USAID
FROM THE AMERICAN PEOPLE

OPERATIONS RESEARCH RESULTS

REVIEW OF HEALTH SERVICES ACCREDITATION PROGRAMS IN SOUTH AFRICA

STUDY OVERVIEW

Still emerging from the vestiges of apartheid, South Africa's healthcare system is, generally, not conducive to quality. As it strives to improve the quality of the healthcare delivery system, the government must particularly focus on equal access, although resource limits deter progress. At the government's request, the Quality Assurance Project (QAP) reviewed South Africa's healthcare accreditation programs to measure their contribution to service quality.

Largely limited to industrialized countries, accreditation is one type of quality initiative: It provides that a disinterested group external to healthcare facilities develops and publishes explicit standards describing how facilities should be organized, what resources are needed to provide care, and how care should be provided. After a period of standards implementation, trained observers visit each facility and measure compliance. Facilities that score high enough are accredited for a specified period (Salmon et al. 2003).

South Africa began to institute accreditation in the mid-1990s; the QAP review occurred in 2004 and consisted of in-depth interviews with stakeholders and document review.

Four institutions are providing accreditation services in South Africa. The nonprofit Council for Health Services Accreditation of Southern Africa (COHSASA) is the only private accrediting institution. Government institutions are the national level Council for Medical Schemes, the Department of Health of Gauteng Province, and the LoveLife National Adolescent Friendly Clinic Initiative (NAFCI). This report presents findings common to all four and then findings related to each of these institutions; it concludes with recommendations.

Interviewees varied widely in their use of the term "accreditation," using it loosely and even misusing it. Almost all respondents felt that accreditation improves health outcomes, although they felt South Africa's programs are too new to show much benefit yet. Most representatives of accredited facilities believed the process had improved their facility. Most respondents thought the process of accreditation should involve an initial phase of learning and instituting standards followed by a second phase where external examiners would assess compliance with those standards.

Most respondents felt that external accreditation would generate more improvements than self-accreditation and that accrediting bodies should be free of external control or influence. Comprehensive facilities (e.g., hospitals) and regulatory authorities indicated a preference for a uniform standard for the entire healthcare industry. Some respondents believed that the government would enforce a particular accreditation model on industry, which they found unacceptable, but most appreciated the role of regulation in driving quality improvement. Views differed as to how regulation should proceed: Suggestions included setting up a regulatory body that would set standards for the whole healthcare sector and oversee accreditation. The regulatory body would have to help in creating an atmosphere conducive to accreditation and quality improvement in general, in both private and public facilities.

2005

This publication was produced for review by the United States Agency for International Development by the Quality Assurance Project. It summarizes views presented in a longer document written by Nomvula Marawa and Piniel Mavengere. These views do not necessarily reflect those of the agency or the United States Government.

Many respondents felt that only accredited facilities should be able to participate in insurance programs, which would stimulate facilities to participate. Another incentive suggestion was to allow facilities to use accreditation in their marketing materials. In this case, the accrediting body would have to define guidelines for such usage. Other respondents said there is too already much commercialization of accreditation and that clients should choose providers without such influence.

Respondents were asked to discuss the four ongoing accreditation programs specifically; their comments are categorized by program.

The Council For Health Services Accreditation of Southern Africa, headquartered in Pinelands, Cape Town, has since 2000 designed both administrative and healthcare delivery standards. It offers accreditation services to hospitals, sub-acute care facilities, home healthcare services, psychiatric facilities/ programs, primary clinics, and general practitioners. It visits facilities seeking accreditation and guides management toward successful program completion. (Some respondents saw potential conflict of interest in this dual role.) It provides both baseline and later assessments and awards both provisionary and final accreditation, both with limited terms.

Four provincial Departments of Health have adopted the COHSASA program: North Western, KwaZulu Natal, Free State, and Eastern Cape. Mediclinic Hospitals were the only private facilities that had sought COHSASA accreditation at the time of the review.

COHSASA-accredited facilities have shown notable, sometimes exceptional, improvement in their management systems and community satisfaction. COHSASA charges 50,000 rands for an accreditation survey and 150,000 for facilitation. Estimates of costs for preparation, compliance, maintenance, opportunity costs, and staff training were not available; nor was the cost of establishing COHSASA.

The COHSASA accreditation program claims several benefits: (1) Standards are based on principles of quality management and continuous quality improvement, (2) Standards aim to accommodate legal and ethical concerns, (3) Standards can be used to guide the efficient and effective management of an organization, (4) Standards guide the organization and delivery of patient care services and efforts to improve the quality and efficiency of those services, (5) The accreditation process and standards themselves help empower facilities to provide quality services, and (6) The accreditation framework lends itself to the development of management systems within the institutions being accredited. However, some respondents expressed concern that accredited facilities have not lived up to the expectations of the public or regulators.

The Council for Medical Schemes (CMS), headquartered in Hatfield, Pretoria, was created by federal statute to provide regulatory supervision of private health financing through medical schemes, a massive and important industry that encompasses all managed care organizations. CMS has created standards for accreditation of medical aid scheme administrators and managed care organizations (MCOs). It also registers brokerage firms.

CMS has improved the compliance of schemes, administrators, and MCOs with relevant laws and has developed its own standards and regulations, such as patients' rights charters, to improve care. It charges 10,000 rands to accredit an administrator or MCO and 1,000 for a broker. MCOs and administrators were undergoing accreditation during the review, but none had completed the process. A list of registered brokers was available on the CMS web site.

The benefits of the CMS accreditation program include: (1) Medical schemes are assured that their service providers meet accepted standards, (2) Trustees of medical aid schemes are better able to engage with competent service providers, and (3) It assures other stakeholders (the public, department of health, doctors, hospitals, etc.) that all organizations within the healthcare-funding industry operate according to statutes and regulations. Concern was expressed over CMS capacity: Would it be able to accredit all organizations in a timely fashion?

A Directorate of Quality Assurance was established by the Gauteng Provincial Department of Health for the overall management of its program to accredit public facilities. The directorate offices are in Johannesburg. The directorate sets standards and trains facilitators and facility-based multidisciplinary quality assurance teams to conduct self-assessments and prepare monthly reports. The standards cover certain areas, such as: (1) inpatient units (e.g., record keeping, prevention of pressure sores); (2) outpatients units (reception and

information, waiting times, patient safety); (3) pharmacies (equipment, waiting times, reception, patients' rights); and (4) hospital management (patient information, complaints system, public participation, monitoring of absenteeism).

Accreditation peer review teams measure compliance with standards as part of a two-phase process. In Phase 1 facility-level quality teams have to form, meet monthly, and implement quality improvements. Monitoring is done at least every nine months, and a report on activities and compliance is sent monthly to the directorate. Phase 1 lasts about a year, and then an accreditation committee performs an exit review before a facility can enter Phase 2. Phase 2 entry requires compliance with Phase 1. Quality teams continue working on quality improvement projects and send regular reports on those projects. External peers and the accreditation committee assess progress.

The program has seven hospitals in Phase 1 and 21 in Phase 2; 15 community healthcare centers are in Phase 1. The 28 hospitals are thought to have benefited in implementing and strengthening quality programs, which include reducing waiting times, pharmaceutical stock control, etc.

The review teams comprise trained representatives from the 28 hospitals and represent all levels at the hospital, including porters, administrators, cleaners, etc. These teams learn from each other through sharing of best practices. Costs include staff salaries, allowances for the accreditation committee, subsistence, and travel. Concerns for this program included the fact that some standards were not yet fully developed and some facilities may not be able to address infrastructure problems, such as the size of consultation rooms.

LoveLife is a five-year, national adolescent reproductive health program aimed to reduce high-risk behaviors among people aged 15 to 24 years. One of its components is NAFCI, which was introduced in 1999 as a nationwide quality improvement program to encourage public health clinics to become more adolescent friendly. NAFCI is implemented through provincially based coordinators who work closely with all categories of clinic-based staff and department of health managers to ensure compliance with NAFCI standards. LoveLife partners with the Reproductive Health Unit (RHU) of the University of Witwatersrand to operate the accreditation program.

NAFCI has developed a recognition system where clinics are assessed according to NAFCI standards and criteria. Clinics are awarded bronze, silver, or gold (good, better, and best, respectively) depending on how well they meet the standards. Five external assessments had been conducted: in Western Cape, Masiphumelele (Silver) and Parkwood Clinics (Gold); in Limpopo Province, Nkowankowa (Silver) and Dan Clinics (Gold); and in Gauteng Province, Empilisweni Clinic (Silver).

There is no direct chargeable cost to the clinics as the program is funded by the Henry J. Kaiser Family Foundation and the national Department of Health. Further funds have also been secured from the Global Fund for Malaria, Tuberculosis, and HIV/AIDS.

The initiative has received enormous support from both the national and provincial departments of health. It has attracted to the clinics a large number of young people who come for information on reproductive health issues as well to participate in other LoveLife activities, including sports, debating, and motivational workshops. The greatest challenges to this program are data collection, analysis, and sharing and ensuring sustainable funding.

RECOMMENDATIONS

Healthcare involves complex interactions between the patient, hospital systems, equipment, and health professionals. When quality failures arise, their origins are frequently traced back to the "corporate culture," management decisions, organizational processes, and staffing, and not individuals. In seeking solutions to quality problems, it is necessary to first understand the system (which is beyond the scope of this study) and then look at the way the different activities aimed at maintaining and improving quality in the system are currently carried out and could be improved.

Toward that end and as a follow up to this quick review, a comprehensive national quality in healthcare strategy covering accreditation and other regulatory mechanisms needs to be developed. The project should culminate in the establishment of a national quality and safety in healthcare framework and/or policy, including an accreditation mechanism, to direct quality assurance in healthcare countrywide.

Before being granted licenses, all healthcare facilities should be required

to meet basic accreditation standards. Accreditation should be done regularly, be supported by self-appraisals, and include unannounced visits by accrediting agencies. Provisional and partial accreditations should have time limits.

The national and provincial governments should increase resources to health providers to enable them to develop databases that routinely gather information on the outcomes of care and use this information to improve the quality.

Accreditation information should not be confidential. Each facility should be required to release such information publicly in a uniform, clearly understandable format. The national and provincial governments should fund the assembly and provision of information about accreditation to the public.

Accreditation should be used to promote community empowerment and development specifically through community involvement in the facility committee structures. District and other local health committees should play a role in the accreditation of facilities in their catchment areas.

The National Health Research and the National Research Ethics Councils should be consulted on what their roles should be in supporting the accreditation of health programs. Research on accreditation is critical, and developing effective coordination mechanisms with all levels of government and local and international partners are necessary to ensure and facilitate the implementation of accreditation.

Accreditation of both facilities and services should be undertaken by nationally recognized organizations that meet specified criteria. The Department of Health or its assignee should maintain a register of these organizations.

CONCLUSION

There is growing evidence of the impact of quality assurance methods on the quality of care in resource-constrained environments like South Africa's, where simple solutions such as re-training of staff or the supply of additional resources have failed. The wealth of quality assurance experience in South Africa thus far can provide lessons that will benefit not only the health sector reform locally but also other quality improvement efforts worldwide.

Urgently needed are guidelines for the interested national stakeholders to use in developing quality initiatives. The review team hopes that the findings and recommendations here will shed light on the status of accreditation in South Africa and pave the way for the establishment of a national framework for ensuring quality—especially equitable—healthcare.

Reference: Salmon JW, Heavens J, Lombard C, and Tavrow P with foreword by Heiby JR and commentaries by Whittaker S, Muller M, Keegan M, and Rooney AL. 2003. The impact of accreditation on the quality of hospital care: KwaZulu-Natal Province, Republic of South Africa. *Operations Research Results* 2(17). Bethesda, MD: Published for the U.S. Agency for International Development by the Quality Assurance Project, University Research Co., LLC.

Quality Assurance Project
University Research Co., LLC
7200 Wisconsin Avenue, Suite 600
Bethesda, MD 20814
Tel: (301) 654-8338
Fax: (301) 941-8427
www.qaproject.org

The Quality Assurance Project (QAP) is funded by the U.S. Agency for International Development (USAID) under Contract Number GPH-C-00-02-0004-00. The project serves developing countries eligible for USAID assistance, USAID Missions and Bureaus, and other agencies and nongovernmental organizations that cooperate with USAID. QAP offers technical assistance in the management of quality assurance and workforce development in healthcare, helping develop feasible, affordable approaches to comprehensive change in health service delivery. The project team includes prime contractor University Research Co., LLC (URC), Initiatives Inc., and Joint Commission Resources, Inc.