Invited commentary

Accreditation is not a stand-alone solution

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Introduction

The politics and purpose of health care accreditation programmes around the world have changed radically from the original models of North America 50 years ago. Then they were hospital-focused, profession-driven, voluntary, self-financing and essentially non-governmental. The 1990s saw a rapid growth of programmes with an increasing emphasis on primary care, networks, health systems and regulation – driven largely by national governments and international donor agencies (1). The traditional collegial model of accreditation is moving towards a semi-regulatory model of external assessment; many newer programmes, for political, economic or technical reasons, have failed to meet initial expectations but others have flourished.

Most recently, in many countries, the ambition of achieving universal health coverage (UHC) has generated a demand (and market) for defining and monitoring “good services” and for the development of accreditation as an independent assessment of the competence and capacity of provider organizations. In practice, UHC tends to focus on one dimension of quality – access to care – and give less attention to providing safe, effective, patient-centered care, or to integrating health care financing to performance and to existing systems such as for patient safety, clinical effectiveness and accreditation. Whatever is the trigger for embarking on an accreditation system, global experience is clear that effective programmes must be integrated with national strategies for change management, not be regarded as a stand-alone injectable solution.

International developments in health care accreditation

Descriptive studies

Global surveys

Based on international surveys in 2000 (2) and 2010 (1), it is evident that health care accreditation is often adopted, in widely differing settings, as a mechanism for service improvement or as a vehicle for health reform. Both new and old programmes are increasingly linked to health care funding, or to an escalating governmental focus on quality health care, or to health system regulation, or all three. Responses from 45 national and international accreditation organizations summarized the drivers for health care providers to participate as: ethical (voluntary, professional); commercial (access to public funding, health insurance benefits and advantage in a competitive market); regulatory (most of the long-established accreditation organizations now offer a degree of regulation by proxy); and international (medical tourism generates a market for accreditation of health care providers across borders) (2).

Europe

A series of surveys of accreditation organizations have been reported from Europe. The most recent, in 2009, identified 18 active national accreditation organizations in the region and concluded that the principal challenges to sustainable accreditation appear to be market size, consistency of policy support, programme funding and financial incentives for participation (3). The “seed” of accreditation may be less

critical to success than the “soil” of the health system.

Eastern Mediterranean Region (EMR)

A survey in 2009 (4) obtained responses on accreditation from 18 of the 22 Member States of the World Health Organization (WHO) Eastern Mediterranean Region:

- 13 countries had a policy on regulatory licensing of health care institutions (of which 5 exempted the public sector, and 8 did not require periodic relicensing)
- 11 countries had a policy on accreditation (of which most were a component of health care reform and supported by legislation, 7 were voluntary systems but only 3 were directly linked to health insurance or third party payments)
- 7 countries had an established accreditation body (of which 4 were within the ministry of health (MoH) and 3 were independent).

An accreditation policy was found in Bahrain, Egypt, Jordan, Kuwait, Lebanon, Morocco, Pakistan, Palestine, Saudi Arabia, Sudan and United Arab Emirates (UAE). A policy had been drafted in the Syrian Arab Republic, and a committee established in Oman and Libya for that purpose. Work is in progress in Yemen, Iraq and Tunisia. In addition to national accreditation organizations, three international programmes are active in the Region – but only in the high-income countries.

Local experience of accreditation in EMR has been a topic for PhD students and has been published in the international press (5-7). Observations from UAE include that, “of 147 hospitals

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accredited by the Joint Commission International outside the United States before the end of 2007, 56 were in the Middle East" (8). From Pakistan, a study of attitudes to accreditation concluded that, "Those planning to support health care accreditation, such as national and provincial ministries and international development partners, need to understand how the components of health care accreditation fit into the local health system and into the broader political and social environment. ... Consideration of local change mechanisms and cultural practices is important in designing a local accreditation approach" (9).

The "Patient Safety Friendly Hospital Initiative" (10), launched by the WHO Regional Office for the Eastern Mediterranean (EMRO) in 2007, demonstrated the potential for improvement by assessing compliance with validated standards, feeding back the results and helping hospitals to develop an improvement plan. The project involved hospitals nominated by the MoH of seven countries (Egypt, Jordan, Morocco, Pakistan, Sudan, Tunisia and Yemen) and developed an assessment manual of 140 patient safety standards, based on review of WHO clinical guidelines, of literature on patient safety, of different countries' accreditation standards (and of the Arab League for Quality in Health care), and research studies published in peer-reviewed journals. This project illustrated the power of peer review and feedback, without the complexity and costs of a formal accreditation programme; but it also demonstrates one gradual and affordable route to introducing and assessing against organizational standards. The published report became the subject of an on-line case study of the International Society for Quality in Health care (11).

Lower- and middle-income countries

Secondary analysis of the 2010 international survey of accreditation organizations showed that accreditation

programmes of lower- and middle-income countries (LMICs) exhibit similar characteristics to those of higher-income countries (12). Where they do differ, the divergence is over specialized features rather than the general logic. The sustainability of accreditation programmes, irrespective of country characteristics, is influenced by ongoing policy support from government, a sufficiently large health care market size, stable programme funding, diverse incentives to encourage participation in accreditation by health care organizations as well as the continual refinement and improvement in accreditation agency operations and programme delivery.

Recent attention in many LMICs has moved to the potential association of accreditation with UHC. The Joint Learning Network (JLN) for Universal Health Coverage is an international consortium of nine countries in Africa and Asia (Ghana, India, Indonesia, Kenya, Malaysia, Mali, Nigeria, the Philippines and Vietnam); in 2011, the Network published a summary of methods available to improve health care quality within UHC schemes, including accreditation (13). All nine of the JLN countries either have accreditation schemes or are developing them, and an analysis of their experience identified key factors including: legal and governance structure; standards development and management; financing and incentives for accreditation; and the interface between insurance and accreditation (14).

Evidence of impact of accreditation

"Considering the amount of time and money spent on organizational assessment, and the significance of the issue to governments, it is surprising that there is no research into the cost-effectiveness of these schemes" (15). Since that observation was made in 2001, published literature shows increasing attention to these issues, but still no clear answers.

Research attention has focused more on evidence of impact on quality and safety in provider institutions than on stewardship of health systems. Publication bias has favoured analysis of successes, rather than (relative) failures.

Controlled studies

South Africa: Hospitals participating in the accreditation programme in Kwa-Zulu-Natal, South Africa, improved their compliance with accreditation standards; non-participating hospitals did not. However, there was no observed improvement on the defined quality indicators (16).

Australia: A significantly positive correlation was reported between accreditation and organizational culture and leadership. An association, albeit non-significant, was also reported between accreditation and clinical performance (17).

United States of America (USA): Accredited hospitals had better baseline performance than non-accredited hospitals and had larger gains over time (18).

A comparison of rural critical access hospitals in the USA (19) found that accredited hospitals showed significant advantage over non-accredited hospitals in 4 out of 16 clinical indicators but noted that, in a sector where only one third of hospitals seek accreditation, self-selection and motivation could explain much of this advantage.

Europe: Recent studies in France include a description of changes in one university hospital centre after the introduction in 1996 of mandatory accreditation (20), and an analysis of the findings and recommendations of the first 100 hospital reports of the same national programme (21).

The European DUQuE study (Developing Understanding of Quality in Europe) examined 73 acute care hospitals in the Czech Republic, France, Germany, Poland, Portugal, Spain and Turkey, concluding that both accreditation and ISO certification are positively

associated with clinical leadership, systems for patient safety and clinical review, but not with clinical practice (22). Both systems promote structures and processes which support patient safety and clinical organization but have limited effect on the delivery of evidence-based patient care.

Literature reviews

Evidence on the effectiveness of health care accreditation based on systematic reviews is limited as few studies have the rigour of randomized controlled trials; evidence of certification has scarcely been researched.

A systematic review by Greenfield and Braithwaite in 2007 (23) of accreditation research classified possible impacts into 10 categories; of these, only promoting change and professional development showed consistent positive association with accreditation, while 3 categories (consumer views or patient satisfaction, public disclosure and surveyor issues) there were not a sufficient number of studies to draw any conclusions. A systematic review from France in 2010 of 46 published studies showed that the majority suggested that accreditation had a positive effect on improving professional practice but only 7 studies included measures of clinical outcomes (24). Other literature reviews have come from Canada (25) and Saudi Arabia (26). A literature review from Accreditation Canada identified positive impacts of accreditation, but also several concerns and research gaps, concluding that, "Until empirical, evidence-based research on accreditation is complete, there will continue to be questions raised, regarding the value and impact of accreditation" (25). A systematic review from Saudi Arabia of 26 studies evaluating the impact of accreditation argued that accreditation can significantly improve the structure and organization of health care facilities, and some programmes significantly improve clinical outcomes (26).

Priority issues

Available resources for programme development

Research and publications have focused more on the successes of accreditation than on synthesising and learning from practical experience of the challenges to be met. However, the World Bank, WHO and the International Society for Quality in Health Care (ISQua) have worked together for over 10 years to provide advice for accreditation and external assessment programmes.

ISQua documents are available for download, free of charge, from <http://www.isqua.org/accreditation/reference-materials> (accessed 24 March 2015) including:

- International Accreditation Standards for Health care External Evaluations, 3rd Edition (27)
- International Principles for Health care Standards (28)
- ISQua's Surveyor Training Standards Programme, 2nd Edition (29)

Updated versions are available on request (free of charge for International Accreditation Programme members and surveyors, and ISQua Members and Fellows) for:

- ISQua Guidelines and Principles for the Development of Health and Social Care Standards, 4th Edition (30)
- ISQua Guidelines and Standards for External Evaluation Organisations, 4th Edition (31)

The first version of the toolkit to help countries, agencies and other groups to set up new health care accreditation programmes was published in 2004 and remains available free of charge from the World Bank website (32). A revised version, extended to a wider range of external assessment organizations, will be published later in 2015 as an aid for funding and development agencies such as the World Bank,

international aid and technical cooperation agencies, WHO, MoHs, other governmental and nongovernmental organizations.

This paper does not aim to summarize these guidance documents, but to underline the importance of preparing the soil of the health care environment to receive the seed – the technology of accreditation and external assessment.

Receptive culture

The effectiveness of proven approaches to improving health care – including accreditation, clinical guidelines, performance indicators and risk management – depends less on the technology itself than on the capacity of individuals and organizations to change attitudes and behaviour. In an ideal world:

- Patients are informed of their rights, and encouraged to participate in their own health care
- Health care staff accept personal responsibility for contributing to performance, safety and organizational improvement
- Managers of institutions have the skills, confidence and authority to manage their own resources and develop internal systems
- Clinicians are trained in evidence-based medicine, performance assessment and team working – and supported by continuing medical education
- Professions are organized to accept ethical responsibility for self-regulation and public accountability
- Quality is assessed on the basis of achievements and performance (process and outcome) rather than failures and capacity (resource inputs)
- Data and information are shared between institutions and agencies to support transparency, communication, improvement and learning

- Health policy and service planning are based on evidence, consultation and evaluation.

In reality, many, if not all, of these features are missing, especially in the developing world characterized by top-down command and control, dysfunctional health ministries, patient exclusion, professional indifference, and denial of personal responsibility. Even in higher-income countries, these ideals have yet to be fully achieved, despite the efforts of several generations.

Defining the purpose of accreditation

Surprisingly few governmental programmes begin with a clear view of what accreditation is intended to achieve, or how it will relate to similar mechanisms, especially statutory regulation. For the purpose of illustration, the two approaches may be contrasted (Table 1).

A key feature of voluntary accreditation is the commitment and participation of managers and staff in an internal process of change, supported by external facilitation and independent validation by peer review. Some regulatory systems have incorporated features of accreditation, such as initial self-assessment, without providing practical support for organizational development and learning between institutions, even in the public sector. Many MoHs do not have the capacity to develop and teach management systems or to facilitate institutions to comply with the more demanding standards of accreditation.

Regulation aims to ensure basic safety by licensing or registering only those institutions which meet basic standards. Accreditation, on the other hand, is a dynamic system aimed at organizational development of all participating institutions by recognizing degrees of excellence in compliance with optimum standards of

Table 1 Contrasting accreditation and regulation

	Regulation	Accreditation
Standards	Minimal	Optimal
Aim	Compliance	Development
Facilitation	No	Yes
Self-assessment	No	Yes
Assessors	Inspectors	Peers
Staff engagement	Low	High

organizational performance (Figure 1).

A useful early step in designing an accreditation process would be to list and consult with stakeholders on potential aims, such as:

- Increase safety for staff, patients and public throughout the health care system
- Develop institutional capacity and systems
- Support *multi*-professional staff development
- Monitor decentralization of management

- Harmonize standards between the public and private sectors
- Complement statutory regulation and stewardship of the health system
- Link organizational performance to funding and reimbursement.

Defining & aligning incentives for change

Management systems are most effective when they support the mission of all stakeholders, not just the MoH or the health insurance fund. Well established accreditation organizations harness the energy and ambition of patients, professionals, managers,

Figure 1 Competence (licensing) and excellence (accreditation). The vertical dotted bars represent licensing (left) and accreditation (right)

teachers and researchers to align incentives, promote a safety culture and facilitate change in health care institutions.

If they are consistently aligned, government policy, legal direction and health care financing are powerful incentives for changing organizations and individuals. To these may

be added public image, professional ethics, peer pressure, undergraduate curriculum, performance benchmarking and communications. These relationships take time to develop; a first step for many countries would be to redesign health care financing to reward performance rather than capacity.

Conclusion

Accreditation is not a bolt-on option for improving the health care system. Like all approaches to improving quality and safety, it must share aims, incentives and rewards with the principal levers for change, notably with health care financing, regulation, information and education.

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