Accountability challenges in state healthcare facilities: systems, staffing and ethical responsibilities. SAMLA 2026

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Professional accountability

Proverbs 10:9:

"Whoever walks in integrity walks securely, but whoever takes crooked paths will be found out."

Proverbs 11:3:

"The integrity of the upright guides them, but the crookedness of the treacherous destroys them."

Ephesians 6:7-8:

"Serve wholeheartedly, as if you were serving the Lord, not people, because you know that the Lord will reward each one for whatever good they do, whether they are slave or free."

Surah Az-Zalzalah 99:7–8:

"Whoever does an atom's weight of good will see it, and whoever does an atom's weight of evil will see it."

Some Axioms

"Everybody lies to cops.

The less you act like a cop, the less you will get lied to. One needs to approach the bedside radiating confidence and friendship if you want to get an accurate history. This is the reason that medical students sometimes get in formation from patients that was not disclosed to the residents or the attending.

"Every day a patient spends in the hospital bed takes a week to recover,"

"A healthy person put in a hospital bed for a week will get sick with something."

"No patient wants a hurried doctor—speed up between patients and slow down with them."

This axiom is hard to live by in the current clinical/economic environment. But, we have to try to listen to everything our patients want to tell us and not constantly interrupt them in an attempt to shorten the visit.

Background

Accountability in state healthcare facilities is a cornerstone of effective service delivery, yet it remains a persistent challenge in many public health systems.

We will examine the structural, human resource, and ethical dimensions of accountability, with a focus on how systemic weaknesses, staffing constraints, and ethical lapses undermine patient care and public trust.

Drawing on governance frameworks and empirical studies, I will propose strategies for strengthening accountability mechanisms in state-run health institutions.

Introduction

State healthcare facilities are the primary access point for millions of citizens, particularly in low- and middle-income countries for access to health.

In South Africa, for example, public hospitals and clinics are mandated to provide equitable, quality care under the constitutional right to health.

However, accountability deficits—manifesting in poor oversight, inadequate staffing, and ethical breaches—have eroded service quality and public confidence.

These deficits are not isolated incidents but systemic patterns that reflect weaknesses in governance, human resource management, and professional ethics.

Systems-Level Accountability Challenges

These include:

- Governance and oversight (corporate and clinical)
- Policy-practice gaps (Best policies never impelemented)
- Staffing and HR accountability (Staffing norms v/s “funded posts”)
- Ethical responsibility and professional accountability

Governance and Oversight

This combine corporate (The facility) and clinical (The delivery unit) governance and oversight

Effective accountability requires robust governance structures, including clear reporting lines, transparent decision-making, and enforceable performance standards.

Unfortunately many state facilities operate within fragmented systems where policy directives are inconsistently implemented. The reasons for this include:

Leadership instability: Frequent changes in senior management disrupt continuity and weaken institutional memory. For example, in some provincial health departments, CEOs of hospitals are replaced multiple times within a single year, leading to inconsistent priorities and stalled projects.

Weak monitoring frameworks: Performance indicators are often poorly defined or not linked to actionable consequences. In many facilities, quarterly reports are submitted but rarely analysed for trends, resulting in missed opportunities for corrective action.

Corruption and procurement irregularities: Mismanagement of resources undermines both operational efficiency and public trust. Cases of inflated medical supply contracts and irregular tender awards have been documented, diverting funds from essential services.

Policy-Practice Gap

Policies on patient rights, quality assurance, and safety exist, but enforcement is inconsistent.

This gap is exacerbated by limited capacity in provincial health departments to conduct regular audits and respond to non-compliance.

For instance,

> while infection control policies are mandated, many facilities lack functioning sterilisation equipment, and inspections are infrequent, allowing unsafe practices to persist.
>
> The guidelines for maternity care are one good example where ideals are presented and the tools to implement it are not provided.

Staffing and Human Resource Accountability

Workforce Shortages

Chronic understaffing in state facilities leads to excessive workloads, burnout, and compromised patient care.

In rural hospitals, a single nurse may be responsible for over 40 patients during a night shift, making it impossible to provide adequate monitoring and timely interventions.

Accountability suffers when staff cannot meet service standards due to structural constraints rather than negligence.

Competency and Training

Inadequate training and professional development weaken clinical decision-making and adherence to protocols. For example, newly graduated nurses may be placed in specialised wards without sufficient orientation, increasing the risk of procedural errors.

Continuous professional development programmes are often underfunded, and attendance is hindered by staff shortages.

Performance Management

Performance appraisal systems are often perfunctory (carried out without real interest, feeling, or effort), lacking meaningful feedback or consequences for underperformance.

In some facilities, evaluations are conducted merely to satisfy administrative requirements, with no follow-up on identified weaknesses.

This fosters a culture where accountability is perceived as optional rather than integral, and high-performing staff receive little recognition.

Ethical Responsibilities and Professional Accountability

Patient-Centred Care

Ethical accountability demands that healthcare providers place patient welfare above personal or institutional interests.

However, overcrowding, resource scarcity, and bureaucratic pressures often compromise this principle.

For example, patients may be discharged prematurely to free up beds, even when clinical indicators suggest continued care is necessary.

Transparency and Truth-Telling

Patients have the right to accurate information about their diagnosis, treatment options, and risks.

This requires many minutes of discussion with a patient, however in an environment of overcrowding, austerity the clinical bears the rauth of the patient and the public while the decision makers are not held to any ethical standards.

"Financial managers must understand the clinical consequences of their financial decisions and clinicians must also understand the financial consequences of their clinical decisions".

Medicolegal consequences

Increased Litigation:

The rise in medico-legal claims is a direct result of the failure to meet the necessary standards of care and accountability. This has led to a significant increase in litigation, which currently strains the healthcare budget and affect service delivery.

Financial Impact:

The payouts for medico-legal claims have a substantial financial impact on the health sector, affecting the budgets of public facilities and the ability to deliver quality healthcare services.

Medicolegal consequences

Patient Safety Risks:

Poor record management and inadequate documentation can lead to serious patient safety risks, as healthcare providers may struggle to defend claims due to missing or inaccurate records.

Staffing Shortages:

The inability to manage medico-legal claims effectively is often due to staffing shortages and a lack of resources, which can lead to mistakes and further exacerbate the situation.

Ethical Responsibilities:

There is a pressing need for healthcare professionals to address ethical responsibilities, such as ensuring patient safety and accountability, which can be compromised by the challenges faced in medico-legal claims.

Are Health workers evil by nature?

Dr Motsoaledi once said that he does not believe that the majority health workers wake up and go to work with the sole purpose of harming patients.

Like everything in life, there are exceptions. Here are a few notorious Drs in the world.

Marcel Petiot: A French physician and serial killer who is alleged to have killed at least 60 persons. After trial, Petitot was beheaded on 25 May 1946.

Walter Freeman: Walter Freeman was an American neurologist who went on to become a notorious physician for his craze about lobotomy. Rather than a brutal intent, Freeman was driven by the passion to perfect the technique, which is outdated now, doing over 20 lobotomies in a single day.

Jayant Patel: Known as 'Doctor Death,' he worked in USA and later in Australia and is believed to be responsible for as many as 87 deaths during his practice between 2003 and 2005. this was due to incompetence and lack of knowledge.

Shiro Ishii: A Japanese microbiologist and a lieutenant general in the biological warfare unit of the Japanese Army during the second Sino–Japanese war. He started his experiments in 1942. He exposed war prisoners and sometimes even civilians to dangerous diseases like plague and anthrax. His other experiments included stimulated strokes and heart attacks, forced abortions etc. Thousands of people died of his experiments. After the Second World War, Ishii was arrested by the American forces. However, he was given immunity in exchange of his medical knowledge.

Are Health workers evil by nature?

The Majority of health workers remain faithfull to the oath of Hippocrates even when the conditions were they are do not make it easy for them.

1992: The 5-year-old who died from aspirating a bean in Acornhoek.

2001: The midwife who managed the labour and delivery of her husband's mistress.

Case study:

An intervention project in a province in South Africa

Case study: A province in RSA

Improving maternal and neonatal outcomes remains a national and provincial priority aligned to the National Development Plan 2030 and Sustainable Development Goals.

While the province has made progress in increasing institutional deliveries, persistent challenges in quality of care, patient experience, and clinical responsiveness continue to undermine outcomes.

The province is currently facing a significant medico-legal burden estimated at billions of rands, driven in part by preventable adverse maternal and neonatal events.

Evidence indicates that negative staff attitudes, poor teamwork, delayed clinical response, and weak accountability systems contribute directly to these outcomes.

Case study: A province in RSA

However, these behavioural challenges are not isolated, they are symptoms of deeper systemic issues, including:

- High workload and staffing pressures
- Weak clinical governance and supervision
- Organisational culture characterised by blame rather than learning
- Limited integration between performance management and patient safety
- Programme Response

The successful implementation of the Initiative is dependent on careful management of operational, behavioural, and stakeholder-related risks, particularly within a complex public sector environment where organised labour plays a significant role in staffing, performance management, and workplace dynamics

Case study: A province in RSA

Healthcare workers are increasingly prioritising the following (following Covid-19)

- Autonomy
- Psychological well-being
- Flexibility
- Purpose-driven work

This shift creates tension within systems that remain hierarchical, compliance-driven, and output-focused, leading to disengagement and weakened organisational commitment.

These emerging risks reinforce the need for a holistic, system-level intervention that goes beyond technical training. There is a growing imperative to:

- Build psychologically safe, adaptive teams
- Support behavioural and cultural transformation
- Strengthen leadership capability in managing complexity
- Balance technological advancement with human-centred organisational design.

Case study: A province in RSA: The Problem statement

A review of maternal and neonatal adverse events indicates that challenges extend beyond individual staff attitudes and are also linked to deficiencies in routine clinical practice, communication, documentation, and multidisciplinary teamwork.

Effective labour and delivery care is a shared responsibility between nurses, midwives, and clinicians, requiring continuous assessment, accurate documentation, timely communication, collaborative decision-making, and appropriate post-delivery monitoring.

However, evidence suggests that these fundamental practices are not consistently applied across all facilities.

Key areas of concern include inadequate maintenance of accurate and contemporaneous clinical records, which compromises continuity of care, clinical decision-making, and medico-legal defence.

In addition, mothers and their families are not always adequately informed about their condition, proposed procedures, or treatment options, limiting shared decision-making and informed consent.

Case study: A province in RSA: The Problem statement

Communication and teamwork challenges between nurses, midwives, and clinicians further contribute to delays in escalation, fragmented care, and missed opportunities for early intervention.

These gaps undermine patient safety, increase the risk of preventable maternal and neonatal complications, and contribute to the Department's growing medico-legal burden.

Furthermore, concerns have been raised regarding the effectiveness of multidisciplinary ward rounds, communication practices, and clinical oversight mechanisms intended to ensure continuity of care and early identification of complications.

The apparent decline in these practices raises important questions about organisational culture, supervision, accountability, workload pressures, and adherence to established clinical governance standards.

Addressing these challenges requires a comprehensive approach that strengthens professional practice, clinical governance, teamwork, communication, leadership accountability, and patient-centred care.

Case study: A province in RSA: the province continues to experience:

Clinical and System Challenges

- Poor intrapartum monitoring and delayed intervention
- Inconsistent adherence to clinical guidelines and protocols
- High rates of preventable maternal and neonatal complications
- Rising medico-legal claims
- Inadequate clinical documentation and record keeping
- Communication breakdowns between nurses, midwives, and clinicians
- Inconsistent multidisciplinary ward rounds and clinical oversight
- Delayed escalation and response to obstetric.

Case study: A province in RSA: the province continues to experience:

Organisational and Behavioural Challenges

- Negative staff attitudes affecting patient care
- Burnout and low morale
- Hierarchical culture limiting communication and escalation
- Weak teamwork across clinical cadres
- A culture of no accountability

Governance and Accountability Challenges

- Culture of blame rather than learning
- Weak linkage between performance management and clinical outcomes
- Limited consequence management
- Underutilisation of data for decision-making.

Case study: A province in RSA: the province continues to experience:

These factors collectively contribute to:

- Rising medico-legal claims
- Poor patient experience
- Reduced trust in public health services

Case study: A province in RSA: Strategic Intent

To drive sustainable improvements in maternal and neonatal health outcomes, patient safety, clinical performance, and medico-legal risk reduction through a system-integrated change management and organisational transformation programme that strengthens both individual behaviour and the organisational systems that shape and sustain performance.

The Initiative seeks to address the interconnected clinical, behavioural, leadership, governance, and workforce challenges that contribute to adverse patient outcomes, poor patient experience, staff burnout, weak accountability, and rising medico-legal claims.

Through a system-integrated approach that combines team coaching, strengthened implementation of clinical protocols and guidelines, leadership and governance excellence, stakeholder collaboration, staff well-being, and continuous learning, the initiative aims to create a patient-centred, accountable, resilient, and high-performing health system capable of delivering safe, quality care and improved health outcomes.

Case study: A province in RSA: Strategic Intent

This strategic intent will be achieved by:

- Improving patient safety, quality of care, and patient experience.
- Strengthening professional accountability, ethical practice, and consequence management.
- Enhancing teamwork, communication, collaboration, and escalation in critical care settings.
- Improving labour monitoring, clinical decision-making, documentation, and response times to obstetric and neonatal complications.
- Promoting staff well-being, mental health, resilience, and self-care as critical enablers of performance.
- Embedding Just Culture principles that balance accountability, learning, and system improvement.
- Strengthening leadership capability, clinical governance, and performance management systems.
- Fostering constructive engagement with organised labour and other stakeholders to support sustainable change.
- Institutionalising systems thinking, continuous improvement, and organisational learning within routine operations.

Case study: A province in RSA: The Theory of Change

If health system constraints (leadership, governance, staffing support) are addressed alongside structured team coaching and clinical reinforcement, then staff attitudes, teamwork, and accountability will improve, leading to better clinical decision-making and patient care, resulting in reduced adverse outcomes and medico-legal claims.

The Initiative is underpinned by an integrated programme architecture that recognises the interconnected nature of behavioral, clinical, organisational, and system-level factors influencing patient outcomes and medico-legal risk.

The model combines change management, team coaching, clinical governance strengthening, leadership accountability, stakeholder engagement, staff wellness, and continuous learning to create sustainable improvements in patient safety, quality of care, workforce performance, and organisational culture.

Through this integrated approach, the Department aims to strengthen both individual behaviour and the systems, structures, and leadership practices that enable high performance.

Case study: A province in RSA: The Theory of Change

Layer 1: System Enablers

- Staffing and workload review (where feasible)
- Strengthening escalation protocols
- Leadership visibility and support
- Integration with HR and performance systems

Layer 2: Team Coaching and Behaviour Change

- Attitude transformation
- Communication and teamwork
- Managing difficult conversations and Problem Solving
- Change management
- Ethical practice and patient-centred care.

Case study: A province in RSA: The Theory of Change

Layer 3: Clinical Governance Strengthening

- Labour monitoring compliance
- Case reviews and audits
- Real-time clinical supervision

Layer 4: Accountability and Performance Management

- Linking behaviour and outcomes to performance reviews
- Strengthening consequence management
- Facility-level accountability

Layer 5: Monitoring, Evaluation and Learning

- Real-time dashboards
- Continuous feedback loops
- Learning from adverse events

Conclusions

The South African healthcare system faces significant challenges in terms of accountability, which are deeply rooted in systems, staffing, and ethical responsibilities.

Key issues include leadership instability, lack of transparency, insufficient accountability mechanisms, and pervasive corruption.

These challenges hinder the effective governance and management of the health system, impacting the quality of healthcare provided to the population.

Overall, we provide an integrated response to maternal and neonatal safety risks in the province by treating clinical practice, workplace culture, governance, and workforce well-being as interdependent.

The systems approach we have proposing to this province are starting to bearf fruit with visible attitude changes within the staff.

INKOMU

Khanimambo

Ndolivhuwa

Melesi

Zikhomo

Asante.

Ngiyabonga

E se

Na gode

Enkosi

Ameseginalehu

Dalu

Ndatenda

Kea leboha.