RHAP
Rural Health Advocacy Project

PROCUREMENT AND AUDIT OUTCOMES

IN THE SOUTH AFRICAN HEALTH SECTOR

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ACRONYMS AND ABBREVIATIONS

AA	Accounting Authority
AG	Auditor-General
AO	Accounting Officer
AO/AA	Accounting Officer/Accounting Authority
BAC	Bid Adjudication Committee
BBBEE	Broad-based black economic empowerment
BBBEEA	Broad-Based Black Economic Empowerment Act 53 of 2003
BEC	Bid Evaluation Committee
BSC	Bid Specification Committee
CSD	Central Supplier Database
EME	exempted micro enterprise
GG	Government Gazette
GN	General Notice
MEC	Member of the Executive Council
MFMA	Local Government: Municipal Finance Management Act 56 of 2003
MSCM	Municipal Supply Chain Management
NDoH	National Department of Health
NHA	National Health Act 61 of 2003
NHC	National Health Council
NHI	national health insurance
NT	National Treasury
OCPO	Office of the Chief Procurement Officer
OHPP	Office of Health Products Procurement
PAA	Public Audit Act 25 of 2004
PFMA	Public Finance Management Act 1 of 1999
PPPFA	Preferential Procurement Policy Framework Act 5 of 2000
QSE	qualifying small business enterprise
SCM	Supply Chain Management

1 INTRODUCTION

The Rural Health Advocacy Project, based in Johannesburg and focusing on equitable access to quality health care for rural communities in the whole of South Africa, commissioned this research report on public procurement and audit outcomes for South Africa's public health sector.

The overall purpose of the report is to provide an overview of the regulatory and institutional arrangements pertaining to the procurement of health services in South Africa with a particular focus on rural health and to make recommendations on potential reforms.

OBJECTIVES

The objectives of the research were as follows:

1. Provide an overview of the institutional arrangements for the healthcare sector, including mandates at national, provincial and local government level.
2. Summarize the legislation that governs the health sector and how funding flows work in relation to public sector health care provision.
3. Describe the legal and regulatory framework that governs procurement in South Africa.
4. Describe pending legislative and regulatory changes in the healthcare sector that have procurement or healthcare financing implications.
5. Provide an outline of how the procurement process works and describes bad practices and the typical ways in which corruption occurs.
6. Describe the categories of audit opinions and types of emphases of matters and provide an overview of audit opinions for the health sector per Auditor-General consolidated reports, listing common concerns related to financial health of health sector departments/institutions and financial management practices that led to the findings.
7. List how bad financial management, procurement and contract management practices in the health sector are specifically affecting rural communities.
8. Recommend actions or procurement reforms that government, civil society and other actors can take to address the common concerns that lead to audit findings in the health sector.

METHODOLOGY

The research methodology involved a document analysis methodology which included doctrinal analysis of existing South African law, content analysis of relevant policy documents and reports, literature study pertaining to public healthcare, public procurement regulation and oversight structures in particular and comparative review of relevant aspects of targeted foreign systems.

The identification of the targeted foreign systems included in the comparative study was done on the basis of existing research conducted, the literature study as well as broad overview of available foreign materials and recently concluded comparative research studies.

This study did not involve any empirical research.

The law is stated as at 24 March 2020.

'... no one may be refused emergency medical treatment.'

2

INSTITUTIONAL ARRANGEMENTS FOR PUBLIC HEALTHCARE FUNDING IN SOUTH AFRICA

2.1 REGULATORY FRAMEWORKS FOR THE PROVISION OF HEALTHCARE SERVICES ACROSS DIFFERENT LEVELS OF GOVERNMENT

2.1.1 Constitutional provisions

The Constitution of the Republic of South Africa, 1996 ("the Constitution"), guarantees access to healthcare services as a fundamental right in the Bill of Rights, contained in chapter two of the Constitution. This guarantee is set out in two specific provisions of the Constitution, namely section 27 and section 28. Section 7 of the Constitution places a duty on the state to "respect, protect, promote and fulfil the rights in the Bill of Rights".

Section 27 (1) (a) guarantees "the right to have access to health care services, including reproductive health care". The right applies to everyone living in South Africa, i.e. it is not restricted to any particular category of people such as citizens.

Section 27 (2) places a specific obligation on the state to "take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation" of these rights. As the Constitutional Court held in the leading judgment of *Soobramoney v Minister of Health (KwaZulu-Natal) 1998 (1) SA 765 (CC)*, the Constitution only requires administrators to take reasonable decisions in realising these rights and the provisions do not constitute a minimum content of healthcare that must be provided (Liebenberg, 2010). This approach was confirmed by the Constitutional Court in *Minister of Health v Treatment Action Campaign (No 2) 2002 (5) SA 721 (CC)*, where the Court held that "it is impossible to give everyone access even to a 'core' service immediately. All that is possible, and all that can be expected of the state, is that it act reasonably to provide access to the socio-economic rights identified in sections 26 and 27 on a progressive basis".

Section 27 (3) states that "no one may be refused emergency medical treatment". Also in the Soobramoney judgment, the Constitutional Court held that what this "section requires is that remedial treatment that is necessary and available be given immediately to avert" "a sudden catastrophe which calls for immediate medical attention".

Section 28 applies specifically to children, which the section defines as any person under the age of 18 years. Section 28 thus applies to all persons living in South Africa under the age of 18. Section 28 (1)(c) provides that every child has the right to "basic health care services". In contrast to section 27, section 28 is not subject to the qualifications on the state's duty to realise the guaranteed right in a progressive manner and within available resources. This suggests that the child's right to basic health care services is directly and immediately enforceable against the state. However, the Constitutional Court has interpreted section 28 along the same lines as section 27, requiring only reasonable action from the state as opposed to a directly enforceable

The actual provision of healthcare services is the joint responsibility of the National Department of Health, every provincial department of health and every municipality under the NHA.

substantive right to health care (Liebenberg, 2010).

The provision of healthcare is a function that is shared between all three levels of government in terms of the Constitution. Health services is listed in part A of schedule 4 of the Constitution, which means that it is a functional area of concurrent national and provincial legislative competence. This means that legislation pertaining to health services may be created at both national and provincial levels, and by implication, that health services may be implemented by both national and provincial governments. Furthermore, in terms of section 156 of the Constitution, national and provincial governments must assign administration of matters listed in part A of schedule 4 to municipalities where such administration will be done most effectively at local level and the municipality has the capacity to do so. Municipal health services is listed in part B of schedule 4 of the Constitution, which means that it is an area that a municipality has the right to administer (Constitution, section 156).

2.1.2 Legislative framework

The key statute setting out the provision of public healthcare in South Africa is the National Health Act 61 of 2003 (NHA). The NHA, in section 3, places the primary, overall responsibility for promoting public health on the Minister of Health.

The actual provision of healthcare services is the joint responsibility of the National Department of Health, every provincial department of health and every municipality under the NHA. The Act enjoins all health establishments and health care providers to provide equitable health services in the public sector (NHA, section 3).

The implementation of national health policy rests with the Director-General of the National Department of Health (NDoH), in terms of section 21 of the NHA. Part of this responsibility is to "co-ordinate health services rendered by the NDoH with the health services rendered by provinces and provide such additional health services as may be necessary to establish a comprehensive national health system" (NHA, section 21).

The NHA creates the National Health Council (NHC), which brings together representatives of all levels of government involved in the provision of public healthcare (NHA, section 22). The NHC must inter alia advise the Minister on national health policy, including "responsibilities for health by individuals and the public and private sector"; "equitable financial mechanisms for the funding of health services" and on "norms and standards for the establishment of health establishments" (NHA, section 23). The NHC must also establish policy and guidelines to facilitate "the adequate distribution of human resources" across the public health system (NHA, section 48).

At a provincial level, the relevant member of the Executive Council (MEC) must ensure the implementation of national health policy within the particular province (NHA, section 25). The head of a provincial department of health is inter alia obliged to "co-ordinate the funding and financial management of district health councils", "plan the development of public and private hospitals, other health establishments and health agencies", "control and manage the cost and financing of public health establishments and public health agencies", "facilitate and promote the provision of comprehensive primary health services and community hospital services", and "provide and maintain equipment, vehicles and health care facilities in the public sector" (NHA, section 25).

The obligation to provide public health establishments rests with the Minister of Health in respect of central hospitals, which are hospitals designated to provide health services to persons from more than one province, and with the relevant MEC in respect of all other public health establishments in the province (NHA, section 41).

Each province also has a Provincial Health Council, fulfilling a role similar to the NHC for purposes of the province (NHA, sections 26 & 27).

Below provincial level, the NHA provides for health districts, which coincide with metropolitan and district municipal boundaries (NHA, section 29). Health districts may also be divided into subdistricts (NHA, section 30). For each health district, a district health council is appointed (NHA, section 31). One of the functions of district health councils is to "ensure co-ordination of planning, budgeting, provisioning and monitoring of all health services that affect residents of the health district" (NHA, section 31). The NHA provides that the functioning of district health councils and the approval of "the detailed budget … for health services in the health district" by the relevant MEC and the relevant municipal council must be regulated by provincial legislation. The NHA furthermore provides that both the provincial government and the municipality must contribute to the budget (NHA, section 31).

Municipalities are, in terms of section 32 of the NHA, responsible for ensuring that "appropriate municipal health services are effectively and equitably provided in their respective areas" within the assignment of the provision of health services to that municipality by the MEC. This assignment must take the form of a service level agreement between the MEC and municipality and must inter alia provide for the "resources that the relevant member of the Executive Council must make available" and the "performance standards" against which the rendering of services will be monitored.

The obligation to provide public health establishments rests with the Minister of Health in respect of central hospitals, which are hospitals designated to provide health services to persons from more than one province, and with the relevant MEC in respect of all other public health establishments in the province (NHA, section 41).

2.2 SOURCES OF PUBLIC HEALTHCARE FUNDING AND THEIR ALLOCATION

The bulk of public funding for the provision of healthcare derives from the annual budget, as divided by the annual Division of Revenue Act. Through the budgetary process, the available national revenue is divided between the three levels of government, resulting in the allocation of equitable shares to the national and each of the provincial and municipal governments as prescribed by the Constitution (sections 214 and 227). In addition to the equitable share, provinces are also allocated conditional grants by national government in order to fund specific programmes. At national and provincial levels, healthcare services are largely funded from the equitable share and conditional grants.

At the national level, the equitable share is divided between different government departments in terms of the annual Appropriation Act. The

same applies at provincial level, where a provincial Appropriation Act divides the province's equitable share and grants between the provincial departments. Through these processes the national and provincial departments of health are allocated the bulk of their budgets.

Since the actual provision of healthcare is primarily facilitated by provinces, national government allocates significant funding for healthcare to provinces by means of conditional grants. These grants are ringfenced funding for specific programmes as prescribed nationally and the spending is subject to the conditions set in the grant.

The allocation of funding to provincial health departments in each of the provincial Appropriation Acts follows a standard format with funds allocated across eight standard programmes. These are:

1. Administration
2. District health services
3. Emergency health services
4. Provincial hospital services
5. Central hospital services
6. Health sciences and training
7. Health care support services
8. Health facilities management

Of these, the second programme, district health services, is the biggest programme in provincial health budgets overall (Blecher et al, 2011). For example, the percentage of the total provincial health budget allocated to district health services was 43% in the Free State Appropriation Act, 2019, 48% in the KwaZulu-Natal Appropriation Act, 2019 48% and 40% in the Western Cape Appropriation Act, 2019.

Gauteng is the exception in this regard where programme 5, central hospital services, was allocated 36% of the health budget, the biggest portion, compared to 34% for district health services in the Gauteng Provincial Appropriation Act, 2019. This can be explained with reference to the urban nature of Gauteng province and the consequent high concentration of central hospitals compared to district health services.

The composition of the national health budget follows the strategic, medium term health and human resources plans that the Director-General of the NDoH is obliged to prepare on an annual basis (NHA, section 21). The Director-General is also obliged to integrate these national health plans with those of the provinces and to submit such integrated plans to the NHC.

In addition to funds allocated from national and provincial budgets, hospitals may be authorised to retain a proportion of the revenue generated by that hospital for specific purposes, as determined by the Minister in the case of central hospitals and MECs in the case of provincial hospitals and in consultation with the relevant Treasury (NHA, section 41).

3

THE FRAMEWORK FOR PUBLIC PROCUREMENT WITHIN THE SOUTH AFRICAN PUBLIC HEALTHCARE SYSTEM

3.1 REGULATORY FRAMEWORK

Public health procurement is done within the regulatory framework for general procurement of goods and services by state departments, primarily at national and provincial government levels. There is, accordingly, no specialised regulatory regime for procurement within the health sector.

The regulatory framework governing public procurement in South Africa is a highly fragmented one, consisting of a range of constitutional and statutory provisions that are only loosely connected within the overall regulatory scheme (see Quinot, 2014a). The most important provisions for purposes of public health procurement are contained in the Constitution, the Public Finance Management Act 1 of 1999 (PFMA), the Local Government: Municipal Finance Management Act 56 of 2003 (MFMA) and the Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA).

3.1.1 The Constitution

Section 217 of the Constitution is of the most obvious and immediate relevance for public procurement regulation and provides as follows:

> **217 Procurement**
>
> *(1) When an organ of state in the national, provincial or local sphere of government, or any other institution identified in national legislation, contracts for goods or services, it must do so in accordance with a system which is fair, equitable, transparent, competitive and cost-effective.*
>
> *(2) Subsection (1) does not prevent the organs of state or institutions referred to in that subsection from implementing a procurement policy providing for-*
>
> *(a) categories of preference in the allocation of contracts; and*
>
> *(b) the protection or advancement of persons, or categories of persons, disadvantaged by unfair discrimination.*
>
> *(3) National legislation must prescribe a framework within which the policy referred to in subsection (2) must be implemented.*

Section 217 (1) clearly lays down the core constitutional requirements for public procurement in South Africa, neatly captured in the five principles of fairness, equity, transparency, competitiveness and cost-effectiveness. These form the basis for public procurement regulation in South Africa.

Section 217 (2) provides a constitutional basis for the use of public procurement for horizontal policy purposes. A horizontal policy objective is one that is not directly linked to the functional purpose of the goods, works or services acquired in the procurement, but aims to achieve some other policy objective, sometimes called a collateral or secondary objective, via

public procurement (Quinot, 2013). This is significant since it removes any doubt as to the lawfulness of the use of public procurement for horizontal policy purposes. Section 217(3), however, continues to restrict the constitutional mandate in section 217 (2) to a framework set out in national legislation. The import of section 217 (3) is thus that public procurement can only lawfully be used for horizontal policy purposes within a statutory framework. The PPPFA is the statutory framework created in terms of section 217 (3) as is evident in the long title of the Act.

3.1.2 Public Finance Management Act

Following the Constitution, the PFMA is the most general statute governing public procurement. The object of the PFMA is "to secure transparency, accountability, and sound management" of all aspects of public finance (section 2), hence including public procurement. The PFMA applies to all organs of state at national and provincial levels of government.

The general institutional scheme of the PFMA amounts to a decentralised financial management structure in terms of which the core financial management function rests with the Accounting Officer/Accounting Authority (AO/AA) of each organ of state. In government departments, the Accounting Officer (AO) is the Director-General (national departments) or Head of Department (provincial departments).

The PFMA itself contains very little by way of public procurement regulation. It places an obligation on AO/AA to create and maintain "an appropriate procurement and provisioning system which is fair, equitable, transparent, competitive and cost-effective" (sections 38 (1) (a) (iii); 51 (1) (a) (iii)). This obligation amounts to a "double decentralisation" of public procurement power. Firstly, it delegates the power to create the system in terms of which procurement will occur to the entity, which includes the specific rules applicable to procurement within that system. Secondly, it delegates the actual procurement, i.e. acquisition, of goods and services to the entity in terms of the system thus created.

National Treasury (NT) and provincial treasuries fulfil an oversight function in respect of financial management within organs of state, including the procurement function.

The PFMA grants NT a host of general functions and powers of oversight, which also apply to public procurement and which can be viewed as fulfilling the mandate given in section 216 (1) of the Constitution. NT's functions include the function to "promote and enforce transparency and effective management in respect of revenue, expenditure, assets and liabilities of departments, public entities and constitutional institutions" (PFMA section 6 (1) (g)). In order to fulfil these functions, National Treasury

(a) must prescribe uniform treasury norms and standards;

(b) must enforce this Act and any prescribed norms and standards, ...;

(c) must monitor and assess the implementation of this Act, including any prescribed norms and standards, in provincial departments, in public entities and in constitutional institutions;

(d) may assist departments and constitutional institutions in building their capacity for efficient, effective and transparent financial management;

(e) may investigate any system of financial management and internal control in any department, public entity or constitutional institution;

(f) must intervene by taking appropriate steps, which may include steps in terms of section 100 of the Constitution or the withholding of funds in terms of section 216 (2) of the Constitution, to address a serious or persistent material breach of this Act by a department, public entity or constitutional institution; and

(g) may do anything further that is necessary to fulfil its responsibilities effectively" (PFMA section 6 (2)).

At provincial level each provincial treasury fulfils largely similar functions in respect of the particular province (PFMA section 18). However, the powers of provincial treasuries are concurrent with that of NT rather than to the exclusion of NT's powers. That means that both provincial treasuries and NT exercise public finance management functions in respect of provinces. That NT's powers also extend to provinces is inter alia clear from the references to "department" in section 6 (2), which is defined in the PFMA as "a national or provincial department or a national or provincial government component" and the reference in section 6 (2) (f) to intervention under section 100 of the Constitution, which governs national intervention in provincial administration.

NT's general mandate under section 6 of the PFMA is amplified by section 76, which grants NT the more specific power to make regulations or issue instructions to entities covered by the PFMA. Section 76 (4) (c) in particular authorises NT to make regulations or issue instructions concerning "the determination of a framework for an appropriate procurement and provisioning system which is fair, equitable, transparent, competitive and cost-effective". Regulations or instructions issued under this power will consequently have the force of law and be binding on those entities to which the regulation or instruction is made applicable. Departures from such regulations or instructions may only occur by approval from NT (PFMA section 79).

The institutional scheme that emerges from the PFMA in respect of public procurement is thus that organs of state (through their AO/AA) have the power to formulate their own rules governing procurement by that entity and to procure in terms of those rules, but that these functions must be fulfilled in terms of the framework created by NT and under the supervision of NT.

Acting in terms of section 76 of the PFMA, NT has made the Treasury Regulations (GN R225 in GG 27388 of 15 March 2005), which include regulation 16A on public procurement. Regulation 16A sets out the framework in terms of which organs of state must determine their procurement systems. However, regulation 16A has a limited scope of entity application and does not apply to state-owned companies and other government business enterprises listed in schedules 2 (major public entities), 3B (national government business enterprises) and 3D (provincial government business enterprises) of the PFMA (Treasury Regulation 16A.2).

The Treasury Regulations only set out in broad framework what must be included in entities' supply chain management systems, without prescribing the details of each entity's system. Of particular relevance is the further incorporation of a number of additional regulatory instruments in the procurement regulatory scheme created by the Treasury Regulations.

Regulation 16A3.2 determines that entities' supply chain management systems must be consistent with both the PPPFA and the Broad-Based Black Economic Empowerment Act 53 of 2003 (BBBEEA) and regulation 16A6.3 states that all bid documents must include the criteria prescribed by the PPPFA and BBBEEA.

Regulation 16A furthermore binds entities to additional instructions from NT in implementing their supply chain management systems. These include the threshold values in terms of which particular methods of procurement must be adopted (Treasury Regulation 16A6.1), the minimum training required of officials staffing supply chain management units (Treasury Regulation 16A5), the procedure for appointment of consultants (Treasury Regulation 16A6.3 (g)), and ethical standards to be adhered to (Treasury Regulation 16A8.2).

Finally, the Treasury Regulations grant NT and provincial treasuries a reporting mandate in terms of which entities must report on their procurement functions to NT and provincial treasuries and the latter must report to NT (Treasury Regulation 16A11). In terms of this regulation entities are obliged to comply with the reporting requirements and NT is given a wide mandate to formulate the information to be included in such reports. NT has, for example, implemented this function through its Instruction Note on Enhancing Compliance Monitoring and Improving Transparency and Accountability in Supply Chain Management of 31 May 2011.

As noted above, both the PFMA and Treasury Regulations authorise NT to issue instructions to entities on procurement. The courts have held that where these instructions are issued in terms of legislation or regulations they are legally binding (Allpay Consolidated Investment Holdings (Pty) Ltd and Others v Chief Executive Officer of the South African Social Security Agency and Others [2013] ZACC 42 (29 November 2013) para 38; Magasana Construction CC v City of Tshwane Metropolitan Municipality and Others [2013] ZAGPPHC 196 (12 July 2013) para 43; TBP Building & Civils (Pty) Ltd v the East London Industrial Development Zone (Pty) Ltd 2009 JDR 0203 (ECG) para 18). Courts have thus assessed the validity of particular procurement decisions against compliance with specific treasury instructions (Gauteng MEC for Health v 3P Consulting (Pty) Ltd 2012 (2) SA 542 (SCA). Also see TBP Building & Civils (Pty) Ltd v the East London Industrial Development Zone (Pty) Ltd 2009 JDR 0203 (ECG)). NT has issued a range of procurement guidelines, circulars, practice notes and instructions under its PFMA powers dealing with the issues expressly foreshadowed in Treasury Regulation 16A (noted above) as well as a number of further topics such as reporting obligations, unsolicited bids, tax clearance certificates and verification of preferred bidders against the database of restricted suppliers. These represent the most detailed rules of general public procurement regulation, that is regulation that applies to public procurement across organs of state as opposed to the specific rules contained in the supply chain management policies of individual organs of state. A notable, recent instruction relevant to public health procurement is NT Instruction No 8 of 2019/2020 issued on 19 March 2020 in which rules were set out on how organs of state should go about procuring goods and services needed to respond to the COVID-19 pandemic.

3.1.3 Municipal Finance Management Act

The MFMA is the equivalent at local government level of the PFMA and applies to all organs of state at local government level (MFMA section 3).

The MFMA allocates responsibility for public finance management, including public procurement, at local government level to individual municipalities, mostly shared between the mayor and municipal manager as AO of the municipality. The AO is in this regard responsible for the creation and implementation of a supply chain management policy (MFMA section 62 (1) (f) (iv) read with sections 111, 115).

NT and provincial treasuries exercise an oversight function over municipalities under the MFMA. NT's powers in this respect amount to monitoring compliance with the prescripts of the Act and taking steps to intervene where it finds non-compliance (MFMA section 5 [2]). As with the PFMA, NT has the general power to "take any other appropriate steps necessary to perform its functions effectively" (MFMA section 5 (2) (f)). The Minister of Finance may also make regulations or guidelines in order to facilitate the implementation of the MFMA (section 168). Departures from these regulations may only occur with approval from NT, although non-compliance may also be condoned (MFMA section 170). NT and provincial treasuries furthermore have the power to require municipalities to report to them on matters related to the MFMA (section 74).

ACT

To secure sound and sustainable management of the financial affairs of municipalities and other institutions in the local sphere of government; to establish treasury norms and standards for the local sphere of government; and to provide for matters connected therewith.

Unlike the PFMA, the MFMA contains significant procurement rules in the Act itself in chapter 11. These rules apply generally to all procurement undertaken by municipalities, with the exception of contracts between the municipality and another organ of state for the provision of goods or services to the municipality or the provision of a municipal service or assistance in the provision of a municipal service (MFMA 110). However, despite the specific rules on public procurement found in the MFMA, the core approach to procurement regulation at local government level is similar to that at national and provincial levels in that individual municipalities are required to formulate their own supply chain management policies, which is to serve as the immediate set of rules governing procurement within that municipality (MFMA section 111), albeit within the much narrower framework prescribed by the MFMA (MFMA section 112).

Acting in terms of section 168 of the MFMA, the Minister of Finance has issued a set of specific procurement regulations for local government, the Municipal Supply Chain Management Regulations (MSCM Regulations – GN 868 in GG 27636 of 30 May 2005). While remaining true to the basic point of departure that individual municipalities will formulate their own supply chain management policies to govern procurement by that municipality, the MSCM Regulations provide a regulatory framework in extensive detail for such policies. In fact, given the level of detail prescriptions set out in the MSCM Regulations, little discretion is left to municipalities in formulating their own supply chain management policies.

Unlike the PFMA, the MFMA does not explicitly provide NT with the power to issue instructions to municipalities in respect of public procurement. Section 168 of the MFMA grants the Minister of Finance the power to make "regulations or guidelines" towards implementation of the Act, which would include matters pertaining to procurement. However, this power must be exercised with the concurrence of the Minister of Cooperative Governance and Traditional Affairs. Regulations made under this provision are furthermore subject to consultation and public participation requirements as well as submission to Parliament (MFMA section 169). Guidelines made under this power will only bind municipalities if the council of the municipality has adopted those guidelines (MFMA section 168 (3)). NT is not always consistent in framing instruments issued under the MFMA as guidelines that will only be binding on municipalities if adopted by local councils. MFMA Circular No 100, issued by NT on 19 March 2020, dealing with emergency procurement in response to the COVID-19 pandemic is a good example. In the circular, NT purports to issue a number of binding instructions to municipalities such as, for example, restrictions on prices at which municipalities may procure certain items. The circular states that it "applies" to all municipalities.

3.1.4 Preferential Procurement Policy Framework Act

The PPPFA is the closest enactment to a general procurement statute in South Africa. Despite its short title and in particular the word "preferential" in the title, the PPPFA in fact deals with public procurement more generally and lays down general methods for tender adjudication. Following the full implementation of the Preferential Procurement Regulations, 2011, made in terms of the PPPFA, the Act also has the widest entity coverage of all procurement statutes in South Africa.

As noted above, the PPPFA was enacted to fulfil the mandate in section 217(3) of the Constitution to give effect to the use of procurement for horizontal policy purposes as contemplated in section 217(2) of the Constitution.

As with the PFMA and MFMA, the PPPFA mandates organs of state to formulate their own preferential procurement policies and to procure on the basis of those policies (section 2 (1)). However, the PPPFA significantly narrows down the scope for variation in individual preferential procurement policies by providing for a set framework within which individual policies must be formulated and procurement be done. This framework, essentially prescribing points systems for bid adjudication in terms of which certain categories of bidders are given preference, applies to bid adjudication in general and is thus not restricted to only the preferential dimension of procurement.

The Minister of Finance is given the power to make regulations on any matter relating to the implementation of the Act (PPPFA section 5 (1)). Three sets of regulations have been issued under the PPPFA (Quinot, 2018). The current regulations are the Preferential Procurement Regulations, 2017. These regulations set out in detail how tenders are to be adjudicated and awarded. The regulations provide for four distinct phases of adjudication (set out in section 3.2 below).

3.1.5 SCM Policies

While the Constitution along with the three main statutes outlined above create the regulatory framework for public procurement, the actual procurement of goods and services is largely governed at a transactional level by the SCM policy of the particular organ of state.

As outlined above, the PFMA, MFMA and PPPFA all require procuring entities to create their own SCM system or policies under the relevant statutory framework. That is, a general SCM policy under the PFMA/MFMA and a preferential procurement policy under the PPPFA. These are often captured in a single SCM policy for the entity. It is this policy that prescribes how the particular entity should go about procuring. When one thus wants to ascertain the framework for a particular procurement, one must start by looking at the SCM policy of the procuring entity at issue.

Diagram 3.1 below illustrates the regulatory framework as it links the constitutional principles of public procurement with actual procurement practices.

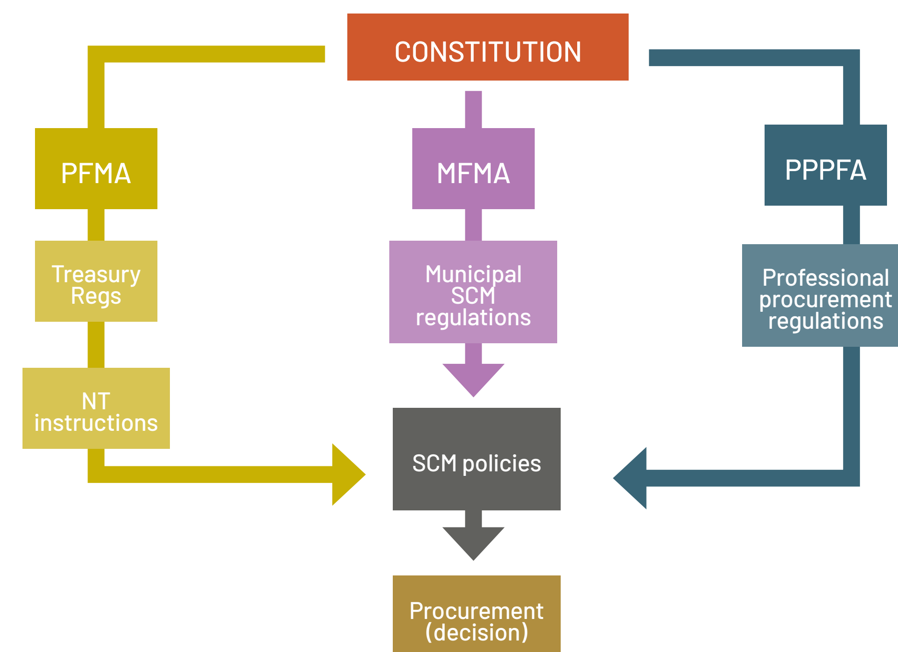


Diagram 3.1: Procurement regulatory framework

3.2 PROCUREMENT PRACTICES

The general regulatory framework for public procurement establishes a number of standard practices in South African public procurement.

3.2.1 Bid committees

The standard institutional framework for public procurement, primarily when conducted through an open bidding procedure (see 3.2.3 below on the different procurement procedures), involves a committee system, making recommendations to the AO/AA that has the power to take procurement decisions, i.e. award contracts. Within particular limits, the AO/AA may delegate this decision-making power to subordinate officials or structures.

The committee system consists of three committees, viz. the Bid Specification Committee (BSC), Bid Evaluation Committee (BEC) and Bid Adjudication Committee (BAC). As the names of the respective committees suggest, they consecutively manage the distinct phases of acquisition within the procurement process (see 3.2.3 below on the phases of tender adjudication). The BSC formulates the specifications for the particular contract, which will form the basis for the invitation to tender and the adjudication of the bids received. The BEC is responsible for the technical evaluation of all bids received, including determining whether bidders qualify for the particular contract. The BEC makes a recommendation to the BAC regarding which bids to consider for award. The BAC does the final adjudication of all qualifying bids and identifies the preferred supplier. Depending on the delegations in place, the BAC may either recommend a supplier to be awarded the contract to the AO/AA or award the contract itself. In terms of membership, there may be overlap between membership of the BSC and BEC, which is in fact common practice, but there must be separation of membership between the BEC and BAC. Members of committees are appointed either on an ad hoc basis for particular tenders or as members of standing committees, as determined by the organ of state's SCM policy.

3.2.2 Procurement procedures

While the Constitution requires that organs of state must contract in terms of a system that is competitive, it also requires that system to be cost-effective. In order to achieve a balance between competitiveness and cost-effectiveness, procurement regulation provides for a range of different types of procurement procedures. The main factor to determine which procedure to use in a given instance is the value of the contract. Under the PFMA and MFMA, thresholds are set for the use of each of the prescribed procurement procedures as set out in table 3.1 below.

Table 3.1: Thresholds for different procurement procedures

Procurement procedure	Threshold under the PFMA	Threshold under the MFMA
Petty cash	Below R2000	Below R2000
Verbal or written price quotations	R2000 – R10 000	R2000 – R10 000
Written price quotations	R10 000 – R500 000	R10 000 – R200 000
Competitive bidding	Above R500 000	Above R200 000

Procuring entities are thus generally obliged to follow the prescribed procurement procedure in procuring goods or services for the value stated in the threshold to which it is subject, i.e. either the threshold under the PFMA if the entity is subject to the PFMA or the MFMA. The value at issue here is the full contract value, including taxes.

The two quotation procedures require procuring entities to solicit quotes from at least three suppliers that are registered on the Central Supplier Database (CSD), maintained by NT. While these quotes may be fairly informal in the case of the lower-value type of quotations (verbal or written price quotations), orders may only be placed against a written quote. The procuring entity itself can determine which suppliers, registered on the CSD, to invite to provide quotations.

Competitive bidding involves the publication of an open invitation to submit bids for the specified goods or services. National and provincial entities must publish invitations to bid in at least the Government Tender Bulletin and NT's online procurement portal, the eTenderPublication portal (https://etenders.treasury.gov.za/). Local government entities must publish invitations publicly in any appropriate manner, which may include newspapers circulating locally and the entity's website. The invitation to bid must stipulate all the relevant details of the goods or services required and the procedure for bidding, including the form and closing date for submission of bids. The phases through which bids are adjudicated are discussed in section 3.2.3 below.

Although the logic of the PMFA and MFMA is that each organ of state will procure for the goods or services it needs itself, the South African procurement system also provides for so-called transversal contracting. A transversal contract is an arrangement put in place by either NT or a provincial treasury and under which more than one organ of state will be supplied. In other words, the relevant treasury will run a procurement process for the benefit of multiple organs of state. Those participating organs of state will consequently simply order the required goods or services from the contracted supplier (s) when required. A participating organ of state will not conduct a procurement process itself. Only a treasury (either national or provincial) may conclude transversal contracts and organs of state have a choice whether they want to participate in such a contract or not. If an organ of state does opt into a transversal contract, it may not procure the same goods or services outside of the transversal contract during the duration of that contract.

A procurement contract may also be concluded in the form of a framework agreement. A framework agreement involves a procuring entity concluding a contract for a stipulated period of time with a supplier or suppliers to provide the identified goods or services as and when needed by the procuring entity. The quantity of goods or services and time of delivery are not set at the outset of the contract, these are only determined by the procuring entity when it orders under the framework agreement. The price, however, will be determined at the outset, typically in the form of a reference price, unit price or some other set formula.

Transversal contracts typically take the form of framework agreements in order to allow participating organs of state to order the covered goods or services when needed. This arrangement is widely used in the context of health procurement. Annexure A contains a list of items within the public health sector that are currently being procured transversally by NT, part of which is administered by the NDoH.

Finally, organs of state may deviate from prescribed procurement procedures under certain

circumstances. Deviations essentially take two forms: contract expansions and direct contracting.

Procuring entities are generally obliged to follow the prescribed procurement procedure in procuring goods or services for the value stated in the threshold to which it is subject.

The first is where an organ of state expands an existing contract rather than concluding a new contract, i.e. going through a new procurement process to contract for the required goods or services. Expansions of existing contracts are limited to 15% of the original contract or R15 million (whichever is smaller). Expansions beyond this limit may only be done with prior approval from the relevant treasury. However, for purposes of procuring items in response to the COVID-19 national state of disaster, the prior approval requirement was waived with the effect that AO/AA's can approve expansions beyond the 15%/R15 million limit (NT Instruction No 8 of 2019/20).

The second type of deviation is when an organ of state enters into a new supplier contract without following the relevant prescribed procurement process, essentially by directly negotiating and concluding a contact with a specific supplier. These deviations are only allowed under limited circumstances. National and provincial entities may only deviate in this way in cases of emergency or single source. An emergency in this context is defined as "a serious and unexpected situation that poses an immediate risk to health, life, property or environment which calls an agency to action and there is insufficient time to invite competitive bids" (NT SCM Instruction Note 3 of 2016/17). In terms of NT Instruction No 8 of 2019/20, organs of state were instructed to follow this approach to procuring items in response to the COVD-19 national state of disaster. Procuring entities may deviate on the basis of single source where there is "evidence that only one supplier possesses the unique and singularly available capacity to meet the requirements of the institution" (NT SCM Instruction Note 3 of 2016/17). Local governments have somewhat more freedom in deviating from prescribed procurement procedures. In addition to deviating in cases of emergency and single source supply, local governments may also deviate "in any other exceptional case where it is impractical or impossible to follow the official procurement processes" (MSCM Regulations 36).

3.2.3 Stages of adjudication

Where an organ of state procures by way of competitive bidding, it is obliged in terms of the PPPFA and its regulations to follow a particular procedure in adjudicating the bids received. There are four basic stages of adjudication:

1. Pre-qualification
2. Qualification
3. Scoring on price and preference points
4. Applying other objective criteria

3.2.3.1 Pre-qualification

Under the Preferential Procurement Regulations, 2017, a procuring entity may decide to limit the relevant procurement to certain suppliers. The criteria used to identify those suppliers that will be eligible to compete for the contract are called "pre-qualification" criteria. The Regulations provide a closed list of factors that may be used to pre-qualify bidders, i.e. to restrict the competition. These are:

(a) a tenderer having a stipulated minimum B-BBEE status level of contributor
(b) an exempted micro enterprise (EME)i or qualifying small business enterprise (QSE)ii
(c) a tenderer subcontracting a minimum of 30% to-
(i) an EME or QSE which is at least 51 % owned by black people
(ii) an EME or QSE which is at least 51 % owned by black people who are youth
(iii) an EME or QSE which is at least 51% owned by black people who are women
(iv) an EME or QSE which is at least 51% owned by black people with disabilities
(v) an EME or QSE which is 51% owned by black people living in rural or underdeveloped areas or townships
(vi) a cooperative which is at least 51% owned by black people
(vii) an EME or QSE which is at least 51% owned by black people who are military veterans
(viii) an EME or QSE.

An organ of state must thus decide in respect of each procurement whether it will restrict bidding to one or more of the categories of suppliers listed above. Such limitation must be noted in the invitation to bid. If this mechanism is used, the first step in the adjudication process is to eliminate all bidders that do not meet the relevant pre-qualification criteria.

3.2.3.2 Qualification

The second stage of adjudication involves an evaluation of the responsiveness and functionality of the bids received. This is the prime function of the BEC.

During this stage, bids are scrutinised to establish whether they meet all the conditions set out in the invitation to tender (other than the pre-qualification conditions that have already been applied). Only bids that comply with all the conditions of tender, as stated in the invitation, will be viewed as acceptable tenders and considered further.

In addition to compliance with all the conditions of tender, bids may also be evaluated in terms of what is called functionality as part of the qualification stage. Functionality refers to "the ability of a tenderer to provide goods or services in accordance with specifications as set out in the tender documents" (Preferential Procurement Regulations, 2017). In other words, functionality refers to the quality of the goods or services offered by the supplier.

If a bidding process includes a functionality assessment, the specific criteria to be used to determine functionality, i.e. quality, must be stated objectively in the invitation to tender with an indication of the method to be used to assess a bid against those criteria. The method must result in a point score allocated to each bidder. The invitation to tender must also state the minimum number of points that a bidder must score in order to be considered functional, that is, in order to meet the minimum quality standard. Only those bids that meet this minimum functionality score will be considered further.

i An EME is defined under the BBBEEA as an enterprise with an annual total revenue of R 5 million or less.
ii A QSE is defined under the BBBEEA as an enterprise with an annual total revenue of between R5 million and R35 million.

It is important to note that bidders are not compared to each other during this stage of adjudication. This stage only involves an evaluation of the quality of each individual bidder's bid against an objective standard. The quality of a bidder's bid compared to other bidders' bids is irrelevant at this stage (Quinot, 2014b). Put differently, the fact that one bidder may submit a bid for a product that is vastly superior to that offered by another bidder is irrelevant as long as both bidders meet the minimum quality (functionality) score.

At the end of this stage of adjudication, the BEC submits a report to the BAC listing all the qualifying bidders. In other words, all the bids left on the table at the end of this stage are bids that can, at a minimum level, fulfil the needs of the procuring entity.

3.2.3.3 Scoring on price and preference points

The BAC scores all bidders recommended by the BEC by comparing the prices they offered and their so-called preference points. To do this, the BAC uses the following scoring methodologies prescribed by the PPPFA and Preferential Procurement Regulations, 2017.

Each bidder is awarded a number of points out of 100. Depending on the value of the contract, the 100 points are divided into either an 80/20 or 90/10 split. For contracts below a value of R50 million, 80 points are allocated to price and 20 to preference. For contracts above R50 million, 90 points are allocated to price and 10 to preference. Only one of these splits is used in an adjudication, i.e. either all bids are adjudicated using the 80/20 split or all bids are adjudicated using the 90/10 split.

To calculate the number of points each bidder receives for price, the following formula is used in case of a contract below R50 million:

$$Ps = 80\left(1 - \frac{Pt - Pmin}{Pmin}\right)$$

Where-

Ps =	*Points scored for price of tender under consideration*
Pt =	*Price of tender under consideration, and*
Pmin =	*Price of lowest acceptable tender*

In case of a contract above R50 million, the following formula is used:

$$Ps = 90\left(1 - \frac{Pt - Pmin}{Pmin}\right)$$

Where-

Ps =	*Points scored for price of tender under consideration*
Pt =	*Price of tender under consideration, and*
Pmin =	*Price of lowest acceptable tender*

The effect of these formulae is that the bidder with the lowest price will score 80 or 90 points (depending on the value of the contract) and all other bidders will score a number of points out of 80 or 90 proportional to the differential between that bidder's price and the lowest price.

In order to arrive at the final score per bidder, a number of points out of 20 or 10 (depending on the value of the contract) are added to each bidder's price points based on each bidder's status level in terms of the BBBEEA. The Preferential Procurement Regulations, 2017 simply prescribe the number of these preference points to be added per BBBEE level, as follows:

For contracts below R50 million:

B-BBEE Status Level of Contributor	Preference points
1	20
2	18
3	14
4	12
5	8
6	6
7	4
8	2
Non-compliant contributor	0

For contracts above R50 million:

B-BBEE Status Level of Contributor	Preference points
1	10
2	9
3	6
4	5
5	4
6	3
7	2
8	1
Non-compliant contributor	0

The total score out of 100 for each bidder determines the ranking between the qualifying bids. Generally, the bid with the highest number of points will be the preferred bidder to be awarded the contract. The PPPFA states that the contract "must" be awarded to the bidder that scored the highest points, unless there are other objective criteria that justify the award to another bidder.

At the end of the third stage of adjudication, the BAC has scored the bids and arrived at a ranking of bidders, which indicates which bidder is the preferred one.

3.2.3.4 Applying other objective criteria

The PPPFA and Preferential Procurement Regulations, 2017 allow procuring entities to add objective adjudication criteria to price and preference in order to arrive at the final award decision. These are the so-called "other objective criteria". If the procuring entity wishes to rely on criteria additional to price and preference, it must explicitly state these criteria in the invitation to tender, including the methodology that will be used to assess bids against such criteria. These criteria must be objective.

Where the procuring entity has included such other objective criteria in the invitation to bid, the final stage of adjudication will be to assess all qualifying bids against these criteria and to determine which bid should be awarded the contract. Since these other objective criteria are applied after the ranking of bids according to price and preference, it follows that the final award decision may depart from the outcome of the ranking in stage three of adjudication. In other words, following the adjudication in terms of the other objective criteria, the procuring entity may award the contract to a bidder other than the one that scored the highest number of points in stage three.

Once this fourth stage of adjudication has been completed, the award decision will be taken, either by the AO/AA or the BAC acting under delegated power and the contract awarded.

If the procuring entity wishes to rely on criteria additional to price and preference, it must explicitly state these criteria in the invitation to tender, including the methodology that will be used to assess bids against such criteria.

3.2.4 Typical corrupt practices

Corruption may occur in any of the phases of public procurement set out above. As Williams-Elegbe (2007) notes, government contracts are particularly susceptible to corrupt practices given the large amounts of money involved, the non-commercial, public nature of contracting entities, classical agency problems emerging from the relationship between the individual procurement official and the public entity, wide discretions with limited oversight, detailed and complex bureaucratic rules making external scrutiny difficult, as well as specific remuneration arrangements in the public sector with may be low and unrelated to performance. There are, however, several common or typical corrupt practices in relation to public procurement that may be highlighted across the procurement cycle.

A first common corrupt practice is where the specifications for a particular procurement is drafted in such a manner that only a specific favoured supplier can obtain the contract. This may be done in several ways. The specifications may include a functionality requirement relating to characteristics of supplier qualification that is tailored to a particular bidder, e.g. the specifications may require a set number of years of experience or similar previous contracts. Or the specifications may define the required goods or services in such a manner that only the specific supplier's goods or services will meet the functionality threshold. This type of corruption obviously requires collusion between the supplier and procurement officials responsible for drafting the specifications.

Corruption may also occur by manipulating the choice of procurement method. A large contract that should be put out for open bidding may be divided into smaller contracts that will each fall below the threshold for open bidding and be procured through multiple quotations. Procurement officials may also decide to deviate from prescribed procurement rules and conclude a direct contract with a favoured supplier for corrupt reasons.

Suppliers may act in a corrupt manner without the involvement of

During the adjudication process corruption may occur when procurement officials unjustifiably favour a specific bidder over others resulting in that bidder unfairly winning the contract, typically in exchange for a bribe

procurement officials. Different suppliers may collude to fix their prices in order to create false competition in the procurement process, thereby guaranteeing the contract to be awarded to one of them. It is not uncommon for that winning bidder to subsequently subcontract part of the work to the other colluding bidders. Fronting is another major form of corruption within public procurement. This involves a fraudulent misrepresentation by bidders to create the appearance of compliance with specific qualification requirements, such as BBBEE status, while those requirements are in reality not met (Sibanda, 2015). It may involve, for example, 'window-dressing', where shareholding is structured to represent majority black ownership while beneficial ownership does not lie with black shareholders, or where black directors or managers are appointed as tokens without in fact having any say in the operations of the enterprise (Bolton, 2007). Fronting may also be done by way of subcontracting. A bidder that legitimately qualifies for the tender, e.g. based on BBBEE status, may win the contract, but then subcontract all of the work to another firm that does not meet the qualification criteria and could never have won the bid, typically against payment of a fee.

During the adjudication process corruption may occur when procurement officials unjustifiably favour a specific bidder over others resulting in that bidder unfairly winning the contract, typically in exchange for a bribe. This may be done for example by manipulating the evaluation or scoring of bids, changing criteria to suit the particular bidder or spuriously disqualifying competing bidders.

Corruption may occur after the award has been made to a supplier. The procuring entity may corruptly agree with the supplier to reduce the goods or services to be rendered without reducing the price to be paid (Mantzaris, 2014). Alternatively, the supplier and procuring entity may agree to expansion of the awarded contract far beyond what was initially awarded through the procurement process. Or most simply, the supplier may invoice and be paid for goods or services never delivered or invoice and be paid at highly inflated prices.

4

CURRENT STATE OF AFFAIRS IN RESPECT OF PUBLIC HEALTH SPENDING IN SOUTH AFRICA

4.1 FRAMEWORK FOR EVALUATING PUBLIC SPENDING

Public spending and public procurement spending in particular are regulated and hence primarily evaluated in terms of the PFMA, MFMA and Public Audit Act 25 of 2004 (PAA).

The main mechanism through which public spending is evaluated is annual audits by the Auditor-General (AG). The AG is mandated by chapter 9 of the Constitution to audit and report on the accounts, financial statements and financial management of national and provincial departments and local governments. The functions of the AG are set out in the PAA.

In respect of each audit conducted, the AG must issue an audit report in which it expresses a view on

(a) the financial statements of the auditee in accordance with the applicable financial reporting framework and legislation

(b) compliance with any applicable legislation relating to financial matters, financial management and other related matters and

(c) reported performance of the auditee against its predetermined objectives

PAA, section 20 (2)

Annual audit reports are published in respect of the PFMA and MFMA. In these reports, the AG expresses a view on the quality of financial statements and performance reports and compliance with key legislation in expenditure by all public entities. The AG can express one of the following opinions in respect of a public entity:

Table 4.1: Types of AG audit opinions

Audit opinion	Description
Clean audit (unqualified opinion with no findings)	The entity produced financial statements without material misstatements, there are no adverse findings in relation to performance reports or in relation to compliance with key legislation.
Financially unqualified opinion with findings	The entity produced financial statements without material misstatements, but there are adverse findings in relation to performance reports and/or in relation to compliance with key legislation.
Financially qualified opinion with findings	The entity produced financial statements that contained material misstatements and there are adverse findings in relation to performance reports and/or in relation to compliance with key legislation.
Adverse opinion with findings	The entity produced financial statements with many material misstatements that are not related to specific amounts, but that pervades essentially all the statements.
Disclaimed opinion with findings	The entity did not produce adequate evidence to enable an opinion to be expressed at all.

A key feature of the evaluation of public spending through AG audits focuses on the alignment of the spending with the prescribed regulatory framework. This framework utilises a number of key concepts to express misalignment between public spending and the regulatory regime.

The first relevant concept is that of overspending, which is defined in the PFMA and MFMA as expenditure that exceeds the annual budget. This can be either in relation to an entire budget vote, that is a particular department's total share of an annual budget, or a main division within that budget vote, i.e. a main division within a particular department's annual budget, as approved by the relevant legislature. In other words, overspending refers to total expenditure by a department that exceeds its total budget allocated or to expenditure within a particular main segment of its budget that exceeds the amount allocated for that particular segment in its approved budget.

Overspending is considered as unauthorised expenditure under the PFMA and MFMA. Furthermore, expenditure that is not in accordance with the purpose of a budget vote or a main division within that vote, is also considered unauthorised expenditure, regardless of whether it amounts to overspending. Thus, even when a department spends within the allocated amount of a main division in its budget vote, but the spending is for a purpose that does not accord with the purpose of that main division of its budget vote, such expenditure still amounts to unauthorised expenditure.

The third key concept is that of irregular expenditure, which is one of the most important in respect of evaluating public spending. Irregular expenditure refers to expenditure that was incurred in a manner not in line with applicable legislation, but does not include unauthorised expenditure. In other words, if the only problem with the expenditure is that it was unauthorised, as that term is set out in the previous paragraph, the expenditure will not be irregular, it will be unauthorised. In the context of public procurement, a transaction that did not adhere to the legislature rules governing public procurement will result in irregular expenditure. For example, if a tender is awarded to a bidder whose bid did not meet the minimum threshold for functionality stated in the tender invitation, the expenditure under that tender contract will be irregular since the Preferential Procurement Regulations, 2017 state that only bids meeting the minimum threshold for functionality may be considered. Irregular expenditure, in short, thus amounts to expenditure falling foul of legislative prescripts. It is important to note that expenditure noted as irregular does not mean that the expenditure was wasted, corrupt or duplicitous in any way. The label of irregular only signals that a formal legislative prescript was not followed.

A further concept is that of fruitless and wasteful expenditure. This is expenditure that, as the label suggests, is wasteful, i.e. was made in vain. Importantly, expenditure can only be viewed as fruitless and wasteful if it would have been avoided had reasonable care been taken. For expenditure to be noted as fruitless and wasteful, two conditions must thus be met. It must, factually, have amounted to a waste, that is made in vain, and reasonable care would have avoided it, i.e. there must be a lack of reasonable care accompanying the expenditure.

A final key concept, introduced most recently by means of an amendment to the PAA (on which more is stated in section 5.3 below), is that of material irregularity. This concept refers to irregularities identified during an audit under the PAA that meet two conditions. Firstly, the irregularity must amount to a transgression. This transgression can be in the form of noncompliance/contravention of legislation, fraud, theft or a breach of a fiduciary duty. Secondly, that transgression must have or be likely to have certain consequences. These consequences

must be material financial loss, misuse or loss of a material public resource or substantial harm to a public sector institution or the general public. A causal connection is required between the transgression and the consequence, either in fact or in likelihood. It is also important to note the degree of consequence required – it is not any financial loss, but only a material one; not misuse/loss of any public resource, but only a material public resource and the harm must be substantial.

A summary of the key concepts in evaluating public spending is provided in table 4.2 below.

Table 4.2: Key concepts in evaluating public spending

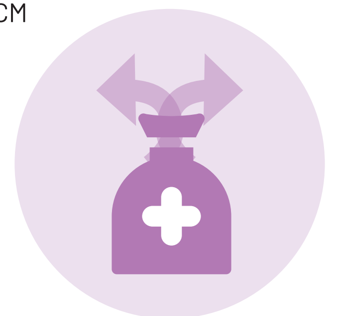
Concept	Source	Description
Overspending	PFMA/MFMA	Expenditure exceeding a budget vote or main division thereof
Unauthorised expenditure	PFMA/MFMA	Overspending or expenditure for a purpose unrelated to a budget vote or main division thereof
Irregular expenditure	PFMA/MFMA	Expenditure in non-compliance with legislation, other than unauthorised expenditure
Fruitless and wasteful expenditure	PFMA/MFMA	Expenditure in vain and avoidable with due care
Material irregularity	PAA	Irregularity flowing from a transgression with serious adverse consequences

4.2 OVERVIEW OF PUBLIC AUDIT FINDINGS IN RESPECT OF PUBLIC HEALTH SPENDING

4.2.1 Overall spending

An overview of the AG reports of national spending overall over the last five years (2014/15 to 2018/19) shows a deteriorating state of public spending. As noted in the 2018/19 AG PFMA audit report: "Our audits show a regression in audit outcomes over the past five years". In 2018/19 only 100 auditees (26%) received clean audits compared to 106 (28%) in 2014/15. Non-compliance with key legislation remains a major concern overall. In 2014/15, 64% of entities had material findings on non-compliance with key legislation compared to 72% in 2018/19. SCM is a main area of concern and accounts for a significant portion of non-compliance with legislation. In 2018/19 as in 2014/15, 64% of entities had findings regarding non-compliance with SCM legislation. In 2018/19, 42% of these were material. Irregular expenditure rose from R25.7 billion in 2014/15 to R42.8 billion in 2018/19. SCM again remains the biggest contributor to these findings. Of the 28 material irregularities found across the 12 audits in 2018/19 in which the AG implemented the first phase of its new mandate relating to material irregularities (see section 5.3 below), 39% related to unfair or uncompetitive procurement processes resulting in overpricing of goods and services procured, 4% related to unfair procurement processes resulting in a supplier appointed that did not deliver, 39% related to payment for goods or services not received, 7% related to payment for poor-quality work and 11% related to invoices or claims not paid on time. It is evident that SCM is the most significant factor in poor public spending in South Africa at present.

Illustration 4.1, taken from the 2018/19 AG PFMA audit report, illustrates the deteriorating state of public finance overall over the last five years.



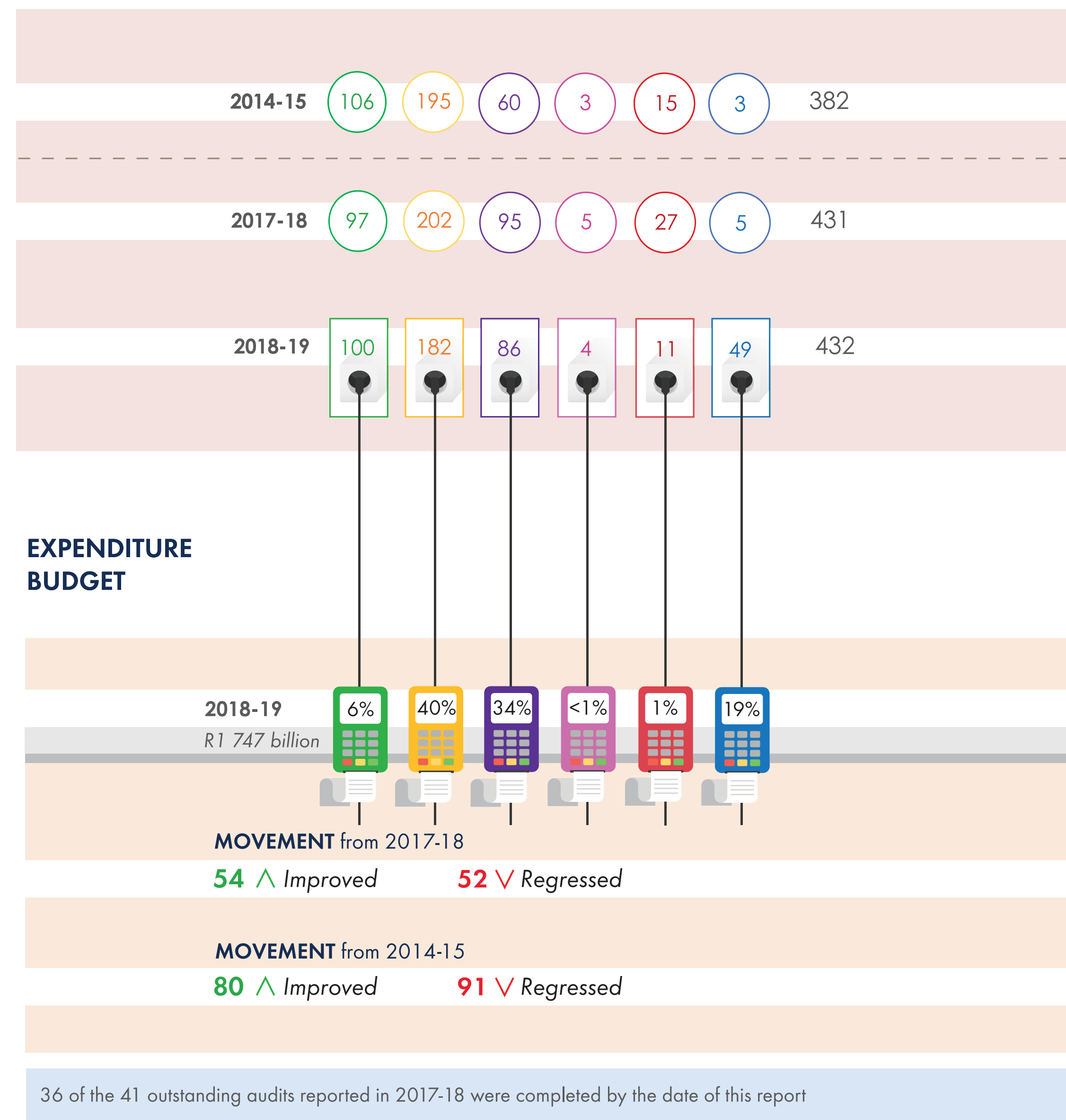
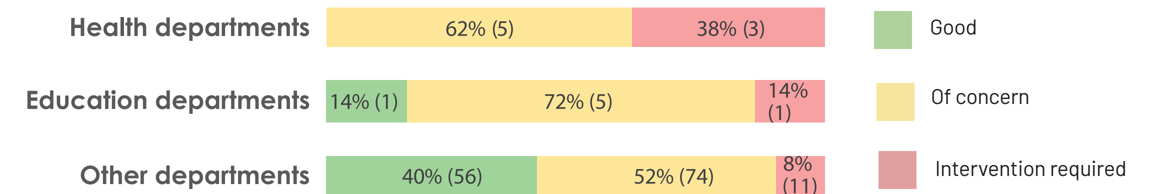


Illustration 4.1: Overview of PFMA audit outcomes between 2014/15 and 2018/19.

4.2.2 Public health spending

When one zooms in on public health spending, the picture looks even more bleak. In the 2018/19 AG PFMA audit report, the AG states that the "financial health of provincial departments of health and education needs urgent intervention to prevent the collapse of these key service delivery departments. In comparison with the other departments, these sectors (particularly the health sector) are in a bad state". This overall state is clear from illustration 4.2 taken from the 2018/19 AG PFMA audit report.



Province	Vulnerable position	Unauthorised expenditure	Deficit	% of cash shortfall funded by next year's operational budget	Claims as % of next year's budget
Eastern Cape	Yes	R569 million	R3 million	7	366,3 (R29 million
Free State	Yes	-	R134 million	7,9	68 (R2 511 million)
Gauteng	No	-	R4 281 million	14,7	116,74 (924 756 million)
Kwazulu-Natal	No	R14 million	RI 347 million	0,3	135 (R20 730 million)
Limpopo	No	-	R1 053 million	0,1	185 (R8 499 million)
Mpumalanga	No	-	R207 million	4,6	182 (R10 091 million)
Northern Cape	No	R22 million	R553 million	8,7	49,1 (R2 107 million)
Western Cape	No	-	No deficit	0	1,4 (R126 million)

Illustration 4.2: State of public spending in health departments, 2018/19 AG PFMA audit report.

Over the last five years, only one department of health, that of the Western Cape, received a clean audit and only in 2018/19. When one scrutinises the audit reports over the last five years, departments of health at both national and provincial levels are consistently identified as one of the primary departments contributing to irregular expenditure. In most cases, these relate to procurement spent. Departments of health also consistently account for the biggest portion of budget deficits. It should be note, however, that this is increasingly due to large litigation claims against especially provincial departments of health that are not budgeted for. Since 2017/18, the AG has started specifically analysing this emerging financial risk. In the 2017/18 audit report, the AG reported that seven of the nine provincial departments of health had claims against them that exceeded the next year's operational budget. In the 2018/19 report, the AG noted that over a third of all government departments had claims against them that exceeded 10% of the next year's budget, with departments of health having the largest liability. Five government departments accounted for 70% of the total liability of R100.9 billion at year-end with four of these being provincial health departments.

4.2.3 Key programmes

In 2018/19, the AG added district health services to its audit of key government programmes. This part of the AG's function involves evaluating selected key programmes to assess their financial and performance management towards the achievement of their planned targets. The district health services programme audited included the subprogrammes HIV and Aids, tuberculosis and maternal and child health services. The programme had a budget allocation of R20.7 billion in 2018/19 of which the vast bulk, viz. R20.4 billion, was allocated to the HIV and Aids subprogramme. Of this amount, R19.6 billion was transferred to provincial departments of health for implementation of the programme.

The audit shows a very high percentage spending of the allocated budget, viz. 98%. Performance indicators also show a high level of achievement of targets, ranging between 84% and 159%. However, the audit concluded that it could not confirm achievement of targets since it could not determine the accuracy of the data reported. This was due to serious systems deficiencies in relation to data reporting. All but one province had material findings in relation to reliability of performance data.

4.3 IMPACT OF PUBLIC FINANCE MANAGEMENT IN HEALTH SPENDING ON HEALTH SERVICE DELIVERY

There can be little doubt that the poor state of public health spending, as borne out by the audit findings outlined above, is having a significant impact on health service delivery in South Africa. Over the last few years, the AG has consistently indicated that health service delivery is threatened by the lack of appropriate public finance management.

At a practical level there are many examples of how the poor state of public finance management in the health sector is impacting adversely on service delivery.

Non-compliance with procurement prescripts often leads to loss of public funds thereby reducing the health budget. For example, in the 2018/19 PFMA audit, the AG found that the Gauteng Department of Health spent R148.9 million more than it should have done, because of a failure to invite open bids in concluding the relevant contract that would have secured lower prices. In the same report, the AG found that the Northern Cape Department of Health paid for mammogram services at a hospital that did not even have a mammogram machine. At the same time, these departments faced very large litigation claims against it resulting in significant budget deficits of R4 281 million and R553 million respectively.

Poor financial management also results in delays in providing services. A good example is the refurbishment of the Boitumelo regional hospital in Kroonstad. The project started in 2011 with a timeline of 36 months and a budget of R138 million. Eight years later the project had not been completed and the budget increased to R209 million with an estimated further R105 million necessary to complete it and rectify poor workmanship.

5

PUBLIC FINANCE MANAGEMENT REFORMS AND PUBLIC HEALTH SPENDING

A number of recent and current reform initiatives can potentially have a significant impact on the regulatory framework pertaining to public health spending in South Africa. Four of these initiatives are discussed in the following sections.

5.1 NHI – OFFICE OF HEALTH PRODUCTS PROCUREMENT

Undoubtedly the most significant initiative regarding public health services currently in South Africa is the introduction of a national health insurance (NHI) scheme. The most recent development in the introduction of NHI is the publication of the draft NHI Bill (B11-2019) for public comment in 2019. The Bill contained several important provisions relating to procurement of public health services.

The central feature of the NHI Bill is that a National Health Insurance Fund will acquire health services on behalf of the public. Throughout the NHI Bill and the explanatory memorandum published with it, the terminology of contract is used to describe the way in which the NHI Fund will go about acquiring such services. For example, section 35 of the Bill states

> *(1) The Fund must actively and strategically purchase health care services on behalf of users in accordance with need.*
>
> *(2) The Fund must transfer funds directly to accredited and contracted central, provincial, regional, specialised and district hospitals based on a global budget or Diagnosis Related Groups.*

There can be little doubt that section 217 of the Constitution will apply to this process of acquiring services, i.e. that the NHI Fund will be engaging in public procurement when it engages health care service providers and health establishments (both in the public and private sectors). It is, however, not clear from the Bill that it is appreciated that this dimension of the scheme will amount to formal procurement and will thus be subject to normal procurement law. The implication would be that one of the prescribed forms of procurement (e.g. quotations or open bidding) must be used in order to secure the services of these providers. The Bill creates the impression that a different type of arrangement may be contemplated for the acquisition of such services – primarily in section 39, from which it seems that accreditation is viewed as the mechanism through which such services is to be acquired. At the moment, the conceptualisation of how medical services will be acquired on behalf of the public from private service providers under the NHI is accordingly not clear. If formal procurement is contemplated, the challenges currently experienced within the health sector relating to public procurement will be multiplied and may significantly undermine the efficiency of the scheme.

The NHI Bill also contemplates the creation of the Office of Health Products Procurement (OHPP) in section 38. There are a number of uncertainties in relation to this structure. It is not entirely clear what the scope of the OHPP's mandate will be. Section 38 (2) states that the OHPP "is responsible for the centralised facilitation and coordination of functions related to the public procurement of health-related products". It is not clear what "centralised facilitation" and "coordination" mean. Similarly, section 38 (3) states that

the OHPP must " (c) coordinate the scm process and price negotiations"; " (d) facilitate ... public procurement" and " (h) facilitate the procurement of high cost devices and equipment". It is not at all clear what "coordinate" and "facilitate" mean in these subsections. It may suggest that the OHPP will be procuring health related products itself. If so, it is not clear what the relationship between the OHPP and service providers will be, given the statement in section 38 (6) of the Bill that "an accredited health care service provider and health establishment must procure according to the Formulary, and suppliers listed in the Formulary must deliver directly to the accredited and contracted health service provider and health establishment", making it clear that service providers will procure products themselves.

The exact products that will fall under the OHPP's mandate is also not clear. Section 38 (2) states that the OHPP should facilitate and coordinate procurement of "health related products, including but not limited to medicines, medical devices and equipment". However, "health related product" is defined in section 1 of the Bill as "any commodity other than orthodox medicine, complementary medicine, veterinary medicine, medical device or scheduled substance ..." It is accordingly not clear whether the procurement of medicine is included or excluded from the OHPP's remit. If "health related product" is defined as excluding medicine, it would be nonsensical to state in section 38 (2) that the OHPP is responsible for procurement of health-related productions including medicine.

The OHPP is also responsible for developing a "national health products list" (section 38 (3) (b) of the Bill). However, nowhere else in the Bill is there any reference to this list and it is not clear what role it will play or what its purpose is. It is, for example, not clear whether this is the same list as mentioned in section 38 (4) where reference is made to "a list of health related products to be used in the delivery of health care services as approved by the Minister". If that is the case there is a tension between these two sections since section 38 (4) envisages that the Benefits Advisory Committee will develop the latter list as part of the "Formulary". The question thus emerges, who has the real power to create the list of health-related products, which will ostensibly form the basis for health-related procurement?

While section 38 (7) of the Bill explicitly states that procurement under the Bill will be subject to public procurement laws, there is significant uncertainty as to the exact arrangements under which health services will be procured in an NHI scheme. In particular, it is not clear who will be the ultimate procuring entity under such a scheme as currently envisage in the NHI Bill.

5.2 PUBLIC AUDIT ACT

As noted in section 4.1 above, public audits by the AG in terms of the PAA is the most important oversight mechanism in public finance management in South Africa. In 2019, amendments to the PAA came into operation with important implications for this oversight function. Given the poor state of public finance management in the public health sector (noted in section 4.2.2 above), these developments are particularly important in this context.

The Public Audit Amendment Act 5 of 2018 added the concept of material irregularity to the PAA (as explained in section 4.1 above). It also added a host of remedial powers to the PAA that the AG may exercise when a material irregularity is found.

Sections 5A and 5B of the PAA, read with the Material Irregularities Regulations made under the PAA, set out the approach the AG must take to remedy material irregularities. When the AG finds material irregularities in an audit and issues recommendations on how such irregularities must be addressed, the relevant AO/AA must report to the AG on the implementation of the recommendations. The AG is also obliged to follow up on whether the AO/AA implemented the recommendations. If the AO/AA has failed to implement the recommendations, the AG must take appropriate remedial action to address such failure. If the material irregularity resulted in loss to the state and the AO/AA failed to implement the AG's recommendations, the AG must instruct the AO/AA to recover such loss from the responsible person. If the AO/AA fails to recover such loss, i.e. fails to implement the AG's remedial action, the AG, acting upon recommendations from an advisory committee, must issue a debt certificate against the AO/AA to repay the amount to the state. The executive authority of the relevant organ of state (e.g. the Minister in the case of national departments or MEC in case of provincial departments) must ensure that the debt is recovered from the AO/AA.

During the 2018/19 PFMA audit cycle, the AG implemented the first phase of auditing for material irregularities. This involved a focus on material irregularities relating to non-compliance with legislation at sixteen auditees, chosen for their audit history of non-compliance. Of these, twelve audits could be completed and reported on in the 2018/19 AG PFMA audit report. Across these twelve auditees, 28 material irregularities were identified.

The twelve entities audited in the first phase for material irregularities included four provincial departments of health (Gauteng, Northern Cape, KwaZulu-Natal and Mpumalanga). Between these four departments, five material irregularities were identified. Four of these five irregularities related to public procurement.

5.3 DRAFT PUBLIC PROCUREMENT BILL

The most significant current development in public procurement law is the wholescale reform of the regulatory regime governing public procurement by way of the proposed Public Procurement Bill. This law reform initiative is aimed at streamlining and consolidating the highly fragmented legislative landscape currently governing public procurement. A draft Public Procurement Bill was released for public comment in February 2020.

The reform that the draft Bill is proposing is quite extensive. It will repeal the vast majority of legislative provisions currently governing public procurement, including the PPPFA in totality, and implement a single comprehensive legislative framework under which all public procurement, at all levels of government, will be conducted. At present, the document is only a draft Bill and there will undoubtedly still be changes to the proposed regime before a final draft is submitted to Parliament and eventually passed into law. As such, it is difficult to comment with a high level of certainty as to what exactly the new regulatory regime will look like or to discuss the detail of a new regime in any specific manner. However, the draft Bill does provide a good indication of what a future public procurement regulatory regime will likely look like and what, at a broader level, the implications for public health procurement may be.

The draft Bill creates a new regulatory body, called the Public Procurement Regulator, within the NT. This entity will largely replace the current Office of the Chief Procurement Officer (OCPO) within NT, although it will have a slightly reduced role. The Regulator will only fulfil a regulatory function, i.e. it will provide oversight over the procurement system, maintain the

public procurement regulatory regime and serve as a dispute resolution mechanism. It will not be engaged in actual procurement. The current procurement function of the OCPO in arranging centralised procurement contracts, in the form of transversal contracts, will not be fulfilled by the Regulator, but by some other unit within NT. Importantly, the draft Bill provides that participation in transversal contracts arranged by either NT or a provincial treasury will be mandatory for all organs of state subject to the relevant treasury's jurisdiction. This means that if NT concludes a national transversal contract for any health-related products, all organs of state will be obliged to obtain those products via that transversal contract. This amounts to significantly increased centralisation of procurement powers.

The draft Bill furthermore grants provincial treasuries significant additional oversight functions over public procurement within the province. This includes acting as a dispute resolution mechanism.

The draft Bill provides very little detail on how procurement will be conducted by organs of state, i.e. what the prescribed procurement methods will be. These will be determined by the Minister of Finance in regulations under the Bill. The draft Bill retains the committee system for adjudication of bids by way of the BSC, BEC and BAC with AO/AA having the power to take final award decisions.

The draft Bill contains a range of measures aimed at curbing abuse of the SCM system. These include numerous mandatory steps that AO/AA must take to prevent abuse and to investigate allegations of abuse and take remedial action. The draft Bill empowers the Regulator to debar, i.e. restrict, suppliers from bidding for public tenders for a set period of time under certain circumstances, including for abuse of the SCM system, corruption and failed performance. The draft Bill also completely prohibits any public office bearer or civil servant from concluding contracts with the state.

6

RECOMMENDATIONS FOR REFORM OF PUBLIC FINANCE MANAGEMENT FRAMEWORKS IN RESPECT OF PUBLIC HEALTH SPENDING IN SOUTH AFRICA

Based on the preceding analysis, the following recommendations can be made in respect of reforming the poor state of public finance management in respect of public health spending in South Africa:

1. Systems integration and improvement is a huge priority. Many of the current initiatives are undermined by systems that are not up to standard and not integrated across the entire public health spending sector. The result is that it is currently often impossible to evaluate whether particular interventions are having any effect or to diagnose where failures in public health service delivery occur and why. It is accordingly imperative that better systems be implemented that can accurately capture data across the entire public health system at all levels of the system, including user data, supplier data, spending data. Such systems should also be fully integrated across the sector in order to evaluate the entire sector and to take appropriate strategic decisions about interventions. A simple example is the highly fragmented manner in which logistics are often managed within the supply chain across all different public health service delivery sites. The lack of quality data and coordination between such sites can easily result in stock-outs at one site and stockpiling at another site.

2. Better systems and data should also support a shift towards more strategic approaches to public procurement within the health sector. The procurement function within the health sector should be viewed as a high priority, strategic tool in delivering health services and not a backroom, administrative support function as is often the case. More strategic approaches to public procurement, involving a clear understanding of the market supplying the sector and dedicated buyer expertise within the SCM function are essential. There needs to be a clear understanding within health departments of the essential role of public procurement in delivering the strategic objectives of the department and SCM units should accordingly be closely integrated in all planning processes within departments. In this way, a much better alignment can be achieved between strategic planning in the department and leveraging public procurement in support of those plans.

3. A more strategic approach to public procurement also involves a clear understanding of the categories of spending within a department, which, again, depends on accurate and readily accessible data regarding spending. Departments should know what the main categories of goods and services are that they are procuring and from whom they are procuring. This facilitates better procurement planning, which in turn allows the market to respond more meaningfully to the needs of the department.

4. The high prevalence of irregular expenditure in essentially all health departments suggests that better internal control mechanisms are required. The South African experience thus seems to bear out findings in the literature that suggests that general public finance management systems are not always well aligned to the needs of public health financing objectives and realities (Cashin et al, 2017). It will be worthwhile to investigate and develop an appropriate internal control model for departmental spending that is suited to the context of health as it is evident that current internal control mechanisms are inadequate.

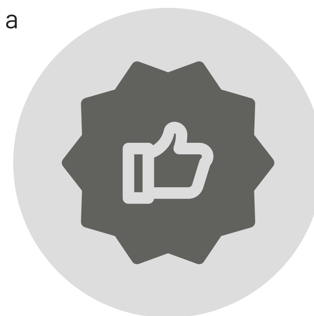
5. It is clear that the dramatic increase in litigation claims against health departments in recent years is having a severe impact on health budgets. This poses a real risk that especially provincial department of health budgets will be largely absorbed by such claims leaving inadequate funding for the provision of health services. This risk can be mitigated by increased allocation of health budgets through conditional grants by national government to provincial governments in order to fund specific health programmes. While this step will of course not limit the overall impact of litigation claims on the budget, it will at least ringfence funds for continued funding of public health services.

6. In respect of current reform efforts, a number of recommendations can be made:

   6.1. The conceptualisation of the exact nature of acquiring public health services from private healthcare providers on behalf of the public in a future NHI should be clarified. The current draft NHI Bill is not conceptually clear in this respect. It is important to clarify whether the relationship between the envisaged NHI Fund and private healthcare providers will take the form of a procurement or not.

   6.2. The roles and responsibilities of various role players within an NHI in respect of procurement should be clarified. Key questions are: who will buy, who will identify what can/should be bought, who will set prices, who will pre-qualify suppliers.

   6.3. At a more general level, the tension between the decentralised nature of public finance management in South Africa under the PFMA and MFMA on the one hand and the highly centralised nature of public health services spending under the proposed NHI on the other hand, will have to be addressed. Again, this tension is internationally a common phenomenon given that decentralised public finance management has become the norm following the shift to new public management while risk pooling is an important principle in public health funding thereby creating the need for a more centralised model of funding and spending. As Cashin et al (2017) point out, "a PFM [public finance management] objective of fiscal decentralization can be directly at odds with a health sector objective to increase national pooling of health funds to improve financial risk protection and redistribution to improve equity." As the process of implementing an NHI in South Africa unfolds, it will be important to highlight this tension.



   6.4. The relationship between health authorities and the public procurement structures proposed in the draft Public Procurement Bill must be clarified. The Public Procurement Bill makes no specific reference to health procurement as a special type of public procurement. At the same time, the draft NHI Bill contemplates a very particular regime in respect of health procurement. These two draft Bills will have to be aligned. For example, the Public Procurement Bill provides that only treasuries may arrange transversal contracts and that all organs of state will be bound to such transversal contracts. As is clear from the list of transversal contracts in Annexure A, health procurement forms a major part of transversal contracting. The question emerges whether health-related transversal contracting is not better placed within the NDoH. If so, the relevant regulations should explicitly mandate the NDoH to arrange such transversal contracts.

   6.5. Framework agreements can be powerful tools in enhancing public procurement practices as the current response to the COVID-19 pandemic illustrates. It is accordingly advisable that more detailed provision be made for how framework agreements should be implemented within the public procurement system.

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ANNEXURE A

Transversal contracts for health supplies and services

Transversal contract number	Description
RT28	Sterilization related items
RT59	Footwear
RT298	Pharmaceutical packaging material
RT2	Medical equipment
RT13	Respiratory aids
RT24	Hospital ward, theatre furniture and ward requirements
RT50	Compressed, industrial bulk and medical gases
RT54	Mental Health Equipment
RT55	Therapeutic Rehabilitation Equipment
RT72	Medical oxygen: Home patients
RT233	Wheelchairs, seating systems, positioners and commodes
RT274	Hearing aids
RT275	Speech therapy equipment
RT4	Ambulance rescue
RT9	Infant feed
RT21	Radiographic material
RT31	Administration accessories
RT32	Surgical sundries
RT35	Medical male circumcision (MMC)
RT40	Crutches and walking aids
RT41	Rapid HIV test kits
RT42	Bandages and dressings
RT75	Condoms and lubrication
RT76	Surgical and exam gloves
RT252	Surgical instruments
RT253	Surgical catheters
RT284	Hypodermic syringes
RT286	Dental equipment
RT287	Dental Instruments
RT296	Dental consumables
RT302	Surgical sutures and ligatures
HP04 (RT290)	Oncology
HP05 (RT291)	Diagnostic agent
HP06 (RT297)	Small volume parental
HP07 (RT280)	Drops, aerosols and inhalants
HP08 (RT281)	Semi solid dosage forms
HP09 (RT289)	Solid dosage forms
HP10 (RT285)	Biological preparations
HP13 (RT71)	Antiretroviral medicine
PPP (RT18)	Vaccines
RT78	Anti-tuberculosis medicines
RT283	Contraceptives
RT299	Large volume parenteral
RT300	Pharmaceutical liquids
RT301	Anti-infective medicines

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