Econex

Trade, Competition & Applied Economics

HEALTH REFORM NOTE 3

JUNE 2010

Practical Implications of Accreditation in South Africa

The previous Health Reform Note introduced the theoretical purposes and expectations of accreditation as it stands internationally and in South Africa, emphasising its importance in the health reform process. The current proposal for a national Office of Standards Compliance (OSC) was compared to the international and local experience. This note will continue the analysis by focusing specifically on the practical implications and probable resource requirements for establishing the proposed OSC.[1]

1 Introduction

The purpose of this research note is to give an indication of the time, financial and human resources that such a process may require. We make a number of assumptions with respect to the time it may take to accredit each facility, the size of surveyor teams, etc. in order to estimate potential resource requirements.

2 Four Options being Considered

In a recent presentation at the annual Hospital Association of South Africa (HASA) conference, Dr. Carol Marshall [2], mentioned that establishing a fully staffed national OSC responsible for accrediting all healthcare providers (as explained in Health Reform Note 2), is only one of the options available to policy-makers deciding on the practicalities of accreditation in South Africa. A second option could entail the establishment of such a national accreditation authority with only limited staff members. In this case staff from the provincial departments of health and hospitals would be contracted to assist with the accreditation of providers in the respective provinces. Although this is potentially a much less

This research note forms part of a series of notes dealing with issues of health reform in South Africa. In the interest of constructively contributing to the NHI debate, the Hospital Association of South Africa (HASA) has commissioned this series of research notes which can be accessed on the Econex website: www.econex.co.za.

1. *Econex would like to thank the following industry experts for valuable inputs and comments to this research: Dr. Dena van den Bergh (Life), John Lawton (Medi-Clinic), Jacques du Plessis (Netcare), Nothemba Kula (MRC), Dr. Carol Marshall (NDOH) and Prof. Stuart Whittaker (COHSASA).*
2. *Director at the National Department of Health and leading the core quality standards and accreditation process nationally. Presentation available at: http://www.hasa.co.za/about/conference/*

expensive option, it may also be less effective. Using different surveyors all the time may lead to inconsistencies across the country and would also require extra time to constantly train new surveyors. (A trial-run of the latter option was implemented in March this year, but with the objective of testing the standards, database and accreditation tool that had been developed by the NDOH over the past two years. According to industry experts, this pilot programme revealed many obstacles and challenges in the system which have to be addressed before a national programme could be implemented.)

A third option would be to outsource the entire accreditation function to a private company which then reports to the Minister or National Department of Health (NDOH) or, alternatively, the NDOH becomes an accrediting authority for multiple private accreditors. In other words, the NDOH (or National Health Insurance Authority (NHIA), depending on how the public health system is structured) may then contract with any company that is accredited by a legitimate accrediting authority. Providers would then be free to choose which authority they want to use, thus increasing competition among accreditors and facilitating more efficient accreditation processes. However, this may also create a perverse incentive for health service providers to choose the most lenient accreditor, having a negative impact on quality standards; although this incentive may be eliminated to some extent if all accrediting organisations were accredited by IsQua (the International Society for Quality in Health Care).[3]

A fourth possibility is to use the existing licensing/inspectorate divisions at provincial health departments to accredit all providers in the specific provinces, with only a sample of these being verified externally at a national level in order to spread the burden of this function across different levels of government. A potential weakness of this option is the fact that quality standards differ substantially between the provinces. Provincial capacity and service delivery are disparate and it would be difficult to standardise such a process. The NDOH may decide to implement any of the four options briefly mentioned here, but for our current analysis we assume that the fully staffed OSC will be established, as recently indicated by Health Minister Motsoaledi.[4]

3 The Process of Accreditation

In this section we provide a brief overview of the accreditation process as described by various local industry experts. This description informs our analysis.

Before a team of surveyors can visit a healthcare provider, substantial preparation time is required (industry experts indicate that it may take a couple of years) in order to assure compliance with thousands of procedures, standards and outcomes being measured. Once it has been accredited, the following pre-accreditation process for the subsequent renewal of accreditation should take no longer than a year. This time is needed to get all systems, policies, processes, treatment protocols, operating procedures, physical requirements, etc. in place before the surveyors visit the hospital. The pre-accreditation process is known to be resource-intensive involving almost all personnel at various levels, as well as ad-

3. *See Health Reform Note 2.*
4. *Department of Health, 13 April 2010. Available at: http://www.doh.gov.za/docs/sp/sp0413-f.html*

ditional time and finances to implement new systems, train staff members and meet physical requirements. However, while the pre-accreditation process may be time-consuming at first, in the long-run these inputs will be beneficial to the hospital and its patients.

Once the healthcare provider has successfully prepared for accreditation (this is measured by internal evaluations), the survey team will visit the facility to measure all the necessary elements and interview the relevant personnel. Such a visit should last anything between 2 and 5 days, depending on the size of the facility and the number of surveyors. On average a team of surveyors would have at least 4 members: a medical doctor, a nurse and one or two other healthcare professionals (most of the time someone with managerial or administrative experience). Some teams would also, for example, require engineers or specialists in medical physics where facilities offer nuclear medicine and/or other highly-specialised services. This team would score many detailed elements in a number of overarching categories such as management and leadership, access to care, health and safety, various medical disciplines, laundry and housekeeping services, food, and so forth. The various elements being measured can add up to more than 3,000 individual items being scored in each facility.

Once the on-site visit is completed, the surveyors will usually give feedback to the hospital shortly thereafter. This may include verbal feedback directly after the visit, but a report will always be compiled and given to the hospital within a week or three weeks at the most. The board of the accrediting authority will then carefully consider the survey findings before making the final decision on accreditation. All in all, the off-site process can take anything from 3 to 5 months, but this is largely due to a delay between the on-site visit and the final decision, rather than requiring further time for analyses, etc.

4 Inputs and Basic Assumptions for Calculations

In order to estimate the potential timeframe and human resource requirements of the first round of accreditation for all healthcare providers in South Africa, we had to make a number of assumptions. During this process we considered many different views in order to inform our assumptions. While these assumptions are potentially optimistic, since the actual process could take longer and be more expensive than the estimates presented here, we believe that they are based on the facts and the views that were presented to us. In modelling the resource requirements we did not allow explicitly for the pre-accreditation process. As mentioned above, this process may take substantial time for each hospital and it is therefore very important that hospitals start preparing as soon as possible.

In addition, we assume that all facilities will successfully prepare for accreditation, i.e. all facilities will be accredited after the initial

About ECONEX

ECONEX is an economics consultancy that offers in-depth economic analysis covering competition economics, international trade, strategic analysis and regulatory work. The company was co-founded by Dr. Nicola Theron and Prof. Rachel Jafta during 2005. Both these economists have a wealth of consulting experience in the fields of competition and trade economics. They also teach courses in competition economics and international trade at Stellenbosch University. Director, Cobus Venter, who joined the company during 2008, is also a Senior Economist at the Bureau for Economic Research (BER) in Stellenbosch. For more information on our services, as well as the economists and academic associates working at and with Econex, visit our website at www.econex.co.za.

on-site visit, with the final accreditation decision being made after the observations have been processed. It is important to point out that in practice, this is rarely the case for public facilities specifically. According to the Council for Health Services Accreditation of Southern Africa (COHSASA), the only local, but internationally accredited, healthcare accreditation organisation which also accredits some public sector facilities in South Africa, these facilities are rarely accredited upon the first visit, even though they have been preparing for the accreditation process. A time consuming, labour intensive process usually follows, trying to facilitate preparation and accreditation in these facilities. We did not explicitly allow for this process in our calculations, but this is an important point which could impact negatively in practice.

4.1 Number of Providers

The accreditation of all public and private sector healthcare providers in South Africa are currently being considered. The latest available data from the *Hospital and Nursing Yearbook for Southern Africa* (2009:141) indicate that there were approximately 428 public hospitals, 3,077 public clinics and 211 private hospitals in the country by 2007. Thus, in sum there are 3,716 facilities (referred to as "hospitals" in our analysis) in this group.

According to data from the Board of Healthcare Funders (BHF) there were 11,801 GP practices and 5,968 specialist practices in 2008.[5] These numbers are contentious since many doctors are registered under more than one practice number, and in some cases various consulting rooms may be registered or bill patients under one collective practice number – suggesting that the numbers may be over- or understated. However, for the current analysis we use the BHF numbers as is, assuming that all 'practice numbers' (as opposed to facilities alone) will have to be accredited for contracting purposes with the NHIA, independent of the number of doctors/ specialists registered to each practice number or the same doctor using different numbers. Accordingly, a total of 17,769 practices have to be accredited.

Note that no pharmacies, private clinics, dentists or any other health service providers that may need to be accredited in order to contract with the NHIA are included here, i.e. these figures are conservative estimates of the total number of providers and the actual numbers may be even higher.

4.2 Working Days and Length of Process

We assume that there are 249 working days in a year, allowing for a 5-day working week and 12 public holidays. For hospitals the accreditation process itself is assumed to take an average of 2 days on-site[6] and 3 months off-site, based on the estimates from industry experts explained above. The on-site visit for individual GP and specialist practices are assumed to take 1 day only, while the off-site process will take 1 month.[7] We do not specifically allow for any travel times between facilities, but we assume that

5. *Eighty20 presentation.*
6. *We use an average of 2 days across the group in order to allow for the evaluation of larger hospitals which may take much longer, and also that of some smaller clinics which may take only a day or two.*
7. *This is an assumption only since we have no previous evidence of private practices being accredited in South Africa. We assumed that it will take much less time to complete the off-site accreditation process (analysing and summarising the report, as well as receiving the board's final accreditation decision) for GP and specialist practices than for hospitals.*

the surveyors will take another 3 days for hospitals and 1 extra day for practices after the on-site visit to finalise and deliver the report, before moving on to the next facility.

4.3 Staff Requirements

Similar to the assumptions above, we assume that the on-site evaluation process will not only take less *time* in the case of GP and specialist practices, but that those facilities will also require less surveyors than the hospitals. Hence, we assume that each team of surveyors will have at least 2 members for practices, while teams evaluating hospitals will consist of 4 members.

In addition to the required surveyors, we assume that the national OSC will employ permanent staff members responsible for administration and other 'back office' duties. It is difficult to put a specific headcount here, since it will depend directly on the type of business model that is followed, the size of the technical committee and board that makes the final accreditation decision, how big the help desk will be, the research function, and how the organisation is finally structured. In order to try and estimate the resource requirements of such an accreditation organisation, one can look at current best practice. At the moment, COHSASA employs 35 full-time staff (excluding all independent/part-time surveyors) with various areas of expertise.[8] Note that these are not the people typically responsible for the on-site visits, the surveyors visit the hospitals, do the surveys and write the accreditation reports. Therefore one might only need a few more support staff for the proposed OSC, even though the organisation itself will be accrediting many more facilities. COHSASA also has the benefit of efficient systems and experience in this sector. Therefore, using their number of workers as an indication might not be the best method, as the new authority will have to build expertise and support systems *de novo*. In addition, the aim of such an authority is to accredit ALL service providers, where COHSASA currently only serves a portion of the market. Industry sources indicate that current estimates for the national OSC are even less. Although no final estimates have been made, it is believed that 20-25 permanent/support staff should be enough. This has to be contrasted to the staff requirements for other countries shown in Table 1. For example, more than 400 people (excluding surveyors) are permanently employed by the French accreditation organisation, one of the few countries in the world where accreditation is mandatory (similar to that being proposed in South Africa). The French accredits fewer hospitals than what would have to be accredited in South Africa, while GP and specialist practices are not accredited.

It seems then that the national OSC could potentially employ anything between 20 and 400, or even more, permanent/support staff members. Based on our research as well as industry interviews, we have decided to add a minimum of 50 people to our calculations. In other words, in addition to the total number of doctors, nurses and other highly skilled surveyors that will be needed, we include another 50 people to calculate the total human resource requirements of a new accreditation body in SA.

5 Implied Resource Requirements

5.1 GP and Specialist Practices

Based on the above assumptions, if the proposed OSC were to accredit all GP and specialist

8. *Interview with COHSASA CEO, Prof. S. Whittaker. (See Health Reform Note 2 and www.cohsasa.co.za for more details on COHSASA accreditation.)*

practices within 5 years (i.e. 20% per year), they would have to do 3,554 on-site practice visits a year (14 per work day) and need 58 surveyors to do so. The off-site process will require at least 296 final accreditation decisions to be made by the board of the accrediting body every month.

5.2 Hospitals

In order to accredit all hospitals within the required time, our calculations show that 60 surveyors will be required to accredit 744 hospitals per year. This means that 3 hospitals will have to be surveyed each day, and 185 final accreditation decisions made every three months.

5.3 Summary

The model outputs mentioned here should be viewed as a whole rather than focusing on the specific numbers of surveyors for hospitals or practices – the mix between these two groups may be very different in practice. Establishing the proposed national OSC will therefore require at least 168 staff members if all healthcare providers were to be accredited within 5 years. Importantly, these figures pertain only to the first round of accreditation for hospitals, GP and specialist practices. Additional staff may still be required to facilitate accreditation on a continuous basis and also if new facilities are built or if other types of providers also need to be accredited.

As indicated above, the intensive resource requirements of the pre-accreditation process are not reflected in this model. One should bear in

Table 1: Cost experience of other countries' accreditation authorities

Country	Organisation	Number of facilities	Staff	Budget	Time accredited for	Source
USA	JCAHO	17,000 (2008)	1,000 full time	Total expenses 2008: US$ 161,941,438	3 years	www.jointcommission.org; Financial report 2008
France	ANAES	2,950 (2009)	400 permanent + 3,000 extra (incl. 780 surveyors)	Budget 2008: EUR 66.2 mil	5 years	http://www.has-sante.fr
Australia	ACHS	1,211 (2008)	56 full time + 400 surveyors	Expenses incl. Cost of sales 2009: AUS$ 10,265,880	4 years	ACHS Annual Report 2008/09
Canada	Accreditation Canada	1,077 (2008)	507 surveyors	Total expenses 2008: CAN$ 21,894,494	n/a	Annual Report 2008 www.accreditation.ca
Taiwan	Joint Commission on Hospital Accreditation	516 (2004)	n/a	n/a	3 years	www.tjcha.org.tw
Malaysia	MSQH	81 (2010)	92 surveyors	n/a	n/a	www.msqh.com.my

mind that the providers usually have staff dedicated to the accreditation process and/or internal evaluation mechanisms throughout the year, and not only when a facility is being visited by the surveyors. Nurses and other staff members have to be trained to capture data and evaluate themselves or their departments continuously, while all staff has to take time to learn and implement the correct procedures/standards that will be evaluated. Public hospitals in particular require much time and effort to build this capacity, including the need to train the relevant people. Nevertheless, although providers potentially face significant resource requirements in order to prepare for, achieve, and maintain accreditation, it will most certainly improve the quality of care to patients and therefore also improve the outcomes of healthcare in South Africa.

6 Cost

In trying to estimate the overall costs of establishing a fully functional accreditation authority in South Africa, we have made several assumptions about the required timeframe needed for each type of facility and the number of staff needed (both surveyors and support staff). We estimated that such an accreditation authority will need at least 168 full-time staff members. The first important aspect to point out is that, given the current shortage of healthcare professionals, it will take time to build this additional capacity.

In order to translate the human resource requirements into a total cost or high level budget, one would need to make detailed assumptions regarding salaries, fixed and variable costs, etc. Given the large number of assumptions required, the outcome of such an exercise might be criticized on the basis of the assumptions chosen. We therefore considered it more appropriate to find examples of countries that have set up similar authorities. These are shown in Table 1.

Ideally, one would like to compare the potential costs with comparable benchmark countries. However, the table contains all the countries that we could find comparable costs for within the allowed time, and it was not possible to narrow it down to a preferred list of countries.

It is difficult to come to any firm conclusion of what the potential costs for South Africa might be, based on Table 1. It is also not clear what is included in each cost figure, e.g. the figure for the Netherlands seems very small compared to the rest of the countries. However, what we can conclude is that this process should not be underestimated in terms of costs and resources; requiring more than 168 highly qualified full-time staff members (based on a conservative estimate excluding the pre-accreditation process requirements).

7 Conclusions

In this note we provide an optimistic estimate of the number of full-time staff that will be needed to ensure that South Africa has a fully functioning accreditation authority within 5 years. We did not allow for the pre-accreditation process nor the process of facilitating accreditation if a facility did

More Information
ECONEX regularly publishes Research Notes on various relevant issues in South African competition, trade and applied economics. For access to previous editions of Research Notes, or other research reports and published articles, go to: www.econex.co.za
If you want to add your name to our mailing list, please send an e-mail to iris@econex.co.za

not meet all the requirements the first time. However, the time and staff requirements for these processes could be substantial, and would make the 5 year timeline quite ambitious.

Given the specific human resource requirements, the lack of qualified healthcare staff currently available in South Africa, and the high indicative cost of establishing such an authority, it might be better to pursue some alternative options. It would be more feasible to use the current structures, including the private accreditation processes already in place. Alternatively, one could consider the option of 'graded accreditation' implying that facilities can be accredited to provide specific services only, if everything in that category of service meet the standards. This would be a good option for the national OSC to have more facilities accredited sooner, but also implies that many services would in the mean time only be available at hospitals that meet the standards.

This note has also not explicitly considered the cost of obtaining accreditation from the provider's side. This cost is currently quite high for the private hospitals. Since accreditation will be mandatory and government will want to include as many providers as possible in order to provide universal coverage, careful consideration should be given to softening the accreditation funding burden for providers.

It was pointed out in the previous note on accreditation that there are strong benefits flowing from such a process. It is therefore important that healthcare facilities and providers in South Africa prepare for accreditation and increase the quality of service delivery and outcomes, regardless of the timing of the proposed NHI.

ECONEX Services

Econex has extensive experience in competition economics, international trade and regulatory analysis. Strategic analysis was recently added as practice area. We have an established reputation for providing expert economic advice for high profile mergers and complaints that appear before the competition authorities. Some of the more recent highlights include the complaint against British American Tobacco, the merger between MTN and iTalk, the complaint against Senwes and the acquisition of KayaFM by Primedia. Apart from competition work we have also been involved in trade matters which included analyses of the effects of tariffs, export taxes and anti-dumping tariffs.
As a result of our work in competition analysis we also have invaluable experience in some of the sectors of the South African economy where regulation continues to play a role, e.g. the telecommunications, health and energy sectors. We use economic knowledge of these sectors to analyse specific problems for some of the larger telecommunications, health and energy companies.