CATHOLIC UNIVERSITY COLLEGE OF GHANA

COMPARATIVE STUDY OF EXPENDITURE CONTROL METHODS IN HEALTH FACILITIES IN THE BONO REGION.

ADAMS ABUBAKARI

2020

CATHOLIC UNIVERSITY COLLEGE OF GHANA

COMPARATIVE STUDY OF EXPENDITURE CONTROL METHODS IN HEALTH FACILITIES IN THE BONO REGION.

BY

ADAMS ABUBAKARI

Dissertation submitted to the Faculty of Economics and Business Administration, Catholic University College of Ghana, in partial fulfilment of the requirements for the award of Master of Business Administration degree in Accounting

JUNE 2020

DECLARATION

Candidate's Declaration

I hereby declare that this dissertation is the result of my own original research and that no part of it has been presented for another degree in this University or elsewhere.

Candidate's Signature: ……Date: …….....

Name: Adams Abubakari

Supervisor's Declaration

I hereby declare that the preparation and presentation of the dissertation were supervised in accordance with the guidelines on supervision of dissertation laid down by the Catholic University College of Ghana.

Supervisor's Signature: …….Date: …….

Name: Dr. Paul Osei Brafi

ABSTRACT

The purpose of the study was to compare various expenditure control systems and practices in various hospitals (government, mission and private) in the Bono region. Specifically, the study ascertained the expenditure control methods adopted by these health institutions, the expenditure control practices, the similarities and differences in these methods and practices, and looked their weaknesses and strengths. The study used explanatory case study design and data were collected using questionnaires. The study population was made up of core management staff of these health facilities. The main findings of the study are the publicly owned hospitals and the Mission or Christian Health institutions (CHAG) use appropriation control, commitment control, control of regularity and accounting cash controls, however, the private hospitals use only one of the controls which is the aggregate cash control. Again, while both the public and the mission hospitals practice similar expenditure control practices, the privately owned health facilities, the processes are dependent on contingencies (i.e. when the needs arise). The study revealed that the public and CHAG health facilities prepare comprehensive and approved budget, have institutional internal audit function, prepare Local Purchase Order (LPO), and the preparation of disbursement vouchers and payments. The study further revealed breaches of the expenditure control processes particularly as top management stepping aside the rules due to interferences, and there is a failure to check the availability of funding before authorizing expenditure, circumvention of controls at key stages, including through collusion, delays in processing of payments, failure to record and maintain data on commitments and reporting delays, and accumulation of liabilities/arrears

ACKNOWLEDGEMENTS

I wish to express my sincere gratitude first and foremost to the ALMIGHTY GOD who granted me the grace to complete this work successfully to His glorious name.

I owe a great debt of gratitude to Dr. Paul Osei Brafi, my supervisor, for his relentless efforts in giving the necessary assistance and guidance. God richly bless you.

The next gratitude goes to all those who helped in diverse ways and contributed immensely to the success of this research work, especially Dr. Mustapha Osman, Mr. Isaac Amankwa and colleagues at my workplace without whose help, this work would not have been successful.

I wish to thank the Management and Staff of the selected hospitals for making it possible for me to administer my questionnaire for this dissertation.

I also thank my wife, Mrs. Adams and Ramadan Adams, my son, for the morale support granted me during this research work. God bless you all. AMEN.

DEDICATION

To my parents, and my son, Ramadan Adams Junior.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

CHAG Christian Health Association of Ghana

DPH Dormaa Presbyterian Hospital

GHC Greenhill Clinic

GoG Government of Ghana

IGF Internally Generated Funds

IMF International Monetary Fund

OMH Owusu Memorial Hospital

SRH Sunyani Regional Hospital

WMH Wenchi Methodist Hospital

CHAPTER ONE

INTRODUCTION

Institutions, irrespective of their forms, sizes and purposes of existence, need to achieve their set objectives. To achieve this would require a lot of management commitment and discipline regarding the management of its resources. Hospitals are no exception. This is because, hospitals, both private and public, are expected to achieve their objectives by providing health care services to the communities they serve. This is achievable if management is able to discipline the resources efficiently and effectively. This can partly be executed by instituting policies in place. One of such policies is expenditure control. A prudent and sound financial management system of which expenditure control is part is critical to the efficient and effective use of resources and achievement of the goals of the health institution in the delivery of quality health care delivery.

Background to the Study

According to the International Monitory Fund (IMF) (2016), effective expenditure control is the sine qua non of good public financial management (PFM). Fiscal rules, medium-term budget plans, and annual budgets are meaningless if expenditure cannot be controlled during execution. A lack of effective expenditure controls not only threatens macroeconomic stability and fiscal discipline, but can also call into question the integrity of the public financial management system and undermine trust in a government's stewardship of public resources. While the institutional arrangements for raising government revenue are typically quite centralized in a national revenue

authority, the expenditure of those resources involves a wide array of public entities at various levels of government.

Expenditure control has been defined as the process by which managers utilize effectively and efficiently, the scarce resource in the achievement of the organisational goals (IMF, 2016; Armah, 2012). Expenditure is the total amount spent on the process of trying to achieve a particular organisational goal. Control means to order, limit, instructor rule something or someone's actions. It is used by either government officials or organisation managers to make restrictions on wages increases, immigrate credit and so on (which are all expenditure). Expenditure control is an important element of budget execution and financial resources management accountability system. Through effective expenditure control system, the agencies will not only be able to maintain high level of fiscal discipline but will also be able to implement planned activities within the approved appropriations. Expenditure control includes elements such as administrative and financial sanctions, ascertaining availability of budgets, recording and processing controls including delegation and segregation, proper recording and processing, verification and certification, and finally approving and disbursing the payments (Royal Audit Authority of Bhutan, 2015).

The objective of expenditure control is to ensure that public resources are spent as intended, within authorized limits, and following sound financial management principles (Flynn & Pessoa, 2014; Royal Audit Authority of Bhutan, 2015)). A distinguishing feature of a government's budget, unlike the budget of a typical business entity, is that it is funded primarily via compulsory taxation of citizens and authorized via an act of Parliament. The role of an expenditure control system is to ensure that the level and allocation of

government expenditure reflect the will of the legislature as voted for in the budget (Flynn & Pessoa, 2014). Expenditure controls should also reflect sound financial management principles, ensuring that public resources are utilized efficiently, incurred obligations are cleared in a timely manner, abuse/ misappropriation of public money is prevented, and private actors compete on a level playing field for government contracts (IMF, 2016).

According to Reisenwitz (2015), healthcare institutions, like other businesses, have certain operating expenses required for the continued function of the business, such as governance and documentation, billing, supplies, energy, rent/property maintenance, transportation, capital charges, cleaning, waste disposal, and other non-clinical personnel expenses.

In Ghana, public hospitals depend mostly on three major sources for their financing, which are Government of Ghana (GOG) Subvention, Internally Generated Funds (IGF) and Donor Pooled Funds (DPF) (Akortsu and Abor, 2011). Of these sources, the internally generated fund is rated the most reliable, and the least reliable is the donor pooled funds.

The incidence of expenditure control weaknesses, unsatisfactory and deteriorating service delivery have the undesired effect of not only weakening the establishment's ability to provide services effectively, but also encourages collusion, fraud, asset conversion, genuine and deliberate mistakes, corruption, lack of transparency and accountability for revenue collection and accountability for revenue collection and other assets. For the enhancement of the attainment of the mission and goals, it is therefore necessary that these hindrances be removed.

Statement of the Problem

With an ever-increasing volume of sick patients and the constant pressure to contain healthcare costs, hospital administrators are acutely aware of the need to reduce expenses, now more than ever. Expenditure control or cost control is part of management control process, in every organisation. This process is very important to any organisation be it profit making organisation or non-profit making organisation. Thus, lack of this practice in any organisation will cause misapplication of cash in cash disbursement process and this will create a very big problem leading the organisation into deficit and at an extreme case, the organisation might wind up. Many researches have been conducted in the reason for winding up of companies and organisation in which lack of expenditure control process had found responsible.

The incidence of expenditure control weaknesses, unsatisfactory and deteriorating service delivery have the undesired effect of not only weakening the Government's ability to effectively provide services but also encourages collusion, fraud, embezzlements, loss of cash (revenue), assets conversion genuine and deliberate mistakes, corruption, lack of transparency and accountability for revenue collection and other assets. Despite considerable investment, public service delivery is unsatisfactory and degenerating. The government is not able to break even and sustain itself from the revenue obtained there from. This impacts so negatively on the government's existence.

Large number of cases of irregularities, violation of laws, rules and regulations, wastages, misuse of public resources, lack of due diligence and prudence in management and use of public resources have continually surfaced in audit, which warrant proper attention and improved accountability. Several

studies highlighted that, poor accounting and financial management practices is one of the factors contributing to massive failure of institutions including the health service in the short run (Babiak & Trendafilova, 2011; Hailu, Venkateswarlu, 2016; Fatoki, 2012; Smith, 2017). Evaluating the strengths of expenditure controls and addressing any weaknesses requires a clear understanding of the key features of an effective expenditure control system as well as the different approaches to putting them into practice. While expenditure control frameworks differ greatly from health facility to health facility, and country and country.

For the enhancement of the attainment of the mission and goals of the firms, it is therefore necessary that these hindrances be removed. The management of the health facilities should familiarize themselves with expenditure control procedures that will ensure effective service delivery and the desired revenue generation. Unfortunately, there has not been empirical research studies in the area of expenditure control methods in the Ghana that compare both public own and privately own health facilities. No determined effort has been made to investigate the problem of weak expenditure control over service delivery and revenue generation. Therefore, the main motivating factor underlying this study is the desire to break new grounds with the intent of shedding more light on this problem and seeking avenues for solving it.

Empirically, most of the studies done are found in either the broader financial management practices (Arnaboldi et al, 2015; Asante et al, 2014; Karadag, 2015; Nadzri, Omar & Rahman, 2017; Byarugaba, Karyeija, & Twinomuhwezi, 2014), financial control (Asante, 2011; Armah, 2012; Adua, Frimpong, Li, & Wang, 2017) or budgetary controls (Cleverley, Song &

Cleverley, 2011). Very few studies have been done specifically in the area of expenditure controls in health institutions which in this case was done in Nigeria (Pembi, 2018).

It is against the above background that this study sought to compare the expenditure control system in operation of health facilities in the Bono region.

Purpose of the Study

The purpose of this study is to compare various expenditure control systems and practices in the various hospitals (government, mission and private) in the Bono region. Based on this, the differences and similarities are examined between these health facilities.

Research Objectives

The main objective of this study was to investigate and compare expenditure controls and practices in government, mission and private health facilities in the Bono region. The specific objectives of the study are to:

I. Ascertain the expenditure control method adopted by the government, mission and privately owned hospitals.
II. Examine expenditure control practices of health facilities in the Bono region
III. Find out similarities and differences in the expenditure control practices in health facilities in the Bono region
IV. To identify the strengths and weaknesses of the system of expenditure control in all the selected hospitals in the Bono region.

Research Questions

The study was guided by the following broad questions:

I. What are the expenditure control method adopted by the government, mission and privately owned hospitals?

II. What are the various expenditure control practices of health facilities (government, mission and private)?

III. Are there similarities and differences in terms of expenditure control practices between these health facilities (government, mission and private)?

IV. What are the strengths and weaknesses of the system of expenditure control in all the selected hospitals?

Significance of the Study

This study is significant for the following reasons:

The findings of this study would highlight the accounting and administrative control problems plaguing the selected hospitals in the region.

It would enable managers of services, organizations and government owned public utility establishments to bring the accounting and the expenditure control procedures inherent in them in conformity with expenditure accounting standards and practices.

It would help government owned and the privately owned establishments to assess then expenditure control measures and make amends where necessary.

The study could arouse further research into some other further research into some other functional areas in the government by students and accountants. It would also help to broaden (my) researchers' knowledge.

Delimitations

Although the study was to evaluate the expenditure control system in operation at health facilities in Bono region, to ensure accurate and reliable data collection, it was limited to the study of the expenditure control measures at selected hospitals (government, mission and private). This covers expenditure control as it affects revenue generation (handling of cash) assets control administrative control and manpower control as well. The main focus of the research was limited to the comparative analysis of expenditure controls in private, mission and government hospitals in the Bono region. In this research, the study identified the different methods of expenditure control being adopted by these hospitals and their practical application and their level of effectiveness. This study will form a basis for our analysis which will help to answer some research questions.

The study was also delimited to selected hospitals namely government (fully owned or public funded), mission or Christian Health facilities, and privately owned hospital in the Bono region.

Limitations

The findings of this study must be interpreted in the context of a number of limitations. The researcher due to the following could not take a wider range of study:

Inability to have access to some relevant documents from the officials in the selected health facilities. This is due to attitude of workers: owing to the fact that so many workers (employees) are not aware of what research is all about and its importance, they have non-challant attitude towards the researcher making it difficult for her to get the information's needed.

Another challenge had to do with financial and time constraint, which confined the researcher to only one region (Bono region). The corona virus pandemic has put a lot of strain on the finances of individuals and businesses and therefore equally affected the limited financial situation of the researcher in terms of travel expenses, and other logistics to help complete the study on time.

Definition of Terms

For the purpose of clarity, the following terms used in this context are hereby elaborated.

Revenue: This describes the amount of money a Government generates in a set period of time through the sale of products or services.

Expenditure control: Management tools that guides and ensures that company/organisational spending are in accordance with the policy plans.

Expenditure Control System: This is the whole system of control, financial and otherwise established by the management in order to carry on the business of the enterprise in an orderly and efficient manner.

Auditing: An activity earned on by the auditor when he verifies or examines accounting information determines the accuracy and reliability of the accounting statement and reports and then expresses his opinion.

Control Activities: Policies and procedures that management has established

Audit: An independent examination of and the subsequent expression of opinion upon the financial statements of an organization.

Expenditure Check: This is the allocation of authority and work in such a manner as to afford checks as the routine transactions of day to day work

by means of the work of one person are being proved independently by another or the work of a person being complementary to that of another.

Current expenditures: are expenditures to finance the daily and routine activities like expenditures on pay and allowances, maintenance of buildings and properties, office supplies, utilities, etc.

Capital expenditures: are expenditures incurred either for a short or medium-term which entails long-term returns like, expenditures on acquisition of immoveable properties, trainings, structures, plant and equipment, vehicles, etc.

Comparative study: to examine the difference between two or more things.

Privately owned Hospital: Hospital owned and financed by an individual or group of people.

Government owned hospitals: Hospitals owned and controlled by government or state government.

Organization of the Study

This study was organized in five chapters. Chapter one constitutes the background of the study, statement of the problem, objectives, significance, delimitations, limitations, definition of terms and organization of the study. Chapter two comprises of the theoretical literature review, empirical literature review, summary of literature review and research gaps and conceptual framework. Chapter three encompasses the methodology which presents the research design, target population, sampling design, research instrument, data collection procedure, data analysis and ethical considerations. Chapter four constitutes the research findings and discussion which presents the response

rate, background information, descriptive statistics, inferential statistics and discussion of results. Chapter five presents the summary, conclusion, recommendations for policy and practice, and recommendations for further study.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The purpose of this chapter is to explore the literature and provide a comprehensive overview relating to expenditure control systems in selected health facilities including government, quasi health facilities and private hospitals. The primary themes identified from this review were used to inform the content of an instrument to ask management of these health facilities about similarities and differences in terms of expenditure control practices between these health facilities. The chapter is organized into theoretical, empirical and conceptual frameworks.

Theoretical Framework

Relevant key theories were reviewed to support the theoretical anchorage of the study besides conducting an empirical review of related studies. The study considered the two theories which are agency and institutional theories.

Agency theory

Agency theory focuses on the behavioral relationship between the owners (principals) and those others (agents) who are contracted by the owners to execute duties on behalf of the principal where the agent is given some decision making power. It is also used to define the relationship between managers and investors by defining the duties and responsibilities ran by the manger on behalf of the investor and the reward that the manager receives from the investor (Jensen & Mckling, 1976). The theory further poised that managers are more informative than investors making it hard for investors to effectively

determine whether their interests are well taken care of. Therefore, the theory stated that there is need to have proper and adequate contracts in an organization to minimize opportunistic behaviors by the managers (Mwangi, 2012). To address the interest of both the manager and investor, the contract should draft in a manner that captures the two interests. A good agent-principal relationship is whereby the investor has systems that enable them to effectively monitor the work of their managers (Jussi & Petri, 2004). The theory also stated that incomplete contract information on the expectation of the investors as well as the managers could have adverse effects on the general performance of the organization. This is because the managers will have inadequate knowledge on what is expected of them by the agents leading to under-performance. Therefore, this theory assumes the nature of the relationship between managers and agent is based on wealth maximization (Jensen & Meckling, 1976). This theory is relevant to the study since expenditure control mechanisms are established in organizations to minimize agency cost and improve general organizational performance (Payne, 2003; Abdel-Khalik, 1993). This study borrows from this perspective and makes assumptions that the staff and management of the institution have given mandate to the management of the institution to effectively manage the resources and ensure smooth running of the institution on a daily basis through delegation of duty. Effective expenditure control systems ensure that investors' interests are well taken care of. In addition, this theory supports existence of control activities, control environment and risk management.

Institutional theory

The study of institutions traverses the academic fields of economics, sociology, political science and organisational theory. The common denominator for institutionalism in various disciplines appears to be that of, 'institutions matter' (Kaufman, 2011). An underlying assumption in the study of institutions is that organisations are deeply embedded in the wider institutional context (Abbot, DiMaggio & Powell, 1992). Thus, "organisational practices are either a direct reflection of, or response to, rules and structures built into their larger environment" (Paauwe & Boselie 2003, p.59). This institutional environment is the source of legitimisation, rewards or incentives for, as well as constraints or sanctions on, organisational activities (Meyer & Rowan, 1977). The institutional approach used in organisational analysis is referred to as organisational institutionalism (Greenwood et al., 2008). Organisational institutionalism deals with the overall question: 'What does the institutional perspective tell us about organisational behaviour?' Institutional theory is a useful lens to analyse organisational behaviour because it can respond to empirical mismatch, where, 'what we observe in the world is inconsistent with the ways in which contemporary theories ask us to talk' (March & Olsen, 1984, p.747). The theory is credited with its emphasis on the contextual, historical and processual aspects in which organisational actions take place (Currie, 2009).

Institutions constrain hospital behavior by identifying legal, moral, and cultural boundaries, which must be balanced in all aspects of decision making. Hospitals that conform to institutional pressures are rewarded through increased legitimacy, as well as stability and resources when faced with hardships (Meyer

& Rowan, 1977; Scott, 2008). While conformance to institutional pressures can provide economic benefits to organizations, such forces do not arise from an exclusive consideration of economic costs and benefits.

Concept of Expenditure Control

According to Bhattacharyya and Bandyopadhyay (2012), expenditure control is a comprehensive approach for appropriate fiscal management. Expenditure control has been defined as the process by which managers utilize effectively and efficiently, the scarce resource in the achievement of the organisational goals. It also described as management tools that guides and ensures that company/organisational spending are in accordance with the policy plans.

The objective of assessment of expenditure control is to determine whether all expenditures have been approved and utilised for the intended purposes. The expenditures are classified and recorded correctly and that government agencies achieve value for money in the use of public resources (Royal Audit Authority of Bhutan, 2015). According to the International Monetary Fund (2016), the objective of expenditure control is to ensure that public resources are spent as intended, within authorized limits, and following sound financial management principles. The role of an expenditure control system is to ensure that the level and allocation of institution expenditure reflect the will of the institution in the budget.

Clarifications of Expenditure

According to Royal Audit Authority of Bhutan (2015), for the purpose of proper classification and recording, the expenditures are broadly classified under two categories namely, Current and Capital. Current expenditures are

expenditures to finance the daily and routine activities like expenditures on pay and allowances, maintenance of buildings and properties, office supplies, utilities, etc. also stated as Recurrent expenditure, Bhattacharyya and Bandyopadhyay (2012) referred to expenditure outlays necessary for the day-to-day running of government business. It is regarded as final government consumption expenditure. Capital expenditures are expenditures incurred either for a short or medium-term which entails long-term returns like, expenditures on acquisition of immoveable properties, trainings, structures, plant and equipment, vehicles (Bhattacharyya & Bandyopadhyay, 2012). Capital expenditures refer to funds that are used by a company for the purchase, improvement, or maintenance of long-term assets to improve the efficiency or capacity of the company. Long-term assets are usually physical, fixed and non-consumable assets such as property, equipment, or infrastructure, and that have a useful life of more than one accounting period.

Also known as CapEx or capital expenses, capital expenditures include the purchase of items such as new equipment, machinery, land, plant, buildings or warehouses, furniture and fixtures, business vehicles, software, or intangible assets such as a patent or license. The expenditure amounts for an accounting period are usually stated in the cash flow statement. Capital expenditures normally have a substantial effect on the short-term and long-term financial standing of an organization. Therefore, making wise CapEx decisions is of critical importance to the financial health of a company. Many companies usually try to maintain the levels of their historical capital expenditure to show investors that the managers of the company are investing effectively in the business. There are normally two forms of capital expenditures: (1) expenses

for the maintenance of levels of operation present within the company and (2) expenses that will enable an increase in future growth. A capital expense can either be tangible, such as a machine, or intangible, such as a patent. Both intangible and tangible capital expenditures are usually considered assets since they can be sold when there is a need.

In the government's financial management system, current and capital expenditures are further categorized into different object codes as classified under FRR 2001. However, the classification and recording of expenditures for other audited agencies, which are not operative under the government budgetary system (LC and PLC operations) are done as per the relevant accounting and reporting standards (Royal Audit Authority of Bhutan, 2015).

Types of Controls and Institutional Actors

The International Monetory Fund (IMF) (2016) classified controls applied at different stages of the expenditure cycle. The various controls applied during the expenditure cycle can be grouped into six main categories. These are (i) appropriation control; (ii) commitment control; (iii) aggregate cash control; (iv) control of regularity; (v) accounting control; and (vi) other specific controls. Other specific controls relate to specific types of transactions and are designed to either reinforce macro-fiscal discipline and sustainability (e.g., controls on payroll, pensions, and incurrence or liquidation of liabilities or guarantees) or safeguard the integrity and efficiency of public procurement and payroll systems.

Appropriation control: Ensures that expenditure is covered in the budget and the proposed amount of expenditure includes all relevant expenses. The main features of this control is that budget cover (against the relevant

appropriation) is checked after deducting all expenditures previously approved. The amount should be correctly calculated and there should be no hidden expenses. This control is applied during the apportionment, reservation, commitment and payment order stages and virements during budget execution (IMF, 2016).

Aggregate cash control: the idea of this control is to minimize the cost of financing programs by smoothing the gap between cash inflows and outflows. This control is a key element of the overall cash management system. The features of this approach are release of spending authority (warrants, notification de crédit, etc.) is controlled against an annual cash plan that is updated on rolling basis. Payments by spending units are coordinated with the cash manager to ensure that sufficient cash is available in the TSA. This is applied during the apportionment and payment stages (IMF, 2016).

Commitment control: this ensures that expenditure commitments by spending units are fully in line with the expenditure limits and the released spending authority. The key feature of this approach is the spending units enter into commitments only against unencumbered spending authority and the cash plan covers the expected payment profiles of commitments. This is seen during the commitment stage (IMF, 2016).

Control of regularity: this approach verifies the legal and administrative compliance to ensure that the expenditure operation and related documents/contracts follow the procedure, prescribed in the law and/or financial regulations. Features of this approach included legality of the operation is controlled by verifying that the officials approving a transaction have the authority to do so, and that the required supporting documents have

been prepared in line with the law/regulations (for audit). Stages that this approach are applied include mainly commitment, verification, payment order and payment stages, but also at other stages (IMF, 2016).

Accounting control: this approach is adopted to ensure that transactions are properly recorded and accounted for to produce timely and reliable fiscal reports and financial statements. In this approach, transactions are recognized, classified, and recorded in the books/general ledger according to institution's or country's accounting policies/standards and chart of accounts. They are also reconciled with bank statements. This approach is applied during the payment and verification (in case of accrual accounting) stages (IMF, 2016).

Other Controls Specific to Particular Types of Transactions

Controls on liabilities or guarantees (contrôle de liquidation): This control is applied on the incurrence of a liability or guarantee and again at the payment stage when the liability is extinguished or guarantee is paid. It seeks to verify: (i) the existence of budget cover or space within the authorized limits; and (ii) that the payment is being made to extinguish the liability to a real creditor and for a claim that was not paid earlier (IMF, 2016).

Payroll controls (a subset of commitment control): The objective of payroll controls is to control personnel expenditures and staffing numbers. This requires that personnel database (where personnel information files are kept) and payroll records be linked, regularly updated, and reconciled. Where the two are not routinely or automatically reconciled, special surveys may be required to identify ghost workers and remove them from the payroll. Payroll audits should also be undertaken regularly to identify weaknesses in the control system (IMF, 2016).

Pension controls: The liability and associated expense for pensions and other retirement benefits should be recognized at the time the employee's services are rendered. Any part of that cost unpaid at the end of the period is a liability. To be able to exercise upfront control over the future resource requirements related to pensions, countries implementing accrual budgeting (e.g., the UK, Australia and New Zealand) include the accruing cost and any unfunded liabilities of pension schemes17 within budgetary limits for each government department (IMF, 2016).

Verification of goods and services (contrôle du service fait): This control involves: (i) verification of the goods and/or services delivered by a supplier to ensure that these conform to the specified quality and quantity; and (ii) a calculation of the liability incurred by the government to the supplier. This control can also apply to the wages/personnel expenditure in the sense that a designated official (e.g., the head of the division/department) certifies that the respective staff have performed their duty during the time period for which wages are to be paid (IMF, 2016).

Control of procurement: Significant public spending takes place through the public procurement system. The main objective of the government as a purchaser is to obtain high quality goods and services at a competitive price. Procurement procedures should provide a fair opportunity for all bidders to compete for government contracts, and be designed to get good value for money and to minimize risks of corruption and patronage. Manual processing controls: Key manual processing controls for purchasing, payment, and confirmation of receipt of goods and services are performed outside the typical information systems (e.g., FMIS) environment and should be subject to periodic internal

control checks and audit. They can be more easily circumvented, presenting the potential for error or fraud (IMF, 2016).

Key Stages of Expenditure Control Framework

Expenditure controls should also reflect sound financial management principles, ensuring that resources are utilized efficiently, incurred obligations are cleared in a timely manner, abuse/ misappropriation of institutions money is prevented, and private actors compete on a level playing field (IMF, 2016).

Seven key stages of the expenditure cycle

To ensure these objectives are met, government expenditures typically go through seven stylized stages between authorization by the body and payment to the final beneficiary. These stages are:

1. Authorization of expenditure. A fundamental principle of public finance is that expenditure and revenue proposals must be legally authorized to ensure accountability. The authorization for expenditure is usually given through the budget law which defines the time horizon for, limits on, purpose of, and administrative unit accountable for government expenditure. To provide accountability, the budget proposals should be sub-divided by entity/purpose. This objective is achieved by appropriations. An appropriation is defined as a sub-division of a government budget established for accountability purposes, which shows the amounts legally authorized to be spent for specific purposes in a specific time period. To deal with unanticipated spending pressures, some flexibility in the allocation of expenditure between sectors may be allowed subject to clear rules/criteria (e.g., through virements and/or allocation from a contingency reserve). Budgets are not the only

mechanisms that provide the legal authorization to incur expenditure. Certain sums may be spent under permanent rather than annual (Jacobs, Hélis & Bouley, 2009).

2. Apportionment of authorization for specific periods and spending units. The purpose of apportionment is to prevent spending agencies from incurring obligations at a rate which would require the authorization of additional funds for the fiscal year in progress. Once expenditure authorization is in place, it is apportioned for specific periods and/or specific spending units. Apportionment usually follows two steps: (i) apportionment by the ministry of finance, which consists of releasing the appropriation on a quarterly or monthly basis to the line ministries; and (ii) allotment by the line ministries or main spending units of their apportioned appropriations to their subordinate spending units. This authority to spend is released to the spending units through the issue of warrants/allotments/décret de répartition, or other mechanisms. Some form of centralized control during this phase of the expenditure cycle is common in almost all countries and is usually enforced by the budget department of the ministry of finance. The apportionment process is critical to ensuring that expenditure totals are respected and any virements or claims on the contingency reserve are reflected in the revised allocation of appropriations. Each request for apportionment or reapportionment should be accompanied by a financial or cash plan from the relevant ministry or spending agency supporting the request for ensuring that apportionment and cash management functions are well integrated (Radev & Khemani, 2009).

3. Reservation. According to Radev and Khemani (2009), once the apportionment of expenditure authorization is made and the spending authority has been released, some countries' PFM systems include a stage at which funds are reserved for a specific known expense but for which no contract has yet been issued. This is known as retenciones de crédito in Spain (and a similar arrangement in Portugal) and "engagement budgétaire" in France which precedes the "engagement juridique" or legal commitment stage. At this stage, there is no commitment, but it is known that the expense will be incurred during the budget year and, therefore, the reserved funds should not be used for other activities. This setting aside of an allotment for a future expenditure should not be confused with a legal commitment as no specific contract is signed at this stage.
4. Commitment. The commitment stage is the point at which a potential future obligation to pay is established. A commitment occurs when a formal action, such as placing an order or awarding a contract, is taken that renders the government liable to pay at some time in the future when the order or contract is honored by its counterpart. A commitment thus entails an obligation to pay when the third party has complied with the provisions of the contract. In cases where the expenditure is subject to a previous ongoing contract (e.g., wages, utilities, rent, debt service) or statutory obligation (e.g., transfers to subnational governments), an estimate of obligation to pay should be made and treated as a commitment. Since commitments usually mature as payments, their control is an essential part of overall expenditure control and prevention

of expenditure arrears (Radev & Khemani, 2009). A commitment does not mean that a payment will necessarily be made within the same fiscal year. This is especially true for expenditure on multi-annual investment projects (see Section III for multiyear expenditure limits on commitments).

5. Verification (or certification). At this stage, after goods have been delivered and/or services have been rendered by a supplier, an authorized officer within the spending unit concerned verifies their conformity with the contract or order, and that a liability and due date of payment are recognized. Assets and liabilities of the government are increased and recorded in the books, if an accrual accounting system is established. In cases where the expenditure involves a previous ongoing contract (e.g., wages, utilities, rent, debt service) or statutory obligation (e.g., transfers to subnational governments, payments of household benefits, etc.), the verification requires confirmation that the obligation has actually fallen due. Expenditures at the verification stage are sometimes called accrued expenditures (e.g., in the US), accounts payable, or actual expenses. The defining characteristic of an expenditure at the verification stage is that a liability has been incurred. Arrears are the expenditures at the verification stage that have not been paid by the due date of payment specified either in specific contracts or procurement legislation or assumed under general commercial terms (Flynn & Pessoa, 2014).
6. Payment order. Once checks are made to ensure that all previously stipulated controls have been performed and documented, a payment

order is issued. A payment order is an authorization for payment (usually against a bill or invoice) made by officials of line ministries, other spending agencies, or the ministry of finance. Before issuing a payment order, the issuing authority will typically check that sufficient funds are available to make the payment. Following confirmation that sufficient liquidity is available, a designated official approves the payment and issues a payment order (Radev & Khemani, 2009). In cases where a centralized payment system has been established, the individual spending units may prepare the payment orders electronically and submit them to the central unit/treasury for payment through a Financial Management Information System (FMIS).

7. Payment. Once a payment order has been issued, payments are made through various instruments including checks, electronic fund transfer (EFT), and sometimes cash, in favor of a supplier or other recipient to discharge the liability. In line with internationally accepted good practice, the payment should be made through a treasury single account (TSA) system (Pattanayak & Fainboim, 2011). Payments by checks are, in most countries, recorded at the point of their issuance. The process of issuing checks should be managed to monitor and minimize check float and ensure that sufficient cash is available when they are presented for encashment. Sometimes, a consolidated check is issued to cover multiple payments by the bank to the respective beneficiaries' accounts (e.g., payroll payments) as per the treasury's instructions. To ensure bank reconciliation and reliability of expenditure data used for financial reporting, it is important to compare and reconcile the transactions

recorded in the cash book (which records the details of checks issued) with those in the bank statements. When the float of unpaid checks is significant, payments should also be reported on the basis of checks encashed/paid. It is not a good practice to net payments against revenue due from the same recipient, as it hinders the transparent reporting of government revenues and expenditures as they pass through the various stages (Flynn & Pessoa, 2014).

Financial Control and Healthcare Delivery

Financial control which is part of expenditure and budget control is concerned with tracking, and reporting on allocation, disbursement and utilization of financial resources, using the tools of auditing, budgeting and accounting (Cleverley et al., 2011). The literature in this area deals with compliance with the laws, rules and regulations regarding financial control and management (Karadag, 2015). In his view, accountability involves the delegation of individuals or agencies to provide information about and/or justification for their actions whiles financial control is concerned with the managers' responsibility to account on the performance of the resources for which they have control and authority. This is supposed to be done diligently by emphasizing organisational and stakeholders' interest.

According to Adua, Frimpong, Li and Wang (2017), financial control is a management function that is crucial for proper accountability and, accountability for all funds should be maintained at all times. Burrell and Morgan (2017) said that every organisation is subject to some kind of risks depending upon several factors such as; the products and services it offers, the market in which it functions, the sources through which it is financed, and the

way it utilizes its resources. In addition, the innovative developments in the financial sector have led to increased demand for an effective risk management as well as sophisticated corporate governance. Hence, the activities that are covered in the implementation of a good corporate financial control are overseeing activities in connection with authorizations and reconciliations, reviewing of employee performance, security of assets, and segregation of duties (Cooperrider, & Srivastva, 2017).

Limitations/Challenges of Expenditure Controls

No matter how well expenditure controls are designed, they can only provide reasonable assurance that objectives have been achieved. Some limitations are inherent in all expenditure control systems (Mercer University – United States of America (Georgia). These are discussed below.

Judgement

The effectiveness of expenditure controls is limited by decisions made with human judgment under pressures to conduct business based on the information at hand. According to Lannoye (1999), effective expenditure control may be limited by the realities of human judgment. Decisions are often made within a limited time frame, without the benefit of complete information and under time pressures of conducting agency business. These judgment decisions may affect achievement of objectives, with or without good expenditure control. Expenditure control system may become ineffective when management fails to minimize the occurrence of errors, for example misunderstanding instructions, carelessness, distraction, fatigue, or mistakes (Williams, 2000).

Breakdowns

No matter how well expenditure controls are designed, they can break down. Sometimes employees misunderstand instructions or simply make mistakes. Errors may also result from new technology and the complexity of computerized information systems (Williams, 2000).

Management override

High level personnel may be able to override prescribed policies and procedures for personal gain or advantage. This should not be confused with management intervention, which represents management actions to depart from prescribed policies and procedures for legitimate purposes. According to Lannoye (1999), management may override or disregard prescribed policies, procedures, and controls for improper purposes. Override practices include misrepresentations to state officials, staff from the central control agencies, auditors or others. Intervention may be required in order to process non-standard transactions that otherwise would be handled inappropriately by the expenditure control system. A provision for intervention is needed in all expenditure control systems since no system anticipates every condition (Williams, 2000)

Collusion

Control systems can be circumvented by employee collusion. Individuals acting collectively can alter financial data or other management information in a manner that cannot be identified by control systems. The effectiveness of segregation of duties lies in individuals performing only their assigned tasks or in the performance of one person being checked by another. There is always a risk that collusion between individuals will destroy the effectiveness of segregation of duties. For example, an individual who receives

cash receipts from customer can collude with the one who records these receipts in the customers' records in order to defraud the entity (Williams, 2000).

Empirical Review

A comparative study of expenditure controls method in government and private hospitals by Pembi (2018) aimed at studying and analysing the different methods of expenditure control adopted by the hospitals, their practical application and their level of effectiveness. It aimed at carrying out a comparative analysis of two hospitals. To achieve the aim of this research, secondary data were used through review of some related literatures. Primary sources included questionnaires, interview and observation used for analyzing the data by simple percentages while hypotheses were tested using chi-square statistics. The findings of the analysis indicate, among others, that the method of expenditure control used by both hospitals are not the same. The daily control method for private hospitals and the vote card method for government hospitals. The different methods of expenditure control used by the two hospitals are effective, but with slight loopholes associated with vote card method. The author recommended among others that both hospitals should adhere strictly to authorization procedure for drug purchased and materials purchases. Both hospitals should exhibit high degree of cash management and employ competent personnel for proper and efficient expenditure control.

A study by Akindele, and Oluwafolakemi (2013) examined internal control systems in public and private universities in Nigeria and it confirmed the establishment of private universities in Nigeria as a recent development. Questionnaire was adopted for the study and 12 universities in South West Geo-Political Zone of Nigeria were selected as the study sample using purposeful

sampling technique. Universities selected cover 6 public universities and 6 private universities. Data collected were analyzed using factor analysis and multivariate analysis of variance. The findings of the result confirmed that internal control systems are the same in public and private universities in Nigeria, but that fusion of duties is more pronounced in private universities than public universities. Similarly, the finding rejects the notion that private universities are better funded than public universities and that internal control system can be over-ridden by management in both public and private universities. Examination of the effectiveness of internal control system in the private university shows that ICS is effective in reducing cost of running the university and also strengthened the attainment of a university goal and objective but the findings do not show support for ICS as a means of facilitating timely condition of academic calendar. However, it facilitates management system review in the private universities while results indicate that ICS in public universities showed limited number of efficiency is effective as a cost reducing measure in running the university and as a monitoring tool via an identifiable internal audit department.

Addo (2018) assessed the financial management practices of Ghana Health Service. The study adopted the survey design. A sample size of 69 out of the population of 223 staff in Akim Oda Government Hospital was used. The instrument used for data collection was a self-administered questionnaire. The statistical technique used to analyse the objective was regression technique. The study found that budgets are consistent with the dictates of the accounting and financial management principles in Oda Government Hospital. The study also observed that financial accountability is fairly high in the hospital. The study

indicated that overall, financial control is high in the financial management practice of the hospital.

Asante (2011) evaluated the internal financial controls in public hospitals in Ghana using a case study of Regional and Municipal hospitals, Sunyani and District hospital, Bechem (Brong Ahafo). The study sought to establish the existence of internal financial controls. It was also to find out the level of compliance. Further, to establish the consequences of compliance and non-compliance with regulations. Data was collected from three (3) hospitals and twenty-five (25) members of staff. Purposive sampling and observation technique were used. Questionnaires and structured interview guides were used to gather data regarding internal financial controls in the three Public Hospitals. Data analysis and presentation were done with the aid of Microsoft Excel. Asante (2011) discovered from the findings that there was existence of internal financial controls regulated by Financial Administration, Procurement, Internal Audit Agency Acts and indirect application of COSO. As a government organization, it was more concerned about solving what it considered more pressing issues of fulfilling its objectives than ensuring quality, as it was not a proof it making entity. It was revealed that the level of compliance was high with regard to other financial management regulations like Financial Administration, Procurement and Internal Audit Agency Acts.

Health service delivery system

The health system includes health insurance organizations, general hospitals, and pharmaceutical companies with goals of health improvement, equity, responsiveness to legitimate expectations and fair financing among others (Frenk, 2010; Olden, 2011). WHO defines a health system as “all the

organizations, institutions, resources and people whose primary purpose is to improve health" (WHO, 2000). In the year 2007, WHO identified six building blocks that are deemed relevant in strengthening the health system. These building blocks include: service delivery, health financing, health workforce, medical supplies/equipment (health commodities, vaccines and technology), information system and leadership/governance (University of Ghana, 2018).

Health facilities

Public and private health facilities provide health care in Ghana. The public health care services are mainly those facilities under Ghana Health Service, Teaching hospitals and those established by quasi-government institutions such as the police service, military and public universities (University of Ghana, 2018). The private sector is made up of faith-based, private-for-profit, private not-for-profit health institutions and the traditional health system. Health service in the public sector are organized in a three-tier health delivery system of primary, secondary and tertiary levels. The primary level include health facilities located at the district, sub-district and community. At the district level is a hospital which serves as the main referral facility for the health centres and clinics located at the sub-district level (University of Ghana, 2018). A typical district with a population of 100,000 may have one hospital, 5 health centres and 10-15 Community-based Health Planning and Services (CHPS) zones.

At the regional level is the regional hospital, which is the referral level for secondary care and run by general practitioners and specialists. There are ten regional hospitals receiving referrals from districts and providing outreach support to districts in Ghana (University of Ghana, 2018). Komfo Anokye

Teaching Hospital, Korle-Bu Teaching Hospital, Cape Coast Teaching Hospital and Tamale Teaching Hospital are the current teaching hospitals providing tertiary care and training of doctors. The health sector has adopted an integrated approach to delivery of health services covering preventive and promotive services, clinical care and emergency services. As of 2013, over 75% of all health facilities belonged to the government followed by private institutions (19%) and Christian Health Association of Ghana (CHAG) institutions (4.27%). There are an estimated 3,500 public, private, and faith-based health care facilities in Ghana. Fifty-seven percent of these facilities are public, 33 percent are private, and 7 percent are operated by the Christian Health Association of Ghana (CHAG). Health facilities include compounds, health centers, clinics, maternity homes, and seven types of hospitals: district, municipal, metropolitan, regional, teaching, psychiatric and uncategorized. While all compounds and most health centers and district hospitals are public, most clinics, maternity homes, and uncategorized hospitals are private. One municipal hospital is CHAG-owned, and one teaching hospital is private; all other municipal, metropolitan, regional, and teaching hospitals are public facilities. The share of private facilities ranges from 5.4 percent in the Northern region to 74.9 percent in the Greater Accra region.

Conceptual Framework

The conceptual framework of this study was constructed from available literature based on the purpose and constructs adopted in this current study. The study bases expenditure control variables namely, Authorization and Approval; Disbursement Control; Delegation and Segregation of Duties; and

Classification and Recording. These constructs are interrelated and reflect the independent variables for this present study.

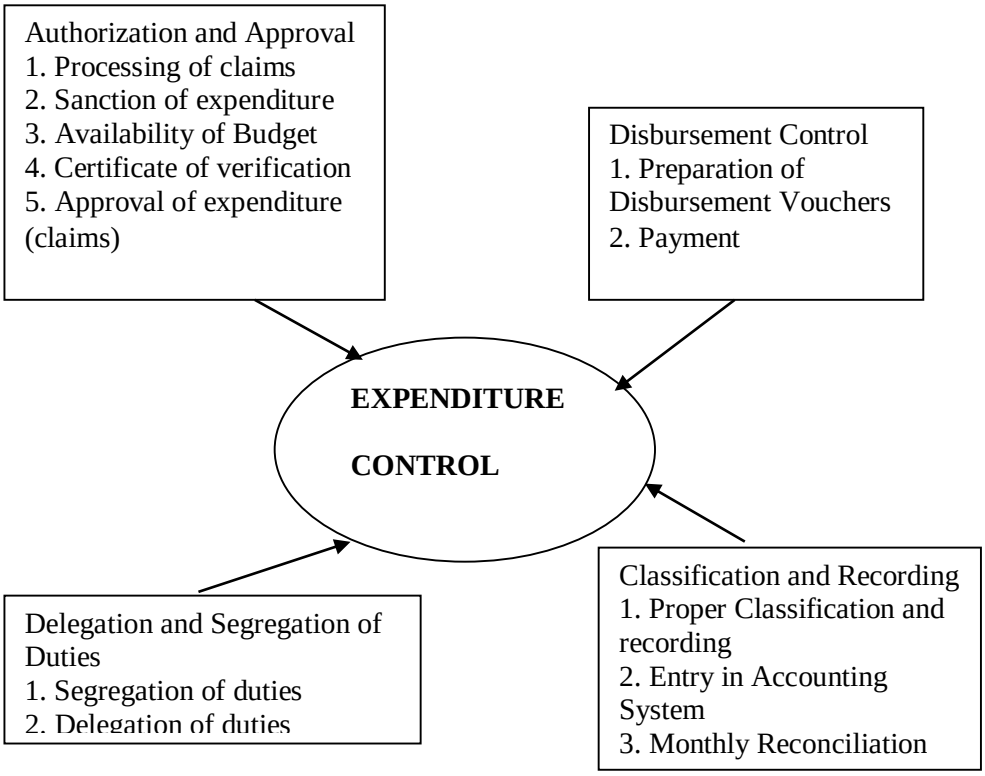

Figure 1: Conceptual framework of the study

Source: Author's construct (2020)

Chapter Summary

The review has highlighted the definition of expenditure controls which relate to system of controls, financial and otherwise, established by management in order to carry on the business of an enterprise in an orderly and efficient manner, ensure adherence to management policies, safeguard its assets and secure as far as possible the completeness and accuracy of the records. It is instituted by the board, management and other legal provisions for the achievement of corporate governance. The components of expenditure control system as revealed by literature include Authorization and Approval;

Disbursement Control; Delegation and Segregation of Duties; and Classification and Recording. The next chapter presents the research methods highlighting the processes that were followed to conduct the study.

CHAPTER THREE

RESEARCH METHODS

Introduction

The chapter presents the methodology that was used during the study. It presents the research design, study population, sample size, sampling methods, data collection methods and instruments, procedure for data collection validity and reliability, data management and analysis and ethical consideration.

Research Design

Research design is the planned arrangement for data collection and analysis in a manner that aims to combine relevance to the research purpose with economy of procedure (Selltiz, Wrightsman & Cook, 1981). Robson (2002) also describes a research design method as research purpose and questions, phenomenon to guide study, method of data collection and sampling strategy. The approach to this study is a case study, which has been referred to variously as "action research" (Bryman, 2012), "qualitative research" (Bryman, 2012; Yin, 2009)., "fieldwork" (Scapens, 1990), and "field-based research (Spicer, 1992). Despite the divergence in views, there are points of agreement among accounting researchers. Hartley (1994, p.208) captures the essence of case study efforts in accounting: A detailed investigation often with data collected over a period of time, of one or more organisations, with a view to providing an analysis of the context and process involved in the phenomenon of study. Case studies can be used in a variety of ways (Ryan, Scapens & Theobold, 1992). This study employs what Ryan et al. (1992) refers to as "explanatory case study" which they say (p.115): "such case studies attempt to explain the reasons for observed accounting practices". Explanatory case

studies focus on the specific case and employ social theory to guide an explanation and understanding. Case study allows the researcher to use multiples of data collection instruments including questionnaire and interview. It is for this reason that the study adopted the case study approach to assess and compare the expenditure control of selected health facilities in the Bono region.

Study Settings

This comparative study was undertaken in six (6) health institutions in the Bono region. These facilities included Public (Sunyani Regional Hospital, Municipal Hospital Sunyani), CHAG (Dormaa Presbyterian hospital, Wenchi Meth. Hospital), and private (Greenhill hospital and Akyereko hospital). This section briefly described these health facilities.

Sunyani Regional Hospital

The Sunyani Regional Hospital is the highest referral health facility in the region based on the order of ranking according to the Ghana Health Service. The hospital is a state of art with ultramodern facility that provides general and specialized health services to the three regions namely Bono, Bono East and Ahafo as well as part of the Cote d'ivoire. The hospital operates under various Units or clinics including the Obstetrics and Gynaecology, Ear, Nose and Throat Clinic, Dental Department, Dietetic Unit, Psychiatric Unit and Internal Medicine. Other services are provided including family planning, general surgery, among others.

Municipal Hospital Sunyani

Sunyani Municipal Hospital (SMH) is situated in the Sunyani East Municipality of the Bono Region. The Hospital was built in 1927 and was used then as the Regional Hospital until October, 2004 when its status was changed

to a Municipal Hospital. This is because a new and bigger Hospital was built and is being used as the Regional hospital. It has a 63 bed capacity and is currently the biggest primary healthcare facility in the Sunyani Municipality and provides services such as; General Out-Patient Department services, In- Patient Department, Obstetrics and Gynecology, General Surgery, Paediatrics, Internal Medicine, Pharmacy, Laboratory, Radiology, Eye/Ophthalmological services, HIV/AIDS/Prevention of Mother To Child Transmission (PMTCT) and Mortuary services. The facility is managed by a 6-member team comprising the Medical Superintendent, Head of Administration, Head of Finance, Head of Nursing, Head of Pharmacy and the Clinical Coordinator. Currently, there are about 225 nursing staff, 7 medical officers, 4 medical assistants, 24 administrative staff including the health service administrator, 8 environmental health staff, 7 health information officers, 14 laboratory/x-ray staff, 12 pharmacy staff, 31casual staff and 9 other clinical staff, working in the various departments in the facility (SMH Half Year Report, 2016).

Presbyterian Hospital

The Presbyterian Hospital, Dormaa Ahenkro in the Bono Region. The hospital is part of the Christian Health Association of Ghana (CHAG) and the municipal hospital for the Dormaa Central municipality. The Dormaa Presbyterian Hospital is located in the Bono region of Ghana and was founded in 1955 by the Presbyterian Church of Ghana under the Brong Ahafo Presbytery. The hospital is close to the regional capital of Dormaa Ahenkro and the region itself is only 15 kilometres from the Cote d'Ivoire (Ivory Coast) border. The hospital is organized into an Outpatient Department (OPD) and an Inpatient Department. The hospital is also organized into several wards, namely

the Maternity Clinic, Paediatric Ward, Surgical Ward (Male/female), Intensive Care Unit, Causality Ward, and the Gynaecology Ward. A Paediatric unit christened, Ansuaa Ababio Paediatric Centre, has a washing bay for cooking and washing of clothes and a recreational centre for children recovering from ailments. It comes third after similar departments in Okomfo Anokye and Sunyani Regional Hospital. The hospital has a bed capacity of 216, five (5) departments and a total workforce of about 547. The facility offers practical training for health service administrators, student nurses and other medical house men and interns.

Wenchi Methodist Hospital

The Wenchi Methodist Hospital, is a Methodist facility operating in Wenchi, the capital of Wenchi municipality. The hospital was established in 1973 by the Methodist Church under the Diocese of Wenchi to provide healthcare to the inhabitants of Wenchi and its environs. The facility serves as the municipal hospital in the Wenchi Municipality. The Hospital is a general hospital and provides a wide range of diagnostic, curative and preventive services befitting its status as the District Referral facility. These include; 24-hour Out and Inpatient (OPD) Care, Laboratory Services, X-Ray, Ultra Sound, Surgical Services (both emergency and elective), Ophthalmic Services (Eye Clinic) Child Welfare and Primary Health care facility, Reproductive Health Care and Safe Motherhood, ear nose and throat services (ENT) as well as Specialized Clinic for Diabetic, HIV/AIDS, TB, and other patients with chronic diseases or conditions.

Greenhill Hospital

The Greenhill Hospital is a private health facility operating in the Sunyani municipality. Located in Asuono along the Abesim road opposite the Sunyani Senior High School. The hospital provides a general services and is organized into an Outpatient Department (OPD) and an Inpatient Department. The hospital is also organized into wards, namely the Maternity Clinic, Paediatric Ward, Surgical Ward (Male/female), and the Gynaecology Ward.

Owusu Memorial Hospital

The Owusu Memorial Hospital popularly known as 'Akyereko hospital' is a private health facility operating in the Sunyani municipality. Located in Tomsuom Estate close to the Jehowah Witness Church and the Seventh Day Adventist Church. The hospital provides a general services and is organized into an Outpatient Department (OPD) and an Inpatient Department. The hospital is also organized into wards, namely the Maternity Clinic, Paediatric Ward, Surgical Ward (Male/female), Dental clinic, Eye clinic and the Gynaecology Ward.

Population

Babbie (2005) defines a population as the people about whom a researcher will like to draw conclusion of a study from. The population of the study comprised management of health facilities in the Bono region. The target population comprises Accounting and Finance staff as well as management of some selected public hospitals within the Bono region. These people included Heads of the units, Accountants, Account officers, Storekeepers, among others. The target population for this organized study was twenty-four (24) workers of Accounting, eight (8) workers of Auditing, eight (8) workers of budget, thirty-

eight (38) Health Workers were workers working in other departments apart from accounting, auditing and administration and twenty-four (24) Administration staff. The choice of these personalities is mainly due to their positions and capability of providing the needed information and their level of expertise and experience in the management of funds of these facilities for at least the last five years. Their experience in the administration of the business and therefore put them in a good position to provide suitable responses to the questions of this research work.

Table 1: Sample Distribution of Respondents by the Hospitals

Respondent category	Regional Hospital Sunyani	Municipal Hospital Sunyani	Dormaa Presby Hospital	Wenchi Meth. Hospital	Greenhill Hospital	Akyereko Hospital	Sample
Accounting staff	5	5	5	5	2	2	24
Audit staff	2	2	2	2	-	-	8
Budget staff	2	2	2	2	-	-	8
Administration staff	5	5	4	4	3	3	24
Other health workers	10	8	8	8	2	2	38
Total pop.	24	22	21	21	7	7	102

Source: Field data (2020)

Sample and Sampling Procedures

The study sample refers to the group selected from the population for the purpose of drawing conclusion about the entire population (Neuman, 2007). Six major hospitals in the Bono region were selected, Public (Sunyani Regional Hospital, Municipal Hospital Sunyani), CHAG (Dormaa Presbyterian hospital, Wenchi Meth. Hospital), and private (Greenhill hospital or Akyereko hospital). Two stage sampling method emphasizing both quantitative and qualitative was used to sample the health institutions and the respondents for the study. The first stage of the sampling involved the selection of the number of health care institutions to participate in this study. The non-probability sampling method allows the researcher to control the elements of the study. Under this sampling method, purposive sampling technique, which deals with purposefully selecting participants who possess certain characteristics that are related to the purpose of the study, is used to select the three health facilities. The accounting and operational procedures were scrutinized to determine their adherence to prudent public sector financial procedures. Again, the purposive sampling technique was also used to select officials due to their position in these institutions and the willingness of the officials to participate in the study. According to Baffour-Awuah (2011), for purposive sampling to be effective, participants must be identified based on qualifications and characteristics they possess, that are related to the study.

A hundred and two (102) key managers were selected using a purposive sampling technique, from the account section and all departments or units of the selected health facilities. The candidate managers are involved in the management of the hospitals, that is have jurisdiction of internal and

expenditure controls. The managers are referred to as 'Employees'. This sample selection mechanism ensures that employees involved in expenditure controls decision-making participated. It makes the sample a proper representation of the case hospital and the research purpose. It is a sampling technique, where the sample units are chosen due to particular features which will enable detailed exploration and understanding of the central themes in the study, and the research to achieve objectives (Ritchie & Lewis, 2003).

Data Collection Instruments

Both primary and secondary sources of data were used in the study. The primary data sought from the participants of the study who are the management officials, and accounts officers from the selected health facilities in the region. The secondary sources also came from other people's work in the form of literature through the review of articles; journals; books; published and unpublished dissertations; Auditor-General's Reports; PFMA; and budgets of these health facilities on the subject matter. All these sources are supplemented by the use of primary sources.

The data collection methods used for this study were only structured questionnaires. The questionnaires composed of both closed and open-ended questions which are intended to give the respondents options and also the opportunity to provide diverse answers on the research questions.

The questionnaire is the best data collection tool because the study participants are literate. In addition, the use of questionnaire ensured that the researcher upholds respondents' anonymity and confidentiality while allowing the researcher to collect data faster from a wide population (Kothari, 2007). The questionnaire (appendix 1) were used to give respondents time and

independence to answer the questions. This was also because of the high literacy level of respondents and also to provide the respondents with anonymity to freely answer the questions. Example with name excluded it provided the respondents with opportunity to answer the questions more truthfully and conveniently. The data collected was a direct response to the research questions. The questionnaire was apportioned into five parts all covering the research questions. The first section is based on biographical data, wherein the respondents are asked questions about their age, academic and professional qualifications, period of service, and period engaged in implementing internal or expenditure controls. The second section tests the competency levels of respondents, and questions to be asked involve the practices of expenditure controls. The third part highlights their views on the similarities and differences of the practices of expenditure control. Fourth, the study asks questions that probe the weaknesses that the respondents feel exist in the expenditure control function and the recommendations they offer for redress. The options of the questionnaire were ranked or set on a likert scale for clarity. The options ranged from 5 – 1 where 5 indicated strongly agree, 4 – agree, 3 – neutral, 2 – disagree and 1 – strongly disagree.

Pilot Study

Pilot studies are used in two different ways in social science research. It refers to feasibility studies which are "small scale version(s), or trial run(s), done in preparation for the major study" (Polit et al., 2001, p. 467). However, a pilot study can also be the pretesting of a particular research instrument including testing its reliability, which was the primary aim here. One of the advantages of a pilot study is that it identifies weakness in the main research project,

circumstances in which the research protocol may not be able to be followed, or whether the proposed methods or instruments are inappropriate or too complicated (Lancaster, Dodd, & Williamson, 2004).

A sample of twenty-two (22) health workers including accounting, audit and other workers from the Berekum Holy Family Hospital was used to pilot test the drafted questionnaires to ascertain the readiness and suitability of the instruments. A Cronbach coefficient alpha test was used. The purpose is to determine internal consistency of the scale used. According to Sekaran (2000), Cronbach alpha is a reliability coefficient that indicates how well the items are positively correlated to one another. The closer the Cronbach alpha is to 1, the higher the internal consistency.

Reliability and Validity

Reliability and validity are ways of demonstrating and communicating the rigour of research processes and the trustworthiness of research findings (Roberts, Priest, & Traynor, 2006). Reliability describes to what extent a particular test, procedure or tool, such as a questionnaire, will produce similar results in different circumstances, assuming nothing else has changed (Cormack, 2000; Roberts et al., 2006). Reliability is the consistency of a set of measurements or of a measuring instrument (Polit & Beck, 2010). That is, a reliable measure is one that is measuring something consistently (De Vaus, 2002; Polit & Beck, 2010). Validity is a subtler concept (Roberts et al., 2006). It is about the closeness of what is believed to be being measured to what was intended to be measured (Cormack, 2000; Roberts et al., 2006). A number of processes have been undertaken to ensure the validity and reliability of the questionnaire. These processes were: 1. determining content validity by seeking

the views of the supervisor on domain and item construction 2. determining face validity by seeking the views of a sample of respondents on clarity and relevance 3. a pilot test–retest for reliability using a sample of other staff from other health facilities.

Table 2: Results of Validity and Reliability Test

Variables	No. of items	Cronbach α
Authorisation and approval	12	0.868
Disbursement control	9	0.665
Delegation and segregation	4	0.766
Classifications and recording	7	0.756

Source: Field data (2020)

The results show that all the items met the required standard indicating that a construct reliability which indicates internal consistency. Therefore, improving the value of α for each cluster of items is not required.

Data Collection Procedures

After selecting and finalising the tools, the researcher visited the hospital under investigation personally for taking prior permission from the management of the hospital. Subsequently the researcher discussed in detail about his investigation with the management of the hospitals and sought the permission from them for collecting the necessary data. Prior to the administration of the questionnaire, formal permission was sought from management of the selected health facilities. On the part of the individual participants, verbal consent was sought with assurances of full confidentiality and anonymity of their participation in the study. The instruments were self-administered to the

respondents, that is, the researcher gave every respondent in the sampled group a questionnaire to complete and later go for the completed questionnaire.

Data Analysis

The descriptive quantitative statistics was used to analyse the data, with the aid of Microsoft Excel (MS Excel) program. The questionnaires were marked to ensure that none is entered twice. Responses provided by the respondents were then entered into the spread sheet analysis template and run afterwards. The MS Excel was used in generating tables for understanding and clarity. The software application was also used to generate frequency tables and percentages to enhance the analysis and provide better and clearer comprehension. Also, the results from the analysed data were presented descriptively using means and standard deviations.

Ethical Consideration

Before the start of the study, formal ethical approval was obtained from the Catholic University of College of Ghana. In addition, the research was guided by a number of ethical principles, specifically consent, autonomy, anonymity and confidentiality. In terms of Consent, all participants were provided with a copy of the Participant Information to ensure sufficient explanation of the study was facilitated. The survey instrument included a statement that the return of the survey form will be taken as implied consent to participate. Regarding autonomy, the cornerstone of protecting autonomy in this study was strictly adhered to, with the researcher providing full disclosure about the nature of the study, the risks, benefits and alternatives, and an extended opportunity to ask questions before deciding whether or not to participate. The researcher also stressed that participants ought not to feel coerced in any way to

participate and that they were free to 'refuse to participate'. With regard to anonymity and confidentiality, each participant's right to privacy was ensured. The confidentiality of the information was thus protected at all times and participants were assured that the information will not be released by the researcher to a third party unless required to do so.

Chapter Summary

The methodological approach has been quantitative case study. This research approach is deemed the most appropriate since the study sought to explore, understand, describe and interpret the phenomenon through the experiences, perceptions and perspectives from participants' standpoint. The study employs non-probability sampling techniques. Purposive sampling technique is used to select the needed sample. Study participants will be drawn from all the management staff of the institutions. In all, 102 workers involved in ensuring internal control at the selected health facilities participated in the study. The main method of data collection is structured interviews with mostly open ended questions. The administration of the instruments was done at the convenience of the study respondents. Results from the analysed data were presented by means of frequencies and charts. The next chapter which is chapter four presents the analysis and discussion of the results.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

The goal of this study is to compare various expenditure control systems and practices in the various hospitals (government, mission and private) in the Bono region. An explanatory case study design was used and population drawn from key management staff of six major hospitals in the Bono region were selected, Public (Sunyani Regional Hospital, Municipal Hospital Sunyani), CHAG (Dormaa Presbyterian hospital, Wenchi Meth. Hospital), and private (Greenhill Hospital or Owusu Memorial Hospital). This chapter presents the results of the study and their discussions. The chapter is organised in line with the study objectives. It also covers the characteristics of respondents. The discussion basically centres on explaining the findings, comparing the findings with both theoretical and empirical evidences and the relevant implications.

Presentation of Results

This section presents the results from the data collected and analysed using various descriptive tools such as mean, standard deviations, among others. For easy reading, the presentation of the results was done in relation to the study objectives including the expenditure control approaches or methods used by these health facilities, the expenditure control practices in the facilities, the strengths and weaknesses in these approaches, and the similarities and differences in these approaches and practices.

Demographic Characteristics of Respondents

This section presents results of the demographic data of the respondents (i.e. management and staff in charge of budget and expenditure controls) from the selected health facilities.

Table 3: Characteristics of Respondents

Age Distribution	No.	Percent
21 - 30 yrs	12	11.8
31 - 40 yrs	30	29.4
41 – 50 yrs	39	38.2
51 - 60 yrs	21	20.6
Total	102	100
Gender distribution		
Male	67	65.7
Female	35	34.3
Total	102	100
Educational Qualification		
DBS	5	4.9
HND	10	9.8
1st Degree	52	51.0
Masters	23	22.5
Professional	6	5.9
Medical Doctor	6	5.9
Total	102	100

Source: Field data (2020)

Table 3 shows that 11.8% of the respondents are between the ages of 21 and 30 while 29.4% is between 31 and 40 years. A little above one-fifth of the respondents (20.6%) of the respondents are aged between 51 and 60. The age group of the respondents who are between 41 and 50 are also 38.2% and constitute the majority. Per the results, the officers are in their prime age to learn and implement expenditure and internal control measures as well as gaining the needed experience to improve financial management practices in hospitals.

With reference to gender**,** Table 2 shows that the majority of the respondents (65.7%) are male whiles 34.3% are female. Thus, the internal control officers are male dominated.

Regarding to academic qualification, the majority of the respondents' highest academic and professional qualification acquired is bachelor's degree constituting 51%. This is followed by officers with master's degree qualifications representing 22.5%, with 9.8% holding Higher National Diploma (HND) and 4.9% of the respondents holding Diploma in Business Studies (DBS) Certificate. The rests, 5.9% each hold professional and medical certificates.

Table 4: Period of Service at the Hospital

Periods	No.	Percentage
0 - 5 years	25	24.5
6 – 10 years	57	55.9
11 – 15 years	16	15.7
16 – 20 years	4	3.9
21 – 30 years	0	0.0
Total	102	100

Source: Field data (2020)

The statistics in the table above indicate that 25 (24.5%) of the respondents have worked at their respective hospitals for at most five years. Those who have worked there for between 6 and 10 years are at 55.9%, while 15.7% of respondents have worked at their present hospitals for between 11 and 15 years. Very few of the respondents (3.9%) have worked in their current hospitals between 16 to 20 years.

Table 5: Period engaged in implementing expenditure control

Periods	No.	Percentage
0-5 years	47	46.1
6 – 10 years	39	38.2
11 – 15 years	11	10.8
16 – 20 years	5	4.9
21 – 30 years	0	0.0
Total	102	100

Source: Field data (2020)

Respondents with a maximum of five years' work experience in expenditure or internal control implementation are 46.1% whiles those with between six and ten years work experiences are 38.2%. The respondents who are engaged in the implementation of expenditure or internal control for a period between eleven and fifteen years are 10.8%, whereas those who are engaged for between sixteen and twenty years are 4.9%.

Expenditure Control Method Adopted by the Government, Mission and Privately Owned Hospitals

This objective sought to find out from these health facilities the methods or approaches adopted to control expenditure. As indicated, the study used Public (Sunyani Regional Hospital (SRH), Municipal Hospital Sunyani (SMH),

CHAG (Dormaa Presbyterian hospital (DPH), Wenchi Meth. Hospital (WMH), and private (Greenhill hospital (GHC) or Owusu Memorial hospital (OMH)

Table 6: Expenditure Areas of the Health Facilities

Expenditure Areas	SRH	SMH	DPH	WMH	GHC	OMH
Non-mechanised salaries	5%	5%	5%	5%	10%	10%
Procurements of drugs	33%	33%	33%	33%	28%	28%
Procurement of non drugs	35%	35%	35%	35%	35%	35%
Administrative (training)	5%	5%	5%	5%	5%	5%
Maintenance of equipment	1%	1%	1%	1%	1%	1%
Logistics and Basic equipment	2%	2%	2%	2%	2%	2%
Utilities (power, water, etc.)	19%	19%	19%	19%	19%	19%

Source: Field data (2020)

The expenditure areas of the public and CHAG health facilities are similar which include procurement of drugs (33%) and non-drugs (35%). The next area of expenditure is utilities which take 19%, 5% each into non-mechanised salaries and administrative expenses, 2% into logistics and 1% into maintenance. The expenditure areas of the private hospitals include procurement of non-drugs (35%), drugs (28%), utilities (19%), salaries (10%), administrative expenses (5%) and the remaining (3%) into maintenance and logistics.

Table 7: Summary of Main Type of Expenditure Controls Adopted by health Facilities

Controls	SRH	SMH	DPH	WMH	GHC	OMH
Appropriation	✓	✓	✓	✓		
Aggregate cash					✓	✓
Commitment	✓	✓				
Control of regularity	✓	✓	✓	✓		
Accounting	✓	✓	✓	✓		

Source: Field data (2020)

Table 7 shows the main type of expenditure control methods or approaches used by these health facilities in the region. From the results, the Sunyani Regional Hospital (SRH) and the Sunyani Municipal Hospital (SMH) which represented the publicly owned hospitals use appropriation control, commitment control, control of regularity and accounting cash controls. The Christian Health institutions such as the Dormaa Presbyterian Hospital (DPH) and the Wenchi Methodist Hospital (WMH) use the appropriation control, the control of regularity and the accounting cash controls. On the other hand, the private hospitals such as the Greenhill Clinic (GHC) and the Owusu Memorial Hospital (OMH) use only one of the controls which is the aggregate cash control.

Table 8: Summary of Other Expenditure Controls Adopted by Health Facilities

Controls	SRH	SMH	DPH	WMH	GHC	OMH
Controls on liabilities	✓	✓	✓	✓		
Payroll controls	✓	✓	✓	✓	✓	✓
Pension controls	✓	✓	✓	✓		
Verification of goods and services	✓	✓	✓	✓	✓	✓
Control of procurement	✓	✓	✓	✓		

Source: Field data (2020)

Table 8 shows the summary of other expenditure control approaches used by the health facilities. From the results, the public and CHAG health facilities including Sunyani Regional Hospital, Sunyani Municipal Hospital, the Dormaa Presbyterian Hospital and the Wenchi Methodist Hospital use the controls on liabilities, payroll controls, pension controls, verification of goods and services, and control of procurement in their expenditure control measures. Meanwhile, the privately owned health facilities use only the payroll controls and pension controls to safeguard their expenditure.

Expenditure Control Practices of Health Facilities (Government, Mission and Private)

As the main objective of the study which sought to ascertain the expenditure control practices of the health facilities in the region, this section presents the results of the data analysed on the various expenditure control practices of the hospitals.

Table 9: Summary of Other Expenditure Controls practices

Practices	SRH	SMH	DPH	WMH	GHC	OMH
Availability of approved budget for the year	✓	✓	✓	✓		
Formal request from the head of unit/dept.	✓	✓	✓	✓	✓	✓
Administrator/Medical Superintendent approval	✓	✓	✓	✓	✓	✓
Referred to auditing	✓	✓	✓	✓		
Accountant/account office approval of funds availability	✓	✓	✓	✓	✓	✓
Prepared Local Purchase Order	✓	✓	✓	✓		
Procurement of items by the procurement officer/office	✓	✓	✓	✓	✓	✓

Source: Field data (2020)

Table 9 shows the expenditure control processes in the hospitals. The results show that both the public and the mission hospitals practice similar expenditure control practices as they observed the following order of processes in spending or approving expenditure: first, there should be approved budget for the year and quarterly budget plans to warrant spending or approval of expenditure. Second, memos or formal requests should be made from the department/sections/units requesting demand or purchase or approval of items needed for work to go on to the administrator or the medical superintendent for approval (note: before the authority giving approval, it is expected that all the

necessary verifications would have been made). Third, the documents are referred to the audit unit for proper auditing. This is where the internal audit checks or verify it with the approved quarterly or yearly approved budget. Fourth, the documents are sent to the accounts section for the checks to be made about the availability of funds for approval and payments. The fifth stage is the preparation of Local Purchase Order (LPO) which indicates the prices, quantities and amounts of the items. The sixth and final process is the referral to the procurement department for the necessary approvals.

However, in the privately owned health facilities, the processes are dependent on contingencies (i.e. when the needs arise). The medical superintendent who doubles as the owner, checks with the other staff (sometimes upon notification from the administrator or a staff in-charge of the unit) of the various items they need. The medical officer/owner checks with the accountant/account officer the availability of funds for spending or purchase. The order is then made for the purchase or supply of the items.

Table 10: Authorization and Approval Stage in the Expenditure Control Process

Key stages	Done		Not done	
	Freq.	%	Freq.	%
Sunyani Reg. Hospital	24	100	0	0.0
Sunyani Muni. Hospital	22	100	0	0.0
Dormaa Presby. Hospital	21	100	0	0.0
Wenchi Meth. Hospital	21	100	0	0.0
Greenhill Hospital	7	100	0	0.0
Owusu Mem. Hospital	7	100	0	0.0

Source: Field data (2020)

Table 10 shows the authorization and approval stage of the expenditure control process. The results show that all the health facilities in one way or the other have authorization and approval process where the needed approval and orders are given before spending is done.

Table 11: Disbursement Control Stage in the Expenditure Control Process

Key stages	Done		Not done	
	Freq.	%	Freq.	%
Sunyani Reg. Hospital	24	100.0	0	0.0
Sunyani Muni. Hospital	22	100.0	0	0.0
Dormaa Presby. Hospital	21	100.0	0	0.0
Wenchi Meth. Hospital	21	100.0	0	0.0
Greenhill Hospital			7	100.0
Owusu Mem. Hospital			7	100.0

Source: Field data (2020)

Table 11 shows the disbursement control stage of the expenditure control process. When respondents were asked if this process is adhered to in the expenditure control process, all the respondents (100%) in the public and mission hospitals (CHAG) said disbursement control is very much practiced. However, at the private health facilities, disbursement control is largely not done.

Table 12: Delegation and Segregation of Duties Stage in the Expenditure Control Process

Key stages	Done		Not done	
	Freq.	%	Freq.	%
Sunyani Reg. Hospital	24	100.0	0	0.0
Sunyani Muni. Hospital	22	100.0	0	0.0
Dormaa Presby. Hospital	21	100.0	0	0.0
Wenchi Meth. Hospital	21	100.0	0	0.0
Greenhill Hospital	3	42.9	4	57.1
Owusu Mem. Hospital	3	42.9	4	57.1

Source: Field data (2020)

Data in Table 12 shows that delegation and segregation of duties in the expenditure control process is done as all the respondents (100%) in the public owned and CHAG facilities indicated. However, while 42.9% said it done, the majority of the respondents (57.1%) said it is not done in the private health facilities.

Table 13: Classification and Recording stage in the Expenditure Control Process

Key stages	Done		Not done	
	Freq.	%	Freq.	%
Sunyani Reg. Hospital	24	100	0	0.0
Sunyani Muni. Hospital	22	100	0	0.0
Dormaa Presby. Hospital	21	100	0	0.0
Wenchi Meth. Hospital	21	100	0	0.0
Greenhill Hospital	7	100	0	0.0
Owusu Mem. Hospital	7	100	0	0.0

Source: Field data (2020)

Table 13 shows that all the respondents (100%) from the six selected health facilities indicated they practise classification and recording of the expenditure control process.

Table 14: Respondents' Views on Authorization and Approval of Expenditure

Processing of Claims	Mean	Std. Dev.
In the processing of claims, authorities verify the maintenance of bill Inward register in prescribed form.	4.59	.572
In the processing of claims, authorities review the BIR to see that the settlement of claims has been done within 30 days from the date of receipt of claim	2.80	1.10
In the processing of claims, authorities verify the payments against the claims were made upon fulfilment of all the requirements including sanction of expenditure, recording of verification of claims, approval of expenditure and payment	4.99	.44225

Source: Field data (2020)

Once all the health facilities practise authorization and approval stage of the expenditure control practice, the study subsequently asked them series of questions to understand how this stage is well-practiced and the responses are shown in Table 13. The results show that respondents agreed that the following practices are done including in the processing of claims, authorities verify the payments against the claims were made upon fulfilment of all the requirements including sanction of expenditure, recording of verification of claims, approval of expenditure and payment (4.99), and authorities verify the maintenance of bill Inward register in prescribed form (4.59). Meanwhile, respondents were not

sure whether authorities review the BIR to see that the settlement of claims has been done within 30 days from the date of receipt of claim with mean score of 2.80 and standard deviation of 1.10.

Table 15: Sanction of Expenditure in the Authorisation and Approval Process

Sanction of expenditure	Mean	Std. dev.
Authorities sanction expenditure by verify that all expenditures have been authorized by appropriate sanctions (technical, financial and administrative) of competent authorities.	4.44	.968
Authorities obtain sanction orders and see whether expenditure sanctioned exceeded the prescribed limit.	4.10	1.174
Authorities enquire whether there is any system put in place that sanctions accorded are further verified by accounts section to validate sanctions accorded are within the powers of the authorities.	4.55	1.023
Grand mean	4.36	

Source: Field data (2020)

Table 15 shows the sanction of expenditure by authorities in the authorization and approval process of the expenditure control. The results show that respondents generally agreed that there is authorities sanction of expenditure with mean score of 4.36. For instance, respondents generally agreed that Authorities enquire whether there is any system put in place that sanctions accorded are further verified by accounts section to validate sanctions accorded are within the powers of the authorities (4.55), Authorities sanction expenditure by verify that all expenditures have been authorized by appropriate sanctions (technical, financial and administrative) of competent authorities (4.44), and

Authorities obtain sanction orders and see whether expenditure sanctioned exceeded the prescribed limit with mean score of 4.10 and standard deviation of 1.174.

Table 16: Availability of Budget in the Authorization and Approval Stage

Availability of budget	Mean	Std. dev.
Authorities obtain the approved budget document and verify that the expenditures were made within the approved budget limit	4.99	.44225
Authorities verify whether the accounting unit has maintained an appropriate control register in form FAM to keep check that the expenditures are within the approved budget limit	4.99	1.262
Grand mean	4.99	

Source: Field data (2020)

Table 16 shows respondents from the public and CHAG health facilities about the availability of budget in the authorisation and approval of expenditure control process. The results show that respondents generally agreed to Authorities obtain the approved budget document and verify that the expenditures were made within the approved budget limit, and Authorities verify whether the accounting unit has maintained an appropriate control register in form FAM to keep check that the expenditures are within the approved budget limit with mean score of 4.99 each.

Table 17: Verification and Approval in the Authorisation and Approval Stage

Verification and Approval	Mean	Std. dev.
Verification and Certification of claims by authorised officials (to establish goods and services have been received and recorded)	4.39	.960
Authorities see that the verifying officer has appended a certificate of verification on the claims stating all relevant records	3.90	.632
Authorities verify that the Head of Agency or the DDO has prepared and approved disbursement/journal voucher for payment and adjustment	3.01	.836
Authorities verify that the approval was accorded by approving officer within the delegated authority.	4.99	.445

Source: Field data (2020)

Table 17 shows the verification and approval in the authorisation and approval stage of the expenditure control process. The results show that respondents generally agreed that there is verification and certification of claims by authorised officials (to establish goods and services have been received and recorded) with mean of 4.39, and Authorities see that the verifying officer has appended a certificate of verification on the claims stating all relevant records (3.90).

Also, the results show that Authorities verify that the approval was accorded by approving officer within the delegated authority with mean score of 4.99 and standard deviation of 0.445. On the other hand, respondents were not sure whether Authorities verify that the Head of Agency or the DDO has prepared and approved disbursement/journal voucher for payment and adjustment with mean score of 3.10 and standard deviation of 0.836.

Table 18: Respondents' Views on Appropriate Disbursement Control

Independent Variables	Mean	Std. Dev.
Authorities check the disbursement vouchers to see whether it were prepared in Form FAM and were filled in properly by Account section.	4.8966	.30993
Authorities verify that the JV in form FAM is prepared for recording the adjustments entries.	2.98	1.176
Authorities verify that the cancelled vouchers are defaced by striking a double line through the face of voucher and the word 'cancelled' should be clearly written by indelible ink.	4.33	.81308
Authorities verify that the disbursement vouchers are supported by valid and relevant documents.	4.24	.91805
Authorities ensure that payments are made by cheques to the payees or authorised representatives	4.90	.30993
Authorities check that the payment in the form of cash had not exceeded the limit	4.99	.44225
Authorities verify that the payees have signed the vouchers/ acknowledgement on receipt of the payments	3.19	0.677
Authorities verify that the disbursement vouchers are approved by the DDO/head of office	3.14	1.117
Authorities check from DV that all statutory deductions have been made.	4.87	0.998

Source: Field data (2020)

Table 18 shows the various processes of appropriate Disbursement Control in the health facilities. On whether appropriate Disbursement Control is done with regard to Authorities checking the disbursement vouchers to see

whether it was prepared in Form FAM and were filled in properly by Account section, respondent generally agreed to the statement with mean score of 4.89 and standard deviation of 0.309. Again, the results show that respondents were not sure whether Authorities verify that the JV in form FAM is prepared for recording the adjustments entries with mean score of 2.98 and standard deviation of 1.176. On whether Authorities verify that the cancelled vouchers are defaced by striking a double line through the face of voucher and the word 'cancelled' should be clearly written by indelible ink, the results show that respondents generally agreed to the statement with mean score of 4.33 and standard deviation of 0.81308. Similarly, respondents agreed that Authorities verify that the disbursement vouchers are supported by valid and relevant documents with mean of 4.24 and standard deviation of 0.91805. Furthermore, almost all the respondents generally affirmed that Authorities ensure that payments are made by cheques to the payees or authorised representatives with mean score of 4.90 and standard deviation of 0.3099. Moreover, respondents generally agreed that Authorities check that the payment in the form of cash had not exceeded the limit with mean score of 4.99 and standard deviation of 0.44225. The results also show that respondents were not sure whether Authorities verify that the payees have signed the vouchers/ acknowledgement on receipt of the payments with mean score of 3.13 and standard deviation of 0.677. Again, respondents were not sure to the effect that Authorities verify that the disbursement vouchers are approved by the DDO/head of office with mean score of 3.14 and standard deviation of 1.117. Finally, respondents agreed that Authorities check from DV that all statutory deductions have been made with mean score of 4.87 and standard deviation of 0.998.

Table 19: Respondents' Views on Delegation and Segregation of Duties

Independent Variables	Mean	Std. Dev.
In the segregation of duties, Authorities review the accounting process and verify that responsibilities and functions are segregated and assigned to different people.	4.6889	.50163
In the segregation of duties, Authorities review that the functions are in line with individual job description.	2.7778	.95828
In the delegation of duties, Authorities verify that the responsibilities and functions are appropriately delegated and office orders issued to that extent.	2.6111	.77754
In the delegation of duties, Authorities obtain office orders relating to delegation of responsibilities and observe the actual performance of activities to see that responsibilities are discharged in accordance with the delegated responsibilities.	2.6111	.60768
Grand mean	2.67	

Source: Field data (2020)

Table 19 shows the summary of practice of delegation and segregation of duties during expenditure in the health facilities. The results, shows that respondents agreed to the practice of delegation and segregation is very much enshrined in the expenditure control practices. For instance, respondents generally agreed that Authorities review the accounting process and verify that responsibilities and functions are segregated and assigned to different people (4.69). On the other hand, respondents were not sure about Authorities review the functions are in line with individual job description (2.78), Authorities verify that the responsibilities and functions are appropriately delegated and

office orders issued to that extent (2.61), and Authorities obtain office orders relating to delegation of responsibilities and observe the actual performance of activities to see that responsibilities are discharged in accordance with the delegated responsibilities with mean score of 2.61.

Table 20: Respondents' Views on Appropriate Classification and Recording

Independent Variables	Mean	Std. Dev.
Authorities ensure the expenditures are classified and recorded as per the object code	3.83	.902
Authorities ascertain correctness of the entries in the system	3.88	.864
Authorities ascertain timeliness of input in the system.	3.89	.888
Authorities check bank reconciliation statements are prepared on a regular basis.	4.23	.864
Authorities ascertain accuracy of bank reconciliation statements.	3.99	.971
Account wise reconciliation carried out and balance of each account ascertained	3.74	1.144
Checks on bank statements, deposit challans, deposit slips etc., are documented appropriately	3.97	1.194
Grand mean	3.93	

Source: Field data (2020)

Table 20 shows the level of agreement with classification and recording stage of the expenditure control. The results show that respondents generally agreed that the health facilities prioritize classification and recording stage of the expenditure control. For instance, respondents agreed that authorities check bank reconciliation statements are prepared on a regular basis (4.23), Authorities ascertain accuracy of bank reconciliation statements (3.99), checks

on bank statements, deposit challans, deposit slips etc., are documented appropriately (3.97), Authorities ascertain timeliness of input in the system (3.89), Authorities ascertain correctness of the entries in the system (3.88), Authorities ensure the expenditures are classified and recorded as per the object code (3.83), and Account wise reconciliation carried out and balance of each account ascertained with mean score of 3.74.

Similarities and Differences In Terms of Expenditure Control Practices between these Health Facilities (Government, Mission and Private)

This objective sought to identify the similarities of the expenditure control on the one hand, and the differences in the expenditure control practices.

Table 21: Summary of Similarities in the Expenditure Control Practices

Similarities	SRH	SMH	DPH	WMH	GHC	OMH
Expenditure areas	✓	✓	✓	✓	✓	✓
Authorisation and approval	✓	✓	✓	✓	✓	✓
Recording and classifications	✓	✓	✓	✓	✓	✓
Verification of goods and services	✓	✓	✓	✓	✓	✓
Final approval authority	✓	✓	✓	✓	✓	✓

Source: Field data (2020)

Table 21 shows the summary of similarities in the expenditure control practices in the selected health facilities. The results found the following similarities in the expenditure control including the expenditure areas (procurement of drugs and non-drugs taking about 80% of the revenue of the facilities; utilities; non-mechanised salaries, among others); the authorisation and approval; classification and recording stages of the expenditure control

process; verification of goods and services, and the final authorisation or approval authorities.

Table 22: Summary of Differences in the Expenditure Controls Adopted by Health Facilities

Differences	Public	CHAG	Private
Methods or approaches used in the expenditure control	Appropriation, commitment, control of regularity & accounting cash controls	Appropriation, commitment, control of regularity & accounting cash controls	aggregate cash control
Comprehensive and approved budget	Prepares comprehensive & approved by officers	Prepares comprehensive & approved by officers	No comprehensive budget
Internal audit function	Institutionalized internal control function	Institutionalized internal control function	No institutionalized internal control function
Prepared Local Purchase Order	A requirement by rules to prepare LPO	A requirement by rules to prepare LPO	No LPO prepared
Disbursement control	Preparation of disbursement vouchers and payments	Preparation of disbursement vouchers and payments	Payments made upon agreement and supplied

Source: Field data (2020)

Data in Table 22 shows the summary of differences in the expenditure control processes. The results show that these health facilities though have expenditure control practices, there are differences in how they adopt and practice the expenditure controls including methods or approaches used in the

expenditure control (i.e. while the public and CHAG facilities used appropriation control, commitment control, control of regularity and accounting cash controls, the private hospitals used the aggregate cash controls); comprehensively prepared and approved budget are available at the public and CHAG health facilities, the private hospital barely prepare comprehensive budget to control expenditure; the public and CHAG health facilities both have institutionalized internal control function, the private hospitals used the accounts as the audits. The results further show that the public and CHAG health facilities prepare Local Purchasing Order (LPO), there is no such practice found in the private hospitals. Lastly, in both public and the CHAG health facilities, authorities must ensure the preparation of disbursement vouchers and payments, however, in the private hospital only payments are made.

Strengths and Weaknesses of the System of Expenditure Control in all the Selected Hospitals

The objective is intended to identify the strengths and weaknesses of the system of expenditure control in all the selected hospitals.

Table 23: Strength of the Expenditure Control Systems used in the Hospitals

Items	Mean	Std. Dev.
Proper definition/specification of key stages of the expenditure cycle, including the control criteria	3.79	1.23943
Clarity of the legal and regulatory framework, including the roles of the key actors	3.67	1.00000
There are clear laws and financial regulations regarding the controls and the authority and responsibility of relevant actors who should apply them	3.86	1.13398
The associated business rules and processes have been clearly defined	4.20	.90328
The required controls at each stage have been clearly specified and consistently applied	4.26	.90738
Clear sanctions that will be given to breaches of the rules and regulations regarding key stages of the expenditure cycle	3.80	1.10638
Line units directly accountable for the use/control of their appropriations	3.85	.89629
Separation of responsibility for key control tasks	3.82	.92982
Easy for tracking key stages of expenditure cycle	3.64	.777
Grand mean	3.88	

Source: Field data (2020)

Table 23 shows the level of agreement with the strengths in the hospitals' expenditure control procedures. The results show that the majority of the respondents agreed that there are strengths in the hospital's expenditure control procedures with mean score of 3.88. Specifically, there are required controls at each stage have been clearly specified and consistently applied (4.26), there are associated business rules and processes have been clearly defined (4.20), there are clear laws and financial regulations regarding the controls and the authority and responsibility of relevant actors who should apply them (3.86), all the line units directly accountable for the use/control of their appropriations (3.85), there are separation of responsibility for key control tasks (3.82), and clear sanctions that will be given to breaches of the rules and regulations regarding key stages of the expenditure cycle with mean score of 3.80. Other strengths include the proper definition/specification of key stages of the expenditure cycle, including the control criteria (3.79), Clarity of the legal and regulatory framework, including the roles of the key actors (3.67) and easy for tracking key stages of expenditure cycle with mean score of 3.64 and standard deviation of 0.777.

Table 24: Weaknesses of the Expenditure Control Systems used in the Hospitals

Items	Mean	Std. Dev.
Failure to check the availability of funding before authorizing expenditure	3.59	.840
Failure to record and maintain data on commitments	3.98	1.176
Delays in processing of payments	4.00	.419
Circumvention of controls at key stages, including through collusion	4.04	1.093
Poor record keeping, including of verification documents	2.98	0.995
Reporting delays	3.93	1.468
Accumulation of liabilities/arrears	4.23	.843
Frequent and redundant controls make the expenditure process slow (and encourage proliferation of "special procedures")	4.23	.864
Stepping aside the rules due to interferences from top management	3.89	.888
Grand mean	3.87	

Source: Field data (2020)

Table 24 summaries the level of agreement with the various weaknesses in the expenditure control measures in the hospitals. The results show that respondents agreed there are weaknesses in the expenditure controls. For instance, respondents agreed that there are frequent and redundant controls make the expenditure process slow (and encourage proliferation of "special

procedures"), and accumulation of liabilities/arrears with mean score 4.23 and standard deviation of 0.864 and 0.843 respectively. Again, respondents agreed that there is circumvention of controls at key stages, including through collusion (4.04), delays in processing of payments (4.00), failure to record and maintain data on commitments (3.98) and reporting delays with mean value of 3.93. Furthermore, respondents agreed that top management stepping aside the rules due to interferences (3.89), and there is a failure to check the availability of funding before authorizing expenditure (3.59). on the other hand, respondents were not sure whether there is poor record keeping, including of verification documents with mean score of 2.98.

Discussion of Results

This section presents the discussion of the results in relation with the study objectives which include the expenditure methods used by these health facilities, the expenditure control practices, similarities and differences in the expenditure control practices, and the strengths and weaknesses in these practices.

Research Objective 1: Expenditure Control Method Adopted by the Government and Privately Owned Hospitals

The results on the main type of expenditure control methods or approaches used by these health facilities in the region indicate that the Sunyani Regional Hospital (SRH) and the Sunyani Municipal Hospital (SMH) which represented the publicly owned hospitals use appropriation control, commitment control, control of regularity and accounting cash controls. The Christian Health institutions such as the Dormaa Presbyterian Hospital (DPH) and the Wenchi Methodist Hospital (WMH) use the appropriation control, the

control of regularity and the accounting cash controls. On the other hand, the private hospitals such as the Greenhill Clinic (GHC) and the Owusu Memorial Hospital (OMH) use only one of the controls which the aggregate cash control. The findings support the IMF (2016) guidelines that classified the various controls applied during the expenditure cycle such as appropriation control, commitment control, control of regularity and accounting cash controls.

Again, the summary of other expenditure control approaches used by the health facilities. Indicate that the public and CHAG health facilities including Sunyani Regional Hospital, Sunyani Municipal Hospital, the Dormaa Presbyterian Hospital and the Wenchi Methodist Hospital use the controls on liabilities, payroll controls, pension controls, verification of goods and services, and control of procurement in their expenditure control measures. Meanwhile, the privately owned health facilities use only the payroll controls and pension controls to safeguard their expenditure. The findings support the IMF (2016) guidelines that classified other controls applied during the expenditure including liabilities, payroll controls, pension controls, verification of goods and services, and control of procurement in their expenditure control measures.

Research Question 2: Expenditure Control Practices of Health Facilities (Government, Mission and Private)

The results show that both the public and the mission hospitals practice similar expenditure control practices as they observed the following order of processes in spending or approving expenditure: first, there should be approved budget for the year and quarterly budget plans to warrant spending or approval of expenditure. Second, memos or formal requests should be made from the department/sections/units requesting demand or purchase or approval of items

needed for work to go on to the administrator or the medical superintendent for approval (note: before the authority giving approval, it is expected that all the necessary verifications would have been made). Third, the documents are referred to the audit unit for proper auditing. This is where the internal audit checks or verify it with the approved quarterly or yearly approved budget. Fourth, the documents are sent to the accounts section for the checks to be made about the availability of funds for approval and payments. The fifth stage is the preparation of Local Purchase Order (LPO) which indicates the prices, quantities and amounts of the items. The sixth and final process is the referral to the procurement department for the necessary approvals. However, in the privately owned health facilities, the processes are dependent on contingencies (i.e. when the needs arise). The medical superintendent who doubles as the owner, checks with the other staff (sometimes upon notification from the administrator or a staff in-charge of the unit) of the various items they need. The medical officer/owner checks with the accountant/account officer the availability of funds for spending or purchase. The order is then made for the purchase or supply of the items.

With regard to the key stages of the expenditure control process. The results show that all the health facilities have authorization and approval process, and classification and recording. While the public and Christian Health facilities full practice delegation and segregation of duties, and disbursement controls, the private hospitals have partial or non-use of these control practices.

During the authorisation and approval stage of the expenditure control, processing of claims are done as, authorities verify the payments against the claims were made upon fulfilment of all the requirements including sanction of

expenditure, recording of verification of claims, approval of expenditure and payment, and authorities verify the maintenance of bill Inward register in prescribed form. Again, there is authorities sanction of expenditure by enquiring whether there is any system put in place that sanctions accorded are further verified by accounts section to validate sanctions accorded, Authorities sanction expenditure by verify that all expenditures have been authorized by appropriate sanctions (technical, financial and administrative) of competent authorities, and Authorities obtain sanction orders and see whether expenditure sanctioned exceeded the prescribed limit. Also, approved budget to guide the authorisation and approval of expenditure control process as Authorities obtain the approved budget document and verify that the expenditures were made within the approved budget limit, and Authorities verify whether the accounting unit has maintained an appropriate control register in form FAM to keep check that the expenditures are within the approved budget limit. Furthermore, there is verification and certification of claims by authorised officials (to establish goods and services have been received and recorded), and Authorities see that the verifying officer has appended a certificate of verification on the claims stating all relevant records. Also, the results show that Authorities verify that the approval was accorded by approving officer within the delegated authority. The results on the processes of appropriate Disbursement Control in the health facilities show that Authorities checking the disbursement vouchers to see whether it was prepared in Form FAM and were filled in properly by Account section, Authorities verify that the cancelled vouchers are defaced by striking a double line through the face of voucher and the word ‘cancelled’ should be clearly written by indelible ink, Authorities verify that the disbursement

vouchers are supported by valid and relevant documents, Authorities ensure that payments are made by cheques to the payees or authorised representatives, Authorities check that the payment in the form of cash had not exceeded the limit, and Authorities check from DV that all statutory deductions have been made.

Responses to the practice of delegation and segregation of duties during expenditure in the health facilities show that the practice of delegation and segregation is very much enshrined in the expenditure control practices as Authorities review the accounting process and verify that responsibilities and functions are segregated and assigned to different people.

The results show that the health facilities prioritize classification and recording stage of the expenditure control as authorities check bank reconciliation statements are prepared on a regular basis, Authorities ascertain accuracy of bank reconciliation statements, checks on bank statements, deposit challans, deposit slips etc., are documented appropriately, Authorities ascertain timeliness of input in the system, Authorities ascertain correctness of the entries in the system, Authorities ensure the expenditures are classified and recorded as per the object code, and Account wise reconciliation carried out and balance of each account ascertained.

Research Question 3: Similarities and Differences in Terms of Expenditure Control Practices between these Health Facilities (Government, Mission and Private)

The results found the following similarities in the expenditure control including the expenditure areas (procurement of drugs and non-drugs taking about 80% of the revenue of the facilities; utilities; non-mechanised salaries,

among others); the authorisation and approval; classification and recording stages of the expenditure control process; verification of goods and services, and the final authorisation or approval authorities. The findings support Akindele, and Oluwafolakemi (2013) study which found that internal control systems are the same in public and private universities in Nigeria, but that fusion of duties is more pronounced in private universities than public universities.

The results show that these health facilities though have expenditure control practices, there are differences in how they adopt and practice the expenditure controls including methods or approaches used in the expenditure control (i.e. while the public and CHAG facilities used appropriation control, commitment control, control of regularity and accounting cash controls, the private hospitals used the aggregate cash controls); comprehensively prepared and approved budget are available at the public and CHAG health facilities, the private hospital barely prepare comprehensive budget to control expenditure; the public and CHAG health facilities both have institutionalized internal control function, the private hospitals used the accounts as the audits. The results further show that the public and CHAG health facilities prepare Local Purchasing Order (LPO), there is no such practice found in the private hospitals. Lastly, in both public and the CHAG health facilities, authorities must ensure the preparation of disbursement vouchers and payments, however, in the private hospital only payments are made.

Research question 4: Strengths and Weaknesses of the System of Expenditure Control in all the Selected Hospitals

Responses to this objective are divided into two broad areas including the strengths and weaknesses in the expenditure controls of these health

facilities. With regard to the strengths in the hospitals' expenditure control procedures. The results show that majority of the respondents agreed that there are strengths in the hospital's expenditure control procedures. Specifically, there are required controls at each stage have been clearly specified and consistently applied, there are associated business rules and processes have been clearly defined, there are clear laws and financial regulations regarding the controls and the authority and responsibility of relevant actors who should apply them, all the line units directly accountable for the use/control of their appropriations, there are separation of responsibility for key control tasks, and clear sanctions that will be given to breaches of the rules and regulations regarding key stages of the expenditure cycle. Other strengths include the proper definition/specification of key stages of the expenditure cycle, including the control criteria, Clarity of the legal and regulatory framework, including the roles of the key actors, and easy for tracking key stages of expenditure cycle.

The results show that there are weaknesses in the expenditure controls. For instance, respondents agreed that there are frequent and redundant controls make the expenditure process slow (and encourage proliferation of "special procedures"), and accumulation of liabilities/arrears. Again, respondents agreed that there is circumvention of controls at key stages, including through collusion, delays in processing of payments, failure to record and maintain data on commitments and reporting delays. Furthermore, respondents agreed that top management stepping aside the rules due to interferences, and there is a failure to check the availability of funding before authorizing expenditure.

Chapter Summary

The chapter has analysed and presented the results, based on which discussed of the results was made in line with the study objectives and with reference to literature. The results show that both the publicly owned hospitals and the Christian Health institutions (CHAG) use appropriation control, commitment control, control of regularity and accounting cash controls, while the private hospitals use only one of the controls which the aggregate cash control. The results further show that both the public and CHAG health facilities use the controls on liabilities, payroll controls, pension controls, verification of goods and services, and control of procurement in their expenditure control measures. Meanwhile, the privately owned health facilities use only the payroll controls and pension controls to safeguard their expenditure. The results identified similarities in the expenditure control including the expenditure areas; the authorisation and approval; classification and recording stages of the expenditure control process; verification of goods and services, and the final authorisation or approval authorities. The differences in the practice of the expenditure controls include specific methods or approaches used in the expenditure control, budgeting, internal control, among others. The next chapter presents the summary, conclusion and recommendations.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter gives the summary of the study, conclusions drawn from the major finding and makes the necessary recommendations. The chapter is divided into three main parts. The first part presents the summary and the key results of the study. The next section contains conclusions from the key findings. It is then followed by the recommendations of the study.

Summary

The purpose of the study was to compare various expenditure control systems and practices in the various hospitals (government, mission and private) in the Bono region. Specifically, the study ascertained the expenditure control methods adopted by these health institutions, the expenditure control practices, the similarities and differences in these methods and practices, and looked their weaknesses and strengths. The study reviewed relevant literature on the concept of expenditure controls. The study used explanatory case study design and data was collected using questionnaires. Secondary data was used to augment the primary data in the study. The study population was made up of core management staff of these health facilities.

The main findings of the study are as follows in line with the study objectives:

Expenditure control method adopted by the government and privately owned hospitals

The study revealed that both the publicly owned hospitals and the Christian Health institutions (CHAG) use appropriation control, commitment

control, control of regularity and accounting cash controls. On the other hand, the private hospitals use only one of the controls which the aggregate cash control.

The study revealed that other expenditure control approaches used by the health facilities. It was found out that both the public and CHAG health facilities use the controls on liabilities, payroll controls, pension controls, verification of goods and services, and control of procurement in their expenditure control measures. Meanwhile, the privately owned health facilities use only the payroll controls and pension controls to safeguard their expenditure.

Expenditure control practices of health facilities

The study observed that both the public and the mission hospitals practice similar expenditure control practices as they observed the following order of processes in spending or approving expenditure:

1. There should be approved budget for the year and quarterly budget plans to warrant spending or approval of expenditure.
2. Memos or formal requests should be made from the department/sections/units requesting demand or purchase or approval of items needed for work to go on to the administrator or the medical superintendent for approval.
3. The documents are referred to the audit unit for proper auditing.
4. The documents are sent to the accounts section for the checks to be made about the availability of funds for approval and payments.
5. The fifth stage is the preparation of Local Purchase Order (LPO) which indicates the prices, quantities and amounts of the items.

6. The final process is the referral to the procurement department for the necessary approvals.

However, in the privately owned health facilities, the processes are dependent on contingencies (i.e. when the needs arise). The medical superintendent who doubles as the owner, checks with the other staff of the various items they need. The medical officer/owner checks with the accountant/account officer the availability of funds for spending or purchase. The order is then made for the purchase or supply of the items.

It was evident that all the health facilities have authorization and approval process, and classification and recording. While the public and Christian Health facilities ensure full practice of delegation and segregation of duties, and disbursement controls, the private hospitals have partial or non-use of these control practices.

Similarities and differences in terms of expenditure control practices between these health facilities

The study found out the following similarities in the expenditure control:

1. the expenditure areas (procurement of drugs and non-drugs taking about 80% of the revenue of the facilities; utilities; non-mechanised salaries, among others);
2. the authorisation and approval; classification and recording stages of the expenditure control process;
3. verification of goods and services, and
4. the final authorisation or approval authorities.

The study revealed the following differences in the practice of the expenditure controls:

1. specific methods or approaches used in the expenditure control (i.e. while the public and CHAG facilities used appropriation control, commitment control, control of regularity and accounting cash controls, the private hospitals used the aggregate cash controls)
2. comprehensively prepared and approved budget are available at the public and CHAG health facilities, the private hospital barely prepare comprehensive budget to control expenditure;
3. The public and CHAG health facilities both have institutionalized internal control function, the private hospitals used the accounts as the audits.
4. The public and CHAG health facilities prepare Local Purchasing Order (LPO), there is no such practice found in the private hospitals.
5. Lastly, in both public and the CHAG health facilities, authorities ensure the preparation of disbursement vouchers and payments, however, in the private hospital only payments are made.

Strengths and weaknesses of the system of expenditure control in all the selected hospitals

The study revealed the following strengths in the hospitals' expenditure control procedures:

1. there are required controls at each stage have been clearly specified and consistently applied, there are associated business rules and processes have been clearly defined,
2. there are clear laws and financial regulations regarding the controls and the authority and responsibility of relevant actors who should apply

them, all the line units directly accountable for the use/control of their appropriations,

3. there are separation of responsibilities for key control tasks, and
4. clear sanctions that will be given to breaches of the rules and regulations regarding key stages of the expenditure cycle.
5. proper definition/specification of key stages of the expenditure cycle, including the control criteria,
6. Clarity of the legal and regulatory framework, including the roles of the key actors, and easy for tracking key stages of expenditure cycle.

The study also revealed the following weaknesses in the expenditure controls:

1. there are frequent and redundant controls that make the expenditure process slow (and encourage proliferation of "special procedures"), and accumulation of liabilities/arrears.
2. there is circumvention of controls at key stages, including through collusion, delays in processing of payments, failure to record and maintain data on commitments and reporting delays.
3. top management stepping aside the rules due to interferences, and there is a failure to check the availability of funding before authorizing expenditure.

Conclusions

Health facilities have the primary role of providing care to patients and this would require financial resources. However, due to the limited financial resources due to the non-payment of NHIS claims and other issues, there is the need to ensure that expenditure is controlled at every stage of the budget. All uses of funds should be governed by financial regulations. These regulations,

among other things, prescribe the establishment of responsibility for financial decisions, the segregation of duties to ensure appropriate checks and balances, and documentation procedures for maintaining a defined audit trail. The findings indicate that there are various controls applied during the expenditure cycle can be grouped into six main categories. These are (i) appropriation control; (ii) commitment control; (iii) aggregate cash control; (iv) control of regularity; (v) accounting control; and (vi) other specific controls. Other specific controls relate to specific types of transactions and are designed to either reinforce macro-fiscal discipline and sustainability (e.g., controls on payroll, pensions, and incurrence or liquidation of liabilities or guarantees) or safeguard the integrity and efficiency of public procurement and payroll systems. While the publicly owned hospitals and the Christian Health institutions (CHAG) use appropriation control, commitment control, control of regularity and accounting cash controls, the private hospitals use only one of the controls which the aggregate cash control. Again, while both the public and the mission hospitals practice similar expenditure control practices, the privately owned health facilities, the processes are dependent on contingencies (i.e. when the needs arise). Moreover, findings indicate that public and CHAG health facilities have authorization and approval process, classification and recording, delegation and segregation of duties, and disbursement controls, however, the private hospitals practice only authorization and approval process, and classification and recording.

The findings showed the public and CHAG health facilities prepare comprehensive and approved budget, have institutional internal audit function, prepare Local Purchase Order (LPO), and the preparation of disbursement

vouchers and payments. However, these measures are not practiced and if practice, they are not done fully.

Findings indicate clear breaches of the expenditure control processes particularly as top management stepping aside the rules due to interferences, and there is a failure to check the availability of funding before authorizing expenditure, circumvention of controls at key stages, including through collusion, delays in processing of payments, failure to record and maintain data on commitments and reporting delays, and accumulation of liabilities/arrears.

Recommendations

From the key findings and conclusions from the study, the following recommendations are made.

The study revealed that one of the weakness is that the expenditure process is slow leading to accumulation of liabilities/arrears. The study therefore recommends to these health facilities to ensure that payments are made within the due date to prevent accumulation of payables/arrears, extend the horizon of the cash plan which also reflects expected payments, and eliminate exceptional procedures for payment.

The study recommends to these health facilities to stop interferences in the expenditure control processes to ensure proper and appropriate delegation and segregation of duties are followed to the later. This will ensure full compliance of the laid down expenditure and internal control measures in these institutions.

The study recommends to hospital management to ensure regular bank reconciliation to ensure integrity of expenditure data. Particularly if accounting is on cash-basis, there is regular reporting and monitoring of overdue payables.

The study recommends to management to update core management staff on the current financial management practices through training and as much as possible communicating effectively to all relevant stakeholders a broad understanding of why the training and development are necessary and what objectives are sought to be achieved.

Finally, private hospitals should develop a budget that will guide them of the expenditure patterns. The budget as done should be implemented as formulated and authorized with as little deviation as possible, but there should be room to adjust to changing circumstances (e.g., genuinely unexpected events) by modifying the budget as necessary during the year.

Suggestions for Further Study

This study has concentrated on selected health facilities in the Bono region and it is suggested that a replica of the study should be expanded to include more health facilities to give more national outlook for generalization.

REFERENCES

Abbott, A., Powell, W. W., & DiMaggio, P. (1992). *An old institutionalist reads the new institutionalism.* Retrieved from https://www.jstor.org/stable/2075613

Abdel-khalik, A. R. (1993). Why do private companies demand auditing? A case for organizational loss of control. *Journal of Accounting, Auditing and Finance 8,* 31–52.

Addo, S. (2018). *Financial management practices of Ghana health service using evidence from Oda Government Hospital*. Unpublished master's dissertation, University of Cape Coast, Ghana.

Adua, E., Frimpong, K., Li, X., & Wang, W. (2017). Emerging issues in public health: a perspective on Ghana's healthcare expenditure, policies and outcomes. *EPMA Journal*, 1-10.

Akosile, A. I. Fasesin, O. O. (2013). A comparative assessment of internal control system in public and private universities in South-West, Nigeria. *Research Journal of Finance and Accounting*, *4*(13), 25-33.

Akortsu, M.A., & Abor, P.A. (2011). Financing public healthcare institutions in Ghana. *Journal of Health Organisational Management, 25*(2), 128-141.

Armah, M. (2012). *Evaluation of financial control system in the health sector of ghana a case study of Korle Bu Teaching Hospital*. Unpublished doctoral dissertation, Kwame Nkrumah University of Science & Technology, Kumasi.

Arnaboldi, M., Lapsley, I., & Steccolini, I. (2015). Performance management in the Public sector: The ultimate challenge. *Financial Accountability & Management, 31*(1), 1-22.

Asante, E. (2011). *An evaluation of internal financial controls in public hospitals: A case study of Regional and Municipal Hospital, Sunyani and District Hospital, Bechem (Brong-Ahafo*). Unpublished master's dissertation, Kwame Nkrumah University of Science & Technology, Kumasi, Ghana.

Asante, F. A., Arhinful, D. K., & Kusi, A. (2014*). Who is excluded in Ghana's National Health Insurance Scheme and why: a social, political, economic and cultural (SPEC) analysis?* Health Inc-Towards equitable coverage and more inclusive social protection in health. Retrieved from http://193.190.239.98/bitstream/handle/10390/8131/2014wegn0012.pdf?sequence=1

Babbie, E. (2005). *The basics of social research* (3rd ed.). Canada: Thomson Wadsworth.

Babiak, K., & Trendafilova, S. (2011). CSR and environmental responsibility: Motives and pressures to adopt green management practices. *Corporate Social Responsibility and Environmental Management, 18*(1), 11-24.

Bhattacharyya, S., & Bandyopadhyay, G. (2012). Expenditure and budgetary control in urban local bodies in India - Developing Prism Model. *International Journal of Governmental Financial Management*, 16-36

Bryman, A. (2012). *Social Research Methods* (5th ed.). Oxford: Oxford University Press, Sage.

Burrell, G., & Morgan, G. (2017). *Sociological paradigms and organizational analysis: Elements of the sociology of corporate life. Routledge*.

Byarugaba, C., Karyeija, G. K., & Twinomuhwezi, I. (2014). *Financial management practices and health service delivery in uganda local*

governments: A case study of Rukungiri District. Retrieved from https://www.academia.edu/download/33503560/Byarugaba__Karyeija__Twino-Ivan.pdf

Cleverley, W.O., Song, P.H., and Cleverley, J.O. (2011). *Essentials of health care finance* (7th ed.). Columbus, OH: Jones and Bartlett Learning

Cooperrider, D., & Srivastva, S. (2017). *Appreciative Inquiry in Organisational Life.* In Research in organisational change and development (pp. 81-142). Emerald Publishing Limited.

Cormack, D. (2000). *Research process in nursing* (4th ed.). Oxford: Blackwell.

Currie, W. (2009). Contextualising the IT artefact: Towards a wider research agenda for is using institutional theory. *Information Technology & People, 22*(1), 63-77.

De Vaus, D. (2002). *Surveys in social research* (5th ed.). Spanish (International) Sort; Sydney, Australia: Allen & Unwin.

Fatoki, O. (2012). An investigation into the financial management practices of new micro-enterprises in South Africa. *Journal of Social Science, 33(2), 179-188.*

Flynn, S., & Pessoa, M. (2014). *Prevention and management of government expenditure arrears.* Technical Notes and Manuals, Washington: International Monetary Fund.

Greenwood, R, Oliver, C, Sahlin, K., & Suddaby, R. (2008). *Introduction*. In R Greenwood, C. Oliver, K Sahlin & R Suddaby (Eds.). The Sage Handbook of Organizational Institutionalism, SAGE Publications, London.

Hailu, A. Y., & Venkateswarlu, P. (2016). Financial Management Practices of Micro and Small Enterprises in Addis Ababa, Ethiopia. *Financial Management, 2*(3), 50-64.

Hartley, J. P. (1994). *Case -Study in organisational research.* In Cassell, C. and Symon, G. (Eds) Qualitative Methods in Organisational Research: A Practical Guide, Sage Publications

International Monetary Fund (2016). *Expenditure control: Key features, stages, and actors*. IMF.

Jensen, M., & Meckling, W. (1976). Theory of the firm: Managerial behavior, agency costs and ownership structure. *Journal of Financial Economics, 3*(4), 305-360.

Jussi, N., & Petri, S. (2004). Does agency theory provide a general framework for audit pricing? *International Journal of Auditing*, *8*(2), 253-262.

Kaufman, B.E. (2011). *Comparative employment relations: Institutional and neo institutional theories*, In M Barry & A Wilkinson (Eds.). *Research handbook of comparative employment relations*, Edward Elgar Publishing.

Karadag, H. (2015). Financial management challenges in small and medium-sized enterprises: A strategic management approach. *Emerging Markets Journal, 5*(1), 26-40.

Kothari, R.C. (2007). *Research methodology: Methods and techniques*, (3rd ed.). Delhi: New Age International.

Lancaster, G. A., Dodd, S., & Williamson, P. R. (2004). Design and analysis of pilot studies: Recommendations for good practice. *Journal of Evaluation in Clinical Practice*, *10*(2), 307-312.

March, J.G., & Olsen, J.P. (1984). The new institutionalism: organizational factors in political life. *The American Political Science Review, 78*(3),34-749.

Meyer, J. W., & Rowan, B. (1977). Institutionalized organizations: Formal structure as myth and ceremony. *American Journal of Sociology*, 340-363.

Mwangi, B. M. (2012). *The impact of information communication technology development on financial performance of commercial banks in Kenya.* Unpublished master's project, University of Nairobi, Kenya.

Nadzri, F. A. A., Omar, N., & Rahman, R. A. (2017). Micro financing: Accountability and financial management practices of micro entrepreneurs. *Indian Journal of Science and Technology, 10*(15), 1-14.

Neuman, W. L., (2007). *Basics of social research, qualitative and quantitative approaches* (2nd ed.). London: Pearson Educational Inc.

Paauwe, J., & Boselie, P. (2003). Challenging strategic HRM' and the relevance of the institutional setting. *Human Resource Management Journal, 13*(3), 56-70.

Pattanayak, S., & Cooper, J. (2011). *Chart of accounts: A critical element of the public financial management framework.* Technical Notes and Manuals Washington: International Monetary Fund.

Payne, S. (2003). A basic study of agency cost source and municipal use of internal versus external control. *Accounting and Business Research, 35*(1), 53-67.

Pembi, F. (2018). A comparative study of expenditure control methods in government and privately owned hospitals. A study of University of

Nigeria Teaching Hospital, Enugu. Unpublished bachelor's project, University of Enugu, Nigeria.

Polit, D., & Beck, C. (2010). *Essentials of nursing care: Methods, appraisal and utilization* (7th ed.). Philadelphia: Lippincott Williams and Wilkins.

Polit, D., Beck, C., & Hungler, B. (2001). *Essentials of nursing research: Methods, appraisal and utilization* (5th ed.). Philadelphia: Lippincott Williams and Wilkins.

Radev, D., & Khemani, P. (2009). *Commitment controls.* Technical Notes and Manuals, Washington: International Monetary Fund.

Reisenwitz C. (2015). *The secret to reducing hospital administration costs.* Retrieved from. http://blog.capterra.com/the-secret-to-reducing-hospitaladministration-costs/.

Roberts, P. M., Priest, H., & Traynor, M. (2006). Reliability and validity in research. *Nursing Standard, 20*(44), 41- 45.

Royal Audit Authority of Bhutan (2015). *Financial resources management accountability index (FRMAI). An assessment tool to promote accountability in the use of public resources.* Retrieved from http://prr.hec.gov.pk/jspui/handle/123456789/10268

Ryan, B. Scapens, R. W. & Theobold, M. (1992). *Research methods and methodology in finance and accounting,* Academic Press, London

Scott, WR. (2008). *Institutions and organisations*: *Ideas and interests.* Thousand Oaks: SAGE Publications, Inc.

Sekaran U. (2000). *Research methods for business: A skill –building approach.* New York: John Wiley & sons. Inc. 308- 313.

Smith, B. (2017). Determinants of sound budgeting and financial management practices at the decentralised level of public administration. *OECD Journal on Budgeting, 16(2), 109-128.*

Scapens, R. W. (1990). Researching management accounting practice: the role of case study methods. *Management Accounting Research*, 5, 301-321

Spicer, B. H. (1992). The resurgence of Cost and management accounting: A review of some recent developments in practice, theories and case study research methods. *Management Accounting Research*, *3*(1)1-37

University of Ghana (2018). *The State of the Nation's Health Report*. School of Public Health

Yin, R. K. (2009). *Case study research: Design and methods*. London: Sage.

APPENDIX A

CATHOLIC UNIVERSITY COLLEGE OF GHANA, FIAPRE

FACULTY OF ECONOMICS AND BUSINESS ADMINISTRATION

MBA (ACCOUNTING OPTION)

QUESTIONNAIRE FOR MANAGEMENT

SECTION A: Personal Information

(1) Sex of Respondents

a. Male [ ]

b. Female [ ]

(2) Age of Respondents

a. 21-30 years [ ]

b. 31-40 years [ ]

c. 41-50 years [ ]

d. 51 years and above [ ]

(3) **Educational Background of Respondents**

a. Diploma [ ]

b. Higher National Diploma [ ]

c. First Degree [ ]

d. 2nd Degree [ ]

e. PhD. [ ]

f. Others please specify…….

(4) Employee Rank in the hospital

a. Account staff[ ]

b. Audit staff [ ]

c. Administrative staff [ ]

d. Head of Department[ ]

e. Other specify……..

(5) Number of years working in this hospital

a. Less than 1 year [ ]

b. 1- 3 years [ ]

c. 4- 6 years [ ]

d. 7 - 10 years [ ]

e. 10 years and above [ ]

6. Current position.....

7.Department.....

Expenditure control practices of health facilities (government, mission and private)

Please use the spaces below the table to choose and rank the expenditure areas of the facility

Sn	**Factors**	**Rankings**				
		1	**2**	**3**	**4**	**5**
1	personnel emoluments					
2	Service delivery (drugs and service)					
3	Administration					
4	Investments					
5	Others, please specify					

Authority structure of expenditure control

1. The following practices have been identified in literature as key stages in the expenditure controls. Based on your experience in this facility rate each of the variables on a scale of 1-5 where 1 – not at all influential 2 – slightly

influential 3 – somewhat influential 4 – very influential 5 – extremely influential

Please use the spaces below the table to add other practices and rank

Sn	Key stages	1	2	3	4	5
1	Authorization and Approval					
2	Disbursement Control					
3	Delegation and Segregation of Duties					
4	Classification and Recording					
5	Others, please specify					

Authorization and Approval

In the scale of Strong agree (5), Agree (4), Uncertain (3), Disagree (2) and Strongly Disagree (1), indicate your view of the following items on how authorities ensure appropriate Authorization and Approval related factors are complied with in the health facility

Statements	5	4	3	2	1
In the processing of claims, authorities verify the maintenance of bill Inward register in prescribed form.					
In the processing of claims, authorities review the BIR to see that the settlement of claims has been done within 30 days from the date of receipt of claim					
In the processing of claims, authorities verify the payments against the claims were made upon fulfilment of all the requirements including sanction of expenditure,					

recording of verification of claims, approval of expenditure and payment					
Authorities sanction expenditure by verify that all expenditures have been authorized by appropriate sanctions (technical, financial and administrative) of competent authorities.					
Authorities obtain sanction orders and see whether expenditure sanctioned exceeded the prescribed limit.					
Authorities enquire whether there is any system put in place that sanctions accorded are further verified by accounts section to validate sanctions accorded are within the powers of the authorities.					
Authorities obtain the approved budget document and verify that the expenditures were made within the approved budget limit					
Authorities verify whether the accounting unit has maintained an appropriate control register in form FAM to keep check that the expenditures are within the approved budget limit					
Verification and Certification of claims by authorised officials (to establish goods and services have been received and recorded)					
Authorities see that the verifying officer has appended a certificate of verification on the claims stating all relevant records					

Authorities verify that the Head of Agency or the DDO has prepared and approved disbursement/journal voucher for payment and adjustment					
Authorities verify that the approval was accorded by approving officer within the delegated authority.					

Disbursement Control

In the scale of Strong agree (5), Agree (4), Uncertain (3), Disagree (2) and Strongly Disagree (1), indicate your view of the following items on how authorities ensure appropriate Disbursement Control related factors are complied with in the health facility

Statements	**5**	**4**	**3**	**2**	**1**
Authorities check the disbursement vouchers to see whether it were prepared in Form FAM and were filled in properly by Account section.					
Authorities verify that the JV in form FAM is prepared for recording the adjustments entries.					
Authorities verify that the cancelled vouchers are defaced by striking a double line through the face of voucher and the word ‘cancelled’ should be clearly written by indelible ink.					
Authorities verify that the disbursement vouchers are supported by valid and relevant documents.					
Authorities ensure that payments are made by cheques to the payees or authorised representatives					

Authorities check that the payment in the form of cash had not exceeded the limit					
Authorities verify that the payees have signed the vouchers/ acknowledgement on receipt of the payments					
Authorities verify that the disbursement vouchers are approved by the DDO/head of office					
Authorities check from DV that all statutory deductions have been made.					

Delegation and Segregation of Duties

In the scale of Strong agree (5), Agree (4), Uncertain (3), Disagree (2) and Strongly Disagree (1), indicate your view of the following items on how authorities ensure appropriate Delegation and Segregation of Duties related factors are complied with in the health facility

Statements	**5**	**4**	**3**	**2**	**1**
In the segregation of duties, Authorities review the accounting process and verify that responsibilities and functions are segregated and assigned to different people.					
In the segregation of duties, Authorities review that the functions are in line with individual job description.					
In the delegation of duties, Authorities verify that the responsibilities and functions are appropriately delegated and office orders issued to that extent.					
In the delegation of duties, Authorities obtain office orders relating to delegation of responsibilities and observe the actual performance of activities to see that					

responsibilities are discharged in accordance with the delegated responsibilities.					

Classification and Recording

In the scale of Strong agree (5), Agree (4), Uncertain (3), Disagree (2) and Strongly Disagree (1), indicate your view of the following items on how authorities ensure appropriate Classification and Recording related factors are complied with in the health facility

Statements	**5**	**4**	**3**	**2**	**1**
Authorities ensure the expenditures are classified and recorded as per the object code					
Authorities ascertain correctness of the entries in the system					
Authorities ascertain timeliness of input in the system.					
Authorities check bank reconciliation statements are prepared on a regular basis.					
Authorities ascertain accuracy of bank reconciliation statements.					
Account wise reconciliation carried out and balance of each account ascertained					
Checks on bank statements, deposit challans, deposit slips etc., are documented appropriately					

Similarities and differences in terms of expenditure control practices between these health facilities

Strengths and weaknesses of the system of expenditure control in all the selected hospitals.

What are some of the strengths identified in the hospital's expenditure control measures?

In the scale of Strong agree (5), Agree (4), Uncertain (3), Disagree (2) and Strongly Disagree (1), indicate your view of the following items on strengths identified in the health facility's expenditure control measures

Statements	**5**	**4**	**3**	**2**	**1**
Proper definition/specification of key stages of the expenditure cycle, including the control criteria					
Clarity of the legal and regulatory framework, including the roles of the key actors					
There are clear laws and financial regulations regarding the controls and the authority and responsibility of relevant actors who should apply them					
The associated business rules and processes have been clearly defined					
The required controls at each stage have been clearly specified and consistently applied					
Clear sanctions that will be given to breaches of the rules and regulations regarding key stages of the expenditure cycle					
line units directly accountable for the use/control of their appropriations					
separation of responsibility for key control tasks					
Easy for tracking key stages of expenditure cycle					

What are some of the weakness identified in the hospital's expenditure control measures?

In the scale of Strong agree (5), Agree (4), Uncertain (3), Disagree (2) and Strongly Disagree (1), indicate your view of the following items on weaknesses identified in the health facility's expenditure control measures

Statements	**5**	**4**	**3**	**2**	**1**
Failure to check the availability of funding before authorizing expenditure					
Failure to record and maintain data on commitments					
Delays in processing of payments					
Circumvention of controls at key stages, including through collusion					
Poor record keeping, including of verification documents					
Reporting delays					
Accumulation of liabilities/arrears					
frequent and redundant controls make the expenditure process slow (and encourage proliferation of "special procedures")					

What are some of the major challenges you have encountered in implementing and applying the laid down expenditure control measures in your facility?

……

……

……

……

……

……

……

……..

What in your candid opininon should be done to ensure and improve expenditure control in your facility?

……

……

……

……

……

……

……

……..