Quality Standards for Healthcare Establishments in South Africa

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Possible complementary interactions between accreditation standards and the National Core Standards are discussed.

This chapter traces the development of quality standards and associated methods for bringing about improvements in healthcare facilities across the globe, with a specific focus on their development in South Africa.

The evolution of State legislation and programmes to improve the quality and safety of health care is described, with a focus on development of the National Core Standards (NCS). The genesis and functions of the South African Office of Health Standards Compliance are discussed, as are possible complementary interactions between accreditation standards and the proposed NCS. Different definitions of accreditation are considered, while fast-tracking as a strategy to expedite the establishment of functional quality improvement programmes is described.

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Introduction

Over a period of 60 years, evaluation of quality in health care has evolved into a dynamic and exciting modern science which plays a significant role in patient safety, quality assurance (QA), benchmarking and continuous quality improvement (CQI). Improved quality has a positive impact on patient and staff satisfaction, improving the efficiency and effectiveness of healthcare provision in both the public and private sector, eventually leading to increased trust in the health system.[1]

In recent years, the South African National Department of Health (NDoH) has shown an unwavering commitment to improving the quality of health care. This commitment has been further cast into the spotlight through the publication of the 10 Point Plan for improvement of the health sector (2012-2014) in July 2010.[2] The NDoH's Strategic Plan for 2010/11-2012/13 states that the department's vision is to ensure "an accessible, caring and high quality health system".[2] Its mission is "to improve health status through the prevention of illnesses and the promotion of healthy lifestyles and to consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability".[2] This links directly with the 10 Point Plan which has improving quality of health services as one of its objectives, and improved patient care and satisfaction and accreditation of health facilities for quality as key activities and priorities.

The introduction of the Negotiated Service Delivery Agreement[3] (NSDA) in October 2010 with its focus on PHC re-engineering and National Health Insurance (NHI) as a means to obtain universal coverage, has re-emphasized high-level governmental commitment to improving quality. To attain the NSDA objectives (increasing life expectancy; decreasing maternal and child mortality; combating HIV and AIDS and decreasing the burden of disease from tuberculosis; strengthening health systems effectiveness), improving quality at all levels of the health system is of paramount importance.

PHC re-engineering, which represents a shift in focus from delivering curative health services to a more patient-centred one that encourages health promotion, prevention and community involvement, will be greatly enhanced by continuous quality assessments and accreditation processes. To this end, the NSDA identifies strengthening patient care and satisfaction, accreditation of health facilities for compliance, and improved health infrastructure availability, amongst others, as key to strengthening health systems effectiveness. It has set a target of 25% of all health facilities accredited on an annual basis by 2012/14. Furthermore, it states that rapid and visible improvement of physical infrastructure and provision of appropriate technology will be complemented by quality improvement, quality assurance and compliance programmes. Compliance with prescribed standards will also be written into the performance agreements of all managers to ensure that stipulated levels of standards are met.[3] Ultimately, improving the quality of health services will ensure that facilities are 'NHI-ready'.

In this chapter global development of quality improvement and accreditation programmes for healthcare facilities will be briefly described. Thereafter, an overview of quality improvement initiatives in South Africa (SA) will be presented. The chapter will conclude with an overview of methods to evaluate quality in healthcare establishments.

Since this area is a newly evolving discipline that is starting to gain ascendancy in SA, several key concepts are defined below in Box 1.

Box 1: Definitions of key concepts

Quality in health care refers to the extent to which an organisation meets its clients' needs and expectations. It is a complex, multifaceted concept which can be assessed and measured against predetermined standards.

Quality assurance (QA) is oriented toward meeting the needs and expectations of the patient and the community; it focuses on systems and processes, uses data to analyse service delivery processes; and encourages a team approach to problem solving and quality improvement.[4]

Continuous quality improvement (CQI) differs from quality, as it aims to identify performance gaps between actual service delivery and the expectations of services. CQI is based on the principles of quality management and continually strives to achieve a standard of excellence in a healthcare system over time. If an organisation is to improve, it must undergo change, but not all changes bring about improvement. If a change is to be effective, it must take into account how component parts of systems are co-ordinated and interlinked, rather than focusing on a single component. Defining improvement in an organisation is complex, but it is measurable and quantifiable and can be used to evaluate sustainable success over time. Changes must therefore be tested for their potential to improve quality of care and the performance of the different services and divisions within healthcare establishments.

Standards in healthcare facilities are statements that define the required key functions, activities, processes and structures so that various departments in a facility can provide quality services. Standards are determined by professional bodies, healthcare professionals, staff, patients and citizens, and should be regarded as optimal and achievable, and should be designed to encourage continuous improvement. Standards typically go through several phases of development. First, the normative phase, when an ideal is suggested by professionals. Second, the empirical phase, when it is tested in pilot sites. Finally, the consensus phase, when final standards are modified and consolidated to achieve a useful balance between what is ideal and what is real.[5]

Accreditation is a formal process carried out by a recognised body, and involves detailed and critical assessment of all aspects of a healthcare facility against a predetermined set of standards and criteria. The facility is then scored as being compliant, partially compliant or non-compliant with the standards, and awarded accreditation if found to comply with standards to a substantial degree. Follow-up surveys are conducted at predetermined times to ensure that standards are maintained.[5]

"*Licensing* is a statutory mechanism by which a governmental authority grants permission to an individual practitioner to engage in an occupation or to a healthcare organization to operate and deliver services. Licensing allows governments to ensure basic public health and safety by controlling the entry of healthcare providers and facilities into the healthcare market and by establishing standards of conduct for maintaining that status."[5]

"*Certification* is a process by which a recognized authority – either a governmental agency or nongovernmental organization – evaluates and recognizes an individual provider or an organization as having met predetermined requirements, usually to demonstrate competence in a specialty area. Certification generally implies a specialization in a single technical area, while accreditation reflects overall facility performance and competence."[5]

Certification and accreditation are voluntary processes undertaken by a provider or a facility to demonstrate special competence or capability beyond the minimum required for licensure.[5]

History of evaluation of healthcare standards

Three evolutionary periods can be identified in the history of healthcare standards evaluation: the period prior to 1950, when pioneering groundwork set the platform for later developments; a reactive period between 1950 and 2000, when poor outcomes in health care were addressed with increasing efficiency; and from 2000 onwards – a proactive period during which evaluations of healthcare facilities have benefited from application of increasingly sophisticated methods, with evidence of improvement in quality of healthcare provision.

Prior to 1950 there was minimal formal evaluation of quality in healthcare services. An exception to this trend was the work of United States surgeon Ernest Codman, acknowledged as the founder of outcomes management in patient care. Codman's pioneering work resulted in many of the evaluation processes used in healthcare facilities today, including:

➤ morbidity and mortality meetings – a common practice in hospitals;

➤ a systematic approach to tracking patient outcomes after surgery;

➤ standardisation of hospital practices; and

➤ development of a case report system by the American College of Surgeons that ascribed responsibility for adverse outcomes.

Codman's work in quality assessment led to the founding of the American College of Surgeons and its Hospital Standardization Program which eventually evolved into the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). JCAHO inspired healthcare accreditation programmes around the world and marked the beginning of the formalisation of quality improvement methods linked to quality and safety standards which took place between 1950 and 2000.

During this period Avedis Donabedian developed landmark methods (that are still in use) to measure structure, process and outcomes in healthcare facilities. His work led to an understanding of the systems approach to evaluating healthcare facilities.

After several meetings between international health professionals to discuss the assurance of quality in medicine, and following the Donabedian tradition, the Secretariat of the International Society for Quality in Health Care (ISQua) was established in 1995 based in Melbourne, Australia. Since then ISQua has relocated to Dublin, Ireland and grown into a global movement to drive improvement in the quality and safety of health care through education, research, collaboration and dissemination of evidence-based knowledge. ISQua accreditation lasts for four years, after which organisations are required to submit themselves for re-accreditation.

South African quality improvement initiatives

Since 1993 a number of developments in the area of quality have taken place in the health sector. These are described in more detail below.

Council for Health Service Accreditation of Southern Africa

Hospital and later primary health care (PHC) clinic accreditation was introduced in SA in 1993 at six pilot sites across the country representing public and private hospitals. By the end of 1995, 13 hospitals had completed the accreditation programme, and the not-for-profit Council for Health Service Accreditation of Southern Africa (COHSASA) was registered in the same year to implement quality improvement and accreditation in South African hospitals.[7-9] COHSASA was first accredited by ISQua in 2002 and re-accredited in 2006 and 2010, in line with ISQua regulations.

Figure 1:   **Universitas Hospital service and departmental standard compliance scores**
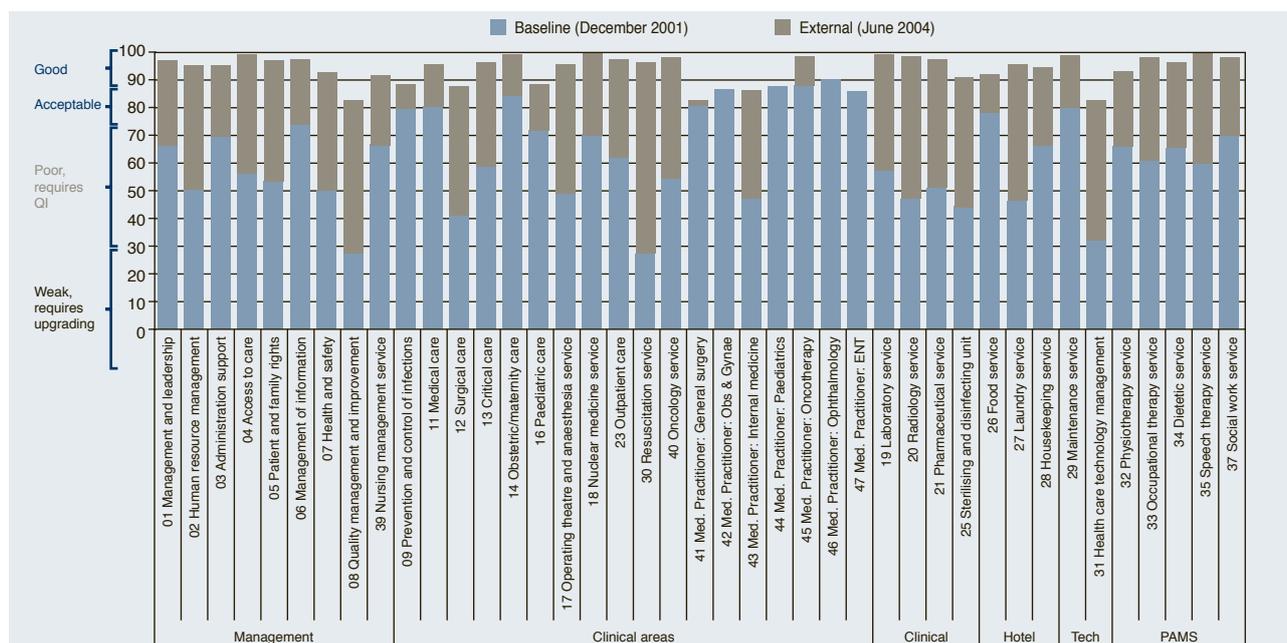
Source: COHSASA, 2004.[11]

COHSASA's approach differs from that of its counterparts in that it encourages and facilitates gradual improvements in quality in hospitals. For example, healthcare staff have been assisted to understand and implement standards, and a graded, step-wise system of awarding certificates to provide momentum and encouragement towards accreditation has been introduced. These initiatives have been particularly useful in large public sector hospitals that start from a low baseline, where it may take up to three years before there is any realistic chance of becoming accredited.[10] Figure 1 shows the average levels of compliance with standards achieved by the various departments after a period of 2.5 years at the Universitas Hospital in Pretoria, where the accreditation programme was started in 2001.

Figure 1 shows that most services were assessed as performing at poor to weak levels in 2001 (baseline). Hospital staff were then trained to understand the intention behind the process of setting standards, and on how to implement and monitor quality improvement programmes aimed at achieving standard compliance in all areas.[12] Improvements in performance were noted in the 2004 assessment, where scores achieved by the various departments improved from poor to good.

COHSASA has accredited a wide range of facilities, including nursing agencies, rehabilitation centres, frail-care centres, emergency services, clinics, hospitals and hospices. Its work in 588 facilities in both the private and public sector has shown that strictly applied quality improvement methods can improve patient safety and quality of care by guiding interventions, monitoring progress and identifying improvements. Besides SA, COHSASA has worked in Botswana, Lesotho, Swaziland, Namibia, Rwanda, Tanzania and Nigeria.[1,13,14]

As an example of standards in action, the Medical Research Council found a significant negative correlation between COHSASA's overall facility standard compliance scores and perinatal mortality rates in babies weighing more than 1 000g in Level 1 facilities that provide a consistent, 24-hour caesarean section service but do not receive referred patients.[15]

The impact of accreditation programmes on healthcare facilities differs, depending on whether the facility has been accredited previously or not. In previously accredited facilities which have maintained a high level of standards compliance between surveys, the programme acts as a motivator for maintenance of quality standards. If facilities have not maintained substantial standard compliance, they are required to correct deficiencies if they wish to maintain their accreditation status.

The situation is different in facilities entering the programme for the first time, particularly in developing countries. Such facilities frequently do not comply with most of the accreditation standards. In such cases the multidisciplinary accreditation standards are used as a blueprint to guide them towards establishing systems and processes required for safe, quality service provision in all clinical, clinical support, technical and management services.[16]

National Core Standards

As indicated in the introduction, in recent years there has been increasing public sector attention on improving quality of care and on the setting of standards of health care. The National Health Act (No. 61 of 2003), in section 30 (2)[17] which relates to the district health system, states that services rendered must have due regard to the principles laid down in the Constitution of SA (Sections 27 and 195)[18] as well as, *inter alia*, quality, effectiveness and efficiency. Section 36 of the Act refers to licensing of both public and private health establishments, setting out the process for issuing a Certificate of Need. Regulations related to this process are not yet available.

In 2008 the Office of Standards Compliance (OSC) within the NDoH developed and piloted a set of National Core Standards (NCS)[19] which form the basic requirements for quality and safe care, while also reflecting existing Government policies and guidelines.[20] The NCS set the benchmark for quality improvement in public health establishments' standards, defined as "an expected level of performance". The main purposes of the NCS are to:

➢ develop a common definition of quality of care which should be found in all health establishments in SA as a guide to the public and to managers and staff at all levels;

➢ establish a benchmark against which public health establishments can be assessed, gaps identified and strengths appraised; and

➢ provide a framework for national certification of public health establishments.

The NCS and assessment tools were revised and further piloted in 2010. A significant process in revision of the tools was benchmarking the NCS against other accreditation systems and aligning the standards with policy imperatives of the NDoH. The current set of NCS and associated measures were developed over a three-year period, and are still being refined.

Structure of the NCS for health establishments in South Africa

The NCS for health establishments in South Africa was first launched in 2008 and reflect the NDoH's vision for South Africa's health services and focus on what needs to be done to meet that vision. The standards are based on the existing policy environment, are tailored to suit South Africa's health care context, and reflect international best practice and evidence base. According to the NCS document, the NCS reflect what is expected, and required, to deliver decent, safe, quality care, and are complemented by a set of measurement tools to assess compliance with these measures.

The NCS are structured into seven cross-cutting domains to reflect a health systems approach, and define the scope or intent of assessing a health area where quality or safety might be at risk. The first three domains relate to the core business of the health system while the final four domains refer to the support system that ensures that the former are delivered. These domains are further divided into sub-domains (Table 1) which comprise a set of standards with associated measurement criteria and measures.[19] The provinces are currently being trained by the NDoH to implement the NCS, although associated funding, staffing and training requirements have not yet been finalised.

Table 1:   Domains and sub-domains of the NCS

Domain	Sub-domain
Domain 1: Patient Rights The domain of Patient Rights sets out what a hospital or clinic must do to make sure that patients are respected and their rights upheld, including getting access to needed care and to respectful, informed and dignified attention in an acceptable and hygienic environment, seen from the point of view of the patient, in accordance with Batho Pele principles and the Patient Rights Charter.	Respect and dignity Information to patients Physical access Continuity of care Reducing delays in care Emergency care Access to package of services Complaints management
Domain 2: Patient Safety, Clinical Governance and Care The Patient Safety, Clinical Governance and Clinical Care domain covers how to ensure quality nursing and clinical care and ethical practice; reduce unintended harm to healthcare users or patients in identified cases of greater clinical risk; prevent or manage problems or adverse events, including health care-associated infections; and support any affected patients or staff.	Patient care Clinical management for improved health outcomes Clinical leadership Clinical risk Adverse events Infection prevention and control
Domain 3: Clinical Support Services The Clinical Support Services domain covers specific services essential in the provision of clinical care and includes the timely availability of medicines and efficient provision of diagnostic, therapeutic and other clinical support services and necessary medical technology, as well as systems to monitor the efficiency of the care provided to patients.	Pharmaceutical services Diagnostic services Therapeutic and support services Health technology services Sterilisation services Mortuary services Efficiency management
Domain 4: Public Health The Public Health domain covers how health facilities should work with NGOs and other healthcare providers along with local communities and relevant sectors, to promote health, prevent illness and reduce further complications; and ensure that integrated and quality care is provided for their whole community, including during disasters.	Population-based service planning and delivery Health promotion and disease prevention Disaster preparedness Environment control
Domain 5: Leadership and Corporate Governance The Leadership and Corporate Governance domain covers the strategic direction provided by senior management, through proactive leadership, planning and risk management, supported by the hospital board, clinic committee as well the relevant supervisory support structures and includes the strategic functions of communication and quality improvement.	Oversight and accountabiity Strategic management Risk management Quality managment Effective leadership Communications and public relations
Domain 6: Operational Management The Operational Management domain covers the day-to-day responsibilities involved in supporting and ensuring delivery of safe and effective patient care, including management of human resources, finances, assets and consumables, and of information and records.	Human resource management and development Employee wellness Financial resource management Supply chain management Transport and fleet management Information management Medical records
Domain 7: Facilities and Infrastructure The Facilities and Infrastructure domain covers the requirements for clean, safe and secure physical infrastructure (buildings, plant and machinery, equipment) and functional, well managed hotel services; and effective waste disposal.	Buildings and grounds Machinery and utilities Safety and security Hygiene and cleanliness Linen and laundry Food services

Source: National Department of Health, 2011.[19]

Fast track to quality programme

Given the long-term nature of quality improvement programmes to address deficiencies identified in certification and accreditation systems, the NDoH has used information gleaned from patient complaints and satisfaction surveys to develop a plan entitled *Fast Track to Quality – The six most critical areas for patient-centered care.*[21] The plan is based on the Constitution of SA, the Batho Pele principles, the Patients' Rights Charter and the NCS, and is in accordance with the NSDA. This identifies six priority areas for immediate improvement, which are largely reflected in the first three domains of the NCS and consist of the following:

➢ **Values and attitudes** of staff, so that patients are treated in a respectful manner with due respect for patient privacy and choice (Domain: Patient Rights).

➢ **Reducing waiting times and queues** for administration, assessment, diagnosis, pharmacy, surgery and referral and transfer time (Domain: Patient Rights).

➢ **Cleanliness of hospitals and clinics**, including buildings, grounds, amenities, equipment and staff (Domain: Patient Rights).

➢ **Keeping patients safe and providing reliable care** by reducing adverse events resulting from care given, including operations and failures of the system and its workers through ignorance, inadequate inputs, systems failure or negligence (Domain: Patient Safety, Clinical Governance and Care).

➢ **Preventing infections from being passed on in hospitals and clinics**, specifically hospital-acquired infections (Domain: Patient Safety, Clinical Governance and Care).

➢ **Ensuring that medicines, supplies and equipment are available** and that patients get their prescribed medicine on the same day (Domain: Clinical Support Services).

The initiative acknowledges that there are many public facilities where a demonstrable change in practice and improvement has taken place. In these instances it is important that continuous self-assessment, removal of barriers to improvement, and information systems that can continuously drive improvement and show results are in place. Critical inputs in weaker facilities include supported self-assessment, development and training, and competent and supportive management and supervision.[21]

Establishment of the Office of Health Standards Compliance

In January 2011 the NDoH called for public comment on the intended National Health Amendment Bill to amend the National Health Act of 2003 and to provide for the establishment of the Office of Health Standards Compliance (OHSC) and matters connected with it.

In this initial draft Bill, the OHSC is described as "an organ of state at the national sphere of government",[22] and is headed by an Executive Director who reports to the Minister of Health and provides relevant information so that he/she can carry out this portfolio efficiently.

The OHSC's purpose is to ensure that complaints from healthcare users are investigated properly and dealt with expeditiously through an independent mechanism. It will also facilitate compliance with the norms and standards of the national health system (NHS) by healthcare providers and health establishments, facilities and workers.

The functions of the OHSC will be to:

➢ advise the Minister of Health on the development of norms and standards for the NHS and on the review of such norms and standards;

➢ ensure compliance with these prescribed norms and standards by health establishments;

➢ certify health establishments as compliant with the prescribed norms and standards;

➢ monitor indicators of risk as an early warning system relating to serious breaches of standards; and

➢ establish competences and capabilities in its operations, which include but are not limited to (a) an inspectorate and (b) an ombudsperson.

In addition to the above, the OHSC must also develop and recommend QA and management systems for the NHS in order to:

➢ identify levels and categories of health services in relation to categories of health establishments;

➢ promote the effectiveness and sustainability of the NHS;

➢ objectively measure and evaluate quality and health outcomes;

➢ empower healthcare funders and users to recognise and evaluate health establishments with regard to quality and other standards, and promote transparency of such standards to the general public;

➢ monitor and evaluate activities and processes designed for the purpose of quality management and QA in health establishments;

➢ create incentives for health establishments to participate in quality improvement programmes;

➢ identify areas where urgent intervention by a national or provincial Department of Health is required in order to meet prescribed norms and standards;

➢ detect fraud and corruption or abuse of the health system, insofar as it affects compliance with prescribed norms and standards;

➢ develop and recommend guidelines on the implementation of prescribed norms and standards;

➢ publish information relating to prescribed norms and standards through the media and, where appropriate, for specific communities;

➢ maintain records relating to prescribed norms and standards;

➢ assess information submitted by health establishments to determine compliance with prescribed norms and standards; and

➢ conduct inspections and certify healthcare providers, health facilities and health establishments in accordance with prescribed norms and standards and keep records of such inspections.

The Bill gives extensive powers to inspectors acting on the instructions of the ombudsperson to deal with any complaint relating to the health system. These powers include ordering of affidavits, obtaining information from any person under oath, issuing of subpoenas, hearing witness information; and referring matters to the Executive Director, who can in turn refer matters to the South African Police Service.

This gives rise to a number of policy and implementation issues which require attention if the OHSC is to be implemented success-fully.

Firstly, estimating and implementing the manpower, training and funding resources required to meet the requirements of the proposed Act will be a challenge, since at this stage the magnitude of the task cannot be estimated, particularly since the NCS and measurement tools are still being refined. Secondly, the OHSC has a large and difficult mandate and little experience in the field. It is therefore important that the Office be given sufficient time to develop the necessary skills and experience to successfully implement this important task. This will include having documented processes and an evaluated assessment system which has the confidence of the public and health professionals.

The SafeCare Initiative

Many resource-restricted countries struggle to meet their citizens' healthcare needs and provide a safe level of quality of health care, exacerbated by a shortage of financial support for PHC providers and inefficient use of available funding. The SafeCare Initiative was founded to address these issues, and represents integration of three organisations with experience in improving the quality and safety

Figure 2:   SafeCare quality standards are specifically tailored for category 3 - 6 medical providers, ranging from nurse-driven health clinics to district hospitals
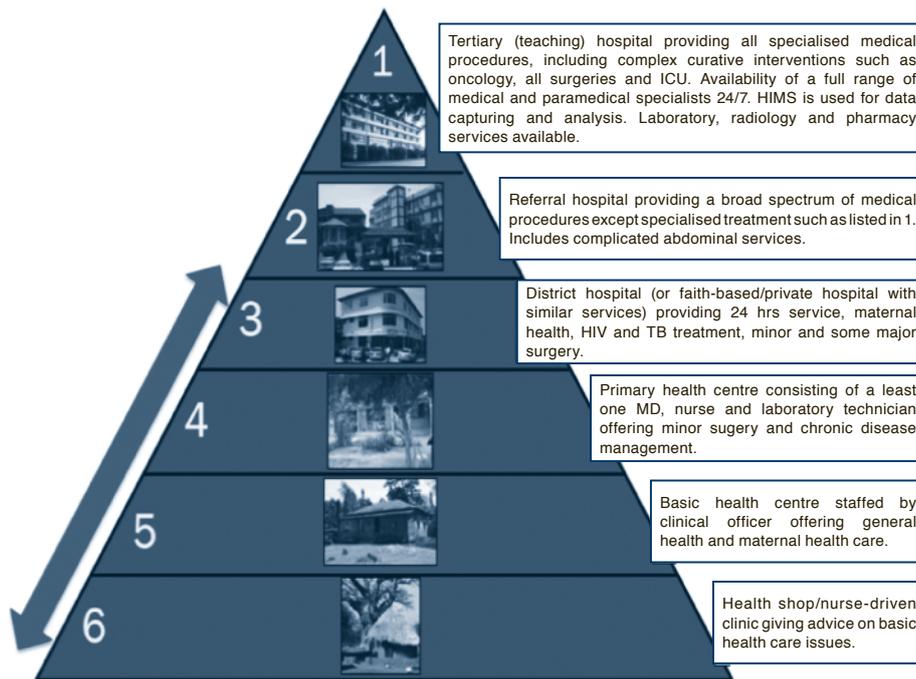
Source: SafeCare Initiative, 2011.[23]

of facilities in resource-poor settings: PharmAccess Foundation of The Netherlands, the Joint Commission International from the United States of America, and COHSASA in SA. The initiative is currently operational in Kenya, Tanzania, Ghana and Nigeria and plans to extend to the rest of Africa. The SafeCare Initiative aims to assist facilities by providing an upgrading programme designed to address limitations. This includes a step-wise system that recognises improvements, which may be linked to incentives that include practical, performance-based financing. Figure 2 indicates the range of facilities that the SafeCare Initiative focuses on.

Category 3 - 6 facilities typically represent the main healthcare delivery channels for low-income citizens in Africa, which also often struggle with patient safety issues.

The Medical Credit Fund is an affordable loan programme which is linked to the SafeCare Quality Improvement Programme.[24] The Fund aims to help clinics obtain access to finance for upgrading equipment and infrastructure, as well as providing resources for improvement of skills and processes leading to sustainable health care improvement.

When applied to a range of facilities, the SafeCare Initiative allows for benchmarking and data-driven resource allocation, leading to efficient use of available resources. This enables donors, investors and governing bodies to use SafeCare data collected during the upgrading and quality improvement process to make strategic and cost-effective decisions about how funds are allocated.

Once a required level of quality and safety has been achieved, facilities are encouraged to work towards gaining accreditation, assuring clients, investors and regulators of the motivation and capacity of healthcare providers to steadily enhance performance.

## Methods used to evaluate healthcare establishments

As alluded to throughout this chapter, there are a variety of methods that can be used to evaluate healthcare establishments. These are listed in Table 2. The NCS can be classified under both licensure and certification processes, while COHSASA standards are classified under accreditation.

Table 2:   Different evaluation methods and standards used to evaluate healthcare establishments

Process	Issuing organisation	Object of evaluation	Components/Requirements	Standards
Licensure (QA) (Mandatory)	Governmental authority	Individual organisation	Regulations to ensure minimum standards, exam or proof of education/ competence Regulations to ensure minimum standards, on-site inspection	Set a minimum level to ensure an environment with minimum risk to health and safety
Accreditation (QI) (Voluntary)	Recognised tools. Usually an NGO	Facilities and organisation	Compliance with published standards, on-site evaluation; compliance not required by law and/or regulations	Set at a maximum achievable level to stimulate improvement over time
Certification (QA or QI)	Governmental or NGO	Individual or an organisation	Compliance with predetermined requirements or criteria	Minimum level

Source: Rooney and vanOstenberg, 1999.[25]

Figure 3: An illustration of the synergistic interaction between the standards aimed at quality assurance (licensing/certification) and standards aimed at continuous quality improvement (accreditation)
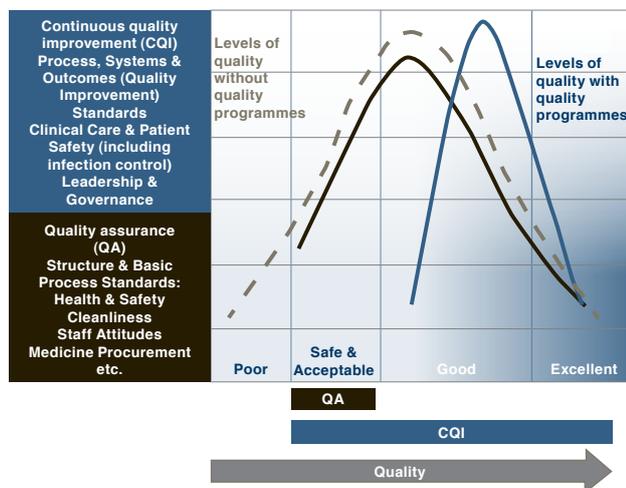
Source: Whittaker, 2011.[26]

The potential impact of the NCS (QA standards) is shown by the black curve in Figure 3. Such standards are designed to identify unacceptably low levels of standards compliance and hence eliminate poor quality and unsafe, dangerous and unacceptable practices. Accreditation standards are designed to continuously improve the quality of care, leading to increasing overall excellence, illustrated by the blue curve in Figure 3. The figure clearly demonstrates the difference between QA and CQI. Figure 3 and Table 3 show that the potential exists for certification/ licensing and accreditation programmes to complement each other. This complementary relationship between accreditation standards and the NCS means that the two systems could be implemented together, with great benefit to health establishments.

The NCS framework identifies and eliminates poor quality and unsafe practice by ensuring that core safety and quality standards set for each domain are implemented, while accreditation standards establish systems and processes required in each of the facility's departments (covering all domains) to deliver safe, quality care on a continuous basis. In this way the NCS requirements would be maintained and strengthened over time.

Conclusion

Licensing, certification and accreditation of healthcare facilities and its progressively evolving methodology is now an accepted scientific process. Accreditation programmes began slowly but have now developed in many countries and are being implemented in Africa with some success, depending on the level of management support and available resources. An increasing number of countries are developing quality standards and programmes to improve the quality of their healthcare services.

The emerging African experience shows that accreditation is achievable by a wide range of facilities, ranging from poorly supported, rural PHC clinics to sophisticated public and private tertiary level facilities. A rewarding aspect of the change taking place in those undergoing accreditation is the establishment of a culture of quality, identification of best practice protocols, and the drive towards CQI.

An important initiative in SA is the development and implementation of the NCS and fast-track programme. These have been given high priority in order to prepare the country for implementation of the NHI programme.

Acknowledgements

Table 3: Comparison of system-based and domain-based standards

Level	System-based standards (e.g. COHSASA)	Domain-based standards (e.g. NCS)
1	Criteria	Criteria
2	Standards	Standards
3	Performance measures	Sub-domains
4	Services and departments	Domains / areas of risk
5	Overall scores	Overall scores
6	Guidelines on system requirements guide scoring of criteria	Detailed assessment of internal process guides scoring of criteria
7	Criteria assessed as non-compliant, partially compliant, compliant or not assessed	Criteria assessed as compliant or non-compliant
8	Measure whether the systems and processes are in place to ensure that the correct things happen	Measure whether required activities and actions have been carried out, required consumables, medicine, technology are available, etc.
9	In COHSASA one service usually deals with a number of domains	In the NCS one domain usually applies to a number of service areas

Source: Whittaker, 2011.[26]

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