Strategic Purchasing Policy Brief Series

Brief 5: Certification, accreditation, quality measurement and quality improvement

About this series

National Health Insurance (NHI) refers to a wide-ranging set of reforms of the South African healthcare system, including the establishment of the NHI Fund as a new entity tasked with the *strategic purchasing* of healthcare.

The broad aim of the NHI reforms is to achieve universal health coverage (UHC) in South Africa. UHC offers "all individuals and communities the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. UHC emphasizes not only what services are covered, but also how they are funded, managed, and delivered" (World Health Organization 2019).

Much of the discussion in South Africa on how we achieve these aims has been divisive and polarised. For many, it is difficult to engage in the debates meaningfully without understanding the jargon and myriad of complex concepts. In support of meaningful discourse, we offer this series of briefs to deepen public awareness and enrich discussions on one particular aspect of the proposed reforms: the notion of strategic purchasing. What is strategic purchasing? Who will do the purchasing? How do we hold the purchaser(s) accountable?

The providers of healthcare services, both public and private, are important stakeholders in a healthcare system. The ways in which the proposed reforms are likely to impact on providers is an often-neglected perspective, one which we hope to consider here.

Seven briefs explore what a purchaser-provider split in a healthcare system is, what strategic purchasing is, the nuances of matching the need for care with the supply of services, how to ensure quality and access and how to balance all this with affordability.

At the time of writing these briefs, NHI as a concept was informed by the framework as set out in the draft NHI Bill (2019) which was preceded by a previous draft version of the Bill (2018), two White Papers (2015 and 2017) and a Green (Policy) Paper (2011).

This work was funded by the Hospital Association of South Africa, although the views presented here are the authors' own.

In this brief…

The 2019 revised NHI Bill uses the term accreditation to refer to the Fund's own process of determining the eligibility of healthcare facilities and providers to contract with the Fund. Compliance with the process is mandatory for those wanting to contract with the Fund. This process encompasses certification by the Office of Health Standards Compliance (OHSC) that their standards and norms are met. This certification is only a subset of the accreditation requirement: there are other requirements that will also have to be met as part of the accreditation process such as (but not limited to): providing the minimum list of services specified; having an appropriate number and composition of staff given services that are being provided; adhering to treatment protocols and guidelines; and submission of information to the national health information system.

Given the focus on certification and accreditation in the revised NHI Bill (2019 version), we take time to explain these two concepts. We describe current approaches to the measurement and management of healthcare quality of care in South Africa and comment on the steps required to move from the current to the ideal.

In this brief, we explore how certification can be married with other quality indicators and health outcome data, public reporting and contracting to drive a holistic approach to quality that is rigorous enough to change healthcare provider behaviour. In our view, the ultimate aim should be to build a culture of continuous improvement and a health system that is focussed on outcomes that matter to patients in and of themselves.

Why it matters

The philosophical paradigm underpinning a move to universal health coverage (UHC) is the provision of high-quality care for all citizens. It is now acknowledged that more individuals die, globally, from poor quality healthcare than from limited access to healthcare (Kruk et al. 2018). While until now organisations such as the World Bank and World Health Organization have placed much of their focus on the important issue of *physical access to healthcare services*, the Lancet Commission on High-Quality Healthcare Systems which released its final report in 2018 helped to bring to the fore the importance of *quality healthcare services*. In order to achieve true universal health coverage, individuals need access to appropriate *and* effective healthcare services, with both these dimensions closely related to the quality of healthcare services.

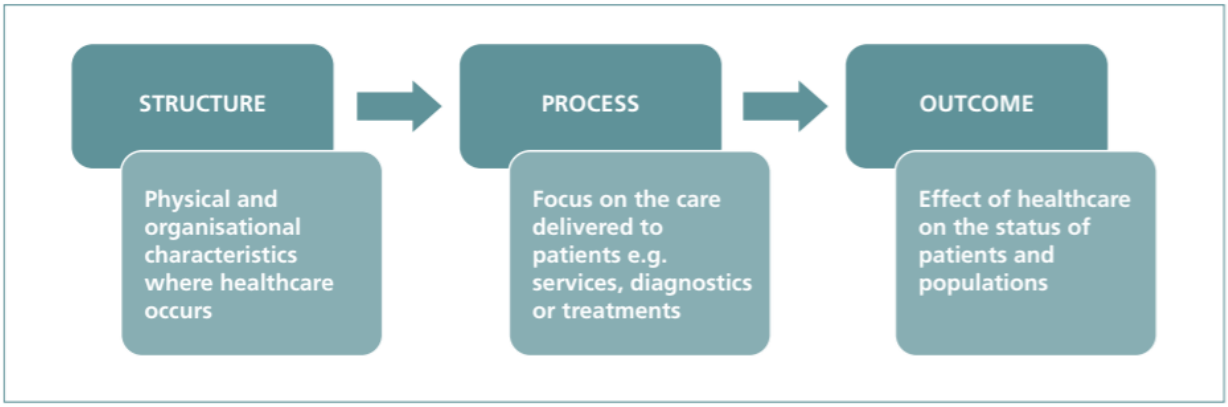
In order to achieve true universal health coverage, individuals need access to appropriate *and* effective healthcare services (i.e. quality healthcare).

The bigger picture: how does certification serve quality

Donabedian's framework provides a useful lens for understanding quality in terms of its potential measurement - of which certification would form a part (Donabedian 2005). Donabedian distinguishes between three types

of quality measures: structural measures, process measures and outcome measures (Donabedian 2005). Structural measures of care typically focus on the physical and organisational characteristics of the spaces where care is provided (traditionally, these are the items which facilities would be assessed against – infrastructure, staffing, policies), while process measures of care focus on the nature of care provided to clients such as the services, diagnostic approaches used and ultimately treatments. Lastly, outcome measures entail a focus on the effect of the provided healthcare on the health status of clients and overall populations.

Figure 1: Donabedian's quality framework



Measures of all three of these dimensions have certain benefits and limitations. Data on structural measures are typically easy to collect (structural measures can easily be seen), but their importance as a quality measure is reliant on the existence of a strong positive relationship between these measures and health outcomes, which is not always the case, particularly where management and leadership are weak.

Outcomes measures are often the missing link in national systems of quality measurement. This crucial aspect of quality measurement has not been clearly articulated as part of the accreditation process in the NHI Bill.

Process measures are less easy to collect, though critical from a quality perspective. Process measures that are routinely collected through the data information management systems of public or private facilities are reliant on the honesty of the provider reporting the data, as well as accurate capturing. The conceptualisation of accreditation in the NHI Bill encompasses submission of information to the national health information system. Health systems often do not have sufficient incentives built into the system to encourage accurate and honest process measure reporting and frequently quite a lot of effort is required to demonstrate the long-term value of monitoring these measures.

Outcome measures are arguably the measures that matter most as they indicate the ultimate impact of care on health: both in terms of when health status is negatively affected such as a patient death and when health status is positively affected such as increased mobility or reduced pain. Health outcomes are influenced by a multitude of factors,

The value of certification ultimately lies in; buy-in, a focus on issues of quality of care and use of the data collected to inform action.

such as income, education, home environment and nutrition, which fall outside the influence of the health system. It is therefore difficult to disentangle quality or impact of healthcare from other influencing factors and therefore relative improvement is often a better measure of quality than absolute performance.

Outcomes data is seldom routinely collected in a health system and there is considerable effort required to agree on appropriate measures and then to collect the data over time. In South Africa currently, we have national measures of certain key outcomes (such as life expectancy and maternal and child mortality). We also collect patient satisfaction data from facilities in both the public and private sectors. There are also efforts through clinical registries to collect specific outcomes related to particular clinical areas. Private hospitals collect and report on some outcomes measures, largely relating to adverse events such as pressure ulcers, falls and hospital-acquired infections. However, these efforts are largely uncoordinated with inconsistent definitions and a lack of comparability.

Understanding certification

Certification is one of the building blocks for quality. At its simplest, certification entails the assessment of healthcare facilities, whether hospitals, clinics or other types of health facilities, against a defined set of standards (Jovanovicæ 2005). The facilities will be assessed based on set criteria and often receive certification as proof of this. Typically, facility performance against standards is measured through a variety of approaches, including self-assessments, surveyor on-site visits, interviews of staff by the surveyors, scrutiny of documentation in facilities and the checking of equipment that is used. It can therefore be a fairly manual and human-resource-heavy process.

Certification can be a once-off measurement process or repeated to see how facilities' performance against the measured standards change over time. When facilities also receive support in trying to better comply with minimum standards, accreditation forms part of a larger quality improvement process.

It is assumed that compliance with a minimum number or set of standards will ensure the provision of high-quality healthcare. Certification is often viewed as a risk-reduction activity (O'Leary 2000). The presumed benefits of certification are reliant on the assumption that if the facility as a whole, as well as the individual staff, adhere to minimum standards and rules, any potential errors and adverse outcomes will be minimised.

There is limited evidence that certification mechanisms have a positive impact on health outcomes or outputs in and of themselves. A recent review of available literature on the relationship between hospital certification and both clinical outcomes and process measures concluded that there exists **insufficient evidence to clearly link hospital certification to measurable positive changes in quality of healthcare** (Brubakk et al. 2015). This

The OHSC conducted 627 unannounced health establishment inspections during 2015/16 financial year. More than half of the health establishments (which were all in the public sector) failed to meet the regulated norms and standards for quality and safety.

could be because certification measures are often developed without having a clear causal chain of impact (in terms of health outcomes) in mind. Variation in how certification is applied, i.e. variation in the quality of the certification process itself, may contribute to the absence of a clear relationship between certification and improved healthcare quality (Brubakk et al. 2015). Part of the reason there does not exist a clear link between certification and improved outcomes may be due to differing viewpoints on the role of certification. In the context of government-mandated programmes, certification may become simply a regulatory and public accountability tool, rather than something providers are self-motivated to engage in and ultimately a quality improvement tool (Shaw 2004).

A recent review of six studies of the costs of certification found that the incremental (additional) costs of certification ranged from 0.2% to 1.7% of total costs of these facilities over the certification cycle, with limited evidence to support any benefits (Mumford et al. 2013). The cost impact for especially smaller facilities can be quite high (Mumford et al. 2015). It is therefore important to ask whether the same objective of delivering quality care can be achieved at a lower cost with potentially higher benefits. Ultimately, it is necessary to implement a variety of quality monitoring and improvement strategies that do not impose an unnecessary burden on facilities and providers.

Certification in South Africa: now

South Africa began actively working towards certification in 2008, developing the first set of Norms and Core Standards (NCS) in 2010. The NCS were then used to measure public facilities from 2011, with the process managed by the NDoH. In 2013, the National Health Act was amended and the OHSC was promulgated, setting up a semi-independent[1] certification body. The OHSC promulgated revised norms and standards in 2018 which were supposed to come into effect in February 2019 after sector-wide engagement. Inspections of public health facilities have been ongoing since the establishment of the OHSC in 2013, however these revised norms and standards set the OHSC up for system-wide (public and private sector) inspections with a unified tool and method for evaluation. The National Health Act (NHA) makes oversight of both public and private providers the Minister of Health's responsibility and therefore standards should in theory be

Certification can be viewed as a risk reduction activity – particularly relevant in contexts where the risk of poor-quality care is high. As has been the case in the SA public sector, it also acts as a red flag for systemic failures.

[1] Appointments are still within the ambit of the Minister of Health

aligned across sectors. However, the alignment of standards is not straight forward given the structural differences between the sectors.

The OHSC received a government grant of R88.9 million for the 2015/16 financial year through the budget vote of the National Department of Health (NDoH). The 2016/17 budget was approximately R100m, growing to R133m in 2018/19. All funding for the OHSC is planned to come from government funds. This budget will need to grow considerably if efforts are to extend to private facilities.

The Ideal Clinic Realisation and Maintenance (ICRM) Programme was launched in 2014. It provided detailed, tangible standards for how the National Department of Health wants clinics to function and what it means to be a well-functioning clinic. According to the National Health Council directive, the aim was for all clinics to achieve Ideal Clinic status by April 2018. This was developed separate to the OHSC and does highlight one of the common pitfalls of certification processes - duplication of efforts that make the experience for a provider cumbersome. The conceptualisation of accreditation as being more than OHSC certification in the NHI Bill runs a similar risk of duplicating effort.

In the private sector, there have been separate certification efforts - while the sector waits for the OHSC to reach them. One example of this is the Council for Health Standards Compliance of Southern Africa (COHSASA). COHSASA implements the standards and approaches advised by the International Society for Quality in Health Care (ISQUA) and is the only internationally-accredited quality improvement and accreditation body for healthcare facilities in Sub-Saharan Africa. Membership with COHSASA is optional, and some hospital groups in the private sector have used COHSASA to improve quality across their facilities. This provides some security to clients that their standard of care at least adheres to the same minimum standard - a rare situation in both the public and private sectors.

While certification, as currently undertaken by the OHSC, is widely accepted as important for ensuring a minimum level of quality, the mechanisms for measuring and monitoring providers is more complex than initially meets the eye. OHSC certification is largely focussed on structural elements of quality which are key for the attainment of **minimum** standards. However, these are unlikely to be sufficient to drive quality **improvement** and provide no guarantee of good health outcomes (such as increased longevity, positive patient reported outcomes and improvements in the quality of life).

Accreditation in South Africa under NHI

As we have discussed, the OHSC will continue to be the body responsible for certification under NHI. Another important new policy is the National Public Health Institute Bill of South Africa (NAPHISA) which was tabled in 2017, passed by the National Council of Provinces (NCOP) early 2019 and has now been passed back to the National Assembly for final approval (Sabinet 2019). The Bill provides for the establishment of a Public Health Institute that will "conduct disease and injury surveillance and provide specialised public health services, public health interventions, training and research directed towards the major health challenges affecting South Africa's population". NAPHISA could allow facilities to link their achievement of certification standards against their catchment population's well-being – allowing us to understand the relationship between certification and population health over time.

Ultimately it will be important for the Fund to set accreditation criteria that deal with the process and outcomes dimensions of quality since structural measures of quality are not sufficient to ensure good health outcomes.

Significant differences in the quality of care between providers raising questions of equity, depending on if and how patients are allocated to providers.

If the information collected through healthcare quality measurement processes is publicly shared, consumers of healthcare can use this information to make better decisions about where to obtain high(er) quality healthcare. The information then becomes part of a larger accountability process and if the information is actively used by both funders or purchasers of healthcare, as well as clients of the health system, it can help the system to become more efficient by directing healthcare in the direction of providers who are better and more efficient (Carvounes et al. 2017). This assumes, of course, that clients will have a degree of choice as to where to access care.

The Fund itself should also report on outcomes measures and be held accountable for its ability to purchase effectively on behalf of those covered by the Fund.

The risk of shifting attention to being compliant, as opposed to genuinely committed to providing quality care, is a material one.

The benefits of intense competition between providers in terms of contracting and quality should not be underestimated. Especially in markets where a clear price ceiling has been established (as is likely to be the case under NHI), competition between providers occurs on the non-price aspects, e.g. quality, becomes possible (Gaynor, Ho, and Town 2015).

The implementation of the NHI Fund theoretically allows for a clear separation between purchaser and provider, which is assumed will enable a much greater focus on quality. As we have discussed in other briefs, the cleanness of this split may be marred by giving the Minister of Health oversight over both the purchaser and the provider

- as the revised NHI Bill suggests. However, if the purchaser-provider split is well implemented, it is likely to improve competition among both public-sector health providers (clinics and hospitals), as well as between public and private providers, as the Fund can choose who to contract with and set minimum standards in terms of performance in contracts. Providers who do not continually meet minimum standards face the possibility of being locked out from providing services to the NHI Fund. It is therefore crucial that the measures used are the right ones and don't only focus on easy to measure (or unimportant) structural components. If prices are excessively constrained, there is also the risk of quality sinking to the minimum standard, particularly if competitive mechanisms are weak (for example, if patients have little choice over which facilities to visit).

Due to a generalised shortage of healthcare workers and health facilities, it is unrealistic to expect that purchasing from both public and private accredited providers would be sufficient. This shortage could result in a situation where the Fund cannot realistically terminate a contract without decreasing access and is locked into buying services from unaccredited or low-quality providers. Therefore, a quality ***improvement*** process will be important under NHI and should be led by a designated organisation, given the current low-quality status of many of our health facilities.

One of the most prominent mechanisms through which quality can be promoted is through reimbursement approaches. Neither a fixed-cost approach (salary remuneration), as is the case in the public sector, nor fee-for-service payment mechanisms, as is the case in the private sector, lend themselves to incentivising either good or improving quality. Reimbursement mechanisms that reward high quality care, implicitly or explicitly, can play a large role in improving quality, although some of the pitfalls of performance-based financing (e.g. it not having a long-lasting impact on organisational culture and the impact dwindling once incentives are removed) may remain and will have to be carefully managed. Ideally, as explored in Brief 6, a combination of reimbursement approaches such as capitation and performance-based financing may work best to achieve an optimal level of servicing (avoiding both under- and over-servicing) while also encouraging quality. This, coupled with strong accreditation mechanisms, can steer the health system to delivering high quality care.

Conclusion

Quality doesn't have to be an abstract and elusive concept. There are clear ways to concretise monitoring and measurement of which certification is not the only aspect, although doing so requires investment in data collection and systems. The accreditation foreseen as a necessary step under NHI to enable purchasing from a group of providers who have achieved minimum functionality is a clear signal of a commitment to quality and will be important to get right. However, there has to be caution in terms of quality measurement biases and measuring the wrong metrics, i.e. elements of quality that may not matter that much in terms of improving healthcare outcomes. The tension between a commitment to quality of care, and access will need to be carefully managed

Data on health outcomes can be a powerful tool for purchasers, providers and healthcare users.

to ensure that standards are not eroded over time and that the accreditation process outlined in the Bill is practical. Fairness between the public and private sector will also be a key consideration.

Up to now the emphasis in the public sector has fallen on mostly structural measures of care and some monitoring of patient satisfaction with very little evidence that these measures have been leveraged for improvement of healthcare outcomes. It will be important for the accreditation that the NHI Bill intends to implement to not only focus on easy-to-measure measures of care. Whilst basic certification and compliance may make sense as a starting point, particularly given the current systemic failings of our facilities, a movement towards the more telling measures of the actual impact of care on client wellbeing is desirable.

The imposition of additional requirements for accreditation will come with additional compliance costs. These will need to be quantified and tracked to ensure that the additional costs associated with measurement are warranted by the consequent improvements in the quality of care.

The allowance for accreditation to encompass more than certification signals a recognition of the limitations of certification. However, it also creates an additional dimension of power for the Fund over providers, generating uncertainty: What conditions might be imposed on providers in order for them to contract with the Fund? Will different conditions be imposed on public and private providers? What principles and controls guide the basis for accreditation? Who has the decision-making power to change accreditation conditions? All of these questions point to the need for discourse and trust-building between the Fund and providers. The risks for providers associated with a monopsonist purchaser are clear.

The critical issue remains how quality through accreditation can be improved at a systemic level. While effective reimbursement and greater competition between providers can improve quality, it will need to be carefully monitored and adapted as instances of gaming are detected. Furthermore, the level of competition that will be brought by a purchaser-provider split may not be sufficient to vastly improve quality in a poor performing health system: even more reason to get a robust quality measurement system in place that goes beyond just certification.

References

Brubakk, Kirsten, Gunn E. Vist, Geir Bukholm, Paul Barach, and Ole Tjomsland. 2015. "A Systematic Review of Hospital Accreditation: The Challenges of Measuring Complex Intervention Effects." *BMC Health Services Research*. https://doi.org/10.1186/s12913-015-0933-x.

Carvounes, Angeliki, Barry Childs, Kathryn Dreyer, Gareth Kantor, and Shivani Ranchod. 2017. "Quality Measurement and Reporting in the South African Private Hospital Industry. Research Commissioned from

Insight Actuaries & Consultants by the Hospital Association of South Africa." Cape Town.

Donabedian, Avedis. 2005. "Evaluating the Quality of Medical Care. Reprinted 1966 Article." *The Milbank Quarterly* 83 (4): 691–729. https://doi.org/10.1111/j.1468-0009.2005.00397.x.

Gaynor, Martin, Kate Ho, and Robert J. Town. 2015. "The Industrial Organization of Health-Care Markets†." *Journal of Economic Literature*. American Economic Association. https://doi.org/10.2307/24433982.

Jovanovicæ, Branislava. 2005. "Hospital Accreditation as Method for Assessing Quality in Healthcare." *Archive of Oncology* 13 (4): 156–57.

Kruk, Margaret E, Anna D Gage, Catherine Arsenault, Keely Jordan, Hannah H Leslie, Sanam Roder-DeWan, Olusoji Adeyi, et al. 2018. "High-Quality Health Systems in the Sustainable Development Goals Era: Time for a Revolution." *The Lancet Global Health* 6 (11): e1196–1252. https://doi.org/10.1016/s2214-109x(18)30386-3.

Mediclinic International. 2018. "Clinical Services Report 2018."

Mumford, Virginia, Kevin Forde, David R Greenfield, Reese Hinchcliff, and Jeffrey Braithwaite. 2013. "Health Services Accreditation: What Is the Evidence That the Benefits Justify the Costs." *International Journal for Quality in Health Care* 25 (5): 606–20.

Mumford, Virginia, David Greenfield, Anne Hogden, Kevin Forde, Johanna Westbrook, and Jeffrey Braithwaite. 2015. "Counting the Costs of Accreditation in Acute Care: An Activity-Based Costing Approach." *BMJ Open* 5 (9): 1–9. https://doi.org/10.1136/bmjopen-2015-008850.

O'Leary, Dennis S. 2000. "Accreditation's Role in Reducing Medical Errors." *Western Journal of Medicine* 172 (6): 357–58. https://doi.org/10.1136/ewjm.172.6.357.

Peters, Shrikant Maurice. 2017. "Comments on the National Public Health Institute of South Africa Bill, as Contained in the Government Gazette 40688 of 15 March 2017."

Sabinet. 2019. "NCOP Passes Public Health Institute Bill." 2019.

Shaw, Charles D. 2004. "Toolkit for Accreditation Programs: Some Issues in the Design and Redesign of External Health Care Assessment and Improvement Systems." Melbourne, Australia.

South African National Department of Health. 2018. *Draft NHI Bill*.

World Health Organization. 2019. "Universal Health Coverage (UHC)." 2019. https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc).

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