Gvt crafts its own hospital quality standards, sans world-class local body

The 15-year-old, not-for-profit NGO – the Council for Health Service Accreditation of Southern Africa (COHSASA) – has already independently assessed, monitored and accredited 55 public and 25 private sector local hospitals, based on essential performance indicators. It has more sets of standards accredited by the International Society for Quality in Health Care (ISQua) than any other health care accrediting body in the world and advises the World Health Organization (WHO) on patient safety and quality issues. Its quality assurance methods and protocols are the gold standard in Botswana, Swaziland and Lesotho and the City of Cape Town (clinics and community health centres), and are also in use to varying degrees at private and public hospitals in Namibia, Nigeria, Zambia, Tanzania and Rwanda.

A full quarter (28) of all hospices in South Africa are fully accredited by COHSASA with 97 headed towards full accreditation, hugely elevating their credibility and opening international funding doors, the Hospice and Palliative Care Association of South Africa told Izindaba.

In spite of this, the OSC is now using a British-based company, the Care Quality Commission, to audit the tools and processes it has developed, citing important similarities with the proposed local NHI funding model. South Africa’s impending NHI system rests on hospitals and clinics in the private and public sector being gradually and incrementally accredited according to a set of minimum health care delivery standards. The systematic ‘upgrade’ of the larger public sector via preparatory quality assurance and monitoring has been touted by leading NHI architect, Dr Olive Shisana, and various health ministers as a vital rehabilitation tool and a pre-requisite for effective NHI functioning.

His counterpart, OSC director, Dr Carol Marshal, admitted that ‘they put in resources’ but strongly denied any imputation that COHSASA was ‘ditched.’

‘They excluded themselves because they felt we should be using their product. There are products on the market for which one goes through normal tender procedures. The NGO model is not the only one out there. We ran a very open, participative process,’ she asserted. Marshal added, ‘It’s a great pity. I think they made a decision that they would never be listened to. If you’re going to be in on a process as an expert, you must be careful not to be a salesman.’ She said she believes health minister, Dr Aaron Motsoaledi, ‘feels something as fundamental as quality assurance needs to be under the control of the government.’

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Each side complained to Izindaba that the other wanted to be ‘both player and referee.’ The OSC feels vulnerable at the prospect of paying for both standards development and on specific standards of measurement and training. He and his staff spent an ‘inordinate amount’ of time commuting between Cape Town and Pretoria, staying in hotels and serving on pivotal OSC advisory committees, making themselves available to answer queries and giving advice, much of it last-minute. One source claimed COHSASA spent R250 000, but Whittaker declined to confirm this, saying only that an ‘out of pocket’ figure existed.

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Beleaguered public hospitals and clinics, due for a quality assurance ‘make-over’ and continual monitoring in advance of the much-vaunted National Health Insurance (NHI), may emerge little better in spite of strenuous government efforts.

The pivotal Office of Standards Compliance (OSC), tasked with drafting and monitoring minimum health care standards nation-wide, has parted ways with the local leaders in the field and could be headed for dysfunction, some experts believe.

After intermittent OSC consultation with, and several last-minute appeals for help from the local NGO with the strongest track record, the two bodies have reached a stand-off, neither talking to the other after disagreement on several issues. Several consultants to the OSC also believe that its failure to fully incorporate the best local advice and keep its top local advisor on board has led to poorly developed measurement standards, a dangerously accelerated process and deeply flawed pilot studies. The OSC denies this, claiming to have obtained ‘enormous buy-in’ from provincial teams and other stakeholders and to be on track with ‘reliable, flexible and validated’ measurement tools.

Were they pushed or did they jump?

The OSC/COHSASA collaboration ended this March after two years of ad hoc consultation in which the relationship grew increasingly strained over COHSASA CEO Professor Stuart Whittaker’s insistence
ongoing monitoring, yet is arrogating that
dual role to itself.

Down the line, the OSC is envisaged
as independent of the health department,
accountable directly to parliament. Debate
looms over financing after officials confided
that in the present economic climate, the best
the OSC can hope for is seed funding. They
claim their objectivity would be enhanced by
rotating surveyors (whose quality COHSASA
is severely sceptical about) through the
provinces.

In February this year, after three months
of little or no contact with COHSASA, the OSC
suddenly asked it to pilot OSC standards at
two hospitals, one community health centre
and several clinics per province. Whittaker
reiterated, reiterating reservations over time
frames and a lack of proper measurement
tools inherent in OSC standards.

**OSC ‘re-inventing the
wheel’ – experts**

A theme of ‘re-inventing the wheel’ emerged
during Izindaba’s survey of experts in quality
assurance-related fields, most of them
involved with the OSC process. Speaking on
condition of anonymity, one top provincial
health official said: ‘I would have thought
that the national approach would be to try
and avoid reinventing the wheel. COHSASA
has already developed internationally
accredited standards that are in place in
many provinces and in other countries. It
would have been easier as an approach to ask
whether we cannot start with what we have
and then develop it to suit the needs of the
entire country and where we’re trying to get
to with the NHL. Instead we have this parallel
process. At this stage it’s not even clear what
it will mean if you comply with the OSC’s
core standards. This just meets the bare
minimum, never mind where we should
be for the NHL.’ Another provincial official,
a protagonist of the OSC model, claimed
that COHSASA interventions seldom built
ongoing capacity and that facilities often
‘slipped back’.

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A benefit and risk manager in private
sector funding suggested using all quality
assurance bodies with a local track record
to implement OSC standards on the same
basis that agencies do Black Economic
Empowerment (BEE) accreditation. Marshal
acknowledged this but said it would depend
on ‘how costs play out – things are pretty
tight right now’. The risk manager added,
‘Why reinvent the wheel when all the OSC
need do is accredit programmes? These guys
(like COHSASA) have the standards going
and the track record’.

**With national health minister
Dr Aaron Motsoaledi having set
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bar at 20% of the country’s 3 716
hospitals and clinics by July next
year, Marshal and her staff are
under huge pressure to deliver.**

Sharon Slabbert, Executive Officer for
Health Service Delivery at the Hospitals
Association of South Africa (HASA), said it
was ‘sad that people like COHSASA are
being ignored by people who are trying to
set standards for our country for something
as important as the NHI. It’s also crazy that
the OSC has been given such a short time to
implement such a complicated thing. Rather
wait and do it properly. We’ll be stuck with
this’.

**Hospital accreditation
target creates pressure**

With national health minister Dr Aaron
Motsoaledi having set the health facility
accreditation bar at 20% of the country’s
3 716 hospitals and clinics by July next
year, Marshal and her staff are under huge
pressure to deliver. She said the OSC standards
had already been disseminated to hospitals and
clinics which were doing self-assessments
against them. ‘We piloted the standards in all
provinces in March and got their input. As a
result there was a fair amount of technical
work which we tried to do on a shoestring
basis. But there was enormous buy-in from
provincial teams to make standards reflect
their reality and what they felt would be
most useful.’

She denied that the resultant working
group had failed to consider measurement
tools and added: ‘We feel we’ve validated
and tested for reliability and made it quite
flexible’. She explained ‘flexibility’ as one
province perhaps being more interested in
infrastructure and another in mother and
child health, adding: ‘It’s pretty robust’.

COHSASA successes graphically illustrate
the potential for reducing the country’s	ragically high and avoidable infant mortality
rates and addressing the overall parlous state
of public health care delivery – when quality
assurance is properly implemented. (South
Africa is one of only 12 countries in which
mortality rates for children have increased
since the 1990 baseline for the Millennium
Development Goals (MDGs)).

A national sample study of COHSASA-
linked hospitals by Professor Bob Pattinson,
one of South Africa’s top neonatal and
maternity experts, shows that the higher
their levels of standards compliance, the
lower their infant mortality rates. Using
COHSASA scores as the gold standard,
he identified public hospitals that also used
the Perinatal Problem Identification Programme
(a perinatal care audit system). Pattinson
found that at district hospitals, the better
the standard of care (COHSASA score),
the lower the perinatal mortality rate and
the neonatal death rate.1 He told Izindaba
that South Africa had ‘pretty good’ health
coverage, ‘but it’s the quality of care where
we fall down’.

This August, the Eastern Cape’s Health
MEC, Phumulo Masualle, conceded after an
internal probe that ‘a significant percentage’
of the 100 premature baby deaths at Mthathas
Nelson Mandela Academic Hospital since
January this year were due to ‘clinical,
administrative and infrastructural factors’. Pattinson’s research indicates that patient
referrals are a strong contributory factor
to negative outcomes at tertiary hospitals. The
Mthatha deaths follow multiple avoidable
baby deaths at Mt Frere and Cecilia Makiwane
district hospitals in that province three years
ago amid outrage by the then deputy health
minister, Nozizwe Madlala-Routledge, who
was subsequently fired.

**Praise song from the grave**

The late deputy health minister, Dr Molefi
Sefularo, embraced the expertise of
COHSASA in correspondence which
Izindaba has seen, and was a champion of
the quality assurance process. In a letter
dated 11 February, less than two months
before his death in a car accident this year,
Sefularo describes COHSASA’s role as a
member of one of the OSC’s technical quality
improvement working groups as ‘critical’.

‘The areas identified for fast-track quality
improvement, namely strengthening our
commitment to our core values, ensuring
facilities are clean, reducing waiting times,
improving patient safety, strengthening the
control of healthcare-acquired infections

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and ensuring the availability of essential medicines and supplies lie at the centre of our commitment to better services. Our staff will be in touch with you in the near future with respect to the work to be done,' he promised.

Observers of and participants in drawing up the much revised standards compliance framework say this was done without any ‘attested instruments’ to measure facility performance over time and without adequately prepared evaluators.

Says Professor Whittaker: ‘We’ve expressed our ongoing willingness to assist but we’re concerned about the processes used, in particular the lack of consultation with the Colleges of Medicine of South Africa and other academic bodies. We’re also worried that the approach of the International Society for Quality in Health Care in developing accreditation standards has not been followed to any substantial degree’.

He said that, in his view, the OSC process was neither appropriate nor adequate.

Whittaker said that development and acceptance of standards by all role players was ‘but the first step’ in bringing about the accreditation of a health care facility. Before the accreditation of a facility, ‘evaluative instruments’ should be developed and surveyors trained to provide assessments. Once this was done, problems identified in facilities by the standards needed to be corrected before accreditation could be awarded. He said that, in his view, the OSC process was neither appropriate nor adequate.

COHSASA takes six months to a year to train facility assessors (OSC training is by comparison a crash course), followed by the painstaking enrolment of staff at hospital and clinics to ‘secure their buy in’. Whittaker said it took a special kind of skill to persuade overworked nurses, doctors and administrative staff to shoulder the extra burden of, among other things, adverse event reporting and continuous monitoring. This, and the diligence required to scientifically validate quality improvement to enable full accreditation could take up to two years. He added that several public sector facilities that had failed to maintain COHSASAs required level of standards compliance had lost their accreditation status and would only regain it once they were back up to standard.

Marshal said core standards and quality assurance on their own would not cure the public health care sector’s ills. ‘They have to be part of a much bigger effort.’ She said she was contemplating calling Whittaker to ask ‘if he won’t reconsider’ (his role as a consultant). One observer quipped: ‘I wouldn’t hold my breath’.

Chris Bateman


Picture: Chris Bateman

Professor Robert Pattinson, Director of the MRC’s Maternal and Infant Health Care Strategies Research Unit.