EFFECTIVENESS OF CASH MANAGEMENT AND QUALITY OF SERVICE: A CASE STUDY OF MOROGORO REGIONAL HOSPITAL

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By

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A Dissertation Submitted in Partial/Fulfillment of the Requirements for Award of the Degree of Master of Business Administration (MBA-CM) of Mzumbe University

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CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled **Effectiveness of cash management and quality of Service: A Case study of Morogoro Regional Hospital,** in partial/fulfillment of the requirements for award of the degree of Master of Business Administration (CM) of Mzumbe University.

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Major Supervisor

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I, **Joseph, John Kabeya Emmanuel**, declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

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Date ----------

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Though writing this dissertation has been a personal demanding journey, it could not materialize without assistance from various people. Therefore, I extend my sincere gratitude and appreciation to all who, with their help in whatever form, have made my study possible.

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DEDICATION

This dissertation is dedicated to the memory of my father the late Emmanuel Mahenda Joseph and my late mother Elizabeth Paul Kalunde for their care, love, patience and inspiration.

The work is also dedicated to my family (wife Emelda, my sons Valentine, Victor and Junior) who missed my presence at home when conducting this study.

ACRONYMS AND ABBREVIATIONS

CHF	Community Health Fund
FY	Financial Year
GDP	Gross Domestic Product
GoT	Government of Tanzania
HIV	Humane Inefficiency Virus
HSF	Health Service Funds
IPD	In-Patient Department
MoH	Ministry of Health
MRH	Morogoro Regional Hospital
MSD	Medical Store Department
NGO	Non Governmental Organisation
NHIF	National Health Insurance Fund
OPD	Out Patient Department
PHC	Primary Health Centre
REPOA	Research on Poverty Alleviation
SPSS	Statistical Package for Social Science
US	United State of America
URT	United Republic of Tanzania
WHO	World Health Organisation

ABSTRACT

Health care provision in developing countries like Tanzania is usually provided in collaboration with national authorities, International aid agencies and NGOs. In order for donors to have direct control over the funds, support has traditionally been organised as stand-alone vertical programmes to address specific health system. But these separate programmes have led to duplication of funding, wastage of resources and lack of coordination in terms of controlling specific diseases. The general objective of this study was to examine the effectiveness of cash management and quality of service at Morogoro Regional Hospital.

Cross-sectional research design was used in the methodology. A sample size of 43 respondents who comprised management, accountants and supplies officers, patients and other stakeholders were involved. Data were collected using questionnaires, interview and observation. Data collected was analysed descriptively by SPSS computer software.

The findings from respondents revealed that sources of funds were unreliable and unable to fulfill the targeted goals resulting to seeking assistance from the regional administrative secretary's (RAS) office and incurring debts from the medical stores department (MSD). The majority of respondents showed disagreement on cash management control system practices in the hospital. This resulted in mismanagement, misallocation and misuse of funds provided; hence cash management discrepancies accounting to inadequate quality health services deliveries as reported by respondents. The quality of healthcare provision remains poor at the Hospital even with the additional funds from user fees. However, funds from own source seemed to contribute a small something which does not reveal the reality of their operations. The research adds to the argument for a (bottom-up approach) Participatory approach for cash management control system practices for the enhancement of quality health services which enables intervention in management and development activities regarding health service providers.

TABLE OF CONTENTS

Page

LIST OF TABLES

Page

LIST OF FIGURES

Page

CHAPTER ONE

INTRODUCTION AND BACKGROUND INFORMATION

1.1 Introduction

This chapter presents the background information regarding the study which examined the effectiveness of cash management and quality of service at Morogoro Regional Hospital. This chapter is organized into the following sub-sections as; the background to the problem; an overview of Morogoro regional hospital; the problem statement; the research objectives and questions; justification and significance of the study; and finally the structure/organization of the research.

1.2 Background to the problem

Health is a serious developmental issue. The link between health and development has been articulated in much of the policy and academic literatures resulting in many initiatives to introduce integrated health information system at local level (Richard, 2006).

Issues of health services provision are central to any development discussion. In Africa a disease such as Malaria is estimated to cost African countries more than 1% of their GDP (UNICEF, 2000) and has been classified as one of the biggest impediments to poverty alleviation (WHO, 1997; Gallup& Sachs, 1997). Health care provision in developing countries is usually provided in collaboration with national authorities, International aid agencies and NGOs. In order for donors to have direct control over the funds, support has traditionally been organised as stand-alone vertical programmes to address specific health system. But these separate programmes have led to duplication of funding, wastage of resources and lack of coordination in terms of controlling specific diseases. The International Donor

community has recognised this and there is a global trend backed by the World Bank and WHO towards integrating stand-alone programmes at local level in order to coordinate efforts in delivering healthcare to local communities (Wolinsky, 1998) and the major attempt being equitable access to basic health services in developing countries to all members of the community.

Many countries, including Tanzania, need support for more specialized health care staff (especially in rural areas), modern medical curricula, adequate facilities and resources for patient care. Though medical services are generally available in urban and rural areas of Tanzania, facilities and supplies remain insufficient to serve a population that suffers from a high risk of malaria, childhood illness, obstetric emergencies, tuberculosis, and HIV/AIDS (Gilson, 1994). Drug shops with pharmacists and doctors called in Swahili *"Maduka ya madawa baridi"* are often consulted in cases of common illness, especially in remote areas where access to basic quality medicine continues to be a problem. Traditional healers called in Swahili *"waganga wa asili"* are also consulted, especially in rural areas where modern medical practices may not be accessible, affordable, or fully accepted. In order to have equitable healthcare provision, a good cash management control and resources are needed which should start and this is nothing than internal cash management control system (Finger, 1998).

The need for enhanced internal cash management control is a natural part of managing new streams of revenues at a health care facility. While internal cash management has many purposes, its chief aim within the health care facility setting is twofold; it is intended to provide health care managers with measurable assurances of (1) their facility's effective and efficient operations and (2) the reliability of facility's financial reports which are sent to various external organisations in support of applicable laws and regulations. In addition, internal cash management seeks to minimize the risks of unauthorised acquisition, use or disposition of assets. It also seeks to control fraud or minimally identify and detect fraud in a timely manner

(Davidson, 1997). Examples of internal cash management include; Proper control of procedures for receipts, storage and use of drug, medical supply inventories and effective control procedures for collection, recording and accounting of cash from user fees.

For the public sector, the general expectations are that, public servants should serve the public interest with fairness and manage public resources properly as citizens should receive impartial treatment on the basis of legality and justice (Richard, 2006). Therefore, public ethics are a pre-requisite to, underpin public trust and are a keystone of good governance. Since resources in the public sector generally embody public money and their use in the public interest requires special care, the significance of safeguarding resources in the public sector needs to be stressed. Therefore, the integrity of any cash management activity depends on the application of internal control principles and standards (REPOA, 2008).

People are the ones who make internal cash management work. It is accomplished by individuals within an organization, by what they do and say. Consequently, internal cash management control is implemented by people. People must know their roles and responsibilities and limits of authority (Pearson, 2007). An organization's people include management and other personnel. Although management primarily provides oversight, it also sets the entity's objectives and has overall responsibility for the internal control system. As internal cash management provides the mechanisms needed to help understand risk in the context of the entity's objectives, the management will put internal control activities in place, monitor and evaluate them. The implementation of internal cash management requires significant management initiative and intensive communication by management with other personnel. Therefore internal cash management is a tool used by management and directly related to the entity's objectives. As such, cash management is an important element of internal control. However, all personnel in the organization play important roles in making it happen (Hill *et al.,* 1992).

Similarly, internal cash management is affected by human nature. Internal cash management guidelines recognize that people do not always understand, communicate or perform consistently. Each individual brings to the workplace a unique background and technical ability and has different needs and priorities (Bishop, 1991). These realities affect and are affected by internal cash management. For instance, fraud and manipulation have been existed in cash transactions for quite some time, which in turn cause the ineffectiveness of internal control over cash transactions; as the result organisation's objectives cannot be realised and in our case, dissatisfaction in health services deliveries.

1.3 Statement of the problem

In Tanzania the health services during the colonial period and immediately after independence were seriously deficient in providing basic health facilities to the majority of Tanzanians as it was geared towards servicing a small elite group. As the result at independence in 1961 the health status of the majority of Tanzania's population was poor (Hiza and Massanja, 1997). The 1967 Arusha Declaration sought to restructure the health sector as part of a comprehensive strategy to ensure sustainable development based on the principles of socialism and self-reliance and aimed at providing health services free to all the Tanzanians attending government health facilities (Hiza and Massanja, 1997). However, this policy was deemed unrealistic as the Government of Tanzania (GoT) financing capacity was insufficient to truly provide all services for all of the population, at the same time cash management was poor to manage the little finance available, as the result, the policy resulted in poor quality and inequitable health services delivery. The poor suffered the most, as they had fewer alternatives, whereas the wealthier members of the population could opt out of the government system and pay private providers (Masuma and Bangser, 2006). This move prompted to community contribution which was introduced in 1993 whereby people are now supposed to contribute for health services when they go for treatments in health facilities.

Despite the introduction of community contribution, health consumers express dissatisfaction in quality of services and managing hospital revenues. The poor members of the society are still suffering as they are still getting poor quality health services (REPOA, 2008). Moreover, little is known on the importance of community contribution and proper cash management in government hospitals. Therefore, this study intended to examine the effectiveness of cash management and provision of quality services in government hospitals particularly at Morogoro Region hospital.

1.4 Research Objectives

1.4.1 General Objective

The general objective of the study is to examine the effectiveness of cash management and quality of health service provision at Morogoro Regional Hospital.

1.4.2 Specific Objectives

a) To identify the sources of funds for Morogoro regional hospital
b) To identify the cash management control system practices for the enhancement of quality health services in Morogoro Region hospital.
c) To identify finance related factors affecting the quality of health services in Morogoro Regional hospital
d) To determine the cash management discrepancies affecting the quality of health service provision.

1.5 Research Questions

a) What are the sources of funds for the Morogoro regional hospital?

b) What are the cash management control system practices for the enhancement of quality of health services in the Morogoro regional hospital?

c) What are the finance related factors affecting the quality of health services in Morogoro regional hospital?

d) What are the cash management discrepancies affecting the quality of health services provision?

1.6 Justification of the study

a) Tanzania spends a huge amount of money in health care provision every year and the health expenditure per capita (US dollar) in the country was last reported to be 30.91 in 2010 according to a World Bank report published in 2012. Hence there is need to study if such huge expenditures are properly managed.

b) The country has both international and national commitments to fulfill, for example, the fulfillment of the Development Millennium Development Goals and Poverty Reduction Strategy, therefore this study is timely and necessary as it may contribute in improving ways to fulfill those goals and strategies related to health care provision.

1.7 Significance of the study

This study is important in various ways as follows:

(a) It will be used by different institutions as reference material for academic endeavours

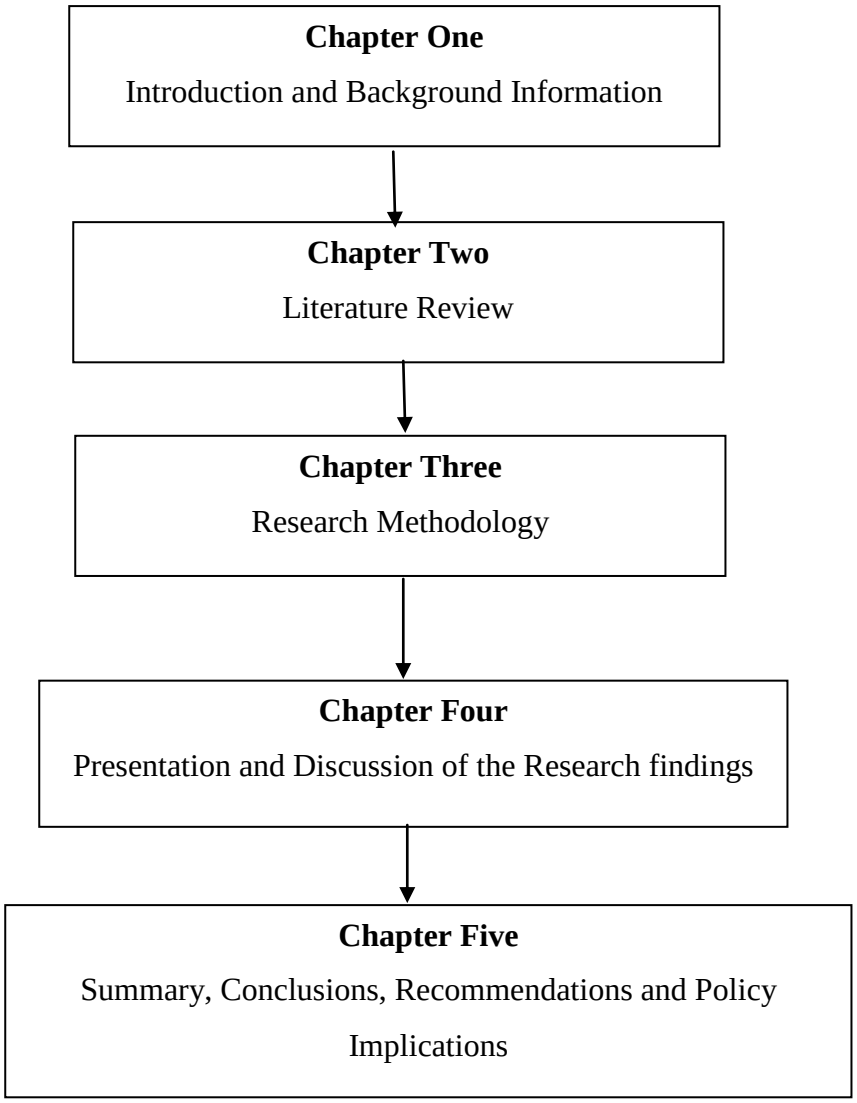
(b) The study may help to improve the techniques which are being used for cash management at the hospital and may enable the management of MRH to put an eye on the problems which are disclosed in this study

(c) The findings of this study may stimulate other studies on cash management and quality of health services and might act as pointer for further studies

1.8 Structure/organization of the research

The research consisted of five chapters/sections as shown in Figure 1.1.The first chapter was an Introduction and Background Information. The second chapter presented the Literature Review, the third chapter discussed the Research Methodology used, the fourth chapter analysed the Presentation and Discussion of the Research findings and the fifth chapter presented the Summary, Conclusions, Recommendations and Policy Implications.

Figure1.1: Structure/Organization of the Research



Source: Personal adaptation, 2013

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviewed the literature of other studies in order to provide a theoretical framework which guided the development of the study on which analysis of data for the present study was based. It is based on Theoretical definitions of terms, Cash Management and Health Care Models, Empirical analysis of the study and the Conceptual framework.

2.2 Theoretical literature review

2.2.1 Definition of key terms

a) Cash

Cash is an organization's livelihood. If managed properly an organization remains healthy, strong and vibrant. However, if an organization manages the cash-flow poorly, then the organization can suffer some forms of a cardiac arrest. Organizations that do not value cash management as an important issue are probably undermining organization's short-term stability, and its long-term survival (Davidson, 1997). In some ways, managing cash flow is the most important job of managers. If at any time an organization fails to pay an obligation when it is due because of the lack of cash, the organization is insolvent. Insolvency is the primary reason organizations/firms go bankrupt. Obviously, the prospect of such a dire consequence should compel organizations to manage their cash with care. Moreover, efficient cash management means more than just preventing bankruptcy. It improves the profitability and reduces the risk to which the firm is exposed (Hill *et al*., 1992).

b) Cash management

Cash management is a broad term that refers to the collection, concentration, and disbursement of cash (Hill *et al.,* 1992). It encompasses an organization's level of liquidity, its management of cash balance and its short-term investment strategies. Cash management is particularly important for new and growing organizations. As Davidson (1997) indicated in his book Cash Traps, cash flow can be a problem even when a small organization has numerous clients, offers a superior product to its customers and enjoys a sterling reputation in its industry. Organizations suffering from cash flow problems have no margin of safety in case of unanticipated expenses. They also may experience trouble in finding the funds for innovation or expansion. Finally, poor cash flow makes it difficult to hire and retain good employees. "Cash is the lifeblood of a [store]," wrote Richard Outcalt and Patricia Johnson in Playthings. "Without cash for inventory, payroll, and other expenses, an emergency is imminent."

Cash management attempts, among other things, to decrease the length and impact of these "float" periods. A collection receipt point closer to the customer—perhaps with an outside third-party vendor to receive, process, and deposit the payment (check)—is one way to speed up the collection. The effectiveness of this method depends on the location of the customer; the size and schedule of their payments; the organization's method of collecting payment; the costs of processing payments; the time delays involved for mail, processing, and banking; and the prevailing interest rate that can be earned on excess funds. The most important element in ensuring good cash flow from customers, however, is establishing strong billing and collection practices (Hill *et al.,* 1992).

c) Effectiveness

Effectiveness means the achievements of goals and objectives without much regard to the amount of input resources involved. Emphasis of attention is realization of the goal or objectives of the purchase transaction (Mhilu, 2006).

d) Quality of health care

Quality health care can be more exactly described as striving for and reaching excellent standards of care. It involves assessing the appropriateness of medical tests and treatments and measures to continually improve personal health care in all fields of medicine, from the aids that help you eat to the surgeon who removes a tumour from your brain (Harteloh, 2007)

e) Total quality management

Total quality management advocates define quality as "Doing the right thing right, right away." An essential factor to consider when analyzing the quality of care of health facilities is the perspective of the client. For clients and communities, quality care is something that meets their perceived needs. Since a client's needs often differ, their personal satisfaction ultimately depends on the perception, attitude and expectations of each individual (Finger, 1998). However there is no one way to define quality in healthcare. Of the many definitions, perhaps the most important one, the one emphasized by the FDA, is defined in terms of patient safety. A high quality product or service minimizes the risk of harm to the patient. Another important measure is the effectiveness of the product or service; that is, how well it serves its intended use (Mhilu, 2006).

Patient satisfaction is a strong influencing factor in determining whether a person seeks medical advice, complies with treatments and maintains a relationship with the provider/health facility (Gilson, 1994). Ultimately, the dimensions of quality that relate to client satisfaction affect the health and well-being of the community. Campbell (2002), in defining quality of health care suggested that there are two principal dimensions of quality of care for individual patients; access and effectiveness. In essence, do users get the care they need, and is the care effective when they get it? Within effectiveness, Campbell (2002) defines two key components—effectiveness of clinical care and effectiveness of inter-personal care. These elements are discussed in terms of the structure of the health care system,

processes of care, and outcomes resulting from care. The framework relates quality of care to individual patients and suggested that quality of care is a concept that is at its most meaningful when applied to the individual user of health care. However, care for individuals must be placed in the context of providing health care for populations which introduces additional notions of equity and efficiency. Campbell (2002) showed how this framework can be of practical value by applying the concepts to a set of quality indicators contained within the UK National Performance Assessment Framework and to a set of widely used indicators in the US (Kamoieka, 2007).

2.2.2 Theoretical reviews

There is limited positive evidence that user fees in Tanzania have in general achieved their original objectives of sustainability, drug availability, and quality of care, equity and access for the poor. More specifically, the study done by Hemed (2009) found that government-run PHC facilities appeared to face severe shortages of drugs and supplies. In addition, user fees were not always retained at PHC level, but deposited in the HSF account which mainly benefited the purchase of supplies for the district hospital. Positive results were seen for reinvestment of CHF funds. In total, 50% of the health workers and patients reported improvements in drugs availability, diagnostic facilities and maintenance. However, equity criteria for the distribution of available resources from the user fee income to PHC level are not systematically followed (Mhilu, 2006).

Gilson (1994) suggested that the most important dimensions of quality health service delivery for the client are technical competence, interpersonal relations, accessibility and amenities. Technical competence refers to the skills and actual performance of the health providers in regards to examinations, consultations and other technical procedures. It is important to note that although clients are looking for proficient providers, often they cannot assess this dimension accurately. Furthermore, communities do not always fully understand their health service needs. The interaction between the provider and the client comprises the category of

interpersonal relations. In this area, effective listening and communication skills have a critical impact on customer satisfaction. Accessibility to the client means that the health care services are unrestricted by barriers such as geography, economy or language. Finally, amenities refer to a client's perception of the physical health care facility, as well as supplies and equipment within the facility (Kamoieka, 2007).

According to Bishop (1991) successful cash management involves not only avoiding insolvency (and therefore bankruptcy), but also reducing days in account receivables (AR), increasing collection rates, selecting appropriate short-term investment vehicles, and increasing days cash on hand all in order to improve a company's overall financial profitability. With this regard, the need to know exactly the sources of funds is necessary. However, Bishop's (1991) study did not highlight how to get proper sources of funds as to finance any business undertakings. According to Kilagane (2006), in order for organization to have a strong cash management; it must establish a plan which must indicate clearly the departments or personnel responsible for such functions as purchasing, receiving incoming shipments, maintaining accounting records, approving credit to customers and preparing the payroll one person should be clearly responsible for each duty.

Davidson (1997) provided the mechanism for the control of cash flows as follows; a) Inflows. It is necessary to minimize the interval between the time when cash is received and the time it is available for carrying out expenditure programs. Collected revenues need to be processed promptly and made available for use; b) Outflows. For cash management, the control of cash outflows, which is directly related to organizational arrangements for budget execution, can pose more difficulties than the control of cash inflows. The major purpose of controlling cash outflows is to ensure that there will be enough cash until the date payments are due and to minimize the costs of transactions, while keeping cash outflows compatible with cash inflows and fiscal constraints. The first condition for ensuring that cash outflows according to fit fiscal constraints is good budget preparation and budget implementation covering both cash and obligations. However, during budget implementation, cash outflows must also be regulated through cash plans to smooth cash outflows and; c) Payment

techniques. Payment methods affect the transaction costs of cash outflows. Depending on the banking infrastructure and the nature of expenditures, various payment methods may be considered (check, cash, electronic transfer, debit card, etc.). Modern methods of payment, for example, payment through electronic transfers instead of through checks or cash, allows the organisation to plan its cash flow more accurately, expedite payments, and simplify administrative and accounting procedures. However, whether one mode of payment is preferable to another depends on many factors, such as the degree of economic development of the country, the banking network and the status of computerization. Furthermore, Davidson's (1997) mechanism did not clearly provide the cash management control system practices for the enhancement of the quality of services.

Cash management has the following purposes: controlling spending in the aggregate, implementing the budget efficiently, minimizing of the cost of government borrowing, and maximizing the opportunity cost of resources (the last two purposes yielding interest). Control of cash is a key element in macroeconomic and budget management (Hill *et al*., 1992). However, it must be complemented by an adequate system for managing commitment. For efficient budget implementation, it is necessary to ensure that claims will be paid according to the contract terms and that revenues are collected on time. It is necessary to minimize transaction costs; and to borrow at the lowest interest rate or to generate additional cash by investing in revenue-yielding projects. It is also necessary to avoid paying in advance and to track accurately the dates on which payments are due. Performance concerns have also had an impact on cash management and some countries have implemented reforms to make spending agencies more responsible for cash, while maintaining instruments to ensure fiscal discipline.

2.2.3 Cash Management and Health Care Models

2.2.3.1 Health Care Models

There is a wide variety of health care systems around the world with as many histories and organizational structures as there are nations (Campbell, 2002). In some countries, health care system planning is distributed among market participants. In others, there is a concerted effort among government, trade unions, charities, religious, or other coordinated bodies to deliver planned health care services targeted to the populations they serve. However, health care planning has been described as often evolutionary rather than revolutionary (Mhilu, 2006). The goals for health systems, according to the World Health Organization (1997), are good health, responsiveness to the expectations of the population and protecting families against financial ruin from medical bills. Progress towards them depends on how systems carry out four vital functions provision of health care services, resource generation, financing, and stewardship. Other dimensions for the evaluation of health care systems include quality, efficiency, acceptability, and equity. They have also been described in the United States as "the five C's": Cost, Coverage, Consistency, Complexity, and Chronic Illness. However, Continuity is a major goal. For all the local variations, health care systems tend to follow general patterns.

2.2.3.2 Baumol Model of Cash Management

Baumol model of cash management helps in determining a firm's/organisation's optimum cash balance under certainty. It is extensively used and highly useful for the purpose of cash management. As per the model, cash and inventory management problem is one and the same (Bishop, 1991). William J. Baumol (1978) developed a model (The transactions Demand for Cash: An Inventory Theoretic Approach) which is usually used in Inventory management and cash management. Baumol model of cash management trades off between opportunity cost or carrying cost or holding cost and the transaction cost. As such, an organisation attempts to minimize the sum of the holding cash and the cost of converting marketable securities to cash. Baumol

model of cash management is useful in this regard as at present many organisations/firms/companies made an effort to reduce the costs incurred by owning cash (Karulzama, 2009). They also strived to spend less money on changing marketable securities to cash.

It enables organisations/firms/companies to find out their desirable level of cash balance under certainty. The Baumol model of cash management theory relies on the trade off between the liquidity provided by holding money (the ability to carry out transactions) and the interest foregone by holding one's assets in the form of non-interest bearing money. The key variables of the demand for money are then the nominal interest rate, the level of real income which corresponds to the amount of desired transactions and to a fixed cost of transferring one's wealth between liquid money and interest bearing assets (Hill *et al*, 1992).

2.2.3.3The Beveridge Model of health care

It was named after William Beveridge (1999) the daring social reformer who designed Britain's National Health Service. In this system, health care is provided and financed by the government through tax payments, just like the police force or the public library. Many, but not all, hospitals and clinics are owned by the government; some doctors are government employees, but there are also private doctors who collect their fees from the government. These systems tend to have low costs per capita, because the government, as the sole payer, controls what doctors can do and what they can charge (Magnus and Pieter, 2005).

2.2.3.4 The Bismarck Model of health care

It was named after the Prussian Chancellor Otto von Bismarck, who invented the welfare state as part of the unification of Germany in the 19th century. Despite its European heritage, this system of providing health care would look fairly familiar to Americans. It uses an insurance system - the insurers are called "sickness funds" –

which is usually financed jointly by employers and employees through payroll deduction (Monica and Peyvand, 2004).

2.2.3.5 The National Health Insurance Model of health care

This system has elements of both Beveridge and Bismarck. It uses private-sector providers, but payment comes from a government which runs insurance programme that every citizen pays into. Since there is no need for marketing, no financial motive to deny claims and no profit; and these universal insurance programmes tend to be cheaper and much simpler administratively (Hammer *et al.,* 2007). The single payer tends to have considerable market power to negotiate for lower prices. National Health Insurance plans also control costs by limiting the medical services they will pay for or by making patients' health care cheaper.

2.2.3.6 The Out-of-Pocket Model of health care

Only the developed, industrialized countries (perhaps 40 of the world's 200 countries) have established health care systems. Most of the nations on the planet are too poor and too disorganized to provide any kind of mass medical care. The basic rule in such countries is that the rich get medical care; the poor stay sick or die. In rural regions of Africa, India, China and South America, hundreds of millions of people go their whole lives without ever seeing a doctor. They may have access, though, to a village healer using home-brewed remedies that may or not be effective against disease (WHO, 1997). In the poor world, patients can sometimes scratch together enough money to pay a doctor's bill; otherwise, they pay in potatoes or goat's milk or child care or whatever else they may have to give. If they have nothing, they do not get medical care. This model is well known and mostly applicable in developing countries including Tanzania (Andersen and Newman, 2005)

2.2.3.7 Andersen Model of Health Care Utilization

Andersen (1968) developed a model of health care utilization which looks at three categories of determinants: 1) predisposing characteristics. This category represents

the proclivity to utilize health care services. According to Andersen, an individual is more or less likely to use health services based on demographics, position within the social structure, and beliefs of health services benefits. An individual who believes health services are useful for treatment will likely utilize those services; 2) enabling characteristics. This category includes resources found within the family and the community. Family resources comprise economic status and the location of residence. Community resources incorporate access to health care facilities and the availability of persons for assistance; 3) need based characteristics which is the third category includes the perception of need for health services, whether individual, social, or clinically evaluated perceptions of need (Wolinsky, 1988).

In the 1970's, Andersen's model was later expanded and refined to include the health care system which included health policy, resources, and organization, as well as the changes in these over time. Resources comprise of the volume and distribution of both labor and capital, including education of health care personnel and available equipment. Organization refers to how a health care system manages its resources, which ultimately influences access to and structure of health services. According to this level of the revised model, how an organization distributes its resources and whether or not the organization has adequate labor volumes will determine if an individual uses health services. In addition, the updated model includes recognition that consumer satisfaction reflects health care use. Furthermore, the model includes the notion that there are several health services available, and both the type of service available (i.e., a hospital, dentist, or pharmacy) and the purpose of the health care service (i.e., primary or secondary care) will determine the type of service utilized. Thus, according to the revised model, whether or not a specific health care service is utilized and the frequency a service is utilized will have different determinants based on characteristics of the population and the health services (Andersen, 1995; Andersen and Newman, 2005).

During the 1980's-1990's Andersen's model was again revised to form three components with a linear relationship: 1) primary determinants; 2) health behaviors; and 3) health outcomes. Primary determinants are noted as the direct cause of health

behaviors. These determinants include characteristics of the population (demographics), the health care system (resources and organization), and the external environment (i.e., political, physical, and economic influences of utilization). In addition, the model explains that health behaviors determine health outcomes. Health behaviors include personal health practices (diet and exercise) and the use of health services. Lastly, the model indicates that health behaviors are the direct cause of health outcomes. Health outcomes include perceived health status, evaluated health status, and consumer satisfaction which in turn determine the quality of health care of a particular community (Andersen, 1995).

2.3 Empirical Literature Review

The study by REPOA (2004) found that reliable, transparency, user fee income data for district, hospital and Primary Health Centre (PHC) level were difficult to obtain due to poor internal cash management control system used by various public health service centers. Based on what information is available, it was concluded that revenues raised from user fees at the hospital level have been lower than what has been projected. Furthermore, the data reflected huge variations between facilities and a decline in the revenues from cost sharing. According to Hemed (1999), the reasons of the reported decline are unclear. The data reflecting the contribution of user fees and Community Health Fund (CHF) to the health budget at district council level showed huge variations as well. The reported user fee income proportion for the district health budget was on average 10.5%. The study team could not establish how the income from cost sharing and the CHF was re-distributed by the council to Primary Health Centres (PHC) facilities or priority areas. A worrying finding was that some council did not spend all health resources in the health sector. The study observed an urgent need for: (1) more accurate and comprehensive recordkeeping at local council level, and (2) more costing and tracking studies to obtain a better insight into cost sharing and expenditures and to adequately inform policy making. Moreover, the studies did not highlight the cash management discrepancies accounting to the quality of health service deliveries for the better running of public as well as private hospitals.

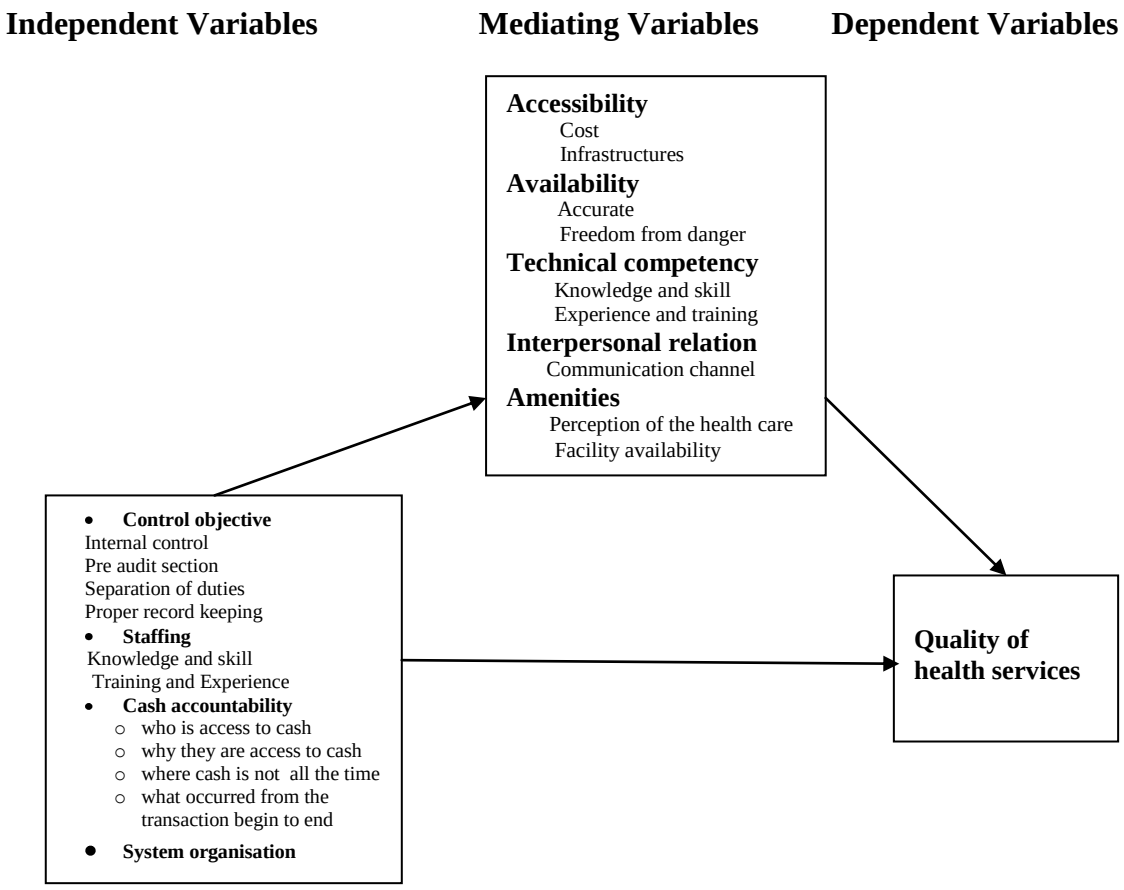
According to REPOA (2007), the national projections of the cost sharing schemes do not reflect an accurate picture, since the data are based on the inaccurate financial data received from the districts. It is likely that the actual and projected data on user fees, community health funds (CHFs) and health service funds (HSF) are underestimations of the real income collected at the different facility levels. This means that the Ministry of Health (MOH) and other stakeholders face a loss of income that cannot be redistributed to the health sector. It also implies that people (both wealthy and poor) are likely to pay more than what is officially reported. The actual potential and use of the non-reported user fees are not known. For example, the total contribution of the cost sharing schemes (excluding NHIF) to the national health resource envelope for FY03/04 was 1.67 Billion Tshs. This equalled a contribution of 0.6% to the overall budget for the health sector. In total, this was US$ 1.56 million. Given the size of the total health budget (US$ 260 million), it can be concluded that the *officially* reported user fees contributed a small proportion only. The actual revenue generated did not meet the initial expectations.

2.4 Conceptual Framework

In order to facilitate collection of data for the study, the Conceptual Framework was established to indicate the relationship of various variables. The conceptual framework consists of independent variables, mediating variables and dependent variables. Independent variables are control objective, staffing, system organisation and cash accountability; mediating variables are accessibility, availability, amenities, interpersonal relationship and technical competency. The dependent variable in this conceptual framework is quality of health services. The conceptual framework indicates that mediating variables influence the relationship between independent variables and dependent variables. The influence can be positive or negative. For example, despite having good staffing levels in the hospital, if they have poor technical competencies then the quality of services can be poor; likewise the hospital can have very good control objectives, but if there is poor interpersonal relationship between staff themselves and between staff and the hospital management delivery

of health services can also be poor. The relationship between the variables is illustrated in Figure 2.1 as follows:

Figure 2.1 Conceptual Framework



CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

Burrell and Morgan (1979) refer to methodology as a way in which one attempts to systematically solve a research problem. The importance of the research methodology emanates from the fact that it provides the logic behind the method selected. Kothari (1985) points out that "when we talk about research methodology, we not only talk about research methods, but also consider the logic behind the methods we use in the context of our research and explain why we are using a particular method or technique so that research results are capable of being evaluated either by the researcher himself or by others"

A hermeneutics methodology, which has been selected and applied in this research, is a research methodology that uses a personal interpretive process to obtain insights about reality, this methodology have been selected because it provides the researcher with the possibility to access and generate the detailed data required for a detailed description of the main research objective. This will provide a sound basis for addressing research questions and with this the possibility to probe issues in detail. This part has been subdivided in the following, study area; research design; population and sample size; sampling procedure and techniques; data collection methods and study variables; and data analysis tools

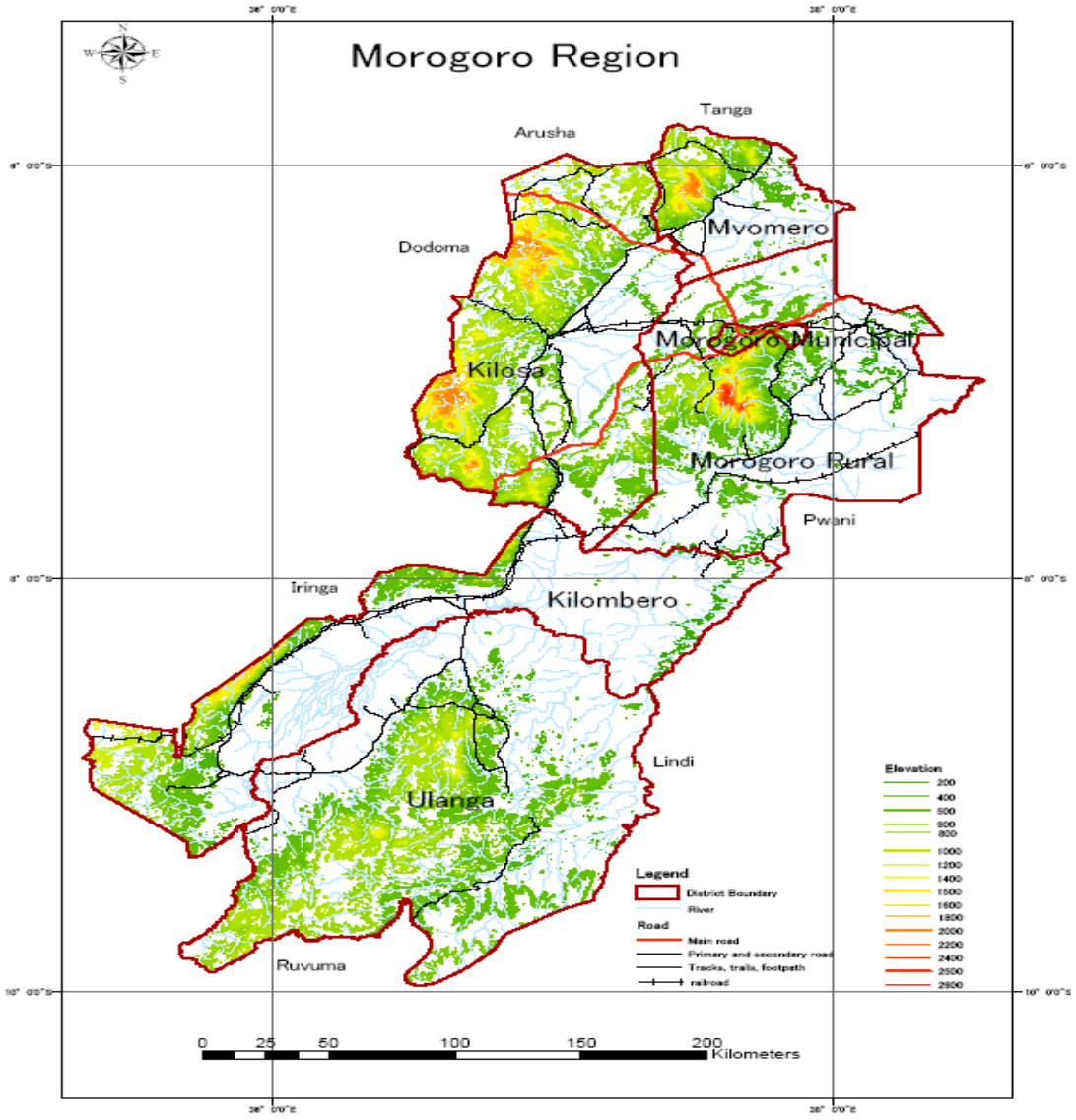
3.2 Study area

Morogoro Region lies between latitude 5° 58"and 10° 0" to the South of the Equator and longitude 35° 25" and 35° 30" to the East. It is bordered by seven other Regions; Arusha and Tanga regions to the North, the Pwani/Coast Region to the East, Dodoma and Iringa to the West, Ruvuma and Lindi to the South. The Region is administratively divided into 6 districts: Mvomero, Kilosa, Kilombero, Ulanga Morogoro Urban and Morogoro Rural, (URT, 1997).

Morogoro regional hospital started in 1954 as a dispensary providing health services for military people and their families. It was promoted to be a Regional Hospital to cater for districts in the entire region right after independence. It serves as district hospital for Mvomero District Council, Morogoro Rural and Morogoro Municipal and also operating as referral hospital for other Health Facilities for the rest of Morogoro Region including Ulanga, Kilombero, Morogoro Rural, Mvomero, Morogoro Municipality, and Kilosa Districts Councils (Kamuzora, 2005).

The Hospital operates three major departments namely Out Patient Department (OPD), In Patient Department (IPD) and Supporting Services. Morogoro Region being situated along the highway connecting other regions of Tanzania and countries like Burundi, Rwanda, Malawi, Zambia and DRC Congo is therefore experiencing high road accident rate which leads to high demand of orthopaedic specialized services in Morogoro Regional Referral Hospital. This evokes for the need of having effective and functional Emergency Medical Department. In the course of operations; the Health service sector in Tanzania has its own Policy that encompasses its vision and mission as stated as; The *vision of the Health Policy* in Tanzania is to improve the health and well-being of all Tanzanians with a focus on those *most* at risk, and to encourage the health system to be more responsive to the needs of the people and the *Mission of the Health Policy* in Tanzania is to facilitate the provision of equitable, quality and affordable basic health services, which are gender sensitive and sustainable, delivered for the achievement of improved health status. However, after long periods of operations, these missions and visions have not attained (Kinemo, 2000)

Figure 3.1 Location of the Morogoro Hospital



Source: URT, 1997

The study was done at Morogoro regional hospital. This hospital operates three major departments namely Out Patient Department (OPD), In Patient Department (IPD) and Supporting Services. Morogoro Region being situated along the highway connecting other regions of Tanzania and countries like Burundi, Rwanda, Malawi, Zambia and DRC Congo is therefore experiencing high road accident rate which

leads to high demand of orthopaedic specialized services and makes it to be a Referral Hospital. This evoked for the need of having effective and functional Emergency Medical Department while adhering to effective cash management for better quality of health services. Moreover, little is known on the importance of community contribution and proper cash management in government hospitals. Therefore, this study intended to examine the effectiveness of cash management and provision of quality services in government hospitals particularly at Morogoro Region hospital.

3.3 Research Design

A research design is a plan for collecting, organizing and analyzing data with the objective of combining the relevance of the research with the economy in procedure (Kothari, 2004). Research design is all about decisions regarding what, where, when, how much, by what means concerning an inquiry or a study. The researcher used cross-sectional research design whereby data (both primary and secondary) were collected at a single point in time (within three months). The design provides a snapshot of ideas, opinions, information and so on (Bryman, 2004). This design is most preferred because of its broad scope and can incorporate many variables of interest to the researcher. The design is useful for descriptive as well as for determination of relationships among variables at the time of the study (Walliman, 2006). The design was of great importance in this study since it helped the collection of data on past events as well as on originally collected data.

3.4 Target Population and Sample size

The target population of this study comprised of all workers and patients being served by Morogoro regional hospital

3.4.1 Sample size

The sample size consisted of 43 respondents (i.e.10 Management personnel, 5 Accountants, 15 Patients and 13 Experts in Health services provision) Based on literature which says that regardless of the population size a sample or sub-sample of 30 cases is the bare minimum for studies in which statistical data analysis is to be done (Bailey, 1994), therefore a sample size of 43 respondents selected is much higher than the recommended minimum sample size.

Table3.1: Distribution of all respondents (N=43) involved in the study

Number			
Type of respondents	**Male**	**Female**	**Total**
Management	6	4	10
Accountants and suppliers	3	2	5
Patients	6	9	15
Experts in health service	5	8	13
TOTAL	20	23	43

Source: Own adaptation, 2013

3.5 Sampling procedures and techniques

If a researcher desires to obtain information about a population through questioning or testing, he/she has two basic options: a) Every member of the population can be questioned or tested, a census; or b) A sample can be conducted; that is, only selected members of the population are questioned or tested.

Contacting, questioning, and obtaining information from a large population, such as all of the households residing in a region is extremely expensive, difficult, and time consuming. A properly designed sample, however, provides a reliable means of inferring information about a population without examining every member or element. Often, researchers are working under strict time constraints which make conducting a census unwieldy. A sample is more accurate than a census of the entire population. The smaller sampling operation lends itself to the application of more

rigorous controls, thus ensuring better accuracy. These rigorous controls allow the researcher to reduce non sampling errors such as interviewer bias and mistakes, non response problems, questionnaire design flaws, and data processing and analysis errors. This study applied two sampling procedures in order to get a relevant sample to be questioned namely; purposive and accidental

3.5.1 Purposive sampling

One of the sampling techniques used by the researcher was purposive sampling. This was applied to health and financial experts, hospital accountant and head of departments in the hospitals e.g. theatre, in-patients head, out-patients head, dental department head, eye head, hospital secretary, accounts department head and head of administration and personnel department. These people were very much important in this study as they are the expert in cash management and supervising health services provision in the hospital. They are also knowledgeable, experienced and understand cash flow and management of hospital funds.

3.5.2 Accidental Sampling

Accidental sampling was used to get the sample from the customers who were visiting the hospital to get medical services. The researcher managed to get 15 respondents from accidental sampling. This was applied because the customers who visited the hospital were not permanent; they were varying from day to day. So it was convenient to select a sample which was available at any particular point in time. That is, a sample population selected because it is readily available and convenient.

3.6 Data Collection Methods

Research methods refer to the techniques employed in collecting relevant research Materials and processing such materials into answers to the research question(s) (Kothari, 1985; Verschuren and Doreeward, 1999). Various methods can be employed in collecting the requisite research material (evidence) required to answer the research questions. In this study interview, questionnaire, observation and

documentary review were used to collect primary and secondary data as follows hereafter

3.6.1 Primary data

Primary data were collected from the field using interview, questionnaire and observation methods were used.

a) Interview

The researcher used interview to the Hospital Management, Accountants, suppliers and key informants (experts who were knowledgeable, understandable and willing to cooperate) were interviewed so as to provide insight information of the cash management and quality service at the hospital The key informants were, financial and health service experts, accounts department head, and head of personnel and administration department.

b) Questionnaires

Questionnaires were used to obtain information from all respondents as shown above. This complemented and supplemented information obtained under interview, observation and documentary review. Questionnaires were distributed to financial and health service experts, hospital accountant and head of departments in the hospitals e.g. theatre, in-patients head, out-patients head, dental department head, eye head, hospital secretary, accounts department head and head of administration and personnel department and to customers of health service(patients)

c) Observation

The researcher used observation method in data collection in order to complement what was not obtained from the interview and questionnaires, Financial and material procedure were observed which included how finance is received, posted on books of

accounts, how expenditures are approved, how money are collected and banked, how orders of hospital materials are made, how are they received and booked on stores ledger, how are they issued who approves the issue and request.

3.6.2 Secondary data collection methods

The researcher used documentary review methods in order to access accurate and reliable data. Documents review comprised of personal profiles, reports, guidelines, directives, policies, regulations, books, journals and minutes of hospital management meetings.

3.7 Study Variables

In this study the variables that were identified to be used in collecting data for the study were as follows: On the one hand, cash management variables were control of funds, staffing, cash accountability, and auditing and reconciliation assets; on the other hand, quality service variables were accessibility, availability, technical competency, interpersonal relation, and amenities. The variables are presented in Table 3.2 as follows:

Table 3.2: Study Variables

Cash management variables	Quality service variables	Decision criterion
▪ Control of funds ▪ Staffing ▪ Cash accountability ▪ Auditing and reconciliation of assets	▪ Accessibility ▪ Availability ▪ Technical competency ▪ Interpersonal relation ▪ Amenities	Above 90 good Between 80-90 Average Between 70- 80 Low Below 70 Poor

Source: Analysed data, 2013

3.8 Data analysis

Both qualitative and quantitative data analysis was used in this study, whereby Quantitative data from the respondents were verified, compiled, coded and summarized before analysis using T-test computer soft ware. More specifically, descriptive statistics was used where; frequencies, means, tables and percentages

distributions of the respondents were used for data presentations/analysis. Cross tabulations were used to determine the correlation between the variables.

Qualitative data collected were analysed using content analysis by observing the themes of the discussion and agreement/disagreement in responses given by various interviewees.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF THE RESEARCH FINDINGS

4.1 Introduction

This chapter provides major results and discussions arising from the data analysis on the examination of the effectiveness of cash management and quality of health services at Morogoro Regional Hospital. These are discussed under four main sections; the first section focuses on respondents' opinions on the sources of funds which the hospital is depending on and their suggestions on the services needed to be provided in order to have better quality of health services; and the second section highlights on the cash management control system practices for the enhancement of the quality of health services; and the third section identifies factors that affect quality of health services provision and the last section focuses on cash management discrepancies accounting to the quality of health services provided by the hospital. The details are provided as follows:

4.2 Respondents' opinions on the Sources of funds of Morogoro Regional Hospital

The data indicated that there are five sources of funds which are available at Morogoro Regional Hospital namely, the Central government, Community contributions, Donor programmes, Rent receivable; and Basket fund. The central government provide funds such as personal emoluments which are provided in monthly basis, apart from that fund it also provide funds for development of the hospital infrastructure and funds for other expenditures (direct cost) including operational funds. It was also indicated that Morogoro District Council, Mvomero District Council and Municipal Council contribute their funds to the Morogoro Regional Hospital through basket fund. This is because in principal the mentioned councils do not own their hospitals (district hospitals) for that case they are used MRH as their district hospital hence they have to contribute for that service.

The Table 4.1 indicates the type of fund and sources from Morogoro Regional hospital.

Table 4.1: Sources and type of funds at Morogoro Regional Hospital (n=15)

No	Type of fund	Source	Frequency	Percentage
1	Personal emolument , other charges and development funds,	Central government	4.0	27.0
2	Contributions from Municipal council, Morogoro rural and Mvomero district councils	Basket fund	3.0	20.0
3	Cost sharing and Drug revolving fund	Community contributions	4.0	27.0
4	Stakeholders funds	Donor programmes	2.0	13.0
5	Funds from hospital's own source	Rent receivables	2.0	13.0
	TOTAL		15	100

Source: Analysed data, 2013

The findings in Table 4.1 above indicated that central government and community contribution contributed 27.0 % each. This give a picture that the major sources of funds in health services are central government and people's contribution. Although it was indicated that the major source of fund is from the central government, the findings went further to examine if the fund from the central government was sufficient to provide quality services in the health sector. It was noted that the amount received was not insufficient at all. For example in year 2008 Morogoro Regional Hospital budgeted 3.5 billion (PE, OC and development fund) but what was received from the central government was 3.4 billion. This indicates that they had the deficit of 69 Million in their annual budget. In the year 2010 Morogoro Regional Hospital budgeted 4.3 billion (PE and OC and development fund), what they received was 4.4 Billion (they had a surplus of 114 million). The surplus might be given under political grounds. In the year 2011 the Morogoro Hospital budgeted 4.8 billion (PE, OC and development funds) but only received 4.5 billion from the central government which make a deficit of 293 million and the deficit in their budget is continuing even to date. It was also noticed that, most funds received was on personal emolument. However, it was explained by management and Accounts

department that the sources of funds are not reliable because the budgeted funds are not released on time from the central government and also it is limited. Yet, only part of the budget given does not match with the hospital actual operation requirements as the result causes shortage of medicine, medical equipment, supplies and payment of statutory benefits to staffs.

The study was also able to identify community contribution as another major source of fund in Morogoro regional hospital. Community contribution was divided in into two parts; the first one was drug revolving funds whereby customers are required to pay in exchange for the services, and the second contribution pertaining to cost sharing funds whereby customers are members of a certain health insurance scheme and contribute on that scheme on monthly basis for their future health services. However, it was observed that due to low economic status of the community it is difficult to some of the community members to pay for health services and hence this reduces the MRH income. This was because large proportions (30%) of patients are not able to pay due to poor economic status as well as child under five years, and old people aged above 60 years. It was also revealed that there are some diseases which are treated freely for example, TB, HIV/AIDS and LEPROSY which in totality created the burden to the government and reduced hospital's income. Moreover, it was noticed that cost sharing fund is disbursed but unreliable and ineffective as well.

The findings in this part imply that, the availability of the sources of funds have not enhanced to the extent of providing good quality health service. One of the reasons may be the inadequate budget from the government, other stakeholders and late disbursement of funds from customers. However, funds from own source through rent receivable from kiosks and canteen seem to contribute a little which does not reveal the reality of their operations something that lowers the quality of health services.

4.3 Cash management control system practices for the enhancement of the quality of health services

The second objective of this study was to identify the cash management control system practise for the enhancement of the quality of health services in MRH. Basing on the five sources of income in MRH, the hospital falls under two votes namely, vote 52 (from the Ministry of Health and social welfare) and 79 (From the Region Administrative Secretary) management of cash both of vote 52 and 79 the medical officer-in-charge of MRH is the custodian of those votes. Normally, the hospital accountant informs the medical Officer- in- charge on the new deposit and status of fund of either vote. The custodian gives permission to the MRH accountant to utilize those particular funds. The Public Finance Act, Chapter 348 (revised edition 2002) and its regulations, requires that before giving permission, the custodian should convey management meeting and inform them about the deposit of the particular fund, and thereafter they have to agree on how those fund are going to be spent. Every head of department has to originate the expenditures which are due for their departments and the accountant has to prepare the documentation for payment and the medical officer-in- charge gives the approval, then payment is made. This study revealed that there was a problem in management and control of cash in MRH as it was noted that, the Accountant of the hospital was doing double roles that are preparation and initiation of payment while the heads of department were not involved which can result on diversion and or misappropriation of funds.

Moreover, this study has also revealed that the money obtained from drug revolving funds was received by nurse attendants who are under the department of outpatient. These people have no knowledge pertaining to accounts as they are mere nurse attendants and when they receive the money they just kept in the table draws which are not made for safe cash keeping. They can also handle the money to the hospital accountant on that particular day or on the next day and sometimes after three days. This was revealed by one interviewee who said that:

> *I am not happy with this system of cash management at this hospital. Everyone is doing whatever he/ she likes. We do not follow financial management regulations. Sometimes money collected through drug revolving fund can be used without been banked or handled over to the accountant and they are collected by anybody. There is no any proper handling procedure of money.*

The quotation above indicates that there is a problem in cash management which automatically mighty lead to misappropriation of financial resource and in turn affect the provision of quality services in MRH. This is because government money demands intact banking, and in order for money to be available for use they need to be banked and follow government financial procedures. Adopting good cash management practices in any organisation ensures objective fulfillment and legal adherence.

Table 4.2: Respondents' opinions on cash management control system practices and the quality of health services (n=20)

Respondents' Opinion			
		Percentage	
	Statements	Yes %	No %
1	Are there accounting and internal control manuals and do they set forth accounting procedures?	20	80
2	Does the Organization have a controller or chief accountant?	00	100
3	Does the Organization have an internal auditor or equivalent person?	00	100
4	Is the general accounting and bookkeeping department completely separate from the cash receipts and cash disbursement function?	00	100
5	Is there an accounting department separate from cashier?	40	60
6	Does the facility deposit each day's receipts without delay?	60	40
7	Are deposits deposited by someone other than the cashier or bookkeeper?	20	80
8	Does someone other than the cashier handle the petty cash fund? The repair fund? The payroll fund?	20	80
9	Does a third party verify this listing against the deposit slips before receipts are deposited?	00	100
10	Are cash receipts deposited intact each day?	00	100
11	Do procedures restrict the accounts receivable bookkeeper from having access to collections from patients/customers?	40	60
12	Does a non-cashier-type person independently check the numerical sequence and daily totals?	00	100
13	Does the accounting department independently compare those reports with the related cash and bookkeeping entries?	00	100
14	Are the following items kept under the strict control of a few designated employee; medicines? Bandages? Topical ointment? Disposable and reusable medical instruments, such as syringes and needles? Etc	40	60
15	Are receiving reports or notifications made upon the arrival of new medicines or other inventory items?	60	40
16	Are adequate inventory levels maintained?	60	40
17	Do all inventory records show quantities, unit costs and aggregate values?	60	40
18	Have there been any reports of inventory theft?	100	00
19	Does a responsible official approve payment of purchasing order?	60	40
	Average	**30.5**	**69.5**

The results in Table 4.2 shows that, on average, few respondents (30.53%) were in agreement with the statements listed for the cash management control system practices for the enhancement of quality health services in that hospital. This suggests that respondents (management, accounts department employees and financial experts) were aware of the weakness resulting to poor services but to some extent not being familiar with the complaints from patients and others who seek health services in that hospital, something which makes them dissatisfied with what is provided.

On the other hand, on average the majority of respondents (69.5%) were not in favour of cash management control system practices for the enhancement of the quality of health services in that hospital as it can be attested from Table 4.2 above. This unfavourable state can be justified by for example; of not having a controller or chief accountant, internal auditor or equivalent person, accounting and book keeping department completely separate from cash receipts and cash disbursement, the third party to verify listing against the deposit slips before receipts are deposited, receipts deposited intact each day and a non- cashier type person independently checking the numerical sequence and daily totals respectively with 100% denial. However, this might be due to the absence of adequate and competent staff on accounting and supplies/purchases departments.

The findings in this part show that, the absence of a controller or a chief accountant, internal auditor, separation of accounting and bookkeeping department, a third party to verify listing against the deposit slips before receipts and deposited and the others render the hospital's fund to be mismanaged, misallocated and make the flow of funds to be not in line with the expected plans because activities are concentrated in one hand therefore fraud, abuse and corrupt practices are likely to occur at every stage of the process as a result of poorly managed expenditure systems, lack of effective auditing and supervision, organisational deficiencies and lax fiscal controls over the flow of public funds; hence resulting to fund malpractices and low quality of health service.

4.4 Finance related factors affecting quality of health services at Morogoro Regional Hospital

The third objective of this study was to identify finance related factors affecting quality of health service at MRH. The researcher developed four main factors which were divided into different statements to capture the opinion of people towards the factors which affect quality of health services delivery at the hospital. The main factors which developed were employees' capacity (staffing), technology, communication channel (interpersonal relations) and financial resources.

One of the factors which measure quality of services in the hospital reported by respondents was the availability of skilled, experienced and qualified staff. Successful recruitment and retention of staff were fixed to empowerment of staff that must be treated as full partners in the hospital operation and given opportunities for advancement (Brown and Duguid, 2003). However, the finding in this study indicated that in MRH there was less staff compared to the hospital requirement. For example in the year 2011 the total number of required staff was 902 but only 409 were available, that means there was a shortage of 493 staff. Moreover, most of these staffs were auxiliary staffs and nurses who were also not qualified to be called full nurses. This has an impact on quality of service delivery to the people in Morogoro Region. The summary of findings is given in Table 4.3

Table 4.3 Respondents' opinions regarding factors affecting quality of services in MRH (n=43)

Respondents' opinion			
		Percentage	
Statements		Agree %	Disagree %
1	Does incompetent staff affect quality of services?	100	00
2	Does employee's capacity influence service quality?	82.1	17.9
3	Does number of staff affect service quality?	100	00
4	Does level of technology affect quality service?	68.1	31.9
5	Does adoption of new technology improve service quality?	85.7	14.3
6	Does the Morogoro regional hospital have effective communication channel?	00	100
7	Do communication channel used lead to patients satisfaction?	00	100
8	Do medical tests and nature of treatment clearly explained?	60	40
9	Do communication channels influence provision of quality services?	75	25
10	Does poor communication channels affects delivery of health services?	80	20
11	Does the hospital operate with fixed annual budget?	100	00
12	Does the hospital have adequate financial resources?	00	100
13	Does inadequate finance affect reliability in delivery of medical services?	65	35
14	Does poor management in financial resources influence provision of quality services?	68	32
15	Does the hospital offer good quality of health services?	35	65

The result in the Table 4.3 above showed that, the majority opinion on the three statements measuring employees capacity indicated on average that (82.1%) agreed with the statements that employee capacity affect the quality of service delivery in MRH. This supported the findings by Argote (2000) that highly skilled physicians, nurses, administrators and ancillary staffs are critical to producing high-quality outcomes and effective quality improvement hence hospital growth.

Another factor which measured quality of services in the hospital was the applicability of technology in the hospital. While the world is moving faster in

advancement of science and technology, some institutions are lagging behind in using modern technology. It was observed that in MRH staffs use old technology for example in diagnosis and even in doing major operations. It was also noticed that most of the staff do not use computers and for those few employees who use computers, they were not well equipped in utilizing them. This caused delay in service provision to customers' hence poor quality of services. The opinion gathered from respondents on the level o technology used and adoption of new technology indicated on average (68.1%) was on agreement on these statements. This is also supported by Allen, (2001) who states that, technology for harnessing of Information and data play a critical role in the quality service delivery in hospitals. Investments in technology that facilitate service assessment and improvement process is essential (Dutton and Starbuck, 2002).

The third factor that measured quality services was effective communication channel. Communication is very much essential in exchanging information from one department to another, between and among persons and between customers and service providers. Communication is the most important aspect of the Service delivery as communication with patients is vital to delivering service satisfaction because when hospital staff takes the time to answer questions of concern to patients, it can alleviate many feelings of uncertainty (EFP, 2006). It was observed that in MRH communication between the customer(patient) and the service providers (nurses, doctors, and supporting staff) was not smooth as most of the service providers do not use good language in communicating with the patients especially those working in wards. Also it was noted that communication among heads of department was not good. The opinions gathered from the respondents (80%) also suggested that communication channel had an adverse effect on quality services. Research done by Payne (2006) indicated that communication challenges have a negative impact on: access to treatment, participation in preventive measures, ability to obtain consent, ability for health professionals to meet their ethical obligations, quality of care, including, hospital admissions, diagnostic testing, medical errors, patient follow-up, quality of mental health care and patient safety.

The last factor that affects the quality of service is financial resources. This in most cases has been the key factor in affecting performance of any organization, and sometimes was regarded as a lifeblood of any organization as without financial resources the existence of any organization is endangered and according to Abuja agreement any country that is a signatory of that agreement has to raise the health sector budget by 15%; Tanzania been a signatory has not attained that target.

Furthermore, the findings from this study indicated that in MRH financial resource is a problem as the hospital does not get their full budget planned, and at the same time the hospital does not get the funds timely. Apart from that it was also indicated that the Hospital cash management was poor. The opinion gathered from the respondents (54%) on average agreed with the statements that there was inadequate fund, unreliable and poor cash management at MRH as the result, the quality of health services offered by the MRH was also poor as respondents opinion on the quality of services majority (65%) did not favor the statement that the MRH offer good quality of health services .One respondent had to say;

> *Public hospitals in Tanzania are in dire need of funding to rehabilitate, redesign, equip and staff them to ensure effective and efficient service delivery to Tanzanians. Low funding for public hospitals in the country has adversely affected the delivery of health services. Most of the public hospitals in Tanzania especially rural areas are in a sad state that has incapacitated them from offering efficient services to patients and to alleviate the deplorable condition proper measures must be taken into consideration.*

This quotation implies that public hospitals in Tanzania, MRH being inclusive have fund problem a situation that needs improvement. Generally this study indicated that, fixed budgets in public hospitals limit flexibility and budgetary autonomy on service processes as a result led to inequities and fails to respond to new demands and priorities while centralized budget systems contributed to technical inefficiency by preventing health staff from optimizing the

deployment of inputs perpetuating poor quality of service in hospital. Insufficient funds lead to purchasing of low quality drugs and medical equipment, low staff payment demotivating them in carrying out their duties as expected as they lack performance based incentives thus affecting provision of high service quality.

4.5 Cash management discrepancies affecting the quality of health service provision

The study examined the cash management discrepancies affecting the quality of health service provision when patients and other stakeholders' accessing services in the hospital in various issues as indicated in Table 4.4

Table 4.4 Discrepancies accounting to the quality of service delivery (n=15)

Discrepancy	Agree	Disagree
Unavailability of accounting and internal control manual	90	10
Absence of a controller or chief accountant	100	00
Absence of internal auditor or equivalent person	100	00
The presence of reports regarding inventory and cash theft	85	15
Un availability of petty cash	100	00
Unavailability of competent and adequate staff	80	20
Poor record keeping	85	15
Non observance of financial rules and memorandum	65	35
Under reporting	73	27

The results on Table 4.4 show that, there are discrepancies affecting the quality of health service provision. These discrepancies are associated with absence of a controller or chief accountant, internal auditor or equivalent person and petty cash as reported by all respondents (100%). However, other discrepancies included the absence of accounting and internal control manual (90%), the presence of reports regarding inventory theft, one personnel doing more than one work which he/she is not specialized in (85%) and inadequate staff (80%), poor record keeping (85%),

under reporting (75%) and non-observance of financial rules and memorandum (65%) as reported by of respondents.

The findings suggest that Morogoro regional hospital requires both financial accountability and technical capacity to effectively exercise oversight and control functions, track and report on allocation, disbursement and use of financial recourses using monitoring, auditing and accounting mechanisms defined by the legal and institutional framework which is a prerequisite to ensure that insufficient allocated funds are used for the intended purposes efficiently. This is because fraud, abuse and corrupt practices are likely to occur at every stage of the process as a result of poorly managed expenditure systems and lack of effective auditing and supervision as reported by respondents

One respondent observed that;

> *At our hospital many funds are been stolen, particularly funds collected from Community contribution before they rich accounts department because of poor Internal control system and lack of competent and qualified staffs, funds are collected by supporting staffs who are unqualified, money can be used before been banked and this is because the hospital does not have petty cash, then how can it meet its Emergency requirement without using community contribution funds unethically.*

This part reveal that cash management practices in this hospital should be enhanced as to cater for a bigger group of people while recruiting adequate staff. It is upon the concerned to solve the problems resulting from poor cash management in order to let each citizen enjoy life through the provision of quality health service. All mismanagement, misallocation and misuse of funds should be dealt with without failure for that regard while providing adequate support of funds as required.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter provides the summary, conclusion and recommendations, policy implications, limitations of the study and areas for further research which result from the findings. It starts with the summary proceeded by the conclusion and recommendations, policy implications, limitations of the study and finally areas for further research are highlighted.

5.2 The Summary

Health is a serious developmental issue. Health care provision in developing countries like Tanzania is usually provided in collaboration with national authorities, International aid agencies and NGOs. In order for donors to have direct control over the funds, support has traditionally been organised as stand-alone vertical programmes to address specific health system. But these separate programmes have led to duplication of funding, wastage of resources and lack of coordination in terms of controlling specific diseases. Though medical services are generally available in urban and rural areas of Tanzania, facilities and supplies remain insufficient to serve a population that suffers from a high risk of diseases such as; malaria, childhood illness, obstetric emergencies, tuberculosis, and HIV/AIDS (Gilson, 1994).

In order to have equitable healthcare provision, a good cash management control and resources are needed which should start and this is nothing than internal cash management control system. The findings from the study showed that the revenue generated by cost sharing has not necessarily impacted positively on quality of health care (69.5%). Unofficial charges are still in place, exemption and waivers have not been effectively implemented and putting the hospital to score poor quality of health service delivery according to the criteria put (below 70% poor).

The quality of healthcare provision at Morogoro regional hospital has not necessarily improved even with the additional funds generated from user fees. Cash misappropriation and malpractice are sometime complained by members of the community to be the sources of poor quality of services as some people are able to pay for the services but they cannot access it. People are willing and able to pay for quality health services after realizing the importance of cost sharing.

5.3 Conclusion

Based on the empirical findings from the study, the study concludes that, the key to successful cash management lies in tabulating realistic projections, monitoring collections and disbursements, establishing effective billing and collection measures, and adhering to budgetary parameters because cash flow can be a problem to the running of an organization. Moreover, the availability of five sources of funds has not enhanced the provision of high quality health services, as there have been inadequate budget from the government and other stakeholders. However, funds from own source (rent receivable) seemed to contribute less something that does not reveal the reality of their operations. Furthermore, the absence of a controller or a chief accountant, internal auditor, separation of accounting and bookkeeping department, a third party to verify listing against the deposit slips before receipts and deposited and the others render the hospital's fund to be mismanaged, misallocated and make the flow of funds to be not in line with the expected plans; resulting to fund malpractices and poor quality of health services. Finally, fraud, abuse and corrupt practices are likely to occur at every stage of the process as a result of poorly managed expenditure systems and lack of effective auditing and supervision as envisaged by respondents of the study.

5.4 Recommendations

In light of the above findings, the researcher has proposed the following recommendations;

(i) Cash collections should be closely monitored with the aim of accelerating cash inflows to speed up the collecting of accounts receivables.

(ii) Administrators and managers should calculate the cash amount best suited for the level of activity, plan timing of relevant payments and collections and draw up a policy of investments in assets that can be converted in to cash to allow transaction costs and serve as support for emergent funds maintained from various sources such as canteen and kiosks by the organisation.

(iii) Instilling a cash conscious culture is integral to maintaining a steady focus on cash. The organisation should employ a cash focus at the top communicating it throughout the organisation for implementation.

(iv) There should be a timely disbursement of the planned funds for enhancement of high quality of health services.

(v) It was found that, the hospital has no petty cash, something which makes the delay of day to day running of activities, and use of funds before banking which is contrary to the law. The availability of petty cash is vital.

(vi) Staff should be motivated and their working environment improved.

5.5 Policy Implications

The research adds to the argument for a(bottom-up approach) participatory approach for cash management control system practices for the enhancement of health services which enables intervention in management and development activities regarding health service providers. Furthermore, the government should formulate strict policy and enhance training on cash management in health services institutions.

5.6 Limitations of the study

The limitations of the study were as follows;

a) Financial Constraints

The financial support expected from researcher's pocket money was limited. For that case, the researcher was limited to gather or collect the whole data from all employees of the respective hospital, hence taking only a small sample

b) Time factors

The time allocated for data collection was very short compared to the importance and tedious work of collecting data which was sensitive to employees, patients and other stakeholders. However, with the respondents' corporation the study was completed.

c) Accessibility of data

Survey studies were subject to both lacks of control limitations and Potential bias associated with self-reporting

d) Response rate

It was expected that the response rate would be low due to respondents being in a hurry, very busy with their daily activities and others were not present always at their working place sometimes. However, continuous follow-ups made the study fulfilled.

5.7 Suggested Areas for Further Research

The issue of cash management and its effects on the quality of health services in hospitals is intricate and tends to prevail in other hospitals not only in the area that was covered in this study. Therefore, undertaking further studies in relation to this

problem is of paramount importance. Thus, the researcher recommends further studies to be carried out on the following topics:

1. Effectiveness of internal control system in hospitals of Tanzania.

2. Hospital employees' capacity in health services delivery in Tanzania

3. Impact of technology on cash management in hospitals of Tanzania.

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APPENDICES

Appendix I: Duration and Schedule of Activities

No	Activity	Duration										
		Year 2011					Year 2012					
		A	S	O	N	D	J	F	M	A	M	J
1	Preparation of Research Proposal, Questionnaire and Submission of Research Proposal	———										
2	Pilot study and Questionnaire testing		———									
3	Field work and Data collection			———								
4	Data Processing and Analysis						———					
5	Dissertation writing and Submission									———		

Appendix II: Budget for the Study

Budget Items	Details	Cost (Tsh)
Research proposal preparation	-Stationary (pens, reams, pencils, drafting papers, note books, flash disks and CDs) -Questionnaire preparation	140,000/= 150,000/=
	Sub-Total	**290,000/=**
Pilot study	-Transport -Training 3 research assistants @ 15,000/= per diem per person for three days	50,000/= 135,000/=
	Sub-Total	**185,000/=**
Primary Data collection	-Transport to and from study area (4 people @ 5,000/= * 30 days -Subsistence allowance for principal research @ 25,000/= * 30 days -Subsistence allowance for research assistant @ 15,000/= * 30 days	600,000/= 750,000/= 1,800,000/=
	Sub-Total	**3,150,000/=**
Data processing and report writing	-Data entry, cleaning and editing -Correction of dissertation -Printing and photocopy -Soft binding 4 copies @ 12,000/= -Hard binding 5 copies @ 50,000/=	140,000/= 80,000/= 70,000/= 48,000/= 250,000/=
	Sub-Total	**588,000/=**
	TOTAL	**4,213,000/=**

Appendix III: Questionnaire for the Management of Morogoro Regional Hospital

Topic: Effectiveness of Cash Management and the Quality of Health Services: A Case Study of Morogoro Regional Hospital

Dear Respondent,

My name is JOHN K.E JOSEPH. **I** am conducting a Survey on the **Effectiveness of Cash Management and the Quality of Health Services: A Case Study of Morogoro Regional Hospital.** In the following questionnaire, I would like to know your opinions about the topic through your participation in an interview aiming at answering the questions which follow. This Survey is a part of my Master's Dissertation and your kind co-operation is essential for my successful completion of this Research Project.

Your responses will be anonymous and the data collected will be collectively analysed as a whole and treated as confidential for academic purposes only.

My mobile phone numbers are; *+255 652 267267.* My supervisor's name is Mrs Moshi, James with her mobile phone number +255 712 581445.

Your participation in this study will be greatly appreciated.

Name of Respondent: …….....…….....……..
Occupation/Title: …….....……
Date: …….....…….

PART A. Sources of funds for Morogoro Regional Hospital.*(Tick/fill where necessary)*

1. Is your Hospital having various sources of funds to run it? A) Yes ( ) B) No ( )

2. If Yes in 1 above, what are these sources of funds? Specify

i)……ii)……
……..

iii)……iv)……
…….

v)……vi)……
……

3. Are these sources of fund reliable and able to fulfill your targeted goals? A) Yes ( ) B) No ( )

4. If No in 3 above, what do you do to fulfill your targeted goal? Specify

i)…….ii)……
…….

iii)……..iv)……
…….

5. If Yes in 3 above, how do your customers/patients rate you regarding the quality of services you provide?

A) Very good ( ) B) Good ( ) C) Poor ( ) D) Very poor ( )

6. Do your hospital implement cost sharing policy? A) Yes ( ) B) No ( )

7. Are customers/patients able to pay for the services provided? A) Yes ( ) B) No ( )

8. If Yes in 7 above, how do they rate your services? A) Very good ( ) B) Good ( ) C) Poor ( ) D) Very poor ( )

9. If No in 7 above, how do they rate your services? A) Very good ( ) B) Good ( ) C) Poor ( ) D) Very poor ( )

10. Are there exemptions such as maternal and child health services, particular age group (children under 5 and aged people over 60 years), particular diseases (tuberculosis and AIDS) services in your hospital? A) Yes ( ) B) No ( )

11. If Yes in 10 above, how do they rate your services? A) Very good ( ) B) Good ( ) C) Poor ( ) D) Very poor ( )

12. Do you have medical and equipment inventories and supplies? A) Yes ( ) B) No ( )

13. Do the supply of medicine and equipments in your hospital fulfill your targeted goals? A) Yes ( ) B) No ( )

14. What weakness do you have regarding the quality of health services delivery in your hospital? Specify

i)……ii)……

iii)…….iv)……

15. What do you think to be done in order to enhance the quality of health services in your hospital?

i)……ii)……

iii)……..iv)……

PART B. Identification *(Please tick where appropriate)*

16. Gender of the Respondent.

Male ( ) Female ( )

17. In which Age category do you belong?

1) 18-28 ( ) 2) 29-39 ( ) 3) 40-50 ( ) 4) 51 and above ( )

18. How many people do you live with?

1) 1-3 ( ) 2) 4-6 ( ) 3) 7-9 ( ) 4) above 9 ( )

19. What is your highest level of education?

1) No formal education ( ) 2) Primary education ( )

3) Secondary education ( ) 3) Higher education ( )

20. What is your marital status?.

1) Married ( ) 2) Single ( ) 3) Widowed ( ) 4) Divorced ( )

PART C. Major Sources of income *(fill or tick where appropriate)*

21**.** What are your major sources of income? (Mention)

1)……..2)……..3)……..

22. What is your estimated income per month?

1) 300,000-400,000/= ( ) 2) 400,000- 500,000/= ( ) 3) above 500,000/= ( )

Appendix IV: Questionnaire for the Accountants/Materials Purchases and Supplies Personnel Of Morogoro Regional Hospital

Topic: Effectiveness of Cash Management and the Quality of Health Services: A Case Study of Morogoro Regional Hospital

Dear Respondent,

My name is JOHN K.E JOSEPH. **I** am conducting a Survey on the **Effectiveness of Cash Management and the Quality of Health Services: A Case Study of Morogoro Regional Hospital.** In the following questionnaire, I would like to know your opinions about the topic through your participation in an interview aiming at answering the questions which follow. This Survey is a part of my Master's Dissertation and your kind co-operation is essential for my successful completion of this Research Project.

Your responses will be anonymous and the data collected will be collectively analysed as a whole and treated as confidential for academic purposes only.

My mobile phone numbers are; *+255 652 267267.* My supervisor's name is Mrs Moshi, James with her mobile phone number +255 712 581445.

Your participation in this study will be greatly appreciated.

Name of Respondent …….....……..

Occupation/Title…….....……

Date….....…….

PART A: General internal cash management (Tick where necessary)

Question	Yes	No
1. Does the hospital have an organisational chart?		
2. Does the organisation have a chart of accounts or an organised financial accounting system?		
3. Are there accounting and internal control manuals and do they set forth accounting procedures?		
4. Does the organisation have a controller or chief accountant?		
5. Does the organisation have an internal auditor or equivalent person?		
6. If there is an internal auditor, is he/she independent from the internal control processes?		
7. If there is an internal auditor, are there internal audit reports available? Have they been reviewed recently?		
8. Is the general accounting and bookkeeping department completely separate from the cash receipts and cash disbursement function?		
9. Is the general accounting and bookkeeping department separate from sales, purchasing and operational departments?		
10. Are regular vacations required for those who control the operational and financial cash, bookkeeping, asset and/or record-keeping functions? (vacations often cause others to notice discrepancies)		
11. Are expenses and costs under budgeted control? In other words, is there a budget plan with which others can compare performance?		
12. Are key and material bookkeeping entries approved by senior management personnel?		
13. Are periodic financial statements prepared and submitted to management?		
14. If periodic financial statements are prepared, are they designed to alert management to significant fluctuations in costs, revenues, assets and the like?		

PART B: Internal control for cash (Tick where necessary)

Question	Yes	No
a) General 1. Is there an accounting department separate from cashier?		
2. Does the hospital use a ledger system of accounting?		
3. Is the accounting system maintained by a trained bookkeeping and/or accountant?		
4. Is there a safe location for cash deposits such as a bank or safe?		
5. Does the facility deposit each day's receipts without delay?		
6. Where is the deposit made? (bank, safe, e.t.c)		
7. Are deposits deposited by someone other than the cashier or bookkeeper?		
8. Does a responsible employee other than the cashier investigate any debits from the deposit location?		
9. Are the cashier's duties segregated from the recording of cash receipts or accounts receivable?		
10. Does an employee other than someone in the cashier's department make entries in the ledger?		
11. Do the procedures prohibit from gaining access to the accounts receivable ledgers and monthly bank/safe/ and /or customer statements?		
12. Does someone other than the cashier handle the petty cash fund? The repair fund? The payroll fund?		
13. Is there a withdrawal cosignature authority process?		
14. Do strong control exist that highlight when cash should have been received but was not?		
15. Does the cashier assume full responsibility for the receipts from the time they are received until the time they are handled over for deposit?		
16. Is the cash adequately safeguarded (physically) within the facility?		
17. Does proper segregation exist between those employees who have access to patient funds (cash) and those employees who have access to non-patient funds (such as payroll accounts)?		
b) Cash receipts 18. Is an independent listing of cash receipts prepared before the receipts are submitted to the cashier or bookkeeping?		
19. Does a third party verify this listing against the deposit slips before receipts are deposited?		
20. Are cash receipts deposited intact each day?		
21. Do procedures restrict the accounts receivable bookkeeper from i) Preparing the bank deposit?		

ii) Obtaining access to the cash receipts book?		
iii) Having access to collections from patients/customers?		
22. When cash sales occur, do all receipts have prenumbered identification?		
23. Are all receipts accounted for daily and matched with the cash collections?		
24. Are the authenticated duplicates of the deposit slips retained and reconciled to the corresponding amounts in the cash receipts records?		
25. Does someone prepare a daily report of cash balances?		
26. Is the bank deposit made by someone other than the cashier or bookkeeper?		
27. Do proper controls exist pertaining to unsatisfactory payments by patients?		
c) Methods 28. Are receipts recorded by cash register or other mechanical?		
29. If so, are the machine totals independently verified by others outside of the area?		
30. Does the facility use sales or cash receipt books?		
31. If so, are they prenumbered?		
32. Does a non-cashier-type person independently check the numerical sequence and daily totals?		
33. Are the receipts matched with the cash collections?		
34. Are the unused receipt books properly safeguarded?		
35. If none of the above is used, is some equivalent system used?		
36. Do adequate controls exist preventing misappropriations of cash by the cashier, such as fictitious discounts, waivers, allowances, etc?		
37. Do the receipts of miscellaneous receipts of cash such as those from the sale of equipment report them to the accounting department and the cashier?		
38. Does the accounting department independently compare those reports with the related cash and bookkeeping entries?		

PART C: Internal control for Medical Inventories and Supplies (Tick where necessary)

Question	**Yes**	**No**
1. Are the following items kept under the strict control of a few designated employee; medicines? Bandages? Topical ointment? Disposable and reusable medical instruments, such as syringes and needles? Etc		
2. If practical, are inventories recorded monthly in bookkeeping or other accounting records?		
3. Are receiving reports or notifications made upon the arrival of new medicines or other inventory items?		
4. Are receipts for issuance made for withdrawal of inventories?		
5. Are withdrawals allowed only under a specific system of designated		

authorizations?		
6. Are adequate inventory levels maintained?		
7. Are physical inventories taken at least yearly (or periodically during the year)?		
8. Is the inventory supervised by an independent manager or equivalent?		
9. Is an overall review periodically made of slow moving or obsolete inventory?		
10. Are adequate accounting controls kept on items kept in patient areas (near nursing areas)?		
11.If periodic inventories are maintained, are they annually reconciled to actual amounts by means of a complete physical inventory?		
12. Do all inventory records show quantities, unit costs and aggregate values?		
13. Are inventory records maintained by and accessible to individuals other than those who have access to the inventory?		
14. Have there been any reports of inventory theft?		
15. Are inventories maintained in centralised storage areas?		

PART D: Internal control for purchases and expenses (Tick where necessary)

Question	**Yes**	**No**
1. Does the hospital or clinic have a purchasing department?		
2. If so, is it independent of the accounting department?		
3. Is it independent of the receiving department?		
4. Is it independent of the shipping department?		
5. Are purchases made only after the appropriate authorisation signatures are acquired according to internal policy?		
6. Are all significant purchases channelled through the purchasing department?		
7. Are purchase orders authorisations required of all significant purchases?		
8. Do certain items get purchased through competitive bidding?		
9. If so, is the review of bids independent and objective?		
10. Are purchase prices thoroughly reviewed and checked by a knowledgeable employee?		
11. At the time of receipts, are purchased quantities checked against actual receipt quantities?		
12. Is the receiving department denied access to the purchasing records?		
13. Does the receiving department fill out receipt of goods documentation?		
14. Are copies of the receiving reports sent to the accounting or bookkeeping department? If not, how are accounting records updated??		
15. Are copies of the receiving reports sent to the purchasing department? If not, how are purchasing orders reconciled to actual goods received?		

16. When goods are returned to vendors, are credits obtained?		
17. Are there only a few, nonmaterial unmatched purchase orders within the receiving reports?		
18. Do safeguards exist for the proper accounting against orders of partial shipments received?		
19. Does a responsible official approve payment of purchasing order?		
20. If purchases are paid directly out of cash, are the systems for purchase authorisation, inventory receipt, quantity verification and cash disbursement authorisation intact, independent of each other and capable of being tracked?		
21. Does the accounting system support sufficient account classification detail to test and validate where expenses were booked versus what was paid out?		
22. For items that are not "tangible" such as electricity and heating utilities, is there any reconciliation of amounts paid with amounts consumed?		

PART E: Identification *(Please tick where appropriate)*

16. Gender of the Respondent.

Male ( ) Female ( )

17. In which Age category do you belong?

1) 18-28 ( ) 2) 29-39 ( ) 3) 40-50 ( ) 4) 51 and above ( )

18. How many people do you live with?

1) 1-3 ( ) 2) 4-6 ( ) 3) 7-9 ( ) 4) above 9 ( )

19. What is your highest level of education?

1) No formal education ( ) 2) Primary education ( )

3) Secondary education ( ) 3) Higher education ( )

20. What is your marital status?.

1) Married ( ) 2) Single ( ) 3) Widowed ( ) 4) Divorced ( )

PART F: Major Sources of income *(fill or tick where appropriate)*

21**.** What are your major sources of income? (Mention)

1)……..2)……..3)……..

22. What is your estimated income per month?

1) 300,000-400,000/= ( ) 2) 400,000- 500,000/= ( ) 3) above 500,000/= ( )

Appendix V: Dodoso/maswali kwa ajili ya wagonjwa na enye ujuzi katika maswala ya utabibu

Mada: Ufanisi katika usimamizi wa fedha kwa ajili ya utoaji wa huduma bora za afya: Utafiti katika Hospitali ya Mkoa wa Morogoro

Jina la Msailiwa …….....…….....……

Kazi yako/Cheo…….....……

SEHEMU A: Maoni ya wagonjwa/wadau wengine katika utoaji wa huduma bora (Weka tiki panapohusika)

Swali	**Ndiyo**	**Hapana**
a) Ushauri katika utoaji wa huduma 1. Je huwa unatumia muda mrefu katika kupata huduma unayoitarajia?		
2. Kama ndiyo, unaona kuna uzembe kwa watoa huduma?		
3. Kama hapana, hii hutokana na wahusika kuwajibika ipasavyo?		
4. Je, taratibu za kupata vipimo na huduma zinaridhisha?		
5. Je matibabu yanafanywa kwa ufasaha kulingana na maadili ya taaluma zao?		
6. Je huendapo hospitalini hapo, huwa unapata maelekezo tosherezi kuhusu matibabu?		
7. Je wauguzi/waganga huwa wanatoa nafasi ya kuuliza maswai kwa mgonjwa?		
8. Je wauguzi/waganga huwa wanatoa rufaa kama inahitajika bila hongo?		
b) Mahusiano baina ya wagonjwa na wauguzi/waganga 9. Je huwa unapata mapokezi mazuri unapofika hosptalini hapo?		
10.Je wauguzi/waganga huwa wanakuwa rafiki na wapole wanapokuhudumia?		
11. Je wauguzi/waganga huwa wanaonesha heshima na kuwahudumia wagonjwa kwa utu?		
12. Je wauguzi/waganga huwa wanatenda haki bila ubaguzi (mf.wakwanza kufika ndiye anayehudumiwa)?		
13. Je wauguzi/waganga huwa wanawasiliana na mgonjwa kwa lugha inayoeleweka na ya kiuungwana?		
14. Je wauguzi/waganga huwa wanaonesha uthabiti katika kuwahudumia wagonjwa?		
15. Je wauguzi/waganga huwa wanatunza siri za wagonjwa?		
c) Utaarifu wa kutoa huduma 16. Je wauguzi/waganga huwa wako tayari kuhudumia wagonjwa wakati wowote		

(mchana/usiku) hata kama mhusika hayuko zamu?		
17. Je wauguzi/waganga huwepo mara zote na huwahi kuhudumia wagonjwa?		
18. Je wagonjwa husubiri muda mfupi ili wahudumiwe?		
d) Gharama za huduma 19. Je huduma za matibabu kwa wagonjwa wanazimudu?		
20. Je kama hawazimudu, huwa wanakataliwa kuhudumiwa?		
21. Je wagonjwa hutozwa hudma za kununulia madawa, lakini huduma za vipimo na ushauri hawalipii?		
22. Je wagonjwa hupata huduma kwa haki kama kitanda, jalada n.k?		
e) Miundombinu 23. Je unadhani miundombinu ya hopitali inachangia utoaji mbovu wa huduma?		
24. Je usafi wa mazingira katika hospitali hii unaridhisha katika utoaji bora wa huduma?		
25. Je miundombinu ya hospitali hii inatoa faragha kwa wagonjwa?		
f) Uwepo wa madawa 26. Je madawa yanatosheleza kwa ajili ya matumizi ya wagonjwa?		
27. Je wagonjwa wanamudu gharama zake?		
28. Je wauguzi/waganga hutoa ushauri wa dawa wanazowapa wagonjwa?		
29. Je unafikiri wauguzi/waganaga waliopo wanataaluma toshelezi katika kutoa huduma kwa wagonjwa?		

SEHEMU B. Uainisho *(Tafadhari tiki panapohusika)*

30. Jinsia ya Msailiwa.

Me ( ) Ke ( )

31. Umri wako uko katika kundi lipi?

1) 18-28 ( ) 2) 29-39 ( ) 3) 40-50 ( ) 4) 51 au zaidi ( )

32. Unaishi na watu wangapi?

1) 1-3 ( ) 2) 4-6 ( ) 3) 7-9 ( ) 4) zaidi ya 9 ( )

33. Kiwango chako cha elimu ni kipi?

1) Sikusoma kabisa ( ) 2) Elimu ya Msingi ( )

3) Elimu ya Sekondari ( ) 3) Elimu ya juu ( )

34. Hali ya ndoa.

1) Nimeoa/nimeolewa ( ) 2) Kapera/sijaolewa ( ) 3) Mjane/Mseja ( ) 4) Ndoa imevunjika (

SEHEMU C. Njia ya kujiingizia kipato binafsi *(Jaza au weka alama ya vema panapofaa)*

35**.** Taja njia unazotumia kujitafutia kipato binafsi? (Taja)

1)……..2)……..…..3)…….

36.Yapi ni makadirio yako ya mapato kwa mwezi?

1) Chini ya 100,000/=( ) 2) 100,000-200,000/= ( ) 3) 200,000-400,000/= 4) Zaidi ya 4