EDITORIAL / VAN DIE REDAKSIE

Assessments of quality are complex and often dependent on the perspective of the observer. Originally, the concept of quality assurance was at the centre of all quality programmes. It involved the setting of standards, their monitoring and evaluation followed by the indicated corrective action, i.e. the classic triad of a value system, an appraisal system and a response system.

This has grown with time into a new paradigm of continuous quality improvement (CQI), also called total quality management (TQM). CQI is a proactive process in which a series of strategies is designed to prevent quality-related problems rather than measure them after they occur. It is aimed at taking prospective corrective action to enhance medical care rather than retrospective and possibly punitive corrective action.

CQI as a philosophy reviews the relationship between quality and cost. It suggests that improvement in quality leads to lower cost by reducing waste, re-work and unnecessary complexity. It emphasises the deeply ingrained principle in medicine of continual learning to improve care. CQI does not focus on standards or minimums, although these have their place, but rather on improved quality and targets.

Provision of the highest quality of care with the available resources is not simply a matter of improving system-wide or macro-level efficiency. Practitioners and institutions at the micro level are the logical focus of efforts to improve quality.

The medical profession’s involvement in quality management will take the form of a range of activities: peer review, medical audit, participation in accreditation programmes, clinical guidelines and participation in research relating to measurement of outcomes. The recent groundswell of international interest in quality management in health care has now reached South Africa, so as the country moves towards a democratic future the focus on equity and efficiency, two quality management activities, will become increasingly prominent.

Quality management programmes in South Africa are a series of dynamic processes by which the population can be assured that everything is being done to provide them with the best quality health care within the available resources.

Two initiatives in the quality management process are included in this issue of the SAMJ: the supplement Quality Health Care in South Africa and the Special Article ‘The South African Pilot Hospital Accreditation Programme: Part I. The process’.

These are among the first steps of a national strategy on quality assurance. It is only by developing such a strategy that the South African health services will have the capacity to monitor progress towards a truly equitable health service accessible to all citizens.

In order to co-ordinate quality activities the National Co-ordinating Committee on Quality in Health was established. The Committee plans to establish priorities for collaborative quality activities, identify resources and liaise internationally. Any health care group interested in becoming involved in quality management activities is welcome to join this initiative.

D. GREEN
V. J. PINKNEY-ATKINSON


SPECIAL ARTICLE

The South African Pilot Hospital Accreditation Programme

Part I. The process

The quality movement in health care has generated renewed interest over the past decade. Whereas the various professions have used it as a regulatory mechanism, other role players in the health industry have a variety of reasons for being interested in this movement.

The providers of health care (health managers) have a legal and ethical claim to uphold the quality of care to patients, whereas the third-party funders add a cost-effective dimension to the quality process. Patients have become more knowledgeable and assertive about health care received and require accountability from both the professional and the health service provider.

In addition the quality movement provides health managers with a mechanism to assist in ensuring that health services become increasingly acceptable, accessible, equitable and affordable to all South Africa’s people. Academic interest in the quality process, as a consequence of the above, has led to a more scientific and systematic approach to health care evaluation.

In South Africa it is generally accepted that a high standard of professional training is, on its own, not sufficient to ensure quality of service. There are few formal mechanisms to define and monitor performance standards for individual private and public hospitals. Although hospitals are subject to statutory inspections in respect of safety and physical environments, and national bodies responsible for the training of professional staff have inspected training posts and their incumbents, these mechanisms are of limited value in assessing overall effectiveness.

In countries such as the UK, clinicians’ interest in defining and monitoring standards in clinical practice, as well as in service organisations, has increased. This reflects a willingness to become involved in management as well as maintain a degree of professional self-direction when faced with an increasingly inquisitive public and diminishing resources with which to administer health services.

The quality of patient care is affected by the abilities of an organisation and its members. These abilities are related to the organisation’s structures and processes and its members’ training, experience and other attributes such as judgement, integrity and technical expertise. Within the context of health care organisations, professionals and other individuals responsible for patient activities include, e.g. practitioners, managerial and support staff.

There is now a growing awareness that quality patient care depends not only on the performance of individuals but also on collaborative efforts and integrated managerial and clinical processes that must function well if care objectives are to be achieved.

The emphasis on how effectively organisations func-
tion in providing patient care has resulted in a shift from case-based problem identification and resolution to monitoring and evaluation of interlinked organisational systems, each of which comprises individuals and service units, e.g. admitting office, radiology service, transport service.

Organisational audit is the process of applying organisational standards to a hospital/acute unit that will improve the quality of services provided. Organisational audit provides a framework for a continuous development of the systems and processes which must be in place to provide effective and efficient health care services.

As South Africa changes, opportunities arise to improve health services. Among these is the opportunity to implement a quality assurance programme that will ensure the good quality of health services. To assist in this process, a pilot accreditation programme for private and public hospitals is being developed. This programme incorporates the principal characteristics of accreditation programmes in North America, Australia and the UK, such as: (i) independence from funding agencies and operators; (ii) published multidisciplinary standards for acute hospitals; (iii) a preparatory self-assessment phase; (iv) assessment by visiting peer group; (v) verbal and written feedback to participants; (vi) repetition of the cycle in 1-2 years; and (vii) a support network for participants.

Early in 1993 a programme was established to test the application of an external audit system, incorporating an accreditation approach for acute hospitals in South Africa. The aims of the programme are: (i) to develop a comprehensive framework of organisational standards for acute hospitals which can be applied to public and private hospitals; (ii) to develop instruments for assessing a hospital’s progress towards meeting these standards; and (iii) to assess the cost-effectiveness of the programme and its potential for encouraging better organisational practices among hospitals.

Draft standards are being developed on all aspects of South African hospital care by specialised task groups utilising a set of standards from the UK as guidelines, as well as for standards achievable and desirable levels of quality of care from the various professional groups. In this process efforts are being made to ensure that all relevant role players in the South African health care professions agree that the standards are necessary and achievable in the South African situation.

Three private and three public hospitals, which have volunteered as pilot sites, will be used to test the practicability of implementing and assessing these standards and will participate in a multiphase programme.

The preparatory phase is one of the most beneficial components of the accreditation programme, since this is the phase during which the hospital receives the draft standards, reviews them and assesses the degree to which they are complied with. During this phase, the hospital sets up a local steering group and appoints a project co-ordinator. Action plans are developed to identify ways in which non-compliance with the standards may be rectified. It is estimated that this process will take 9 - 12 months, during which time hospitals will work towards improving the situation. A few weeks prior to the survey phase each pilot site will submit pre-survey documentation to the accreditation unit. This documentation is intended to establish the degree of compliance with the standards as perceived by the participating hospital.

During the survey phase, the monitoring of compliance with the standards will be undertaken by a survey team consisting of three senior health care professionals (doctor, nurse, manager), who will work according to set procedures. The surveyors will be required to complete documentation developed to record their findings, which will be used in the development of the final report of the hospital's compliance with the standards. The length of the survey will be determined by the number of beds and specialties. It is anticipated that for a 500-bed hospital the survey will take approximately 4 days. The survey team will report back to the hospital executive at a plenary session at the end of the last day.

Pilot hospitals will be invited to nominate senior health professionals to be trained as surveyors for the programme. Similarly, professional associations and other relevant organisations will also be invited to nominate representatives to participate in the programme. As a matter of policy, all surveyors will be amateurs whose regular work is in similar hospitals, and they will be encouraged to share the experiences of others. Participation will be voluntary and surveyors will not be paid; however, their employing authorities will be requested to grant them full paid leave to participate in the programme. Expenses directly related to the programme incurred by surveyors will be met by funding from the accreditation unit.

During the development of the standards, instruments will be developed which will outline the methods to be used in evaluating the degree of compliance which hospitals are required to achieve. These instruments will be tested in the carrying out of surveys, during which the surveyors will be made familiar with the standards and the instruments. In addition, training sessions will be held in hospitals which do not form part of the pilot programme, during which the surveyors’ ability to evaluate the standards will be tested. These workshops will be held prior to the survey and to decide whether the hospital should be awarded accreditation based on the survey report. The pilot accreditation board will comprise members of professional associations, departments of health, private hospital representative associations and representatives of medical aid schemes.

Workshops, conducted by international and local consultants, will be held during which board members will be trained to interpret surveyors’ reports and decide whether hospitals comply with the standards. Based on the UK experience’ common areas of non-compliance with standards are not necessarily the domain of individual departments: (i) safety — patient identification, environmental safety and procedures for handling medication, maintenance and clinical waste; (ii) resuscitation — maintenance of equipment, training and call-out procedures; (iii) systematic clinical review — formal audit of length of stay, clinical services and patient records; (iv) admission/discharge policies — definition and monitoring of case-mix matched to the hospitals’ facilities, staff and training.

Hospitals that comply with the standards will receive accreditation for being hospital on compliance with the pilot accreditation programme.

The hospital will continue to work on the action plans developed during the preparatory phase, and on those developed after the survey to correct areas in which hospitals do not meet the standards. It is envisaged that the cycle of preparatory phase, survey, report and post-survey phase will be repeated every 3 years.
SPECIAL ARTICLE

As the programme develops, further pilot sites will be added. Three areas will be addressed during the evaluation of the pilot accreditation project. These are: (i) the standards and their appropriateness; (ii) the process of the preparation of the survey and the survey itself; and (iii) the impact of the process on the participating hospitals.

Should the accreditation system be shown to be an efficient process for evaluating and improving the quality of care in hospitals and clinics, the possibility of developing a national accreditation system for hospitals will be investigated.

It is anticipated that organisational audit followed by an accreditation process offers a framework for the systematic review of hospital or health care facilities and the systems and processes that must be in place in order to provide an effective and efficient service.

S. WHITTAKER
A. BRUWER
J. F. TALJAARD
C. D. SHAW
D. GREEN
H. J. STEYN
A. SKIBBE


OPINION / OPINIE

Occupational Diseases in Mines and Works Amendment Act, 1993

The last session of the tricameral parliament legislated the historic political and constitutional agreements made at the World Trade Centre. Less publicised was its promulgation of changes to mining health and safety in the form of the Occupational Diseases in Mines and Works Amendment Act, 1993.1

The principal aim of the amendment is the removal of racial differentiation from the Occupational Diseases in Mines and Works Act (ODMWA).2 It creates a single system of medical surveillance for all miners. While the ODMWA made different provisions for black, coloured and white miners, the amended Act makes it compulsory for all miners to be medically examined every 3 years at the expense of mine owners in order to be certified fit for risk-work. In the past, only the Medical Bureau for Occupational Diseases (MBOD) could certify white and coloured miners fit. Black miners did not require certification and underwent only a superficial examination.

While the devolution of clinical functions to the mines could free the MBOD to play an important policing, auditing and enforcement role, there are no such provisions in the Act. Instead, the amendment has commenced rationalisation of staff and is scaling down activities, perceiving a limited role for itself in the new dispensation. There is no guarantee that, with self-regulation, a racially differentiated examination system funded by different health financing mechanisms will not continue on the mines.

Fifthly, the amendment introduces a salary-based compensation system, an improvement on the previous race-based system. However, as the gap between average monthly incomes for black (R946)3 and white (R2 000) miners is particularly wide, the latter will continue to receive higher benefits. Unskilled miners (R686 per month) will be particularly disadvantaged by this system. The amendment tries to overcome this disparity by providing three mechanisms: (i) a minimum benefit of R7 000 to protect the lowest paid workers; (ii) a ceiling of R2 000 in the determination of monthly earnings; and (iii) expansion of the definition of earnings to include the value of food, accommodation and regular overtime.

More generally, the changes in benefits represent an overall increase for all categories of miners, with the largest increase for black miners. For black miners with first-degree compensable disease, the one-sum benefit has been increased from R4 508 to a possible maximum of R31 400 (700%). In the case of disease in the second degree, there is an increase of 21% for white miners. As there was previously no distinction between first- and second-degree disease for black miners, the change represents an increase of between 735% (average) and 1 553% (maximum) for those certified as having second-degree disease. The massive increases required to bring benefits for black miners into line with those of their white counterparts are a reflection of the gross disparities of the past.

In addition, the amendment requires mines to provide ongoing medical cover for a period of 2 years to employees who are certified as having a compensable disease.

The third important change to the principal Act is the reinstatement of the courts' authority to overturn decisions of the certification committees and those of the commissioner. This brings the ODMWA into line with international and local compensation legislation.

Fourthly, while the Compensation for Occupational Injuries and Diseases Act (COIDA) defines four degrees of disability (20%, 40%, 70% and 100%), the amendment defines only two degrees of disability for miners. First-degree disability applies to individuals certified at 11 - 40%, and second-degree to those certified at greater than 40%. In our view, two degrees are insufficient as they do not differentiate between moderately (e.g. 41%) and severely disabled (e.g. 100%) miners.

More importantly, this new categorisation raises the threshold for compensability by excluding individuals who have a 0 - 10% disability. The motivation for this clause is provided for in a memorandum attached to the amendment which states, 'An impairment of not more than 10% is so insignificant that it does not warrant compensation." We are not convinced by this argument and suggest that it indicates the mining industry's refusal to take responsibility for this group of miners. There are indications that miners with up to a 30% deficit in forced expiratory volume in 1 second (FEV1) or with only early radiological (1/0') or pathological (post mortem) evidence of pneumoconiosis, may be included in this 0 - 10% group. Such a clause sets an unhealthy precedent and we would like to see it repealed at the first opportunity.

Fifthly, with regard to compensation for tuberculosis, the amended Act has a more rational approach than its predecessor. While the ODMWA provided benefits to risk-workers diagnosed with tuberculosis regardless of the presence/absence of sequelae, the amendment adopts a two-stage approach to the disease. A risk-worker diagnosed with tuberculosis will first be compensated for loss of earnings (75%) for a maximum of 6 months to allow for treatment and recovery. Thereafter, further compensation will be awarded only if a benefit examination establishes the presence of permanent disability. The widely criticised 9-monthly mass miniature radiography (MMR) has been retained as the only means of tuberculosis surveillance. In the absence of any other...