Poor quality of care reinforces existing inequalities

Carol Marshall, Chief Director: Office of Standards Compliance, National Department of Health.
MarshC@health.gov.za

Inequality is apparent throughout our health system and our society, to a greater degree than is found in many other societies. The PHASA conference examined many different facets of this and how it is manifest in the determinants of health, in the various inputs into our health system and ultimately of course in our health outcomes. However inequality is also apparent in the quality of the care we provide and these differences again reinforce further differences in that care.

This short paper focuses on two specific aspects of quality care which are often not given much attention: care that is acceptable to patients and meets their expectations, and safe care that does not harm. It will argue that in both cases, poor quality is reinforced through existing inequities. The paper will further discuss how the proposed "Office of Health Standards Compliance" (a regulator of quality) could address this.

Acceptable care

Health care is a service industry; "client satisfaction" should be one of the core outcomes. Patients of course want to get better; they want and need that the health services achieve good "outcomes". However, if they are to use the services, they must also be acceptable (that is respectful, sympathetic, clean and efficient). Services that meet these criteria are also absolutely necessary in establishing trust and confidence that the system will help patients and cares about them when they are very vulnerable.

Unfortunately, although what we call "patient satisfaction" or "patient experience" is so fundamental, it does not seem to be regarded as a priority in the public healthcare system, rather as something between a threat and a nuisance, or at the most as a "nice to have but rather idealistic" addition. This is an area where the private sector has a clear lead - why else would patients choose to pay for their services. Add to this the many complaints about "rude, uncaring staff" to the point where the essential trust and confidence in the public health services is being eroded.

Safe and reliable care

Health care is by its nature a high-risk area of work, but the level of actual harm caused by problems in the systems of care is shocking to many. It is system failures that are the root cause of avoidable mortality and morbidity much more often than the "negligent health worker" whom it is so easy and satisfying to blame. Medical error (or adverse events, to use a common term) is estimated to contribute between 10% and 20% of mortality or excess morbidity in hospitals, even in well-resourced countries. The National Confidential Enquiry into Maternal Deaths shows high proportions of "preventable deaths" due to such errors. This is compromising outcomes, probably pushing up costs, and is undermining confidence and trust in the health system. The new focus on "Patient safety" driven by the World Health Organization (WHO) is about strengthening the systems that can reduce the risk of such failures.

Existing inequalities

It seems reasonably clear that existing inequalities extend also to challenges in providing such safe and acceptable care. Inequality shows of course through the persistent (although diminishing) differences in budgets related to the numbers of patients. The stock of equipment and the quality of buildings/infrastructure also reflects existing inequalities. These differences impact directly on care but also result in there being less of a margin to absorb budgets cuts.

However, good leadership and service management are probably even more important than resource inequities in ensuring acceptable and safe care. This can be seen in the excellent care provided in many "disadvantaged" facilities when there is a competent manager. But it is hard to attract and retain such managers in peripheral or under-resourced places of work.

The systems needed to prevent and manage clinical risk, to ensure best practice is observed for every patient every time, and to learn from errors and near misses, all tend to be weaker in disadvantaged settings. In turn, the patients themselves are more likely to be poor and class differences are most evident. The poorest users are the most unlikely to complain effectively and have the fewest choices, so they are the most likely to receive unsafe and unacceptable care.

Strengthening accountability

To correct such a situation there needs to be a clear set of requirements that apply to everyone as well as an objective system that measures where these are met or not. However, the many different sets of requirements originating from multiple role players and authorities, including the differences between provinces, has resulted in a situation where it is difficult to understand where people are in the spectrum in order to take corrective action.

Underpinning this is an overall lack of accountability for delivery of acceptable and high quality service. There are limited significant consequences either when poor delivery is apparent, or when individuals or teams excel. Above all, it is hard to identify who did not do what that they could reasonably have been expected to do. The easiest and perhaps most common response from managers is "It is not my fault", and this is particularly so in a centralised system where the functioning of the support systems is also not monitored, and those at the periphery have very limited power to change this.

The future Office of Health Standards Compliance is proposed as an external regulator of health establishments in order to identify non-compliant establishments. The Bill proposing an amendment to the National Health Act is currently starting the process of Parliamentary review. But how is such a body intended to impact on the system?

Set of standards

The first task for the Office is to advise on a common set of standards that will set a single benchmark for all health establishments across the country, helping us to move away from the "we do things differently here" rationale. A set of standards is also anticipated to impact on culture through bringing more certainty to the functioning of the health care system even where staff have been poorly trained, and making sure that respect for patients and respect for basic rules becomes the norm. A strong focus on communication of the standards will also strengthen dedicated and hard-working staff to argue for the system improvements needed for them to become compliant. However, there have been guidelines and standards before, and the challenge is to implement them.

Measurement of standards

The Office of Health Standards Compliance will measure levels of compliance with standards using a number of methods. Firstly, on-site inspections by a regulator will have a number of advantages in assuring quality and combating inequality. These will be carried out by an external team independent of line management or policy functions and therefore with no reason not to "tell-it-like-it-is". The team will observe and record objective findings on unannounced visits, rather than relying on self-reporting with all the potential biases. And because every facility will have to be visited, the situation in the most peripheral areas will be documented along with (and compared to) that in major urban centres.

Secondly, to compensate for the fact that inspection visits are infrequent, other types of information will be collected and monitored that, when put together, will give a composite picture of each facility and the risks for quality and safety. Making sure this composite picture is facility based and not an aggregated picture also means that the information can be used by management on the ground to introduce changes. However, we also had monitoring systems before, but the response to what is found is often inadequate. Here the key problem seems to be that nothing happens in response to finding problems (or successes); there are no consequences.

Consequences of (non-)compliance

The means by which the future office is expected to impact on quality is through its regulatory powers. The Office is tasked with certifying all establishments in the country as being compliant with standards or issuing notices of corrective action required. Placing findings in the public domain and benchmarking facilities of a similar type against each other has proved internationally to be a very powerful incentive to improve compliance. The possibility that warning notices might similarly be made public has also been found to add to the pressure on local management as well as those in the direct line of support to correct the situation. The Bill does in addition propose some tougher sanctions: mandatory corrective action, removal of certification, imposition of fines, and referral for prosecution. What has been found internationally is that the knowledge of such potential actions has been enough to drive changes in practice in facilities, wherever such changes lie within their power (which is surprisingly often the case).

Relatively few instances of non-compliance are found to require additional resources or authority to correct, though this varies depending on the local situation. However when they are non-compliant, problems can arise if the needed authority or support is not provided. To date, the biggest risk that has been identified is that hospital or district managers can easily land up being blamed for poor levels of compliance and those whose jobs it is to provide an enabling environment are not taking responsibility for their own deficiencies. It will therefore be critical that patterns of non-compliance indicating such weaknesses in support systems form part of the reports. The impact of existing inequalities will therefore become apparent and will have to be corrected if facilities are to become compliant.

There is of course an ambivalent reaction to the whole approach of a regulator; some feel we should not be "policing" people, others affirm that they are already doing all they can and do not need any more demands. A further fear is that rather than moving the system upwards, focussing so strongly on minimum or core standards may actually lead to a drop in quality.

However, the most common view seems to be that unless we can build some consequences into the system in response to the dreadful instances of non-compliance that are seen it will

not self-correct. And if these consequences can also be of the positive kind that recognises excellence, then this is proposed as one of the pieces of the puzzle towards enhancing quality across the system and combating some of the major inequalities.

Note that the views expressed in this article are those of the author(s) and do not necessarily represent the views of PHASA.