HOSPITAL STANDARDS – PRIVATE EXPERTISE VIRTUALLY UNUSED

Professor Stuart Whittaker (centre), MD of COHSASA, with staffers Tshawekazi Ncedana (left), Chief Facilitator and former Chairperson of the COHSASA Board, and facilitator Damaria Molepo.

While the national department of health continuously re-advertises for a strategic manager in quality assurance for its health care facilities, public hospitals and clinics stumble on with inadequate official monitoring of management or standards.

He confirmed that his office was 'not an inspectorate', and that nobody in the DOH currently performed this function.

Just 14 of 380 public sector hospitals currently meet and maintain standards set by the internationally accredited not-for-profit quality improvement and accreditation body, the Council for Health Service Accreditation of South Africa (COHSASA). (COHSASA is only 1 of 6 accrediting bodies in the world to achieve internationally recognised accreditation twice through the International Society for Quality in Health Care (ISQUA). These continuous accreditations from 2002 to 2006 and from 2006 to 2010 mean that COHSASA has been rated as a competent accrediting body.)

Izindaba tracked down Dr Louis Claassens, the national Department of Health's Director of Quality Assurance in Pretoria, whose staff of two help him develop clinical guidelines and packages for primary, district and regional care.

He confirmed that his office was 'not an inspectorate', and that nobody in the DOH currently performed this function.

The new National Health Act makes provision for an inspectorate of standards compliance with a directorship that has not been filled in nearly 2 years. The post was advertised twice last year but no 'suitable candidates' were found. It was re-advertised earlier this year, again without success.

Pressured by *Izindaba*, Claassens confirmed applying for the new inspectorate post but said he was found 'unsuitable'.

The first brief of any incumbent would be to produce some strategic options (probably in consultation with COHSASA) for the health minister to choose from in terms of monitoring the quality of health care service. So far, six of the nine individual provinces have taken their own initiative, hiring COHSASA to assist with the improvement of hospitals.

Using existing expertise 'not on the table'

Asked about the possibility of outsourcing quality assurance for national norms and standards (a central government function) to COHSASA, the only body in the country currently capable of delivering a world-class service, Claassens said this was 'not on the table as far as I know'. However, he said he recently received approval to buy five licences from COHSASA to access their web-based information system, which had proved a major boon to the department.

COHSASA MD, Professor Stuart Whittaker, explained that this was a secure, web-based interface that provided clients with ongoing access to current compliance data relating to their hospitals. 'This enables management at all levels – national, provincial and hospital – to make informed decisions, respond to triggers demanding immediate action and, in this way, bring about continuous quality improvements through the ongoing monitoring of performance indicators.'

The web-based programme was a COHSASA response to the bulky,

user-unfriendly reports generated by the large number of errors detected in hospitals during their assessments.

Claassens revealed that he met with his provincial quality assurance counterpart units (also without inspection functions) once per quarter, but said 'functional ambits and structures' in quality assurance varied widely from province to province.

He also revealed that COHSASA was pioneering a patient 'harm reduction' tool in response to ongoing reports of mortality and morbidity due to systemic failures in hospitals locally and abroad.

Track record self-evident

An example of how outsourcing of hands-on service quality upgrading to COHSASA standards nationally could achieve results emerges on examination of their involvement in the public sector.

Over the last 11 years they have worked with 243 of the 380 public sector hospitals. Of these, 111 made 'substantial progress' by implementing quality improvement programmes aimed at meeting identified system problems.

Whittaker said that on entry into the programme, most hospitals showed a low overall compliance rate with professional multidisciplinary standards (made up of around 3 000 measurable elements). It was 'unlikely' that these would become accredited in the short term.

In order to address this difficulty, COHSASA pioneered a quality improvement programme to assist and encourage hospitals to work towards achieving substantial compliance with the quality standards, leading ultimately to accreditation.

After 18 months - 2 years the hospitals were re-evaluated against the accreditation standards. Hospitals that met the standards were accredited and those that did not reach full accreditation status were recognised in a graded recognition programme.

Altogether, 32 public sector hospitals have been accredited, 18 achieved intermediate pre-accreditation (± 80 out of a potential score of 100), 22 hospitals achieved entry pre-accreditation (± 70 out of a potential score of 100) and 25 hospitals have achieved progress certificates (a 10% progress over the baseline score).

However, 36 hospitals made insufficient progress or withdrew from the programme.

Marilyn Keegan, Communications Manager for COHSASA says, 'What is so encouraging is the written comments from hospital managers who report major improvements in hospital performance as a result of our programme, regardless of whether they have achieved accreditation or not – and their enthusiasm to continue on the path of quality improvement'.

Whittaker, a specialist in public health medicine, says that the programme is a step-by-step quality improvement progression, leading towards full accreditation.

However, he emphasised that this should be maintained by continuing quality improvement efforts on a daily basis, otherwise hospitals 'tend to lapse'. State hospitals 'backslide'. In the past 11 years, 17 public sector hospitals had 'backslid' as a result of not maintaining standards.

New 'harm reduction' tool

He also revealed that COHSASA was pioneering a patient 'harm reduction' tool in response to ongoing reports of mortality and morbidity due to systemic failures in hospitals locally and abroad.

The collaboration with the World Health Organization and Patient Safety International (PSI) was to develop methodologies to detect and monitor adverse events in South African health care facilities. Using an incident monitoring programme developed by PSI, COHSASA conducted a pilot programme at a district hospital (that it refuses to identify) to test its feasibility.

Initial results showed that during November last year 97 incidents were reported, of which 9 were extremely serious. Of the remainder, many were 'near' misses with potential serious consequences for patients.

This work is continuing in the Free State, where it is being integrated with the web-based information technology programmes. The impact of the combined programme is the subject of research being carried out by the Department of Health in the Free State, the University of Pretoria and COHSASA.

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COHSASA earlier this year became the first and only organisation in the world to have its HIV management standards accredited by the ISQUA. It is also only one of five health care quality bodies in the world to be accredited by ISQUA.

In the Free State, the quality body has just completed a pilot project to measure compliance levels in four hospitals against the DOH's norms and standards for district hospitals, using its web-based programme.

Another three sets of COHSASA's standards for hospitals, hospices and primary care, have been accredited by ISQUA until 2010. It is the second time the organisation's hospital standards have received international accreditation.

Asked why COHSASA was not being used more in both the private and public sector, one source, who declined

to be named, said the private sector often preferred to use cheaper overseas models that were not properly tailored to suit local conditions.

He believed the public sector was reluctant 'because it takes so long to show results and that doesn't go down well with most politicians'.

Whittaker denies that overseas models are cheaper. 'The opposite is true. Our strict price modelling comparisons find that COHSASA, free of currency exchange limitations, is much cheaper than international accrediting bodies. 'As for the process taking a long time, it depends on how far the hospital is and how much work needs to be done to reach acceptable standards. It also hinges on levels of provincial and facility commitment,' added Whittaker.

A total of 18 private hospitals, clinics and hospices are currently COHSASA accredited while 103 other private facilities have let their accreditation lapse. MediClinic, however, has re-entered 35 of its facilities for accreditation using the web-based information technology programme.

Since it was set up, COHSASA has supervised 187 health care facilities of all types (public and private) to their minimum standards for accreditation, with 41 currently accredited and 184 'in process'. There are 780 hospitals in South Africa.

Whittaker said interest in COHSASA by several sub-Saharan governments and private hospital groups was growing. Only time will tell whether interest can be stirred at national level, where South Africa's norms and standards legally reside.

Chris Bateman