



Improving quality of care

- Improving clinical practice, through the development and use of clinical management guidelines and the introduction of peer reviews and clinical audits at all facilities.

Equipping health personnel — and particularly front-line managers — to implement strategies to improve quality of care is a critical success factor and key objective.

During 2000 a National Policy on Quality was drafted and endorsed by the Minister of Health and her provincial counterparts. (See box below)

Both the Batho Pele approach and the Patients Charter were actively promoted in all provinces, among health workers and the general public, through a series of launches and workshops. A manual was developed in collaboration with the Progressive Primary Health Care Network to assist health care workers in communicating to service users their health rights and responsibilities.

To address the quality issue of non-standard or sub-standard clinical services, a comprehensive package of primary health care services was developed for clinics (See pages 39-40). Progress was made on equivalent packages for district hospitals, regional hospitals and highly specialised services, but these are not yet ready for implementation.

Private sector and public sector stakeholders contributed during the year to developing a standard complaints procedure. This will be finalised and implemented in 2001/2. Similarly, a tool for measuring client satisfaction was developed together with an instruction manual. It is already in use in a number of district hospitals.

Donor funding ensured technical assistance for a programme to train health managers in strategies to achieve better quality of care. Phase one took place in 2000/1, with a consultant visiting 10 training institutions to assess current management training and five provinces to determine training needs.

Quality assurance

Quality doesn't simply flourish; it has to be cultivated. That's the underlying assumption of the Policy on Quality in Health Care for South Africa, developed by the Department with a task team spanning the public, private and NGO sectors and including academics and international experts.

A range of easily discernible problems gave rise to this policy, including avoidable errors and variable quality of diagnosis and treatment, which occur in both sectors. In the public sector a scarcity of resources sometimes undermines quality of care; in the private sector over-use of resources is not uncommon.

The policy has two main components:

Changing the environment

- * Strengthen the hand of the service user.
- * Focus on equity and on vulnerable groups.
- * Promote accountability.

- * Reduce errors and increases safety of care.
- * Pool expertise in the private and public sectors.

Building capacity to improve quality

- * Foster evidence-based practice and innovation.
- * Adapt organisations for change.
- * Engage the health care work force.
- * Invest in systems to measure quality gains.

The document proposes establishing a National Institute for Health Care Quality, overseen by a board including representatives of professional bodies, public and private service providers, consumer groups and academic institutions. The Institute would provide leadership; set the quality agenda; commission technical assistance and research; and monitor progress.

A new bit of bureaucracy? Not really. It is intended that the Institute would be a "virtual" organisation existing largely through the exchange and pooling of information. Substantive work would be contracted and staff would be minimal.



During the year, every province made visible advances in the area of managing for quality care. There was considerable diversity to their approaches, but the popularisation of the Patients' Rights Charter; the development of governance structures at health facilities; the introduction of complaints and ombud mechanisms; and the use of accreditation systems were features that recurred in various provincial strategies.

Strategic Goal

Delivering a package of services at district level

Situation snapshot

- There are more than 3 500 clinics in the public sector
- These will be managed through 53 health districts and 231 sub-districts
- About 500 clinics were built in the last five years
- All services are free at the point of delivery



In this area, objectives relate to two central principles:

- Affording universal access to basic health services, on an equitable basis and in compliance with clear service standards.
- Ensuring local level political control of and accountability for the services that answer people's most common health needs.

The restructuring of local government has impacted fundamentally on the process of determining governance structures for health districts. Little progress could be made until such time as the boundaries of new local authorities had been finalised and councils elected. This was accomplished towards the end of 2000. The boundaries of health districts have been adjusted to ensure that they are co-terminous with municipal boundaries. This has set the scene for discussion between relevant spheres of government on the future character of district health authorities.

The creation of district health services has structural implications at both the political and the administrative levels. A task team was set up during 2000/1 to advise on the complex processes of merging provincial and municipal district services to form a single entity, looking particularly at the personnel, financial and other resource implications of this restructuring.

Formal structural considerations did not, fortunately, stifle progress on the service development front.

An independent survey to establish a "baseline" of current service provision was undertaken by the Health Systems Trust. The findings became available at the end of the financial year and presented a mixed and sometimes contradictory picture. Illustrative results are presented in the box on page 40. However a reading of the full report is required to appreciate how it will serve as a practical tool in guiding and monitoring service improvement.

This last year saw the completion of "service packages" for primary health care services at clinics and community health centres. These packages have taken years to research (in partnership with the provinces) and write. They spell out with absolute clarity what services should be provided, what the corresponding staffing requirements are, and even the necessary equipment and drugs. There is a protocol specified for each of the core services listed.



Delivering services at district levels

The package of services is a huge advance towards the standardisation of health care on an equitable basis. In the year ahead each local authority will be audited to identify the gap between the primary health care services that exist and the target as specified in the package.

Other initiatives to support and promote the development of district health services included:

- A manual on management for clinic and community health centre supervisors was produced to assist facility managers with their supervisory tasks.
- A study on referral patterns between primary care institutions and other levels of care was commissioned. Recommendations on more effective referrals were made.
- Work to develop the District Health Information System continued. The system is functional in all provinces but some are more advanced than others.
- Continued co-ordination of the annual district service award, which serves both as a monitoring tool and an incentive.

ACCESS:

It's what's inside that counts

Thousands of clinics across the country create the potential for accessible health care. Whether that potential is realised depends on what goes on within clinic walls.

In 2000, the Health Systems Trust went to take a look at 445 clinics — including mobile clinics — representing 10% of clinics in all provinces. They were able to compare the situation across provinces and look at progress since 1997. On the latter count, this is what they found.

- Availability of ante-natal care has improved substantially
- Turn-around times on various tests is better.
- DOTS management of TB is widely used.
- A high percentage of facilities do home visits.
- Health workers perceive the referral system to be efficient.
- Patient to staff ratios at fixed clinics have improved.
- Electricity is much more widely available.
- There were no expired drugs on the shelves.
- Supplies of condoms and oral contraceptives had improved.

■ So had availability of oral rehydration solution and oxygen.

■ Penicillin and ciprofloxacin were available at more clinics.

But:

■ Tests for HIV and syphilis were often not available.

■ Many clinics lacked access to emergency transport.

■ Skills updating on TB and STD treatment had dropped.

■ Some clinics lacked basic equipment, like scales and diagnostic kits.

■ Telephone and electricity services were often interrupted.

■ Many clinics lacked piped water.

■ Medical waste was often not incinerated.

■ Availability of iron tablets, doxycycline and erythromycin had dropped.

■ In some provinces clinics were low on supplies of EDL drugs.

■ TB record keeping was poor.

■ Visits by nurse supervisors were no longer done regularly.

Source: The National Primary Health Care Facilities Survey 2000, Health Systems Trust

Strategic goal

Revitalisation of public hospitals

Situation snapshot

- On average 60% of public health sector funds are spent on hospitals
- Total number of beds in use is 100 413
- Average bed occupancy rate is 56%
- Total number of admissions - 3 324 339

Hospital Revitalisation is a multi-pronged strategy that sprang from an appraisal of the shortcomings of hospital services and a recognition that the service user is not likely to experience an improvement in care unless we tackle these deficiencies coherently and simultaneously.

Accordingly, the Hospital Revitalisation Programme has three core, interrelated components:

- The physical rehabilitation and reconstruction of our hospitals and their re-equipment.
- The quality of services, seen both from an objective clinical perspective and from the service user's subjective experience (See: Improving quality of care).
- Improved management of facilities, through skills development and the introduction of more appropriate management systems.

During 2000/1, the Department became increasingly clear that developing management strength at institution level would be the critical success factor in Hospital Revitalisation. Both the physical renewal of hospitals and the improvement of service standards demand skilled managers and appropriate management systems.

The Programme is guided by the National Hospitals Co-ordinating Committee, which allows extensive provincial participation and is managed by the Hospital Services Chief Directorate.

The Hospital Revitalisation Programme was, in a literal sense, still a plan — albeit a very advanced plan — by the end of the year under review. But during the planning process existing capital works projects and initiatives on hospital management have been shaped by the thinking of the Revitalisation Programme, in anticipation of its implementation.

Presently capital works at provincial hospitals are funded under the Reconstruction and Rehabilitation programme.

- Approximately R423-million was spent on hospital rehabilitation during the year and a further R442-million on the construction of major new hospitals.
- Three large academic complexes are nearing completion — Pretoria Academic (Phase 1), Nkosi Albert Luthuli in Durban and the Nelson Mandela Complex in Umtata.
- Amounts totalling more than R3,5-billion have been allocated over three-year period to restore and replace hospital facilities. In all, 242 hospitals will benefit from this programme. To date 331 individual building projects have been completed at 86 hospitals. (See Page 42)

The development of management systems and skills is essentially an incremental process. But there were some landmarks in the last year.

- A new Uniform Patient Fee Schedule was introduced and will be rolled out in all provinces in 2001/2.





Revitalising hospital services

- An amount of R24-million was spent last year to appoint chief financial officers or senior support staff in the bigger hospitals.
- Financial control in various provincial health departments has improved to the point that overspending on budget allocations has been eliminated or greatly reduced. This progress rests on better financial management in the hospitals where the bulk of spending occurs.
- Pilot projects to pave the way for decentralisation of management powers to hospital managers proceeded during the year. Some of these relate to the establishment of cost centre budgeting in large, complex hospitals.

Nationally funded capital projects at hospitals

Province	Expected cost	Total projects planned		Projects completed 31/3/01	
		Projects	Hospitals	Projects	Hospitals
EC	R598-m	144	40	68	33
FS	R180-m	21	16	3	0
Gau	R418-m	284	25	156	10
KZN	R609-m	120	57	48	17
Mpa	R304-m	42	21	11	6
NC	R83-m	10	7	2	6
NP	R780-m	125	45	21	6
NW	R469-m	38	21	5	0
WC	R115-m	30	10	17	8
TOTAL	R3 558-m	814	242	331	86



Strategic Goal

Mobilising and managing resources

Objectives in this area include:

- Promoting and tracking equity in the allocation of resources.
- Increasing the availability of resources in the public sector through improved generation of revenue, strategic public-private partnerships and rational use of donor funds.
- Contributing to the development of a comprehensive social security system that will include social health insurance.
- Facilitating the development of management systems and management skills at all levels.

The extensive discussion in the Director-General's report on equity in resource allocation and improved access to health services forms a background to this section. The Integrated Planning Framework, the Hospital Revitalisation Programme and the Standard Package of Primary Health Care Services provide the context for the more specific interventions detailed below.

National Health Accounts

A comprehensive exercise to establish all sources of spending on health care (both in the private and public sectors) and to quantify this spending commenced in 1999. It was contracted to a consortium headed by Professor Di McIntyre of the Health Economics Unit at University of Cape Town and closely overseen by the Department. In 2000/1 the draft report on public sector health spending was completed. The full report is expected to be finalised before the end of 2001. The process of compiling this first set of National Health Accounts will be reviewed with the goal of devising strategies to maintain relatively up to date National Health Accounts.

Social Health Insurance

As far back as 1996, the White Paper on Health identified social health insurance as a funding mechanism for income-earning users of public health services. It has since become part of a much broader initiative: the Committee of Inquiry into a Comprehensive Social Security System. There is a specific sub-committee on health where much of the policy development on social health insurance occurs. During 2000/1 a study was commissioned on the willingness and ability of employers and potential members of a social health insurance schemes to pay into such a fund. The findings are due in July 2001.

Financial management by cost centre

Cost centre management in hospitals, which makes every clinical department a separate accounting unit, has been implemented in 14 designated hospitals. The hospitals are utilising a variety of information and management systems, including manual systems in some places.

Implementing the Medical Schemes Act

The Medical Schemes Act of 1998 is a significant instrument to ensure better management of resources in the private health care sector.

The Department does not administer the Act — that function rests with the Council for Medical Schemes and the office of the Registrar of Medical Schemes. But the Minister of Health appoints the 15-member council which is accountable to her.

Furthermore the Council was funded mainly by the Department during the year 2000/1.

Yes, it's government's baby!

The Council for Medical Schemes was conceived in the board rooms of the Department and born with the promulgation of the Medical Schemes Act. In just over a year, the Council and Registrar's Office covered considerable ground to ensure that the Medical Schemes Act became a living reality. Their achievements included:

- A consumer education campaign based on workshops in various provinces to inform consumer advocacy groups and trade unions about the rights of medical schemes members.
- The establishment of a busy and effective complaints division. Between September 2000 and March 2001, this division received 1 327 complaints, mostly from members of schemes and

health service providers. It resolved 78% of these before the end of March.

- The holding of governance workshops for trustees of medical schemes plus joint problem-solving with trustees in respect of problems that threaten stability of schemes.
- The elimination of a backlog of outstanding reports from registrars of schemes for the period 1996 to 1999 plus the introduction of a new user-friendly electronic format for these statutory returns.
- The creation of a Technical Review Committee on Prescribed Minimum Benefits to identify deficiencies in the schedule of benefits and recommend ways to improve it.
- Conducting or supporting research to inform policy development.

