That means the patient, she or he has a copy of the original statement and then on that original statement we only have the reference number and the account number. What I'm going to do is the patient will call me, in order to give him or her the full information as to how they're going to pay. The things that are going to be needed from me (the information needed from me) to give

to the patient will be the right information for the bank. I'm going to tell the patient that he/she must write the name, surname, and then the reference number – we call it the patient ID number.

INTERVIEWER: Patient ID number as a reference.

INTERVIEWEE: Yes, that's the first number but it's not the ID number, it's the patient's ID. That patient ID number – when you register a patient the PUB system automatically is going to give you that number as a reference. What I can say it's a batch or... I don't know.

INTERVIEWER: I understand. The patient number is fine.

INTERVIEWEE: Then always that patient starts with the first three letters of your surname. Let me say my surname is [inaudible 0:18:47.8], so it means my reference is going to be LER- and the four numbers. Those four numbers are always unique. We're going to use it as a reference number and again, we're going to use it in the health account because, for now, one thing for sure that you must know is that if the patient is owing [inaudible 0:19:12.5] and that patient wants to pay us. We are going to give her an account and that money is going to land in the health account and not in Tshwane District account. It is going to be in the health account.

INTERVIEWER: Not the hospital's account?

INTERVIEWEE: Then what the patient is going to do is the patient... We're going to ask the patient to send us a proof of payment. What I'm going to do about that proof of payment I will wait for BAS to close and then after BAS is closed. Remember, the BAS system is being linked to the FNB account. That money is going to appear into BAS. Then monthly I'm going to request a report from BAS and that is going to give me... Usually, us in finance we call it a remittance statement.

INTERVIEWER: A remittance statement, all right.

INTERVIEWEE: That statement has all the payments that were done through EFTs. I'm going to take that payment and I'm going to take it into PUB. Remember PUB is the patient's system. I'm going to do a check in PUB. I'm going to get it as an EFT. There is an icon. There is only one icon that I'm going to use and I'm going to enter the name of the patient, then I'm going to check that the amount is corresponding. From there it is going to ask me which method he or she used and from there I clear the statement. If you pay to the bank, that money is not going... Remember I told you before that PUB is the system on its

own. It doesn't interface with BAS. It only has all the information of the patient. What that means is I have to take that money from BAS, and then I must clear the statement.

INTERVIEWER: I think the last two you've already answered. That you have got two payment methods, which is EFT and the cash method, and the last one was what method of payment would you advise the hospital to implement? Would you suggest any method of payment, besides EFT and the cash method? Is there any other method you can think of?

INTERVIEWEE: For me remember, EFT is broad but we only have one method that we can use to pay EFT. We don't have swiping machines.

INTERVIEWER: All right, you don't have that.

INTERVIEWEE: Yes, so if someone is willing to pay through EFT he or she is only allowed to pay directly to the bank.

INTERVIEWER: You don't have speed points.

INTERVIEWEE: No, we don't have speed points and that's the only disadvantage. Then again, the reason why I'm saying that it's a disadvantage is because we only have one ATM in this hospital, which is Absa. Remember, with that system, we are not responsible for that ATM. If that ATM is off-line, that means we have to wait for the people from Absa to come and fix the ATM. Again, that means it is affecting our revenue collections. The reason why I'm saying that they must give us a speed point – usually, I don't have a good way of putting this but...

INTERVIEWER: I understand that most people nowadays, they carry cards and not cash.

INTERVIEWEE: Especially our hospital situation in the town area, remember the town area mostly the people are white and whites don't use cash, they swipe.

INTERVIEWER: Yes, I understand.

INTERVIEWEE: If they want to swipe and I have to say we don't have the swiping machine. They want to withdraw, the ATM is not working, so that is affecting our revenue.

INTERVIEWER: I understand. We have done more than enough and I just want to say thank you.

Interview Guide

On

THE EFFECTIVENESS OF REVENUE MANAGEMENT IN SOUTH AFRICAN PUBLIC HOSPITALS – THE CASE OF TSHWANE DISTRICT HOSPITAL

By

MAILA JAN PHASODI

Primary data for a study towards the following degree:

MAGISTER TECHNOLOGIAE: COST AND MANAGEMENT ACCOUNTING

in the

Department of Managerial Accounting and Finance

FACULTY OF ECONOMICS AND FINANCE

at the

TSHWANE UNIVERSITY OF TECHNOLOGY

Supervisor: Prof LJ Erasmus

Co - Supervisor: Prof HE Klingelhöefer

1. **Skills and competency**

5.3 Which financial management qualification do you possess?

5.4 What does your institution do to improve skills and competency of financial management staff?

6. **Revenue budget**

6.1 Does each hospital set a revenue target?

6.2 Does the Tshwane District Hospital have a Budget Committee?

6.3 When should hospitals submit the financial performance reports?

7. **Collection of revenue**

7.1 What procedures are in place to prevent under-collection of revenue?

7.2 Does the Department provide incentives to the hospital to collect revenue?

7.3 Does the Department use a third party to collect revenue from medical aid schemes?

8. **Debt Management**

8.1 What is the reason for writing off small amount debts after a 90 day period has passed?

8.2 What measures should be taken by a hospital to pursue patients who are ignoring their debts?

8.3 Are hospitals able to collect revenue due within 30 days?

9. **Payment method**

9.1 Can a patient pay his/her debt at any public hospital?

9.2 Can a patient make a direct payment into a hospital's bank account?

CERTIFICATE OF VERACITY

We, hereby certify that in as far as it is audible the aforegoing is a true and correct transcript of the recording provided by you in the matter:

(NAME OF AUDIO: MANAGEMENT LEVEL- GPDoH)

DATE COMPLETED	:	25/08/2016
NUMBER OF PAGES	:	5
PROOFREAD	:	✓

INTERVIEWER: Our interview guides consists of five sections. I hope it's not too much and I hope we'll be able to finish. The first one is skills and competency. I would like to know which financial management qualification do you possess.

INTERVIEWEE: I have a BCom Economics Degree, and I also have a Masters in Public Administration, whereby I specialised in debt management.

INTERVIEWER: What does the institution or the department do to improve skills and competency of financial management staff?

INTERVIEWEE: We are working closely with the Gauteng Regional Academy, whereby the skills that each section requires – they have study programs. For example there's a Public Finance Management course that some of our members have been nominated to participate in. We also have Management Development programs, like your middle management development programs, whereby it goes through all the competencies, HR, Finance is also one of them. There is also Excel courses and Excel [inaudible 0:01:43.5]. Most of the officials have already gone for advanced Excel training to improve their skill, so we are currently working with Gauteng Regional Academy, in terms of skills. If there's training that is required, they do communicate that with the different institutions, and even ourselves, as head office level.

INTERVIEWER: The second section is all about the revenue budget – does each hospital set a revenue target?

INTERVIEWEE: A revenue target is set by the central office, this office. We are the ones who are responsible to set the revenue target.

INTERVIEWER: For each and every hospital?

INTERVIEWEE: Yes, for each and every hospital, so we're working together with the National Department of Health. Whereby they give us the annual increase of the uniform patient fees schedules, we call them UPFS – patient fees. About 80% of our revenue collection is from patient fees, so we do get that annual adjustment, in terms of how much it will cost. For example, this year the annual increase is 6%, whereby we adjusted the increment, in terms of the collection. We set the revenue target as head office.

INTERVIEWER: Does the Tshwane District Hospital have a Budget Committee?

INTERVIEWEE: I wouldn't know if they have a Budget Committee.

INTERVIEWER: It's within their control to establish it.

INTERVIEWEE: Yes, it's within their controls because we manage, and I manage the revenue, so I don't know that side of it. Do you mean to analyse what they order?

INTERVIEWER: Yes.

INTERVIEWEE: Yes, I'm sure they should have or maybe you must direct that question to the finance manager from Tshwane because if the Budget Committee, it's usually the supply chain, there's finance. If they want to buy something they must make sure they're within the budget and they don't exceed the budget. Which budget are you referring to, the revenue budget?

INTERVIEWER: Exactly.

INTERVIEWEE: The revenue budget – we have Revenue Forums, whereby we communicate the processes that we need to do. We also have a [inaudible 0:04:18.8] whereby we discuss the targets that they will have and the increment thereof. In terms of the hospital having a Budget Committee – I'm not sure.

INTERVIEWER: That's what I wanted to just find out if there are discussions of targets.

INTERVIEWEE: Yes, because ideally... This financial year was not done but the previous financial year what was done, before we issue a budget letter, you call them to a central point to indicate that this was our target last year and this is what we've reached. This year, this is our target, so what we've done this year is we've only communicated the target globally, not for each institution. Then later, after that, each institution received the budget letter for their revenue.

INTERVIEWER: When should hospitals submit their financial performance reports?

INTERVIEWEE: They submit them monthly. The due date is on the 15th. It depends on which report it is because we have different due dates. For example, your 'in year monitoring report' – we do have different dates and guidelines. I can share that with you. We have 'in year monitoring report'. We have your Annexure F, your BAS, Pastel Report, Accommodation Report, Down Time report – there's a few. Then there's a Management Report. There is different timeframes for different reports.

INTERVIEWER: Okay, I just wanted to know about the 'in year monitoring report' one.

INTERVIEWEE: Yes, they do submit the 'in year monitoring report'.

INTERVIEWER: On a monthly basis?

INTERVIEWEE: Yes, on a monthly basis. Even the BAS – even if the system is closed.

INTERVIEWER: Okay, with regards to the collection of revenue – what procedures are in place to prevent under collection of revenue?

INTERVIEWEE: Currently what the Department is doing, we do visit different stakeholders, like our customers. For example, we were at Model B Correctional Services, whereby they are owing us R4.6million. We do engage with the Department that owes us on a regular basis. We also do have companies that we've contracted to assist us in terms of revenue collection. To prevent the under collection of revenue we ensure that we regularly meet with our debtors and also we request them to give us a payment plan. They must also communicate if they have cash flow challenges. For example, RAF is our biggest revenue and they were having cash flow challenges, but they did communicate that with us.

INTERVIEWER: Does the Department provide incentives to the hospital to collect revenue?

INTERVIEWEE: At the moment, no. Currently, the National Department of Health, together with the Financial Fiscal Commission they are looking at the 'Revenue Retention Model'. Because before there was a retention model but it was stopped at around 2008, but now they're looking at reviving it. If the institution has reached their revenue target then a portion of a percentage will come back to the hospital. But at the moment, we don't have that. It is still being processed under the Provincial Treasury, the Financial Fiscal Commission, and our National Department of Health – they are busy with that.

INTERVIEWER: I think the third one you've answered it. You said you do have third parties. You are outsourcing from others outside for collection of revenue.

INTERVIEWEE: Yes, the third one, this one is not per se. We are using Medi-Credit but the reason we're using a third party is to have that link to submit electronic claims to medical aids because the Department, at the moment doesn't have that link. We are currently using Medi-Credit to assist us.

INTERVIEWER: The fourth one is debt management – what is the reason for writing off small amounts of debts, after a 90-day period has passed?

INTERVIEWEE: Are you referring this question from our revenue management process?

INTERVIEWER: Yes.

INTERVIEWEE: The less than R195?

INTERVIEWER: Yes.

INTERVIEWEE: Yes, the less than R195 debts – the reason that we write them off after 90-days, it is not economical to write a letter to a debtor. It's not economical to make a phone call or to refer the matter to the State Attorney because of the small amount. Also, Treasury Regulations also mentions that you must be economical to recover the debt but if you find that it's not, then you can also write it off. That's the reason. We are also seeing a huge volume of H1 patients in our institutions. In order not to clog the debtor's book, after 90-days, we write them off.

INTERVIEWER: Okay, what measures or actions should be taken by a hospital to pursue patients who are ignoring their debts?

INTERVIEWEE: Yes, what's happening when a patient comes to visit, the clerk will remind the patient to say you have R20.00 outstanding.

INTERVIEWER: Verbally?

INTERVIEWEE: Please pay – you have not paid. Others for debts that are more than R1.000 and so on, they do send Letters of Demand to the debtor, and also referring them to the State Attorney. The Department also has an external service provider that is also assisting in the self-paying patients to assist us to recover the debt.

INTERVIEWER: Are hospitals able to collect revenue within, in this case let me say 90-days, because you are saying that you write off small amounts within 90-days. Are hospitals able to collect revenues due within 90-days?

INTERVIEWEE: Yes, some they can and some they can't, but most of the time they are able to collect, depending on when the debtor is committing to settle their account.

INTERVIEWER: With the payment method – can a patient pay his or her debt at any public hospital? Do we have a centralised method of payment or do you have to pay where you received the service?

INTERVIEWEE: For the first question – at the moment, our health information systems are not talking to each other at the moment. Now the Department is moving towards

upgrading the old version of the system that we're currently using. The Department is using two systems, so those systems don't talk to each other. Hence, when you go to Bara, for example, today, you can open a file, get medication, and then you can go to Steve Biko and you can still open a file. It's not interlinked, so now a patient must pay where they've received the service.

INTERVIEWER: Can a patient make a direct payment into a hospital's bank account or a department's bank account?

INTERVIEWEE: Yes, because now each hospital has sub accounts, whereby they can also pay directly to the hospital, or they can use the Provincial account, and also include the reference number.

INTERVIEWER: What would they use as the reference number?

INTERVIEWEE: From the UTT number – the patient's identity number.

INTERVIEWER: Alright, ma'am, I think we have covered all our questions. Thank you very much.

INTERVIEWEE: I hope I've assisted you.

ANNEXTURE C: CONSENT FORMS

Tshwane University of Technology

We empower people

FACULTY OF ECONOMICS AND FINANCE

INFORMATION LEAFLET AND INFORMED CONSENT

STUDY TITLE:

THE EFFECTIVENESS OF REVENUE MANAGEMENT IN SOUTH AFRICAN PUBLIC HOSPITALS- THE CASE OF TSHWANE DISTRIC HOSPITAL

Study leaders: Prof Lourens J Erasmus

Prof Heinz Eckart Klingelhöefer

Researcher: Mr Maila Jan

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Dear potential research participant,

You are being invited to participate in a study that evaluates the effectiveness of revenue management in South African public hospitals. This information leaflet shouldhelp you in decidingwhether you would like to participate or would not like to participate in the study. You are advised to read and understand the contents of this document before you agree or disagree to take part. You should not agree to take part unless you are completely satisfied with all aspects of the study.

THE NATURE OF THE STUDY

This study is being conducted to evaluate the effectiveness of revenue management in South African public hospitals with reference to revenue collection. It is hoped that the results of this study will contribute to financial management area of Tshwane District Hospital (TDH) and add value to revenue management knowledge in South African public hospitals.

The revenue collection has become a low priority in those departments that have a potential to generate high amount of revenue, including the Provincial Departments of Health that charge user-fees for hospital services. Patients are unlikely to pay for health services at the point of service at the time they need medical help. This leaves the responsibility to collect such fees at later stage with the hospital concerned. However, public hospitals hardly take actions to follow up on outstanding patient fees. The hospital managers are faced with the challenge to improve revenue management systems to deal with the change in healthcare system, economy and community growth.

THE INVOLVEMENT OF PARTICIPATANT IN TERMS OF TIME AND ACTIVITIES

Among its objectives, the study also seeks to determine the current state of revenue management at the TDH. Therefore, to gain insight to the matter and achieve this objective participation by those responsible for financial management within the hospital and Provincial Department of Health (PDoH) is of paramount importance.

Should you decide to take part in the study, you will be required to do the following:

- To sign this informed consent form.
- To be available for an interview with the researcher.
- To give permission for the interview to be audio recorded
- The interview should take between 20 and 30 minutes of your time.
- The interview is to be scheduled at your convenience.

ARE THERE ANY CONDITIONS THAT MAY EXCLUDE YOU FROM THE STUDY?

There are no conditions that may exclude you from the study. Should you feel a need to withdraw your participation from the study, the researcher will approach other officials sharing the same responsibilities as you in the financial management of TDH and PDoH.

CAN ANY OF THE STUDY PROCEDURES RESULT IN PERSONAL RISK?

The study and procedures involve no personal risk. You will not suffer any costs as a result of your participation in this study. The information gainedthrough this research will be used solely for the purposes of this study. All the information provided by the participants will be kept in a safe place to protect them from any harm, be unusual stress, embarrassment or loss of self-esteem.

WHAT ARE THE POTENTIAL BENEFITS THAT MAY COME FROM THE STUDY?

Although you may not directly benefit from this study the results thereof will contribute to an area of financial management in TDH and PDoH at large, by adding value to the existing knowledge of revenue management in South African public hospitals.The benefits of participating in this study are:

- You will contribute to a scientific study with the objective to determine an effective means to manage revenue.
- You will gain knowledge on the other aspects of revenue management.

WILL YOU RECEIVE ANY FINANCIAL COMPENSATION OR INCENTIVE FOR PARTICIPATINGIN THE STUDY?

All participants to this study **will not** be compensated nor receive any incentives for taking part.

WHAT ARE YOUR RIGHTS AS A PARTICIPANT IN THIS STUDY?

Your participation in this study is entirely voluntary. You have the right to withdraw at any stage without any penalty or future disadvantage whatsoever. You do not even have to provide the reason/s for your decision. Your withdrawal will in no way influence your continued relationship with your employer.

HOW WILL CONFIDENTIALITY AND ANONYMITY BE ENSURED IN THE STUDY?

All information obtained during the course of this study is strictly confidential. The study data will not be linked to any role/position. Your identity will not be revealed while the study is being conducted or when the study is reported in scientific journals and research reports. All the data sheets that have been collected will be stored in a safe place. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.The information received during the research will only be used for study purposes and will not be released for any employment-related performance evaluation, promotion and/or disciplinary purposes.

IS THE RESEARCHER QUALIFIED TO CARRY OUT THE STUDY?

This research is carried out by M-Tech student with the support of experienced study leaders.

HAS THE STUDY RECEIVED ETHICAL APPROVAL?

The FRIC, DRIC and Research Ethics Committee of the Tshwane University of Technology have approved the formal study proposal. All parts of the study will be conducted according to internationally accepted ethical principles.

WHO CAN YOU CONTACT FOR ADDITIONAL INFORMATION REGARDING THE STUDY?

The study leader at Tshwane University of Technology, Ga-Rankuwa campus, Prof Lourens Erasmus can be contacted during office hours at Tel (012) 382-0566, E-mail at erasmuslj@tut.ac.za. Should you have any questions regarding the ethical aspects of the study, you can contact the chairperson of the TUT Research Ethics Committee, Dr WA Hoffmann, during office hours at Tel (012) 382-6265/46, E-mail hoffmannwa@tut.ac.za. Alternatively, you can report any serious unethical behaviour at the University's Toll Free Hotline 0800 21 23 41.

DECLARATION: CONFLICT OF INTEREST

This research study is funded by the Tshwane University of Technology. No publication prohibitions, conditions or limitations were placed on the researchers.

A FINAL WORD

Your co-operation and participation in the study will be greatly appreciated. Please sign the informed consent below if you agree to participate in the study. In such a case, you will receive a copy of the signed informed consent from the researcher.

CONSENT

I hereby confirm that I have been adequately informed by the researcher about the nature, conduct, benefits and risks of the study. I have also received, read and understood the above written information. I am aware that the results of the study will be anonymously processed into a research report. I understand that my participation is voluntary and that I may, at any stage, without prejudice, withdraw my consent and participation in the study. I had sufficient opportunity to ask questions and of my own free will declare myself prepared to participate in the study.

Research participant's name (optional): _____(Please print)

Research participant's signature: _____

Date: _____

Researcher's name: _____ (Please print)

Researcher's signature: _____

Date: _____

ANNEXTURE D: PERMISSION TO CONDUCT THE STUDY

health and social development GAUTENG PROVINCE	**TSHWANE RESEARCH COMMITTEE (TRC)**	CITY OF TSHWANE
Document No:	RESEARCH APPLICATION FORM	Date:

NOT TO BE COMPLETED BY VENDORS/SUPPLIERS

INTRODUCTION

- The TRC will treat all the information you furnish as strictly confidential.
- The TRC reserves the right to request additional information if required.
- The TRC reserves the right to perform an audit to confirm/verify any of the information in this application.
- Ensure that this application is signed before returning it to the TRC
- Please respond to all sections, as incomplete forms will not be processed.
- **Only original documentation will be accepted.**

CONTACTS

Should you experience any problems in completing this application, please do not hesitate to contact the Secretary of the TRC at Tel 012 4519124.

MANDATORY CONDITIONS

- *Attach a research proposal (Annexure 2 is guidelines that can be used for the protocol).*
- *Attach the ethical research approval by an approved ethical committee.*
- *MMC registration number or approval number for medicine trials is needed.*

If Funding is needed the following mandatory conditions are also applicable:

- *All banking requirements must be attached to this application (Page 3) if funding is needed.*
- *Attach a certified copy of your ID.*
- *Internal and external entities (payroll) must attach a personal printout signed by the team leader and/or director, as well as a date stamp, if funding is needed.*
- *Persal applications: Attach a certified copy of your latest salary advice if funding is needed.*
- *Doctors' practices: Attach the most recent original tax clearance certificate to the application.*
- *Provide a certified copy of VAT103 if applicable.*

ANNEXURES TO THIS FORM

- *Annexure 1: Approval forms signed by the clinic manager or CEO of the hospital to give preliminary permission for the research to be conducted in their facilities.(Researcher must talk to clinic and hospital as part of the research investigations for the proposal)*
- *Annexure 2: Guidelines for the structure of your research proposal*
- *The researcher must submit a detailed costed business plan and budget that specifies cost per line item, hourly rate and fieldwork expenses if applying for government funding.*

SECTION A

PERSONAL PARTICULARS OF RESEARCHER

ID NUMBER	PRACTICE NUMBER	VAT/TAX CLEARANCE NUMBER	PERSAL/PAY NUMBER (if a public servant)	OTHER (STATE)
8903216119088				

Title	Mr
Surname	Maila
First name(s)	Jan Phasodi
Initials	JP
Name of firm or organisation	Tshwane University of Technology

ADDRESSES

Physical address	Postal address
Sedumedi street	P O BOX 912
1702 Zone 1	MARBLE HALL
Ga-Rankuwa	
Postal code: 0208	**Postal code:** 0450

CONTACT TELEPHONE NUMBERS

Business telephone number	
Telephone number – other	
Mobile number	076 019 1373/ 060 953 4756
Fax number	
Email address	Jan.maila77@gmail.com

PARTICULARS IF A PHARMACEUTICAL COMPANY IS INVOLVED

Name of company or firm	
Managing director of company	
Telephone number of Managing Director	
Address of company	

SECTION B

(Only to be completed if funding is needed)

BANKING DETAILS: TO BE VERIFIED BY THE BANK (if funding is needed)

MANDATORY REQUIREMENTS

- FOR CHEQUE/CURRENT ACCOUNTS, ATTACH AN ORIGINAL CANCELLED BLANK CHEQUE.
- FOR TRANSMISSION/SAVINGS ACCOUNTS, ATTACH THE MOST RECENT ORIGINAL LETTER AND STATEMENT (NOT OLDER THAN TWO MONTHS).
- FOR POST OFFICE ACCOUNTS, PROVIDE A STATEMENT NOT OLDER THAN TWO MONTHS.

NOTE:
IN ALL INSTANCES THE ACCOUNT HOLDER MUST BE IN THE NAME OF THE APPLICANT

Bank				
Name of branch				
Account number				
Branch code				
Account holder				
Account holder signature				
Type of account	Current/Cheque	Transmission	Savings	Other (Specify)

FOR BANK USE

Name of bank official		**DATE STAMP OF BANK CERTIFIED AS CORRECT**
Capacity of bank official		
Signature of bank official		
Telephone number of bank official		
Fax number of bank official		

SECTION C

If test the product is pharmaceutical:

State the MMC registration number if registered.	
If not registered, state the MMC trial approval number. (Please attach a certified copy to your application.)	

SECTION D

Briefly state the objective of the research proposal.	To evaluate the effectiveness of revenue management in South African public hospitals through a case study at the Tshwane District Hospital.
In which public Health Facility or communities or area do you want to conduct your research? (For each clinic or hospital mentioned, you must have a form signed by the clinic manager or CEO of the hospital – forms are attached to this application form.)	Tshwane District Hospital
Estimated period of trial/research	3 years
Sample Size	N/A
Will enough test materials and stock be supplied?	The study does not involve any test materials and stock
What laboratory tests will be required, and who will pay for the tests?	No laboratory tests will be required

What other investigations will be required for the research, and who will be responsible for the cost?	Investigations include Observations and Interviews, stage 1 and stage two, respectively. The researcher will be responsible for the cost
How will the research be financed?	Scholarship
Risk and occupational hazards to the public facilities and staff	This research is unlikely to cause any risk and hazard conditions to facilities and staff.

SECTION E

I /We agree to conduct the above trial/research under the conditions stated in the application form.

I/We also agree to conduct this trial/research at no additional cost to the Gauteng Health and Social Development Department or the City of Tshwane.

Signature of applicant: _____

Signature of representative from firm if applicable: _____

Date: 10/06/2015

Witness: _____

Witness: _____

DECLARATION

(To be signed in the presence of a Commissioner of Oaths.)

(If funding is needed, please complete this part.)

By completing this application form, I declare that all the information provided is true and correct					
NAME		**SIGNATURE**		**DATE**	

COMMISSIONER OF OATHS
Signed and sworn to before me at ..... on this the ..... day of .....20 by the deponent, who has acknowledged that he or she knows and understands the contents of this affidavit, that it is true and correct to the best of his or her knowledge, that he or she has no objection to taking the prescribed oath and that the prescribed oath will be binding on his or her conscience.
COMMISSIONER OF OATHS

Annexure 1

Declaration of intent from the clinic manager or hospital CEO

I give preliminary permission to Maila Jan Phasodi (name of researcher) to do his or her research on "The effectiveness of revenue management in South African public hospitals - the case of the Tshwane District Hospital (research topic) in

_____ (name of clinic) or

_____ (name of CHC) or

Tshwane District Hospital (name of hospital).

I know that the final approval will be from the Tshwane/Metsweding Regional Research Ethics Committee and that this is only to indicate that the clinic/hospital is willing to assist.

Other comments or conditions prescribed by the clinic or CHC manager or hospital CEO:

Kindly please submit periodically your findings to our Hospital

Mr Nkosi

Signature
Clinic Manager/CHC Manager/CEO

23/07/2015

Date

ANNEXTURE E: ETHICS CLEARANCE

Tshwane University of Technology

We empower people

Research Ethics Committee

The TUT Research Ethics Committee is a registered Institutional Review Board (IRB 00005968) with the US Office for Human Research Protections (IORG# 0004997) (Expires 9 Jan 2017). Also, it has Federal Wide Assurance for the Protection of Human Subjects for International Institutions (FWA 00011501) (Expires 22 Jan 2019). In South Africa it is registered with the National Health Research Ethics Council (REC-160509-21).

April 21, 2015

Ref #: REC/2015/03/001
Name: Maila JP
Student #: 209208660

Mr JP Maila
C/o Dr LJ Erasmus
Department of Managerial Accounting and Finance
Faculty of Economics and Finance

Dear Mr Maila,

Decision: Final Approval (Stage 1 - Observations)

Name: Maila JP
Project title: *The effectiveness of revenue management in South African public hospitals - The case of the Tshwane District Hospital*
Qualification: M Tech (Cost & Management Accounting)
Supervisor: Dr LJ Erasmus
Co-supervisor: Prof HE Klingelhöfer

Thank you for submitting the revised project documents for ethics clearance by the Research Ethics Committee (REC), Tshwane University of Technology (TUT). In reviewing the documents, the comments and notes below are tabled for your consideration, attention and notification:

- **Proposal**
  - **Data Collection Phases**. The REC took note that data collection will involve a two-stage approach whereby **observation** of operations in the finance office (**Stage 1**) will be used to inform **interview** questions (**Stage 2**). As a result, the interview guide only needs to be submitted for formal REC review once it has been developed following completion of the observation stage.

- **Observation (Section 9.1).** The strategies to effectively manage the Hawthorne reactive effect during collection of observation data are in order and duly noted.

- **Information Leaflet & Informed Consent**

  - **Information Leaflet (Stage 1 Observations).** The revised Information Leaflet and Informed Consent document is in order and duly noted.

The Research Ethics Committee, Tshwane University of Technology, reviewed the revised project documents at its meeting on April 20, 2015. **Final approval (Stage 1 – Observations)** is granted to the study.

The proposed research project may now continue with the proviso that:

1) The researcher/s will conduct the study according to the procedures and methods indicated in the approved proposal, particularly in terms of any undertakings and/or assurances made regarding the confidentiality of the collected data.

2) The proposal will again be submitted to the Committee for prospective ethical clearance if there are any substantial changes from the approved proposal.

3) The researcher will act within the parameters of any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.

4) The current ethics approval expiry date for this project is **December 31, 2017**. No research activities may continue after the ethics approval expiry date. Submission of a duly completed Research Ethics Progress Report (available at: http://www.tut.ac.za/Other/rninew/ResearchEthicsCommittees/Pages/default.aspx) will constitute an application for renewal of SCRE ethics approval.

Note:
The reference number [top right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants.

Yours sincerely,

WA HOFFMANN (Dr)
Chairperson: Research Ethics Committee
[Ref#2015=03=001=Maila JP]

We empower people

Tshwane University of Technology

We empower people

Research Ethics Committee

The TUT Research Ethics Committee is a registered Institutional Review Board (IRB 00005968) with the US Office for Human Research Protections (IORG# 0004997) (Expires 9 Jan 2017). Also, it has Federal Wide Assurance for the Protection of Human Subjects for International Institutions (FWA 00011501) (Expires 22 Jan 2019). In South Africa it is registered with the National Health Research Ethics Council (REC-160509-21).

June 4, 2016

Ref #: REC/2015/03/001
Name: Maila JP
Student #: 209208660

Mr JP Maila
C/o Prof LJ Erasmus
Department of Managerial Accounting and Finance
Faculty of Economics and Finance

Dear Mr Maila,

Decision: Final Approval (Stage 2 - Interviews)

Name: Maila JP
Project title: *The effectiveness of revenue management in South African public hospitals - The case of the Tshwane District Hospital*
Qualification: M Tech (Cost & Management Accounting)
Supervisor: Prof LJ Erasmus
Co-supervisor: Prof HE Klingelhöfer

Thank you for submitting the Stage 2 project documents for ethics clearance by the Research Ethics Committee (REC), Tshwane University of Technology (TUT). In reviewing the documents, the comments and notes below are tabled for your consideration, attention and notification:

- **Information Leaflet & Informed Consent**
  - The information Leaflet and Informed Consent document is in order.
- **Interview Guides**
  - The Interview Guides are in order.

- **Respect of Interviewer Dignity.** The REC wishes to merely sensitise the researcher that the interview question related to the required qualifications and skills for the tasks performed by the respective interview groups may cause them some anxiety and/or discomfort. As such, it is important that these interviewees be treated with respect and dignity to ensure that they don't experience the interviews as a form of personal critique on their respective professional positions and/or work processes.

An expedited review panel of the Research Ethics Committee, Tshwane University of Technology, reviewed the Stage 2 project documents on June 3, 2016. **Final approval (Stage 2 – Interviews)** is granted to the study.

The proposed research project may now continue with the proviso that:

1) The researcher/s will conduct the study according to the procedures and methods indicated in the approved proposal, particularly in terms of any undertakings and/or assurances made regarding the confidentiality of the collected data.
2) The proposal will again be submitted to the Committee for prospective ethical clearance if there are any substantial changes from the approved proposal.
3) The researcher/s will act within the parameters of any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Strict adherence to the following South African legislation, where applicable, is especially important: Protection of Personal Information Act (Act 4 of 2013), Children's Act (Act 38 of 2005) and the National Health Act (Act 61 of 2003).
4) The current ethics approval expiry date for this project is **July 31, 2018**. No research activities may continue after the ethics approval expiry date. Submission of a duly completed Research Ethics Progress Report (available at: http://www.tut.ac.za/Other/rninew/ResearchEthicsCommittees/Pages/default.aspx) will constitute an application for renewal of REC ethics approval.

Note:
The reference number [top right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants.

Yours sincerely,

WA HOFFMANN (Prof)
Chairperson: Research Ethics Committee
[Ref#2015=03=001=Maila JP]

Kuyasheshwa! Gauteng Working Better

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

427 Hilda Street, 4th floor, The Fields Building, Hatfield Pretoria 0001 South Africa. Tel: +27 12 451 9036
Enquiries: Dr. Molapane Chueu-Shabangu
e-mail: Molapane.Shabangu@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE

CLEARANCE CERTIFICATE

Meeting: N/A

PROJECT NUMBER: 49/2015

Title: The effectiveness of revenue management in South African public hospitals - The case of the Tshwane District Hospital

Researcher: JAN PHASODI MAILA

Supervisor: Dr. LJ Erasmus

Co-Supervisor: Prof HE Klingelhoefer

Department:

DECISION OF THE COMMITTEE

Approved

NB: THIS OFFICE REQUESTED A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE

Date: 02/11/15

P.P. .....

Dr. Molapane Chueu-Shabangu
Chairperson Tshwane Research Committee
Tshwane Health District

.....

Mr. Pitsi Mothomone
Chief Director: Tshwane District Health
Tshwane District 2015/11/03

NOTE: Resubmission of the protocol by researcher(s) is required if there is departure from the protocol procedures as approved by the committee.