



COHSASA – NIBBLING AT THE HEALTH CARE ELEPHANT

A total of 27 out of the 502 South African hospitals (public and private) that have worked or are working with the Council for Health Service Accreditation (Cohsasa), currently meet its internationally recognised essential performance indicators.

The only indigenous, locally tailored health facility improvement and accreditation body, Cohsasa, a Section 21 company, celebrated 10 years of existence last year. It has fought an uphill battle to make inroads in a country that sorely needs its services.

There are 780 hospitals in South Africa. Of the 400 private sector hospitals, most of Medi-Clinic (the third largest group) facilities use Cohsasa while the remainder are holding out for preferential tariffs.

In the public sector, work by the national department of health (DOH) on standards definitions for its 380 hospitals is still in progress. The national DOH has no performance measurement capacity outside of Cohsasa, which is involved to greater or far lesser degree in 6 of the 9 provinces.

The success stories among those hospitals whose managements overcame their fear of 'yet more paperwork' and chose to have their shortcomings exposed for gradual correction, provide the inspiration for Cohsasa's 50 experts to continue. It seems daunting when one considers the state of some of public hospitals (164 of which have so far worked with Cohsasa) and the slow incremental up to 2-year grind to full accreditation.

According to Cohsasa MD, Professor Stuart Whittaker, a specialist in public health medicine, many hospitals slide back to a lower Cohsasa ranking within a year or two of reaching accreditation. He explained that this was because they saw accreditation as an end-point and not as the start of an ongoing quality improvement process 'that should be an integral part of day-to-day hospital management'.

Why hospitals fail

There were many reasons why hospitals fared badly during the quality

improvement phase, with some never reaching accreditation. The list provides clues as to the systemic causes behind alarming nosocomial infection death rates, dismal working conditions and non-delivery of basic health care in non-participating facilities.

The main problems were a lack of management skills, the dismal failure of the Public Works Department to provide maintenance and repair services, a failure to act upon identified deficiencies, delayed responses to quality improvement requirements, a 'passing the buck' syndrome, poor disciplinary procedures for staff and the 'low profile' of provincial quality assurance units.

His team also found that hospital staff movement during or after a Cohsasa intervention was a major contributing factor to skills loss and the back-sliding of a facility. Whittaker said willingness and buy-in were key requirements. 'We keep educating hospital managers and say to provinces that if a facility doesn't want to come in, don't put them in, because it will surely fail – the goal should not be accreditation but continuous quality improvement. We all know it's a huge challenge.'

What many reluctant and fearful hospital managements don't realise is that 70% of Cohsasa's standards do not require any outlay, just an examination of existing outcomes, reprioritisation and systemic and procedural improvements followed by ongoing maintenance and monitoring.

'Sometimes the hospitals look at things and say there's just too much and see us as someone else putting pressure on them. But we're not an activist organisation – we try to work with the hospitals to make things better.'

No 'magic bullet'

Whittaker stresses: 'We're not a magic bullet, but our systems can improve health care facilities that have a desire to improve.'

Dr Louis Claassens, the DOH's Director of Quality Assurance, who sits on Cohsasa's board, confirmed that there was 'no official working

relationship' between the DOH and Cohsasa. However, Whittaker had helped him develop the range of services and norms and standards for district hospitals and Claassens sees Cohsasa as a 'major resource'.

Asked what the DOH needed to do, Claassens replied: 'make decisions on the role of Cohsasa and on accreditation as a form of acknowledgment'. Cohsasa has struggled to keep afloat in a public sector climate of reluctance and overwhelm.

Whittaker, whose self-proclaimed 'altruistic tendencies' led him to develop and keep the local concept alive, admits that 'it's really hard and scary for us when contracts end'. Having developed a strong management model with Anglo-American, he soon learnt that he could not run such an ambitious programme on 'altruism alone'.

He found that Cohsasa could survive on a 5% excess of income over expenditure, with any extra profits being ploughed back into research.

'We've been very fortunate with some World Health Organization (WHO) research funding and some from the KwaZulu-Natal provincial government, but we've learnt that we need a fair amount of excess,' Whittaker added.

Six of the 9 provinces are currently on Cohsasa's programme, with the better-resourced Gauteng, Western Cape and Northern Cape seemingly confident of managing alone. Dr Deon Moulder, Chairman of the Cohsasa board, said it was decided early on to remain an independent entity so that 'those hospitals that come to the party do so of their own choice'.

Private sector reluctance

Moulder said it remained 'a mystery' as to why the private sector (89 hospitals and clinics accredited over the last decade with 15 still holding accreditation) were 'not really interested', with some preferring to use overseas quality assurance models.

Moulder said these overseas assurance models failed to adapt their standards to the unique South African environment and that Cohsasa's ability to do this



Cohsasa MD Professor Stuart Whittaker, Chief Facilitator Grissel Ncedana and HIV programme director Dr Morris Mathebula.

Picture: Chris Bateman

had led to much interest and increasing participation by sub-Saharan countries. He said private hospitals rapidly met standards but public hospitals took much longer.

Grissel Ncedana, a former deputy nursing manager at the Tshepong Hospital complex in Klerksdorp, was so impressed with the outcomes and boosting of staff morale after the Cohsasa accreditation process that she retired early and joined Cohsasa. Now she is Cohsasa's chief facilitator and top advocate for the benefits of the process. Ncedana tells her story as a powerful antidote to public hospital management apathy and reluctance to risk the accreditation process.

The Tshepong complex was accredited in 1996 (for 2 years) and again in 1998 (for 3 years) after an extended period of strikes by general assistants and nurses had left the institution debilitated. With management/worker tensions at an all-time high, Cohsasa called a worker meeting in the local hall to explain the health care delivery improvement process.

A happy mix up

Says Ncedana, chuckling: 'Everyone thought it was a union because the name sounds like Cosatu, so the hall was packed to the rafters'. When Whittaker and a colleague explained, to general approval, the new initiative and how they planned to involve everybody, she said she felt 'it was like Jeremiah had come to rebuild the walls of Jericho!'

With Cohsasa's independence having won the trust of the workers, 'we decided that their manual would be the bible to

guide us,' she added. Policies were written for each department, 'from the bottom up. For example, the cleaners suggested we adjust visiting hours so that the floors could be done more efficiently'. When some gardeners who were 'sometimes less than sober until 11 am' were told that they could contribute to healing patients with attractive flower beds, they suddenly arrived in the manager's office 'wanting more flowers'.

'It seemed like everybody suddenly took ownership of their jobs,' Ncedana said. With Cohsasa's experts visiting 6-weekly to affirm improvements and explain how to do what was still needed, teams were built up to help one another. 'It was like eating an elephant by taking small bites – and we could measure our progress,' she said.

Whittaker emphasised that accreditation was a 'snapshot in time, meaning that at a certain point in an organisation's history it has met published standards'. The onus was on the hospital to maintain standards and continue to improve. 'Our standards require excellent managerial and clinical policies, procedures and operations, so that risks to patients will be reduced and the quality of health care improved,' he added.

How accreditation works

All areas of the hospital need to reach compliance with standards before full accreditation can be awarded. Cohsasa has developed two strategies to help the many poorly resourced hospitals that don't initially achieve accreditation but make significant strides after entering the programme.

Besides the Facilitated Accreditation Programme, the Graded Recognition Programme encourages progress by certifying specific, progressive levels of compliance with essential performance indicators. These certificates are for Progress, Entry Level and Intermediate Level, and last for a defined period only.

Whittaker said provinces or private health care companies needed to pay

close attention to the information supplied by Cohsasa, in order to make progress. The best outcome measurement was to ask whether the life of the patient being discharged was better than when they were admitted.

With HIV/AIDS changing the face of health care in South Africa (Whittaker said they are finding up to 90% HIV-positive bed occupancy rates in some hospital wards), Cohsasa had decided to introduce an HIV district evaluation tool. This was currently being piloted in the Umkhanyakude District in KwaZulu-Natal.

The system – a world first – measures HIV management standards of all service providers within a district. Cohsasa's HIV programme director, Dr Morris Mathebula, told *Izindaba* that his initial findings in terms of ART roll-out readiness were 'scary'.

'Some of the institutions will never be ready without help,' he opined. Claassens said his DOH office did not have the mandate or resources 'to move towards the measuring part of assurance'. He would like to see his relationship with Cohsasa 'given more of an official flavour and developed further'.

The size and function of provincial health department quality assurance units, whom he met with once every quarter, varied widely from province to province. 'They each are different in their functional ambit and their structures are very different,' he said.

Health Act silent

While the new National Health Act was silent on accreditation, it did provide for an office of standards compliance with a long list of its functions, but this had yet to be established. 'I'm a small unit in that proposed much bigger unit,' he explained.

Whittaker confirmed that Cohsasa was 'starting to provide the national DOH with information on the state of hospitals'. In terms of the government's *Bato Phele* (People First) principles, Cohsasa was now seen as an ally in delivering health care.

Whittaker said he was reluctant to share reports of individual hospitals publicly because their policy was 'not to blame and shame, but to improve things'.

Chris Bateman