

Toolkit for Accreditation Programs

**Some issues in the design and redesign
of external health care assessment
and improvement systems**



by Charles D Shaw

International Society for Quality in Health Care

Acknowledgement – The World Bank

The project to develop a Toolkit for Accreditation Programs was initiated in 2001 by ISQua, the International Society for Quality in Health Care, following discussions with colleagues at the World Bank also at the World Health Organization, and in response to requests coming to ISQua.

A clear need was expressed for a straightforward tool for implementation in a nation state or health care system. This would be an aid for accreditation providers and would also meet the requirements of funding agencies such as the World Bank, intergovernmental organizations such as the WHO, and individual countries considering the development of a national program.

ISQua warmly acknowledges the generous support which was provided to the project by the World Bank with the appointment of Dr Charles D Shaw as principal investigator and author to draw together all of the information which was received by ISQua, and to assist with the preparation of this publication as a valuable resource.

ISQua is most grateful for the Bank's permission to use this material here. ISQua has prepared the Toolkit to optimise its publication as an online resource in the public domain. The Bank successfully piloted the Toolkit in Russia in early 2003 and prepared a Russian language version.

This is a continuing project. Programs evolve and new accreditation programs have emerged since the survey and its findings which form the basis for the Toolkit. ISQua's own international accreditation program (ALPHA) for example, is also being updated to not only internationally accredit accreditation and other healthcare evaluation programs, but also to accredit healthcare standards and the training programs being provided by these organisations. It is planned to review and update the Toolkit material over time. Input and suggestions for expanding the Toolkit will be welcomed by ISQua.

Toolkit for Accreditation Programs

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E-mail: isqua@isqua.org

Web: www.isqua.org

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Foreword:

THE WORLD BANK

Modernizing and improving health systems lies at the heart of efforts by the international development community to help poor countries reach their 2015 Millennium Development Goals (MDGs)—with their promise of vastly improved human and economic welfare. Despite broad agreement on the urgency of such an overhaul, the practical difficulties involved in grappling with the complex and multi-disciplinary nature of health systems, and resolving widespread concerns about their quality, cannot be underestimated.

It is widely recognized that good governance is required in the health care sector. The general public, organizations of patients and disabled persons, and third party payers want to have more objective assessments of health service quality. Countries have taken different approaches to maintaining quality and improving standards. In some countries, professional organizations and provider associations try to exercise quality control over members to improve standards for care, often without input from government or society. In other countries, the state exercises rigid control over the health sector, leaving almost no scope for professional judgment – resulting in defensive medicine and unnecessary referrals to higher levels of care. The challenge is to balance the roles of health professionals, government policymakers, members of the public, and other stakeholders in enhancing the quality of, and setting the standards for, the health sector.

Accreditation is therefore an important contribution to this process. It is proposed as an objective method to verify the status of health service providers and their compliance with accepted standards. This Toolkit for Accreditation Programs is timely. It provides guidance for government officials, health services providers, and technical staff of donor and aid organizations on how to develop, maintain, and improve external assessment systems over time. The Toolkit reviews international experience and brings together useful sources on options for establishing or upgrading an accreditation system for health services providers.

As standards and quality of health care evolve, and experience with accreditation systems develop, so should this Toolkit. Therefore, users are encouraged to provide regular feedback to ISQua, The International Society for Quality in Health Care, which has endorsed the Toolkit, in order that it be adapted over time to meet changing needs.



Jacques F. Baudouy

Director

Health, Nutrition and Population Network
World Bank, Washington, D.C.



THE WORLD BANK

Foreword:

THE WORLD HEALTH ORGANIZATION

Less than a decade ago, accreditation was still waiting to be included in the agendas of many countries and health institutions. Now, in every region of the world there are established accreditation bodies and agencies. Some experience has been built on how to implement accreditation and on how to improve the quality of the services, knowledge and products that are provided to the population. This experience is primarily framed in developed economies.

During the last decade, the health care systems in many countries were reformed with respect to organization and forms of administration. From having been a system based on ‘trust’ in the professions, health systems are now closer to other types of organizations, services and industries, including private industry. Appropriate ‘standards’ of care have become an issue not only for local managers and political bodies, but also for patients, who are increasingly referred to as ‘consumers’.

If we look at the map of accreditation adoption, it appears that countries with developed economies were the beginners during the fifties until the nineties. And if we look at speed this adoption happened, it is possible to recognize a slow beginning along the first three decades with a very small number of countries adopting the innovation. Only in the nineties, a significant increase of countries adopting accreditation operations begins to change the curve (Fig. 1). In 2002, accreditation systems were clearly identified in over 39 countries which means that there is huge work to be done in order to promote similar commitment in countries where there is not yet an accreditation system in place.

The toolkit for accreditation programs provides a broad audience of health managers, researchers, decision makers, health professionals in general, with the very concrete resources needed to build an accreditation system. As it is a process that should be designed according to each country’s profile of requirements and expectations, the tools are based in the presentation of experiences and lessons learned. During the building stage of a national system of accreditation, each country has experienced different ways to bring together a diversity of players, interest and political approaches. This diversity is reflected in the way the tools are presented in this book, not as rigid guidelines but as good practices to be discussed and improved in every new utilization.

The next stage in the adoption of accreditation practices is going to be of greater expansion. Many countries are interested in providing better health services to their population. In this sense, the contents of this Toolkit are the appropriate ones for the process of building an accreditation system. First, the definition of the purpose of an accreditation policy and which are the best types of institutions for the achievement of this purpose. Decision makers and practitioners, will later face the difficult task of selecting the agency composition, financing and social participation models. Again, the Toolkit will be a source and a critical mirror on where to compare the choices adopted by a country. The toolkit covers the concrete way an agency works, its staffing and the interaction with health system stakeholders. The Toolkit provides, in this sense, a mature discussion about the knowledge needed to define the agency structure; how to develop the accreditation standards; how to train the staff and pilot testing its progress. Finally, to assure the stability of the accreditation system, the Toolkit offers orientation on the costs of the services the agency provides, and experience on the types of financial arrangements with participating institutions.

During the next decade, a greater increase in the establishment of national health accreditation systems is expected. This Toolkit arrives precisely when it is needed and will be a significant contribution for both the already ‘experienced’ systems and also for the ones that are joining the challenge of improving the quality every day. The Toolkit is a relevant contribution of the International Society for Quality in Healthcare and the World Bank. The WHO has been a permanent partner in the promotion of accreditation systems, and with this Toolkit for Accreditation Programs, our activities will benefit.

Mr Orvill Adams

Director

Department of Human Resources for Health (EIP/HRH)
World Health Organization, Geneva

Introduction

During the past ten years there has been rapid growth, worldwide, in the establishment of national and regional accreditation programs for health services. These programs have tended increasingly to be initiated by government, rather than the medical profession.

A clear need has been felt for a straightforward tool for implementing health service accreditation within a nation state or health care organisation: an aid for accreditation providers which would also meet the requirements of funding agencies such as the World Bank, intergovernmental organizations such as WHO, and individual countries considering the development of a national program.

The experience of the last decade shows that accreditation has been a valuable technology for quality improvement in many settings. But the effectiveness of an accreditation program, as well as its affordability and whether it will be sustainable, depends ultimately on many variable factors in the particular healthcare environment of the country or organisation involved. It also depends on the kind of program concerned, and how it is implemented.

In this toolkit, these variables are addressed under four principal headings:

Policy:

- What is the purpose of the proposed program?
- How might it complement or replace alternative mechanisms, such as licensing and certification?
- How would it match the culture of the population and professions concerned?
- What incentives would encourage participation?

Organisation:

- How would the people most likely to be affected (“stakeholders”) be identified and involved?
- How would the program be governed?
- How would it ensure compatibility with associated regulatory and independent agencies?

Methods:

- How will standards be made valid?
- How will assessments be made reliable?
- How will assessors be trained and re-validated?
- How will procedures and results be made transparent and fair?

Resources:

- What are the implications for data, information and training?
- What are the costs to participating institutions?
- How long does it take to set up a sustainable program?
- What does it cost to set it up?

In July 2001, at its meeting in Paris, the ALPHA Council of the International Society for Quality in Healthcare (ISQua) saw sufficient need and interest among accrediting bodies, as well as health project funders, to implement action. It agreed:

- 1) To provide a widely acceptable tool for assessing the readiness for, and feasibility of, implementing accreditation within a country or region;
- 2) To provide, within this tool:
 - A checklist of prioritised items for consideration when beginning an accreditation program;
 - Descriptive evidence in support of the relevance of these items;
 - A list of key definitions.
- 3) To make the tool available to those involved in decisions to implement accreditation programs, such as World Bank, WHO, accreditors and others.

In many countries, accreditation (and similar systems of external assessment against standards) has developed as an effective strategy for continuous improvement of healthcare institutions and systems, with benefits to consumers, regulators, managers, professions and other stakeholders. But the technology of accreditation does not always transplant satisfactorily to different countries and settings, or bring them the same beneficial outcomes.

Common barriers to satisfactory transfer can be summarised as shortcomings in the following areas:

1. Clarity of purpose:

Failure to find a balance between the objectives of *improvement* (internal organisational development) and *regulation* (external control) within an overall policy for *quality* in the health care system.

2. Appropriate technology:

Failure to differentiate the methods of accreditation, licensing and regulation, and to match them to the defined objectives.

3. Quality culture:

Failure to identify stakeholders, and involve them in the design and direction of the accreditation program;

Unwillingness to share information, authority and responsibility.

4. Motivation:

Reliance on directives and sanctions, rather than internal organisational commitment to self-improvement, preferential funding and recognition of professional development;

Perverse incentives for superficial compliance with standards;

Unwillingness of employers to release staff to become accreditation surveyors;

Unwillingness of these surveyors to work without additional pay.

5. Independence:

Government domination of program direction, leading to conflict of interest in assessment of public services;

De-motivation of other stakeholders, and vulnerability to short-term political change;

Failure to authorise and support, by legislation if necessary, an independent governing body.

6. Scope of responsibility:

Unrealistic expectations – that the accreditation program will resolve issues for which it was not designed or resourced, e.g. facilities licensing, professional registration, health care financing;

Failure to identify priority concerns, e.g. patient safety, clinical performance, and priority sectors e.g. primary care, hospitals, and the continuity between them.

7. Clear relationships:

Lack of mechanisms to cooperate and communicate with related professional, academic, independent and governmental bodies, e.g. professional and teaching institutions, health insurers, ISO certification bodies and local government inspectorates.

8. Objectivity and probity:

Lack of (or failure to comply with) defined and transparent procedures for the assessment of facilities and decisions on accreditation awards;

Failure to separate independent functions of facilitation, assessment, awards and payments - leading to bias, lack of credibility and possible corruption.

9. Sustainable resourcing:

Underestimation or under-funding of the time, personnel and skills needed to establish a new program;

Unrealistic expectations of the rate of uptake by health facilities and the capacity of the program to generate income from them;

Lack of long-term government commitment to the program.

10. External technical assistance:

Failure to learn from the experience of accreditation in other countries, which is available from publications, from technical consultancy and from the ALPHA program of the International Society for Quality in Healthcare.

This toolkit aims to illustrate the key factors to be considered before starting an accreditation program, and some options to be adopted or avoided.

It could be used to scan the health care environment involved:

- to identify what is already available,
- to define options for discussion with ministers and other agencies, *and*
- to outline practical implications for organisation, management and funding.

The toolkit is not intended to be a definitive manual, but a reasonably balanced collection of facts and opinions from informed people around the world. A summary of conclusions is given in section 6.

Acknowledgments

Members of the ISQua Toolkit Working Group:

Elma Heidemann (Chair), Executive Director, Canadian Council on Health Services Accreditation

Orvill Adams, Director, OSD, WHO Headquarters, Geneva

Hugo Arce, Director, Instituto Técnico para la Acreditación de Establecimientos de Salud, Argentina

Jan Bultman, Lead Health Specialist, Europe and Central Asia Region, World Bank

Brian Johnston, Chief Executive, Australian Council on Healthcare Standards

Karen Timmons, President and CEO, Joint Commission International

Lee Tregloan, Chief Executive Officer, International Society for Quality in Health Care

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Abbreviations

AAHC	Accreditation Association for Ambulatory Health Care, USA
ACHS	Australian Council on Healthcare Standards
ALPHA	Agenda for Leadership in Programs for Healthcare Achievement
ANAES	Agence Nationale d'Accréditation et d'Évaluation en Santé (France)
CCHSA	Canadian Council on Health Services Accreditation
COHSASA	Council on Health Service Accreditation for Southern Africa
CSB	Clinical Standards Board
HAP	Healthcare Accreditation Program (UK)
HQS	Health Quality Service (UK)
ISO	International Organization for Standardization
ISQua	International Society for Quality in Health Care
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCI	Joint Commission International
MATH	Major Academic Teaching Hospitals Accreditation Project (Ireland)
NCQA	National Committee for Quality Assurance, USA
NCQA	National Centre for Quality Assessment in Health Care (Poland)
NGO	Non-governmental organisation
NIAZ	Netherlands Institute for Accreditation of Hospitals
QAP	Quality Assurance Project (USA)
USAID	United States Agency for International Development
WHO	World Health Organization

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1 Definition and history of accreditation

1.1 Models of external assessment

Many countries requiring assistance with accreditation, already have a collection of voluntary and statutory mechanisms for the periodic external assessment of organisations against certain defined standards. Some of these have been systematically compared^{1 2 3}. They all aim to assure or improve quality. But they are usually run by a variety of disparate organisations which lack the national co-ordination to maintain consistency and to ensure that they are mutually supportive, economical and effective.

Broadly, these mechanisms include variants on five established approaches⁴:

- **ISO: the International Organization for Standardization⁵**: This system provides standards against which organisations or functions may be certificated by accredited certification bodies or organisations. Although originally designed for the manufacturing industry (e.g. for medicines and medical devices), these standards are now applied to health care – in particular, to radiology and laboratory systems – and, more generally, to quality systems in hospitals and clinical departments⁶.
- **Peer review (Dutch *visitatie*)**: This uses a collegial approach, usually within a single discipline. It is mostly applied to the assessment and formal accreditation of training programs, but can be extended to accredit clinical services⁷.
- **The Malcolm Baldrige model for quality management**: The Baldrige criteria for management systems⁸ have devolved from the USA into national and international assessment programs such as those found in Australia⁹ and Europe^{10 11}. Health care providers who seek voluntary development may assess themselves, or be assessed by others, against explicit performance standards. These were designed for application to service industries, but the revised 1999 European Foundation for Quality Management (EFQM) model identifies specific domains of results applicable to clinical outcome, and patient and staff satisfaction, and offers a transparent framework on which organisational standards may be mapped.
- **Accreditation**: “A public recognition of the achievement of accreditation standards by a healthcare organisation, demonstrated through an independent external peer assessment of that organisation’s level of performance in relation to the standards.” These independent, voluntary programs, which began with a focus on training, have developed into multi-disciplinary assessments of health care functions, organisations and networks. Unlike ISO standards, the programs used to assess health care facilities for accreditation have been developed *specifically for health care*. They began in the Anglo-Saxon countries, but spread into Latin America¹², Africa¹³ and South East Asia^{14 15} during the 1990s. Mandatory programs have recently been adopted in France¹⁶, Italy¹⁷ and Scotland¹⁸.
- **Registration and licensing**: These are statutory programs which ensure that professional staff or provider organisations achieve minimum standards of competence (e.g. training, registration, certification and revalidation). There are also function-specific inspectorates for public health and safety (e.g. fire, radiation and infection controls) in many countries.

1.2 Health service accreditation

Care is needed to differentiate health service accreditation from both certification and licensing, as a mechanism for recognition of institutional competence.

The USA-based Quality Assurance Program and Joint Commission Resources have proposed a table of definitions (Table 1)¹⁹. And while this is based on wide international experience, there are significant variations in meaning from country to country, which generate confusion. For example, in many European countries, doctors are individually ‘accredited’ on completion of designated specialty training, and ‘accreditation’ of institutions is increasingly compulsory. Since certification organisations recognised by the International Organisation for Standardisation (ISO) can also be ‘accredited’, there are already three different meanings of the term, “accreditation”:

1. *Recognition of specialty training* – by professional bodies since the 19th century;
2. *Recognition of service delivery* – by consortia of clinicians and managers since 1917;
3. *Recognition of agencies competent to certificate health care providers* – by ISO since 1946.

1.2.1 Definition of accreditation

“Accreditation is usually a voluntary program, sponsored by a non-governmental agency (NGO), in which trained external peer reviewers evaluate a health care organization’s compliance with pre-established performance standards. Accreditation addresses organizational, rather than individual practitioner, capability or performance. Unlike licensure, accreditation focuses on continuous improvement strategies and achievement of optimal quality standards, rather than adherence to minimal standards intended to assure public safety.”²⁰

Table 1: Definitions of accreditation, licensure and certification¹⁹

Process	Issuing Organization	Object of Evaluation	Components/Requirements	Standards
Accreditation (voluntary)	Recognized tools, usually an NGO	Organization	Compliance with published standards, on-site evaluation; compliance not required by law and/or regulations	Set at a maximum achievable level to stimulate improvement over time
Licensure (mandatory)	Governmental authority	Individual	Regulations to ensure minimum standards, exam, or proof of education/competence	Set at a minimum level to ensure an environment with minimum risk to health and safety
		Organization	Regulations to ensure minimum standards, on-site inspection	
Certification (voluntary)	Authorized body, either government or NGO	Individual	Evaluation of predetermined requirements, additional education/training, demonstrated competence in speciality area	Set by national professional or speciality boards
		Organization or component	Demonstration that the organization has additional services, technology, or capacity	Industry standards (eg ISO 9000 standards) evaluate conformance to design specifications

1.3 Licensure of health care organizations

Licensure standards serve to define the quality level required for the safe delivery of patient care, or of health services, such as drug dispensing by a pharmacy. They also define the capabilities required for a health care organization to be entitled to advertise to its public that it is a hospital or health centre. For example, the licensure standards of a particular jurisdiction might require a health care facility to provide surgery, radiology testing, round-the-clock nursing care for patients, pharmacy services, and laboratory services, in order to be classified as a hospital. Unlike accreditation and certification, which tend to be voluntary forms of external evaluation, licensure is by definition mandatory. When the government grants a license to an organisation, that licence signifies its permission for the organisation to be open and providing care or services to patients.

1.3.1 Definition of licensure

“Licensure: process by which a government authority grants permission to an individual practitioner or health care organisation to operate or to engage in an occupation or profession.” ALPHA Council 2002

As described above, licensure is always conferred by a governmental entity or its designated agent, such as a licensing or regulatory board (e.g., a state, provincial, or national medical or nursing board), and addresses the minimal legal requirements for a health care organization or practitioner to operate, care for patients, or function. “Unlike accreditation or certification approaches that are based on optimal and achievable standards or a demonstration of special knowledge or capability, the purpose of licensure requirements is to protect basic public health and safety.”²⁰

The full proceedings of a conference held in Washington in October 2000 on regulation, licensure, accreditation and certification are available from QAP²¹.

“It must be clear to everyone that accreditation is not the same as the licensing process, but is to improve the performance of the health service beyond a minimal level. Many people in the private sector will often be confused about these two programs. The policy makers in the Ministry of Public Health also can be confused and try to bring accreditation under the same organization as licensing.”

1.4 The growth of national accreditation programs

There is growing worldwide demand for quality in health care, and for mechanisms, such as accreditation, to promote and maintain it.

These mechanisms are receiving increasing support from governments, and from inter-governmental and funding agencies:

1. To support health reform,
2. To improve the quality of organisation and management of services; *and*
3. To promote continuous quality improvement .

A global survey of programs in 2000²², and a further survey of Europe in 2002²³, showed that in the 40 years prior to 1991, eight accreditation programs were started. In the following decade, nearly three times that number were introduced. More than half of the programs launched since 1990 are in Europe.

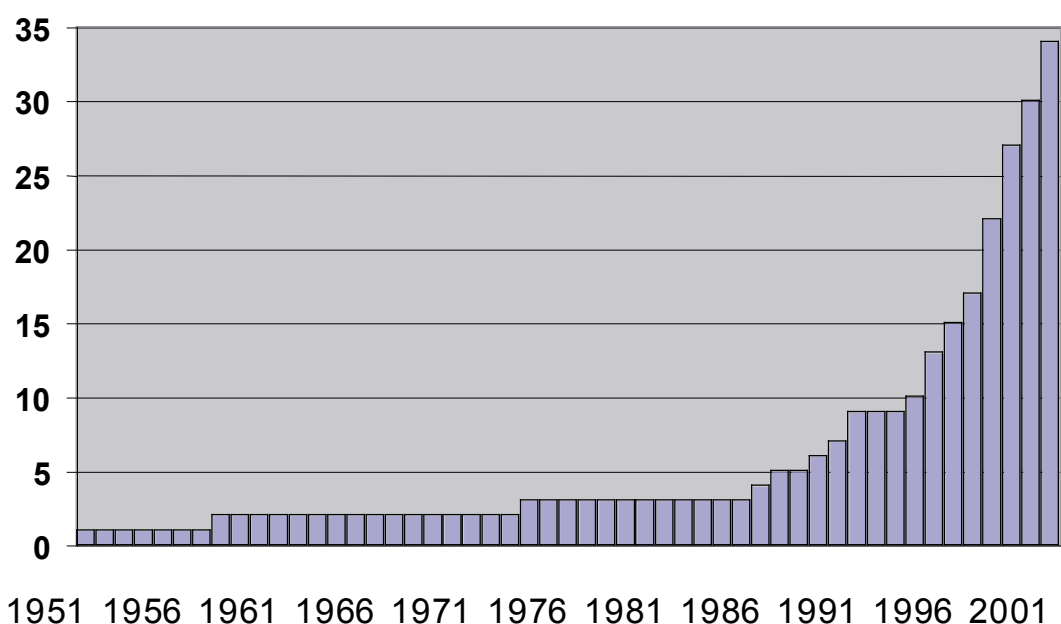
1.4.1 Current trends

Half of these programs - and especially of those introduced during the past five years – have been funded or managed directly by national governments which use them as a tool for regulation and public accountability, rather than as means of voluntary self-development.

Accreditation originated, as did the general concept of quality improvement, in hospitals. From the hospital, it moved out into community services, and thence into networks of preventive and curative services. The current shift of emphasis towards primary care may reflect a move to population-based medicine, reinforced (particularly in developing countries) by the donation policies of overseas aid agencies.

Table 2: Year of Beginning Accreditation Operations

Year first survey	Programs	Total new in year
1951	USA (JCAHO)	1
1958	Canada	1
1974	Australia (ACHS)	1
1979	USA (AAAHC)	1
1986	Taiwan	1
1987	Australia (QIC)	1
1989	New Zealand	1
1990	UK (HAP)	1
1991	UK (HQS), US (NCQA)	2
1994	South Africa	1
1995	Finland, Korea, Indonesia	3
1996	Argentina, Spain	2
1997	Czech Republic, Japan	2
1998	Australia (AGPAL), Brazil, JC International, Poland, Switzerland	5
1999	France, Malaysia, Netherlands, Thailand, Zambia	5
2000	Portugal, UK (CSBS), Philippines	3

Figure 1: Global growth of national accreditation programs

Table 3: Accreditation programs in Europe 2002

Functional status	Program	Total
Active program	Bulgaria, France, Germany, Ireland, Italy (regional), Netherlands, Poland, Portugal, Spain, Switzerland (two), UK (three)	11
In development	Bosnia (RS, FBiH), Croatia, Czech Republic, Denmark (two), Finland, Hungary, Kyrgyzstan, Latvia, Lithuania, Malta, Slovakia	11
No national program	Albania, Armenia, Austria, Belgium, Cyprus, Estonia, Kazakhstan, Luxembourg, Sweden, Turkey, Yugoslavia	11

2 Policy issues associated with accreditation

The principal threats to new accreditation programs seem to be:

- inconsistency of government policy;
- lack of professional and/or stakeholder support;
- lack of continuing finance and incentives; *and*
- unrealistic expectations¹.

This section aims to describe some of the factors which help to achieve a consistent and sustained policy on the organisation and methods of accreditation, as well as strong stakeholder support.

Issues of time and money are dealt with in section 5.

2.1 Purpose of accreditation

2.1.1 Potential impacts

Rooney²⁰ summarised the main purpose of accreditation to be:

- To improve the quality of health care, by establishing optimal achievement goals in meeting standards for health care organizations;
- To stimulate and improve the integration and management of health services;
- To establish a comparative database of health care organizations, which can meet selected structure, process, and outcome standards or criteria;
- To reduce health care costs by focusing on increased efficiency and effectiveness of services;
- To provide education and consultation to health care organizations, managers, and health professionals on quality improvement strategies and “best practices” in health care;
- To strengthen the public’s confidence in the quality of health care; *and*
- To reduce risks associated with injury and infections for patients and staff.

“The aim of accreditation is not to reduce costs or close facilities. Management boards of health care units can better decide how to increase efficiency and meet patient expectations if they are more aware of the actual situation.” Romania

There may be a mismatch between what enthusiasts want of a program, and what accreditation in that particular setting is likely to provide. The Geneva working group acknowledged a range of impacts which various stakeholders may reasonably hope to achieve through accreditation (Table 2). Whether a program will deliver these, and in what proportion, depends largely on the external environment in which it is set and how it is operated. Most of these impacts are well-documented in individual programs. There is, however, little research-based evidence on the impact of the general (and often nebulous) concept of accreditation – or, for that matter, of any other model of external assessment.

Table 4 WHO Working Group on Accreditation, Geneva 2002

A preparatory meeting on the impact of accreditation of health services on a national health system was convened in August, 2002. The chief executives of nine established national accreditation programs met to explore the opportunities and limitations of accreditation in the management of health systems. Topics included:

- The definition and purpose of accreditation: alternative mechanisms;
- The public/private agenda, politics and external environment;
- The role of government in creating the appropriate environment, legislation and regulations; Evidence base for the development of standards used in accreditation;
- Evidence on different approaches to accreditation;
- How evidence from practice is captured, shared and used in improving quality of service provision;
- The management of accreditation and its internal environment;
- Effectiveness of accreditation: what mechanisms and methods are currently being used to assess the effectiveness of accreditation on health systems performance;
- What are the costs of accreditation, how are they measured and who pays;
- What is the demand for accreditation and how is it being met. A report of the meeting is due to be published in 2003¹

Table 5: Ten Potential Impacts of Accreditation

Impact	Associated factors	Stakeholders
1 Health system governance	Legislation, regulation	Health ministries; legal bodies
2 System design, development	Strategic planning, service specification	Health service planners; social scientists
3 System financing	Resource allocation, cost-containment, efficiency	Purchasers, funding agencies, insurers
4 Population health	Protection of public health and safety; reduced variation in provision and performance	Public health agencies, epidemiology
5 Knowledge management, transfer	Research (clinical, health service); technology assessment	Academic, professional, governmental agencies
6 Clinical effectiveness	Evidence-based medicine; improved results; continuity; safety and risk-management	Guideline developers, medical directors, performance managers
7 Consumer empowerment and decision-making	Providing information, choice, respect, accountability	Individual patients, focus groups, consumer groups
8 Professional and personal development	Education, training, CPD; workforce empowerment	Clinical teachers; personnel (HR) managers; professions
9 Management development	Leadership, accountability, communication, teamwork	HCO directors; management associations
10 Quality systems development	Defined quality policy, organisation, methods, resources	Quality co-ordinators, safety managers,

Surveys of providers and users of accreditation reveal a consistent similarity of perceived benefits across different settings and countries. They commonly mention:

- *Increased team work and internal cohesion*: more cooperation between professional groups, specialty departments, clinical and support services, managers and clinicians.
- *Revision of policies*: development, standardization and internal consultation on clinical and administrative procedures.
- *Integration of quality agenda*: bringing together the quality activities and skills of different staff groups.
- *Achievement of standards*: using self-assessment to identify and rectify non-compliance.
- *External networking*: meeting and learning from experienced staff in other hospitals.
- *Marketing, publicity*: opportunity to raise an institution's image in the community and to attract purchasers and personnel

Table 6: Benefits Perceived by Hospital Managers, Australia 1979²

Perceived benefit	Percentage of responders
External objective assessment and comparison with other hospitals	41
Conferring of recognition and status in the community	37
Motivation of staff to participate in improvement of services	34
Constructive evaluation of services	33
Education of staff, including suggestions for improvement	29
Improvement of standards of quality of care	25

Table 7: Risk Management Issues Commonly Identified, UK 1995³

Policy and administration:

- Lack of agreed admission and discharge policies
- Lack of mechanisms to define and monitor clinical policies

Clinical services

- Unclear responsibilities for supervision of trainees and juniors
- Poor stock control, administration and recording of medications
- Clinical records incomplete, fragmented, illegible or unavailable
- X-ray film interpretation not recorded
- Resuscitation equipment not checked; procedures not standard; staff not trained

Environmental services

- Lack of training for food handlers
- Unsafe storage of gases and flammables
- Blocked fire exits
- Lack of maintenance records, e.g. sterilisers, blood bank, generators
- Lack of radiation protection rules and monitoring

2.1.2 Alternative approaches of accreditation and licensing

The aims and processes of accreditation are sometimes confused with licensing. In general, licensing is *obligatory*, and is undertaken by *inspectors* against *minimal standards* of structure and inputs. Until recently, accreditation was *voluntary*, was undertaken by *peers*, against *optimal standards* of process and outcome.

In short, one aims for static conformity at a basic level, the other for dynamic development moving towards excellence. For example, radiation inspection focuses on mechanical calibration, while accreditation would examine how it is used, and how well the service is performing. The two systems developed separately, but are now beginning to converge in some countries to bridge the gap between external public accountability and internal quality improvement. The differences between external review programs driven by professions (collegial), and by government (regulatory), are summarised in Table 5⁴.

Accreditation providers would add that, unlike licensing, accreditation includes:

- Publication of optimal but achievable standards of structure, process and outcome;
- Reliable measurement of compliance against explicit standards;
- Use of standards designed specifically for health care, and based on scientific evidence of validity;
- Emphasis on demonstrating continuing improvement, rather than maintaining existing status;
- Participation arising from a variety of incentives, rather as a product of compulsion.

Table 8: Features of Collegial and Regulatory Systems

Collegial	Regulatory
Focus on education, self-development, improved performance and reducing risk	Direct response to complaints and adverse events
General review of internal systems	In-depth probe of conditions and activities
Based on optimum standards, professional accountability and cooperative relationships	Based on minimum standards, investigation, enforcement and public accountability

“Officials believed that accreditation would be preferable to inspections because it provides consultation and education in addition to evaluation” Zambia

Historically, accreditation aimed for voluntary, professionally-driven continuing improvement. But since the mid-1990s, new and existing programs have increasingly become mechanisms for accountability to the public, and to regulatory and funding agencies. And they have progressively aligned themselves to statutory mechanisms.

“It would be naive to believe accreditation does not have a role in informing decisions on what hospitals should remain and what hospitals should reduce services, re-structure or close.” Australia

The relative priorities of national accreditation programs are influenced by the social, political, economic and historical factors of a locality. In developed countries, the common emphasis is on evaluation and improvement of safety, clinical effectiveness, consumer information, staff development, purchaser intelligence and accountability – and on achieving greater uniformity. In developing countries, the emphasis is on establishing basic facilities and information, and on improving access to services in an environment where there may be no established culture of professional responsibility, as well as very limited resources available for staffing, equipment and buildings. In these countries, clear, agreed standards help to maintain a consistent direction.

2.2 Regulation of accreditation

2.2.1 Government role

Until the early 1990s, almost all health service accreditation programs had been established and operated by independent organisations representing professional, consumer and commercial stakeholders for voluntary organisational development. By contrast, most programs established in the past five years are funded and managed – or at least actively supported – by government, as a contribution towards regulation and public accountability.

When accreditation programs are run by governments, problems arise for providers with continuity, economy and sustainability (Table 9). Of the accreditation programs set up simultaneously with the United States Agency for International Development (USAID) in Hungary, the Czech Republic, Poland and Romania, only the Polish National Quality Assessment Program (NCQA) was sufficiently at arms length from the ministry running it, to survive changes in government⁴.

Table 9: Challenges for Governmental Programs

Stability	Can governments be relied on to define, assess and update standards consistently, and in a timely way? Respondents to a global survey in 2002 ⁵ rated the top priority for new programs to be that “policy and management remain consistent, regardless of changes in government” .
Credibility	In some countries, the public perception of the government is too unfavourable to make it a credible assessor of health care; stakeholders must be more involved to increase public trust.
Adaptability	Most voluntary programs update and republish their standards every one or two years; governments tend to be slower to revise, adapt, and change standards.
Conflict of interest	Third-party assessment gives a better guarantee of continuity and independence from current incumbent government, which may be at the same time purchaser, regulator and insurer. As purchaser, government may tend towards minimal standards, rather than improvement.
Demarcation and consensus	Government-driven accreditation programs must adhere to the legal delegation of powers to regions, provinces, cantons etc. Where autonomy is a major issue, multiple government programs are likely to duplicate the costs of developing standards, training surveyors and operating infrastructure – and be unable to share expertise or resources at a national level.

Four key roles which governments might beneficially play in accreditation include⁴:

- *Enabling the accreditation process*, e.g. through policy decisions such as the reciprocal recognition of assessments or the joint development of standards; *Avoiding conflict*, such as that which arises from perverse incentives and competing mechanisms for assessment;
- *Providing leverage*, e.g. by according preference to accredited facilities, such as in reimbursement tariffs and payment procedures;
- *Using accreditation as a criterion in its own purchasing decisions*, e.g. in defining preferred providers and contract monitoring;
- *Regulating individuals and institutions*, e.g. by ensuring consistency and the distinction between licensing and accreditation.

And for new programs could be added:

- *Acknowledging or endorsing accreditation* of a program against defined criteria, so as to maintain standards and to avoid duplication and potential exploitation.
- *Providing financial support* to establish the program, and/or to fund its continuing development.

2.2.2 Public-private partnership in quality improvement

Independent reviews in USA and Australia have emphasised the need for active collaboration between public and private agencies in order to reconcile the conflict between top-down regulation and bottom-up development. **A partnership between the public sector and any accreditation agency is essential for accreditation to succeed.**

The USA President's Advisory Commission on Consumer Protection and Quality in Health Care⁶ recommended in 1998 that public and private programs work together towards a common set of standards, co-ordinate their activities, and avoid conflict and duplication. In the same year, the USA Inspector General of the Department of Health reviewed the external quality oversight of hospitals that participate in Medicare⁷ and concluded that voluntary accreditation and regulatory Medicare certification by State Agencies should converge their methods, and be held more fully accountable at federal level for their performance in reviewing hospitals.

An Australian taskforce recommended in 1996⁸ that government should formally acknowledge independent assessment programs which meet defined criteria, and should enable them to disseminate information about their processes and findings to the public. Two years later, an expert advisory group recommended "that accreditation or certification of health care organisations be strongly encouraged with incentives, or indeed made mandatory, but choice of accreditation/certification/award approaches be allowed."⁹

Some functions, such as the definition of standards, the assessment of compliance and the grading of awards, could be variously allocated or shared between government and independent accreditors. There are examples in the USA where the government sets standards, but then gets independent assessors to read them; and other examples where government makes the final decisions based on assessments which have been made by independents. In South Africa, the provincial government of KwaZulu-Natal is a major customer of the independent Council on Health Services Accreditation for Southern Africa (Cohsasa) program, which is also beginning to accredit the administrators of managed health care on behalf of the national government. In Canada, accreditation is indirectly supported by the essential goodwill of ten federal and provincial governments, who rely on the Canadian Council on Health Services Accreditation (CCHSA), as a third party, to bring a national consensus on standards and assessments.

Most of the newer accreditation programs in Western Europe (eg Germany, Ireland, Denmark) have been public-private partnerships from the beginning. In Denmark, the County Councils, Copenhagen Hospital Corporation, Ministry of Health and the National Board of Health, are all working together to seek technical assistance from an international accreditation organisation to develop a national program in which all counties will be required to enrol by 2006.

2.2.3 Mandatory or voluntary?

In North America, where there is keen competition among healthcare providers, accreditation is voluntary. But without accredited status, health care organisations can also find themselves without patients, staff or money. Uptake of voluntary programs is typically lowest in isolated rural areas, which tend often to include the minority populations with the greatest health care needs. This situation raises the question: Can accreditation fulfil the government responsibility for regulation and public accountability, if health care organisations can choose not to participate? On the other hand, does 100% participation by coercion foster a culture of transparency and improvement, or merely encourage evasion and perverse behaviour?

"The hospital was grappling with overcrowding, understaffing and the ravages of HIV/AIDS. The last thing anyone at the hospital wanted was more pressure. There was resistance and negativism toward the program at first, as the Provincial Health Department told the hospital to go through the process. But these attitudes soon changed...COHSASA's facilitated program has proved itself to be a dynamic and revealing process that has done a lot for the hospital" KwaZulu-Natal¹

“Quality must come from within. A compulsory program makes people do just what they are told to do. Even financial incentive from the payer may undermine the philosophy of continuous improvement.”
Thailand

“In many situations it is hard to implement a fully independent accreditation organization without legalization and enforcement from government” Indonesia

*“Whether accreditation should be voluntary really depends on the nature of the community norms. Working in Eastern Europe has made me realise that in some places, there must be a degree of compulsion to get things started.”*International advisers

“There is a strong rejection towards anything “obligatory” as that was the way things were handled during the socialist times” Czech Republic

2.2.4 Role of legislation

One third of 34 accreditation programs responding to the WHO survey in 2000 were enabled by legislation, and most of them began in the late 1990s. Some countries, such as Italy and France, have made participation by health care organisations (HCOs) legally compulsory, but most merely authorise the functions of the accreditation agency, e.g. Ireland (Table 10). Notably, the Irish order authorises the Board to set and recognise the standards against which a hospital is granted or refused accreditation. These are not set by government and are not legislated. Statutory instruments usually serve to preserve existing standards, but some governments have chosen to make organisational standards enforceable by law by embedding them in legislation. However, this reduces flexibility, making it difficult to update standards frequently enough to keep pace with advances in medical science.

Table 10: Irish Health Services Accreditation Board (Establishment) Order, 2002¹.

The Minister for Health and Children hereby orders as follows:

5 (1) The functions of the Board shall be:

- (a) To operate hospital accreditation programs and to grant accreditation to hospitals meeting standards set or recognised by the Board;
- (b) To operate accreditation programs in respect of such providers of other health services as may, from time to time, be deemed appropriate by the Minister after consultation with the Board, and to grant accreditation to such providers meeting standards set or recognised by the Board
- (c) To operate such other schemes aimed at ensuring quality in the provision of health services as may, from time to time, be deemed appropriate by the Minister after consultation with the Board

Respondents to a survey in January 2002 showed a range of legislative models in Europe (Table 11). In some countries, such as Portugal, there is no law specifically addressing accreditation, but there is enabling legislation for an agency fulfilling several functions, one of which is accreditation (in this case the government-funded Institute for Quality in Health Care, 1999).

Table 11: Program Legislation, January 2002

Legal status	Program	
Active program without legislation	Germany, Portugal, Spain, UK (HQS, HAP)	
Program enabled	Bosnia FBiH	Law on the establishment of quality improvement system and accreditation in health care (in draft)
	Bosnia RS	Amendment of law on healthcare, 2001
	Bulgaria	Health Care Facilities Act, 1999
	Ireland	Irish Health Services Accreditation Board (Establishment) Order, 2002
	Latvia	Law on Medical Treatment, 1997
	Lithuania	Health care institutions law on mandatory accreditation, 1997. (Revision made it voluntary in 1998)
	Netherlands	Kwaliteitswet zorginstellingen, 1996
	Poland	Health Organisation Act , 1997
	Switzerland	Bundesgesetz über die Krankenversicherung KVG, 1996 (Quality assurance in general)
Program required	France	Parliamentary Law, April 241996
	Italy	Legislation 502, 1992; 229, 1999
	UK Scotland	NHS Act, Scotland 1998

“Accreditation does not need to be ‘embedded’ in legislation. Actions of real support for the principles and philosophies from the government are more important. That said, many societies require the mandate of law because of community norms.” International adviser

“It is vital that the functions of the accreditation program are defined by law” Czech Republic

2.3 Incentives for uptake

What both consumers and regulators of accreditation in any state or institution aspire to, is having *every* health care provider participate in a standards-based assessment process – whether it is mandatory or not – in order to achieve 100% coverage.

Experience from voluntary programs, especially in North America, suggests that participants need to see “business value”, in terms which are professional and social, as well as financial. More specific drivers include systems of payment, licensing and – especially where competition is fierce, as in managed care or nursing homes – market differentiation. The power of these drivers may vary across professional groups (eg according to payment on the basis of fee-for-service, or capitation).

If the program is not mandatory, what incentives are there to participate? What consequences are there for an organisation that fails accreditation?

The range of “carrots” includes:

- *Organisational development*: self-assessment, team-building, bench-marking.
- *Increased public funding*: e.g. health insurance fund payments moderated by accreditation status. “In countries where many of the health care organizations are owned and managed by the government, policy makers may want to consider some form of financial incentives or optional bonuses that reward organizations achieving a high level of performance with standards.”²⁰ Rapid uptake of voluntary programs is therefore associated with direct financial incentives (such as linkage to core funding or to reimbursement).
- *Preference from private insurers*: insurers prefer to deal with facilities whose clinical and management processes have been independently verified. They may also make reimbursement simpler and faster to the accredited organisation.
- *Market advantage*: public recognition brings status and advantage in a competitive market, which can attract patients, staff and income.
- *Reduction of liability insurance costs*: premiums reflect a reduced risk rating.
- *Exemptions from regulatory inspection*: i.e. the state issues a licence to an accredited facility simply on the basis that accreditation standards include and exceed licensing standards (“deemed status”); this may be a condition of receiving public funding.
- *Linkage to training posts*: training status is conditional on accreditation.
- *National quality competitions*: e.g. accreditation status is one of the factors in annual “best department” awards by Time magazine in Poland.

Some countries have no insurance incentives:

- “No financial incentives have been provided so far in Germany. Participation in the accreditation scheme is voluntary.” *Germany*
- “There is no financial incentive for voluntary accreditation in the public system; the Independent Healthcare Association and private health insurers favour accredited facilities; some private groups provide internal incentives for participating hospitals”. *UK*

Some wish that they did have linkage to health insurance:

- “(This would) serve as an incentive for health facilities’ participation in accreditation (and would) play an important role in achieving financial sustainability of the accrediting body. At present Kyrgyzstan has no such system...” *Kyrgyzstan*

Some do have insurance incentives:

- “The national health insurance fund will contract only with those facilities that have been accredited.” *Portugal*
- “The program is voluntary, but in November 2001, the Hospital Association decided that all members should be accredited by 2005. So far 9 accreditations have been issued but 45% of the hospitals are preparing and 65% of the hospitals are involved (through surveyors etc).” *Netherlands*

Some offer caution:

- “If an organisation is not accredited and suffers a financial penalty (the reverse of financial incentive payment) it may be further prevented from improving itself (“limited resources” was cited by 85% of hospitals in a recent national survey as the primary reason for not achieving compliance with accreditation standards). The citizens in that community may be denied access to improved services.” *Australia*
- “Health insurance incentives could accelerate the awareness of healthcare quality, but in developing and underdeveloped countries they make little difference to the implementation of accreditation.” *Indonesia*

“Beyond the intrinsic value that the organization and its leaders find in meeting standards and continuously improving health care services, it is often market forces that add the financial incentive to maintain accreditation once it is achieved.” Zambia

Health reform in many countries has centred on, and been funded on the premise of, the development of primary care, the introduction of universal health care insurance, and the establishment of an independent accreditation program to act as referee. But when these have been set up in some countries, the accreditation and insurance programs did not effectively exchange data to reflect in their purchasing and payments.

Disincentives

In the absence of financial incentives, HCOs may also be deterred from participating by:

- *the cost* in terms of time, management, and money (see 5.6 Costs to participating institutions)
- *fears of the outcome*:
 - sanctions for shortcomings,
 - loss of staff morale if denied accreditation,
 - misuse of performance data, *and*
 - gaining accreditation and then losing it when standards get more demanding.

2.4 Identifying and involving stakeholders

Associated with each aim or potential impact of accreditation, there is a population of stakeholders which includes those who stand to gain from accreditation, and those who might gain by undermining it. How these stakeholders are defined, and how their expectations are reconciled, varies within and between countries.

*“We are in the process of finding the customers’ needs and expectations through a nationwide survey”
Czech Republic*

“Accreditation for hospitals and other health facilities began in 1995 through a joint initiative of the Ministry of Health, the hospital associations, insurance funds, the Czech Medical Association and the Medical Chamber” Czech Republic

“To ensure an ongoing commitment to holding hospitals accountable to standards for quality, key stakeholders such as the professional medical and nursing associations have played an essential role in the formation and implementation of the program.” Zambia

If the program’s aims are clear, those who stand to gain or lose from it are easy to identify. Traditional, profession-driven programs have tended to build links with regulators and consumers, thus becoming more accountable and transparent. More recently, programs have been increasingly influenced by commercial providers and insurers. And lately, there has been active support from government (Table 12).

Table 12: Who Started Current Accreditation Programs?

Organisations	Examples
Professional associations eg hospital, medical, nursing	USA, Canada, Australia, Germany, Netherlands, Czech Republic
Private insurers	Germany, Czech Republic
Health ministries	France, Italy, Netherlands, Czech Republic
University departments	South Africa (University of Stellenbosch), UK Healthcare Accreditation Program (University of Bristol)
Voluntary membership societies	Philippines
Health service charities	UK Health Quality Service (from the King's Fund Centre, London)

Inevitably, this interaction of professionalism and consumerism creates tensions:

- between the leaning towards protection of reputation or “closing ranks”, inherent in a professional self-assessment process, as against its duty to inform the public and to stimulate change externally;
- between encouraging HCOs to enter the program voluntarily (and usually at their own expense), and then publishing their results, for better or for worse;
- between expecting programs to finance the development of their standards and processes, and then expecting them to be made publicly available, free of charge.

Objectivity and Confidentiality:

In order to protect the objectivity of the process, all programs have to ensure that the written observations of individual surveyors remain confidential until the assessment and report are complete and verified internally by the program. Many programs provide a draft report to the HCO, for confirmation, before it is reviewed by the accreditation committee for a decision on the status to be awarded. Surveyors are expected to retain their original notes until this process is completed, in case of dispute or the need for further clarification.

“Results of health facilities accreditation should be widely covered in the mass media. This promotes the status of the accredited health facilities” Kyrgyzstan

Publishing of Results

In 2002, two thirds of programs did not provide full reports to the public. Those which did provide them, with one exception, were government-sponsored²², and they all gave public access to their standards at little or no cost. In voluntary systems, the survey and accreditation reports become the property jointly of the program which provides them and the client HCO which pays for them. However, in these circumstances, clients are often encouraged to publish their reports. Usually lists are published of accredited facilities, but there are no accompanying lists of non-participants or of HCOs which have been assessed and refused accreditation.

Table 13: Public Access To Accreditation Documents, NIAZ (Netherlands) and ANAES (France) 2002

	NIAZ	ANAES
Standards	Free on website	
Free on website		
Organisation and procedures	Free on website	Free on website
Self-assessment	Restricted	Restricted
Surveyors' reports	Restricted	Restricted
Accreditation report	Restricted	Free on website
List of accredited facilities	Free on website	Free on website

Public involvement goes beyond the sharing of information. It also demands the sharing of authority.

Most programs have patients and members of the public represented in their governance structure,

- to ensure their involvement in the development of policy and standards; *and*
- to ensure that agreed procedures are followed throughout the assessment, reporting, accreditation and – if necessary – through the appeal, processes.

Few generic (hospital-wide) programs include lay assessors in the external survey teams which visit and report on health facilities. The Clinical Standards Board for Scotland uses lay observers to assess non-clinical aspects of continuity and care pathways, e.g. coronary care, cancers and chronic disease.

2.5 Configuration of program

2.5.1 Priorities: primary or hospital care; long term or acute?

As with quality improvement generally, accreditation traditionally developed in hospitals, and then moved outwards towards community services and thence to networks of preventive and curative services. The shifting of emphasis towards primary care may reflect a move to population-based medicine reinforced, particularly in developing countries, by the policies of donors of overseas aid.

Finland also includes social services. By contrast, programs such those in Germany and Ireland focused initially on academic and tertiary centres (Table 14).

Table 14: Focus of Accreditation Program, Europe 2002

Focus	Programs
Clinical specialty	UK (CSBS)
All sectors	France, Latvia, Bosnia FBiH, Italy (Emiglio-Romana), Italy (Marche), UK (HQS)
Tertiary, teaching hospitals	Germany, Ireland
Secondary and tertiary hospitals	Bulgaria, Czech Republic, Hungary, Malta, Netherlands, Poland, Portugal, Switzerland,
Primary and hospital	Bosnia (RS and FBiH), Denmark (KISS), Slovak Republic, Spain (FAD/JCI), UK (HAP)
Health and social services	Finland, Czech Rep

The long-established programs mostly began with standards and surveys which reflected the management structure of health care providers.. They used that experience to develop their repertoire and then make the challenging transition to client-focused accreditation. Old and new programs now focus their standards and assessments increasingly on integrated pathways; they follow patients and disease processes (the horizontal path) rather than management units (the vertical path). Several newer programs focus specifically on community and primary care, and on the integration of services across networks.

Some programs in North America accredit entire health networks, and are beginning to shift from individual health care towards population health. Some recent government programs in Europe address public health priorities (e.g. cardiac health, cancer services) by assessing local performance of preventive-to-tertiary services against national service frameworks. In such programs, measures should include the application of evidence-based medicine (process) and population health-gain (outcome); but many health determinants impacting directly on the service (e.g. housing, education, poverty) still remain outside the scope of health-care accreditation programs.

Assessment of single units, services or departments could offer large organisations a gradual entry to a full program, but this approach does not carry the benefits of integration and corporate consistency. It may hide the opportunities for improvement which frequently lie in communication *between* services, rather than within them. However, there are many “specialty” or “focused” accreditation programs which are operated either by a larger “generic” program, or by a provider or association which works only in that area, eg palliative care, laboratory medicine, speech therapy.

A further sub-division of organisation-wide accreditation may be focused upon assessment of the distribution, condition and usage of buildings or equipment. This can be used to inventory and map existing facilities, and to target and budget maintenance, replacement or development.

2.5.2 Public and/or private coverage

Most accreditation programs offer services to both public and private sector institutions.

This has advantages:

- *to HCOs*, in providing a “level playing field” for comparing and benchmarking potential competitors,
- *to surveyors*, in learning from another sector; *and*
- *to self-financing accreditation programs*, in having a larger potential market.

Czech Republic, Netherlands, Australia (QIC), and UK (Clinical Standards Board) do not include the private sector.

2.5.3 Critical mass: economy, consistency, equity, objectivity

Larger countries are in a position to achieve economies of scale. These economies are not available to smaller countries (those with populations of less than 5 million), or to large ones which choose to devolve the process to regional government, as in Italy, or to ethnic or indigenous groups. In these circumstances, the considerable costs of infrastructure and development have to be shared among a smaller number of institutions. This gives rise to higher unit costs and a reduced choice of surveyors, which in turn leads to more potential for conflict of interest.

If standards are defined and assessed on a regional basis, the accreditation program is unable to share expertise (such as management, assessment) or equity (such as access, facilities, performance) at a national level.

Options for avoiding the problems of small programs include:

- sharing a program with a neighbouring state which has a similar culture and language;
- designing one national program, rather than several regional programs;
- using a single agency to provide multiple accreditation programs;
- doubling up the agency as a research and development centre of other quality methods e.g. performance indicators, clinical guidelines, patient surveys;
- purchasing accreditation services from another state

3 Organising for accreditation

This section focuses on the organisations which may be involved in the accreditation program, the links between them, accountability throughout the health system, and attitudes towards it.

3.1 Ministry of Health

The development of accreditation may occur as part of broader health reforms, or in the context of an overall governmental strategy for quality improvement. It may take the form of transition from a centralised system to one which is more open and based on individual rights and/or transition from government to private ownership. It may be necessary for the health ministry to re-define its own duties and responsibilities in line with a reformed organisational structure of the health system.

The relationships between the various departments of government which impact on quality may be unclear. The roles of agencies (e.g. those responsible for public health, blood products, pharmaceuticals, medical devices) and inspectorates (eg those responsible for environment, safety or radiation at either federal or local administrative level) need to be clarified as part of the overall quality plan. This clearer delineation of roles and relationships, if widely disseminated, could then greatly enhance communication between departments and agencies of the aims and operation of an integrated quality system.

Specific to accreditation is the question of whether the program should be run:

- by the ministry of health, directly and solely (like licensing), *or*
- by an independent body totally unconnected to government, *or*
- by something between these two extremes – which has become the norm in the past ten years.

“The licensing unit is a sub-division of the Ministry of Health but the Medical Accreditation Commission is a separate juridical entity (NGO)” Kyrgyzstan

“Professional licensing is in the hands of the Medical Chamber; quality is in the hands of an independent agency, the Center for Quality in Healthcare. The National Board of Medical Standards defines the overall structure.” Czech Republic

3.2 Functions of a national accreditation agency

The Agency should become the principal national centre for the definition, measurement and improvement of standards of service management.

Core functions are described in Section 4 Management of accreditation. These functions must in turn be related to a range of other activities (especially clinical practice) which may be handled by other institutions, or by the accreditation agency itself.

Common extended functions:

- Resource centre for quality improvement standards, methods and experience, and as a focal point for the collection of local information, as well as for comparison with other countries;
- Training in quality improvement;
- Access point for clinical practice guidelines, health technology assessment and evidence-based medicine;
- Development of robust quality indicators of performance;
- Collection, analysis, comparison, publication and active feedback of data on performance of providers (eg quality, quantity, cost and value for money).

- Patient safety and patients’ rights are generally assumed to be part of the core business of accreditation programs.
- Licensing (organisational or individual), specialty certification and patients’ complaints are generally not the business of accreditation systems.

The Kyrgyz Republic restructured and separated licensing and accreditation functions. During 2000, the Ministry of Health Joint Working Group on Health Reform began to feel that the existing standards, and the complexity of the licensing and accreditation process, were no longer cost-effective. The MOH and the Licensing and Accreditation Commission together planned the future separation of “licensing” from “accreditation”, and in 2000-2001, regulations were passed to separate the two functions. “Licensing” was moved to the MOH, applying only to new private physicians and new private clinics. “Accreditation” of health care facilities was allocated to the separate Healthcare Accreditation Commission.

Zambia considered three possible approaches to running the proposed new program:

- *Public-private partnership*: a private organisation would assess hospitals against policies and standards set by government.
- *Integrated approach*: the program would be run by a council comprising representatives from government regulatory agencies, professional organizations, practitioners, and the public.
- *Phased approach*: all hospitals would first seek licensure (by government) to stay open, and then apply for accreditation (by quasi-governmental or private organization), in order to qualify for the annual grant.

Ultimately, they determined that the partnership approach would be difficult to set up because no suitable private organization was available, and the phased approach would entail considerable delays because it would require legal changes to the current licensure arrangements.

Table 15: Some Configurations of Accreditation Agencies

France	ANAES is a centre for accreditation and for developing clinical guidelines.
Poland	The National Centre is developing evidence-based practice guidelines and accreditation, technology assessment and training for quality improvement and receives state support to provide essential services to the health care system
Slovakia	The Centre for Quality and Accreditation in Health Care was set up in 1999 by the Ministry of Health to prepare for launching healthcare accreditation, and to develop accreditation standards
Czech	In January 2002, the Ministry of Health delegated the coordination of all programs and Republic activities related to accreditation, certification and authorization in healthcare to the Center for Healthcare Quality of the National Institute of Public Health. Any legal entity offering accreditation will have to be certified by the Center.
Ireland	A one-year Project to develop an Accreditation Scheme for the acute health services commenced in 1999 and involved the Major Academic Teaching Hospitals (MATHs).

While considering the options and costs of setting up a national program, thought should be given to contracting out for accreditation services. These contacts could be with an agency in another country - most commonly Canada’s CCHSA, Australia’s ACHS or the UK’s HQS, (see Table 30) or with an international agency, such as the USA-based Joint Commission International (JCI). Before setting up their own program, a consortium of teaching hospitals and ministry staff in Ireland reviewed the options available, and concluded that, in the long run, a new national program would be cheaper and more effective than “buying” accreditation services from another country (Table 16). But that does not preclude the advantages of working alongside another program to “learn the trade”.

Table 16: Options for a New Accreditation Program, Ireland 1999¹

	Develop own	Utilise existing
Ownership	National	Non-ownership
Independence	Independence	Dependence
Buy-in	Participative (High)	Inspectorate (Low)
Planning	Lengthy	Rapid
Implementation	Rapid	Lengthy
Cost	Low introductory/ongoing	High introductory/ongoing
Value-added	High local	Low local
Surveyors	High number/ quality assured	Low number/quality assured
Support	Locally driven, externally supported	Externally driven, locally supported
Objectivity	Potential non-objectivity	Assured Objectivity
Updating	National	International
Perspective	Insular	International

3.3 Relationships of national accreditation agency

If the accreditation agency does not itself manage related functions at a national level, it needs to:

- define communications and relationships with other departments and agencies,
- harmonise the setting and assessment of health care standards,
- avoid waste and conflict between systems, and
- minimise the “burden of inspection” on health care organisations.

Should a new program seek to integrate and build upon existing systems of standards and inspections, or merely add a comprehensive but separate layer?

“The program’s vision was to integrate the efforts of the different ‘examiners’ at any given hospital, and to provide a global assessment. For this vision to be realized, Zambia would need to introduce a national policy or procedures to facilitate the integration of different examiners, which has not yet been done.”
Zambia

Other organisations which define and assess standards, and which could usefully collaborate, include:

3.3.1 Regulatory inspectorates and other external agencies

These might include:

- *statutory bodies* e.g. fire, radiation, medical devices, safety, hygiene, health data collection agencies; *and*
- *independent assessors* e.g. laboratory external quality assurance programs.

ISO quality standards are widely recognised in manufacturing and service industries, so the relationship of function and structure between the ISO accreditation institute and the health service accreditation agency needs to be explored and defined.

Most accreditation programs assume that statutory inspections are carried out as intended, and expect to be able to examine safety certificates, e.g. for radiation protection. But in some countries, the statutory radiation protection agency does not have the resources to carry out its own inspections, and may turn to the accreditation program to provide its own expertise.

“There is a national external quality assurance system for clinical laboratories, but just to assure the domination of big laboratories. We have reference laboratories only on paper.” Eastern Europe

3.3.2 Public Health Institutes

Links between PHIs and the Agency provide the means to share data describing the impact of the program on population health, and on the performance of providers and the health care delivery system. Where countries currently employ inspectors to regulate health care facilities, the inspectors' role could be modified to include assisting local facilities to prepare for accreditation surveys by the national Agency, when it is established, and to monitor the implementation of the ensuing recommendations for improvement. This would require initial and continuing education programs.

3.3.3 National technical agencies

(e.g. health technology assessment, clinical guidelines and patient safety agencies)

“Portugal has (had) a national agency for quality in health care since 1999 – the Institute for Quality in Health Care (Instituto da Qualidade em Saude IQS)”

3.3.4 Consumer groups

Representatives of a recognised consumers' council should be identified as supporting the proposed Agency, to make health services more transparent and accessible to the public. They should help define the standards and services that their public have a right to expect, and develop and promote reliable and consistent methods for measuring them.

3.3.5 Professional institutes

Independent bodies, such as medical academies, may offer wisdom and advice to the Agency, and be recognised as acting in this capacity. Organisations responsible for such duties as supervising training, or licensing clinicians (doctors, nurses, dentists, pharmacists etc), may contribute to the setting of standards for their particular client groups, and for their local assessment.

“Licensing of medical educational establishments is provided by the Ministry of Education. There is no independent licensing body.” Kyrgyzstan

“For consistency and credibility it is very important that achievement of accreditation is a condition of recognition of clinical training posts” Australia

In particular, the role of professional bodies, such as associations, chambers and colleges, needs to be defined with respect to:

- professional regulation,
 - the setting and monitoring of clinical performance standards,
 - the monitoring of clinical practice according to these standards,
- and*
- the development and dissemination of quality improvement methods.

The functions of statutory bodies need to be defined in relation to voluntary associations, as well as to the accreditation program, and should be integrated at federal level.

Local government and professional institutions:

The Agency should work at the local administrative level (of municipality, canton, oblast etc) with their ministries, insurance funds and professional institutes and organisations. The aim should be to develop consistent incentives for measurable compliance with agreed national standards of process and outcome in all primary, ambulatory and hospital care.

3.3.6 Health Insurance Funds

Using contracted service providers offers an alternative to the traditional, centralised “command and control” model in health care management. In several countries, laws on health care insurance specify that only accredited institutions, from either public or private sector, have the right to sign contracts to provide services under compulsory insurance. HIFs should obtain and protect best value from available funding, and consider offering financial incentives with an impact, comparable to the achievement of accreditation, on quality improvement.

3.4 Governance structure of the accreditation agency

3.4.1 Authority

While decentralisation is a key component of many health system reforms, decision-making is often reserved by the federal authorities for activities such as the monitoring, assessment and analysis of population health, or health care delivery. Sub-national programs tend to lose the potential benefits of economy of scale, objectivity, learning, consistency and equity.

Table 17: Some Comments on the Governance of Accreditation Programs

“It is important that the program is managed nationally and not delegated, in order to ensure consistency of interpretation and not to be compromised”	Australia
“It is important that the accreditation program should be managed independently, but the status of a government agency may be necessary in some situations.”	Thailand
“There is an extreme variability (in the management of accreditation programs) between regional governments; a national unified policy seems to be far away”	Italy
“The accreditation program will be managed by collaboration between the counties and National Board of Health”	Denmark
“The Oversight Committee on Accreditation includes representatives of the Ministry of Health, Association of Health Care Managers, Alliance of Patients’ Rights Protection, Hospitals Association (HA), and Family Group Practices Association (FGPA)”	Kyrgyzstan
The Lithuanian Health Program of 1997-2010 gives priority to health care quality, particularly to licencing (institutions and personnel), accreditation, certification of quality systems and audit. The State Health Care Accreditation Service is currently being reorganised in preparation for a national accreditation program under the Ministry of Health.	Lithuania
“Agreeing on the organization and structure of the accreditation program was a critical milestone, given the existing, albeit disparate, organizations that were already legally mandated to oversee certain aspects of the licensing, inspection, and evaluation of hospitals	Zambia
“The accreditation program will be managed by an independent Executive Accreditation Agency.”	Portugal
“The accreditation methodology was developed by an independent national institution. The accreditation of individual hospitals is done by separate (commercial) companies which operate locally or nationally.”	Germany

The Agency requires a formal constitution and clear operating procedures. Guidance and criteria are given in the international ALPHA standards on “corporate governance and strategic directions”¹ under the headings:

- Mission, values and vision
- Strategic planning
- Operational planning
- Leadership
- Effective governance
- External relations

3.4.2 Representation

If it is to be a non-governmental organisation, the Agency should have a Board and/or Advisory Council, comprised of and accountable to the various stakeholder organisations (as in USA, Canada, Australia, UK, Netherlands, Poland etc), rather than primarily to Government (as in France and Italy).

The Board should represent professional, public and government interests, and bring to the governance of the agency, individuals with skill and experience in such areas as finance, the law and public relations – while being dominated by none of them.

Typically, independent boards include representatives of professional associations (eg nurses, managers, doctors), funding agencies, consumer councils and statutory bodies.

Table 18: Structure of Board of the Council for Health Service Accreditation of Southern Africa (COHSASA) – a not-for-profit (Section 21) company

The Board has 18 members appointed for their professional skills and affiliations, including: Provincial health service departments:

KwaZulu Natal, Free State, North West Province

Hospital Association of SA

The Consumer Council

The South African Quality Institute

A local Authority

Various managed health care representatives

The Board of Health Care Funders.

3.5 Accountability and culture

Accreditation programs which have succeeded in affecting improvement in organisations have generally done so by stimulating internal motivation and commitment to self-assessment and change. This requires a culture of transparency and acceptance of personal and corporate responsibility among management and clinical staff.

3.5.1 Clinical

Traditional, voluntary accreditation systems have built upon a culture of ethics, self-regulation and mutual respect, where doctors and nurses have clear professional identities and accept responsibility for the quality of their own clinical performance. Most accreditation programs require that health care professionals have – and can demonstrate— effective mechanisms for the governance of their professions, or for collegial self-regulation at the institutional level. The rapid increase in compliance with accreditation standards which usually occurs in the months before an external survey, is directly related to the organisation’s capacity for professional self-regulation. It does not happen simply because inspectors are about to arrive.

The obligations and contributions of professional bodies, and of medical, nursing and other clinical staff, to quality-improvement and accreditation, should also be agreed to at a system level, and be made explicit throughout the health care system.

3.5.2 Managerial

Preparation for an accreditation survey presents the challenge of self-assessment and change-management to the entire organisation, and especially to its leaders. It requires of managers the knowledge and skills to lead the process, to motivate their staff, and to focus on improvement and performance. Accreditation is not easily adopted in a culture, such as that of most hospitals, where management has traditionally been hierarchical, and driven by fixed, input-related funding unrelated to performance, and where there is little opportunity for initiative.

Various expert WHO working groups have recommended that the role of managers in quality improvement should include the knowledge, attitudes and skills which accreditation is likely to require, such as:

- Designated leadership, accountability, supervision, monitoring and communication of quality, at sub-district, district, regional and national levels;
- Public accountability via the reporting of quality improvement systems through objective external assessment by independent bodies;
- Dissemination of quality information to civic groups with a particular interest in health, such as women's groups, health educators, legislators and mass media;
- Coordination of multi-disciplinary quality assurance projects using common protocols on such topics as peri-operative, maternal and peri-natal deaths, and iatrogenic drug reactions;
- Regular, systematic feedback of data on important process and outcome measures to individuals, organizational units and organizations.

The scope of responsibility and authority of healthcare managers for quality and accreditation, and the mechanisms for their accountability to the public, should be explicitly set out at sub-district, district, regional and national levels.

4 Management of accreditation

General guidance on the operation of an accreditation program is given in the ALPHA principles and standards³⁷. These were designed primarily for the systematic external assessment of established accreditation programs, but they have also been used as specifications for new programs in health reform, and as a self-assessment tool for program-development. They therefore serve to promote consistency and compatibility in assessment programs, within and across national boundaries, with or without resulting certification

The key components referred to below are those which differentiate accreditation from other external assessment.

4.1 Standards

4.1.1 Principles

In 2000, a voluntary federation of national accreditation programs agreed the ALPHA principles for standards development. These ALPHA principles set out and expand on the standards against which organisations are assessed in the accreditation process:

- 1) To identify and verify the rights of patients to choice, dignity and information;
- 2) To promote accountability and internal quality improvement mechanisms;
- 3) To focus on improving performance and safety within available resources;
- 4) To be orientated to continuity and to adopt the “patient’s pathway” through the system;
- 5) To seek research evidence and operate in consultation with stakeholders.

“This philosophy - “doing the best, given available resources” - is especially important to consider in developing countries where resource limitations can significantly impact an organization’s ability to achieve optimal performance. If the standards are set unrealistically high, organizations will feel demoralized and unmotivated to work towards meeting them; however, incremental improvements may be possible and should be rewarded.” Rooney A, van Ostenberg P²⁰

4.1.2 Initial sources of standards

Organisational structures and practices are less easily standardised and tested by controlled trials than are individual health interventions. The evidence base for accreditation standards of organisations or health systems is therefore less robust, but countries can draw on a variety of sources:

- **Consensus**, e.g. between professions, stakeholders and districts, on “best practice”;
- **Normative targets of process and outcome**, e.g. immunisation rates, population health;
- **Legislation, government directives, and professional guidance**;
- **Accumulation of empirical descriptions** of how organisations operate and what they achieve, eg benchmarking performance;
- **Accreditation standards of other countries**, whether or not they are evidence-based;
- **Qualitative studies and randomised controlled trials** (RCTs) of clinical interventions and pathways

Table 19: Milestones Achieved in Developing Standards For Accreditation, Poland 1998

Review of overseas accreditation systems (USA Joint Commission; UK HAP; Canada Canadian Council)
Training at JCAHCO in Chicago
Establishment of Accreditation Standards Team
Field, Testing phase
Obtain Feedback from hospitals

4.1.3 Local adaptation

The accreditation standards of most programs develop through a similar continuous, evolutionary process of drafting, testing and revising. The initial cycle of this process lasts at least one year. In the course of this process, it is necessary to:

- Research and combine normative standards with observed practice;
- Check legislation;
- Get consensus on standards, e.g. put on Internet for public viewing;
- Test in field/region, to make sure standards are clear and understandable under survey conditions;
- Reject non-discriminant standards.

4.1.4 Validation and revision

ALPHA criteria state that standards should be revised “on a regular basis”, as a continuing process.

Two thirds of programs which responded to the global survey in 2000 use standards which have been approved within the past two years. In effect, the development of standards is a continuing process which requires an ongoing allocation of resources.

4.2 Surveyor selection, development and deployment

The effective recruitment, selection, development, deployment and performance management of surveyors, assist the accreditation body to deliver a high quality service to its clients in accordance with its scope and operational processes – ALPHA Standard 4

Accreditation programs generally use the word “surveyors” rather than “auditors” to describe the personnel who visit, assess and draft reports. These individuals are central to the credibility, objectivity and sustainability of the program.

4.2.1 Requirements

The number of surveyors to be recruited should be calculated from the volume of surveys planned, their duration (in terms of surveyor-days), the number of days each surveyor would provide per year, and the number of surveyors expected to withdraw each year. Their professional background, culture and skills should reflect the function and scope of the program.

A majority of surveyors in traditional accreditation programs have been loaned by participating institutions, which are themselves accredited, to provide and promote the concept of peer review.

This approach has the advantages of:

- reducing survey costs;
- maintaining the acceptability and independence of peer review; *and*
- sharing the experience and knowledge of accreditation widely throughout the health system.

But it assumes that there are enough personnel with sufficient experience, who are able and willing to be seconded by their employers to be trained as surveyors without raising the perception of conflict of interest.

4.2.2 Selection

The criteria and process for selecting prospective surveyors should be clearly stated and fairly applied. Some programs set out basic core competencies (such as team-working) and levels of professional experience required, to define eligibility. Common profiles of part-time surveyors include:

- Professional experience at senior levels (as doctors, nurses, administrators);
- Experience in senior management;
- Good interpersonal skills;
- Specific education certification;
- Good physical and mental health;
- Current or recent working experience.

Table 20: Recruitment and Training of Surveyors, Poland

– Advertisement
– Application
– Interview
– Training
– Mock surveys
– Certification
– Continuing education

4.2.3 Contractual status

Whether surveyors are seconded (on their normal salary), or employed directly by the program, they must be committed to comply with the rules of the accreditation body, in particular, its rules on confidentiality and independence. If the Agency chooses to employ surveyors directly, rather than have them work as volunteers, it may also have to accept greater legal responsibility for them, and provide extra liability insurance.

4.2.4 Training

The additional knowledge of standards and skills of assessment required by surveyors, should be identified and provided systematically through initial induction, supported by continuing education. In Poland the main topics include:

- Standards' interpretation
- Survey process
- Interviewing and observation skills
- Documentation review
- Specific or specialised areas (safety, infection control etc)
- Report-writing techniques.

Table 21: Days Committed to Surveyor Training, 1997 ¹

Country	Accreditor	Initial days	Ongoing days
USA	JCAHO	15	5
Canada	CCHSA	3	2.5
Australia	ACHS	2	3-4
UK	KFOA (HQS)	2	N/A
UK	HAP	4	1
New Zealand	NZC	3	2

4.2.5 Evaluation

All programs define criteria for selecting, training, retraining and de-selecting surveyors. In addition, some have independent committees to monitor inter-rater reliability, satisfaction surveys by an independent third party, as well as in-house survey team assessment. It is common to ask the HCO being accredited to evaluate the standards, the assessment, and its surveyors, after the external survey has been done. These reports, combined with continuing training, contribute to the systematic appraisal of each surveyor.

Surveyors, the Zambian experience

“Nominees were professionals with full-time job commitments who would conduct surveys on an ad hoc basis and receive a nominal payment for their efforts (eg transportation and per diem). From these nominees, ZHAC selected the most qualified individuals, based on their professional background, hospital experience, general knowledge, and work ethics.

In the past 2 years, the program has experienced significant attrition among surveyors. The attrition arose from several factors: the temporary nature of the work, which meant that surveyors who had permanent jobs without much flexibility had to opt out; the inability of the CBoH (ministry) and ZHAC (program) to set a firm schedule for surveys due to uncertain funding; long hours and pay that was not commensurate with private sector salaries; and deaths of several surveyors” Zambia

4.3 Survey management

The preparation of clients for survey, the survey, and the follow-up after survey, should meet the needs of clients, facilitate objective and consistent decision-making, and are delivered in accordance with documented policies and procedures which have been communicated to and are understood by clients. ALPHA standard 7

4.3.1 Engagement with institution

There should be a defined process to ensure that participating organisations are aware of their rights and responsibilities in relation to the program, and that they understand the procedures and responsibilities of the program. This usually involves a standard contract or memorandum of understanding between the applicant HCO and the program.

Training and educational support are provided by some, but not all, programs as an integral part of the preparatory process. This may include, for example, project manager training, standards interpretation, and internal assessment.

4.3.2 Survey planning

The scope and duration of the survey, and the size of the survey team, should be based on the needs of the institution and the policies of the accreditation body. Surveyor selection for the external survey should ensure an appropriate skill-mix, and avoid conflict of interest. Dates for the external survey are usually set 6-12 months in advance, to allow for self-assessment and preparation.

4.3.3 Self-assessment

Self-assessment against the published standards develops insight and commitment. It reduces the burden of external inspection because it helps organisations to identify, understand and resolve their own problems. Many programs consider this internalisation a key to the rapidly increasing compliance with standards, which happens in HCOs in the months leading up to an external survey.

4.3.4 Performance indicators

Clinical and organisational indicators are also collected as part of the assessment process, either during or between survey visits. They may be submitted directly by the facility being assessed, or alternatively, can be calculated independently by a third party. Their main purpose is to demonstrate that the organisation has the capacity to generate and analyse performance data as part of an internal quality-improvement program. But if the data are complete, accurate and timely, and are standardised across facilities, they can also provide measures for comparing achievement between facilities in such areas as clinical process and outcome.

Programs must decide how much weight, if any, such indicators should contribute to the assessment process, and to subsequent accreditation decisions.

4.3.5 Facilitation

Many programs provide facilitators, such as program staff or trained surveyors, to help prepare institutions for their initial entry to the program, and to feed back to the program notice of any systematic problems that arise. This support acknowledges that the early external assessments are as much a test of the standards, surveyors and procedures, as they are of the institution being visited. The facilitators should not be permitted to take part in, or influence, the external survey.

In Zambia and South Africa, “educational surveys” and “facilitated accreditation” were adopted to encourage and support hospitals embarking on the long road to achieving accreditation.

“After surveyors were trained, Zambia performed 20 educational surveys in the remainder of 1998. Educational surveys are essentially accreditation surveys, except that no accreditation decision is made. Educational surveys are intended to familiarize the hospital with standards for accreditation and to enable staff to appreciate how their hospital functions. While no accreditation decision is made, the hospital receives feedback on the improvements needed to achieve accreditation.”

4.3.6 External survey

Site visits can vary from half a day from one surveyor (for primary care clinics in rural Australia), to continuous, rolling assessment by large teams (for health care networks in North America). Small hospitals often use two surveyors for two days (four surveyor-days); larger ones commonly use three surveyors for five days. To these “on-site” estimates must be added time for surveyor preparation, travel, team-briefing and report completion.

“The ZHAC agreed that for even the smallest hospitals, an on-site survey team would include at least two surveyors to ensure objectivity and reliability. The team was to reach consensus on a rating for each measurable characteristic. The council also determined that each survey would last for at least 2 days in order for the team to complete the survey activities, compile its findings, and complete the scoring document before leaving the hospital.” Zambia

Frequently, both surveyors and surveyed reported feeling that survey time allocated was too short to allow visits to every unit, and the chance to talk to all the staff and clients - both day and night, to read all the relevant documents, and to gain an appreciation of every facet of operations.

The tension arising from time pressure in surveys can be reduced by:

- thorough internal preparation,
 - complete and accurate self-assessments,
 - timely submission of pre-survey documents,
 - explicit sampling procedures,
 - efficient survey programming and time-management,
- and*
- the making available of specified documents for review on site.

Increasing the number of surveyor-days may not help, and will certainly increase the complexity and cost of the survey.

4.4 Process of accreditation

The accreditation body maintains a system for the determination, awarding and maintenance of accreditation that ensures the integrity of the processes. ALPHA standard 8

4.4.1 Responsibilities for accreditation

The accreditation body is responsible for setting the criteria for determining accreditation status, and for the decision to grant or deny accreditation status on the basis of the information in a survey report.

The criteria the accreditation body lays down should ensure:

- Transparency of criteria (for organisations being accredited, for surveyors and for the public);
- Consideration for the customers of the service and their safety;
- Decisions based on the achievement of the standards;
- Consideration of how accreditation status will facilitate further quality improvement;
- Consistency between accreditation decisions;
- A non-adversarial process for appeals.

4.4.2 Basis for accreditation awards

In the past, programs judged awards primarily on the organisation's capacity for good clinical care, as demonstrated by compliance with accreditation standards. More recently, the emphasis has shifted to overall performance. Newer programs, especially those in developing and under-resourced countries, adopt slightly different parameters. The tendency here, at least initially, is to reward basic infrastructure, and demonstrable progress towards – rather than absolute compliance with – the published standards.

“Rules were needed particularly for making accreditation decisions and standardizing the deliberation process, managing surveyors and surveys, and addressing the consequences of an accreditation decision.”
Zambia

Table 23: Examples of Priority Concerns of Accreditation Programs

Critical functional areas (Zambia)	Patient care Infection control Quality assurance Management of the environment
National Patient Safety Goals (JCAHO) ¹	Patient identification Communication among caregivers High-alert medications Wrong-site surgery Infusion pumps Clinical alarm systems
Key areas of difficulty (Poland) ²	Infection control Information flow /Team work Patient records Medical equipment surveillance

4.4.3 Timescale for accreditation decisions

Having worked hard to prepare for the external survey, staff and management of HCOs are usually eager for a decision from the accreditation body. Many programs aim to provide the majority of decisions within two months of the survey. The longer the delay in reporting, the more irrelevant the report and its decision become. Staff lose motivation and improvements achieved are not sustained.

The adjudication process must therefore not only be transparent and thorough, but also timely.

“ANAES, as a public body, is required to have a separate evaluation body, the Collège d’Accreditation, to make decisions on levels of award. In practice, this has slowed the process” France, ANAES

“In retrospect, it would have been advisable to implement pilot testing not only of the standards, but also of the entire process of making and communicating accreditation decisions. The delay in feeding back the results of educational surveys to hospitals (one year after completion of a survey) also raises questions regarding the feasibility of ZHAC’s policies and procedures” Zambia

4.4.4 Duration and maintenance of accreditation

Accreditation awards commonly range in duration from one year (conditional, with reservations) to three (full, with commendations) and are usually subject to continuing monitoring and mid-term or random reviews. Longer intervals between external assessments tend to instil a false sense of security throughout the organisation, and remove the momentum for internal improvement.

“A simple pass/fail assessment against optimum standards might suit the image of a well-funded private sector but is likely to demotivate participants in the public sector; in South Africa, a system of graded recognition has been developed with provincial governments to recognise the progress of public hospitals, sometimes from a very low baseline, and to encourage them to close the gap without artificially lowering the eventual targets” South Africa

4.4.5 Publication of results

The extent and methods of public disclosure of survey findings and accreditation awards, must be agreed in advance by the accrediting body and the various stakeholders.

4.4.6 Checks and balances

Accreditation programs must to be able to demonstrate their objectivity and reliability.

Mechanisms to achieve this include:

- Public access being given to the program’s standards, assessment processes and criteria for accreditation awards;
- Surveyors being selected, trained and evaluated in accordance with explicit published criteria;
- survey teams being tailored to each individual HCO, according to published criteria, to avoid any conflict of interest;
- the survey team reporting initial findings back to the HCO before leaving the site - especially those findings likely to generate recommendations - in order to check the observation and to ensure there are no surprises later;
- team reports being prepared and agreed jointly and in compliance with procedures (which are often defined in a surveyors’ handbook);
- team reports being independently checked within the agency for content, consistency and compliance with procedures;
- final draft reports being referred to the client HCO for verification before the accreditation decision;
- accreditation awards being made by an independent panel, based on the team’s report, and not by the surveyors themselves.

No program should allow accreditation status to be bought.

4.5 Program evaluation

4.5.1 The effectiveness of accreditation as a general model

Given the increasing enthusiasm of governments, insurers and aid agencies to establish new accreditation programs, it is necessary to identify and collate evidence for the effective components of the general model, as well as for those which prove ineffective. Some of the relevant evidence might come from parallel fields of standards-based inspection, such as education and social services, or from the input of other stakeholders, such as correlations of accreditation status with costs and claims to liability insurers.

There is evidence that, given published criteria, adequate motivation, self-assessment skills, as well as sufficient time to prepare for external survey, hospitals do increase their compliance with the standards. In South Africa, COHSASA, Joint Commission International (JCI), and the Quality Assurance Program (QAP) ran a controlled trial, randomising 20 similar hospitals in Kwa-Zulu Natal into control and intervention groups, to compare compliance with standards¹. Over two years, compliance in the control group of hospitals increased by just 1.4%, while the increase in the intervention group was 31.4%.

Most accreditation programs can demonstrate that compliance with specific standards has been directly associated with improved processes (eg resuscitation protocols and pain management) and outcomes (eg reduction of urinary infections, wrong-side surgery, deaths from fire, and suicide).

4.5.2 Independent evaluation

External evaluations of new accreditation programs have also been commissioned, often by governments, or as a condition of receiving initial development funding. Examples from Australia¹, South Africa⁴¹, Zambia and the UK^{2,3} document benefits perceived by organisations and their users, but supply little data on individual or population health improvement.

In 2002, a WHO study of external quality assessment programs for maternal and child health concluded that these programs do produce benefits for clients, their staff, the community and the service. They summarised these benefits as³⁴:

- The linkages, networks and structures which developed and/or were improved in the course of the program, to influence the political, legislative, economic, socio-cultural and public health environment within which services operate (“enabling” mechanisms).
- The reorganisation and/or development of the health care delivery systems at the service level.
- The change in attitude and/or development of personal skills and knowledge in the health service staff.
- Improvements to health facilities and equipment.
- A client-centred and clients’ rights approach to healthcare, in which services become more needs-based, consultative, supportive of, and able to deliver, better care to clients and the community.

At the Redenção Health Centre (Brazil) a change in staff relationships eventuated through team meetings devoted to preparing for the external assessment. Shared problem-solving and decision-making within and across departments led to more knowledge, skill development, shared responsibilities and an ease in workloads³⁴.

4.5.3 Regulatory monitoring

Some regulatory bodies (eg in USA and Canada) monitor independent accreditation programs. This is done primarily by representation on the governing board or by checks on selected surveys. Within a few weeks of the visit, federal government representatives follow JCAHO into 5% of surveys in “deemed status” hospitals, to validate reports. The National Committee for Quality Assurance (NCQA) in USA has a proportion of co-visits; and the Accreditation Association for Ambulatory Health Care (AAAHC) has a similar proportion of post-accreditation validation surveys of ambulatory care centres. In South Africa, the provincial government (which is also the contractor) provides monitoring by co-visiting.

4.5.4 Accrediting the accreditors

In 1999, the International Society for Quality in Health Care (ISQua) launched ALPHA, the Agenda for Leadership in Programs in Healthcare Accreditation³⁷, in order to promote the development, compatibility and uptake of accreditation at an international level. The tasks were to:

- Begin harmonisation of national programs ;
- Define principles of standards and program operation ;
- Evaluate accreditation agencies;
- Support new programs.

ALPHA provides two services for healthcare standards and accreditation bodies:

- Survey and accreditation in accordance with international standards for national healthcare accreditation bodies: CCHSA in Canada, ACHS in Australia, QHNZ in New Zealand, COHSASA in South Africa, and HQS in the UK, have all now been ALPHA accredited
- Standards assessment against international principles for national healthcare: this is a requirement for any program seeking accreditation, but several newer programs have elected to submit their standards for help with their development.

In September 2003, the ALPHA Council began to extend its standards and certification services to include the standards, organisation and training of programs which provide external assessment but do not award accreditation. These include voluntary professional peer review, and statutory regulatory and licensing systems.

Accreditation programs in the European Accreditation Forum have recognised a need to ensure that the criteria and assessment methods of individual systems are sufficiently robust and compatible to indicate to patients, insurers and ministries that accredited hospitals in different countries reach comparable standards. Many smaller and developing programs cannot justify the resources required for full international recognition. But they could embark on a defined progression of development and standardisation starting from self-assessment, graduating to peer review, and aiming eventually for international accreditation.

4.5.5 Internal performance measures

Accreditation programs need to set an example of quality improvement within their own organisations. This includes defining, and regularly monitoring and improving, their own performance. Data routinely collected and reported to governing boards include:

- Recruitment and drop-out of participating facilities;
- Denial rate (proportion of facilities refused accreditation);
- Report turnaround times (from survey date to final report and award decision);
- Financial performance;
- Surveyor recruitment, training and evaluation;
- Client satisfaction with surveyors, education services, and other products provided by the program.

5 Resources for accreditation

In addition to a supportive environment, sustainable programs need targeted resources to develop and operate an accreditation system.

- Time is the most frequently underestimated resource that new programs need;
- Skills training and money are also commonly misjudged when developing budgets. Projecting unrealistic limits on time and expenditure leads to an unsustainable program.

“As of late 2001, the (Zambian) program was at a critical juncture in its development and needed to address urgently the following issues:

- *Achieving ZHAC’s legal recognition and funding to ensure adequate program management and financing*
- *Managing surveyor attrition and ensuring inter-rater reliability (ie consistency) among surveyors*
- *Providing timely feedback to hospitals about the results of their surveys*
- *Providing ongoing training and technical assistance to hospitals on how to meet the standards”¹*

5.1 Staffing the accreditation agency

“The effective planning and management of human resources encourages the highest levels of performance to assist the accreditation body to meet its strategic goals and objectives.” ALPHA standard 3

Personnel who must be selected, trained and, perhaps, paid, include members of the governing body and committees, employed staff, seconded staff (eg surveyors) and sub-contractors (e.g. legal, statistical, marketing, communications).

In larger programs, staff may be structured into functional units such as:

- Survey planning and management;
- Standards research and revision;
- Surveyor recruitment and development;
- User education and development.

Smaller programs can survive on very few core staff, if they have significant support from unpaid experts and staff seconded from employment in health services. The majority of people are usually part-time surveyors. From the European survey of programs, the annual workload per surveyor can be estimated by dividing the total survey days (number by average duration) by the number of available surveyors. This suggests that the time provided by each surveyor each year ranges from 1 to 9 survey days (Table 25).

Table 25: Survey Days Provided per Surveyor, 2001

	Surveyor days	Surveyors	Days each
Bulgaria	400	401	1.0
Switzerland	60	38	1.6
UK (HAP)	86	41	2.1
Portugal	100	36	2.8
France	1968	439	4.5
Spain (FAD/JCI)	84	10	8.4
Poland	250	28	8.9

5.2 Information requirements

“There are clearly defined systems in place to collect, store and retrieve information that is relevant and timely for the accreditation body’s defined information needs for strategic and operational planning, implementation and control of its activities.” ALPHA standard 6

In addition to internal systems for planning and finance, a program needs the capacity to collect, aggregate and compare – over time, within and between participating organisations, standards and surveyors – such data as:

- Compliance profiles of individual standards;
- Profiles of participating facilities;
- Calculation of standard scores, function scores, and overall score for each facility;
- Aggregated results for comparisons in time, function and place;
- Profiles of individual surveyors;
- Overall impact of program.

Data showing improvements made by participating hospitals since the first (baseline) contact with the program, are essential, to demonstrate its value to the health care system.

“This database can provide useful aggregate data that will highlight where many organizations are meeting the expected standards, as well as pinpoint problematic areas or opportunities for improvement... This data can provide powerful testimony to public policy makers. Such information can be useful in identifying both resource priorities, as well as needs for further education and technical assistance.”
Zambia

5.3 External technical assistance

Many countries have national resources which can contribute to a developing accreditation program, such as:

- Institutes for standardisation and norms, which can advise on some elements of the setting of, and measuring against, standards. *But the experience of these bodies is usually focused on the inputs and mechanical processes of manufacturing industry, rather than the human component of clinical practice and outcome.*
- Historical norms and planning guidelines which prescribe numbers of staff and equipment. *However, these make no reference to performance, or to underlying evidence of benefit.*
- Statutory inspectorates of environment, public health and safety. *Again, the incentives and methods of inspection are difficult to translate into the dynamics of organisational improvement.*

Information specific to health care accreditation is becoming widely available through journals, sponsored agencies such as the Quality Assurance Program in Bethesda, voluntary organisations such as the ALPHA Federation, and websites of accreditation providers. These sources describe projects, values, standards, assessment principles, products and customers, but they give little insight into the practical details and challenges which a new program will face.

Every national accreditation program (except Japan’s) can identify a pre-existing domestic initiative, or an international accreditation program on which it based its values and design. The expertise provided may range from copies of operating procedures to long-term technical support on site. A list of accreditation program websites is in Appendix 2.

Table 26: Countries Cited as Primary Influence on Standards, Europe 2002

Country	N	%
USA	7	27
UK	6	23
Canada	5	19
Australia	3	12
France	2	7
Poland, Germany, Ireland	1	4
All	26	100

5.4 Education services

“Education services are systematically designed and implemented to meet quality standards and client needs.” ALPHA standard 10

Training is an essential component of accreditation for program personnel, and for the effective participation of organisations.

It includes:

- induction and development of core staff;
- orientation of members of the governing council or board;
- initial and continuing training of surveyors;
- general preparation of participating institutions and their staff;
- specific methods of internal quality improvement required to meet accreditation standards, such as infection control, risk management, performance measurement, patient surveys.

“Some directors of hospital and health services have formal training in health service management, but because in our country their appointment is on the basis of political criteria, there is no competence-based selection.” Eastern Europe

5.5 Time

The most commonly underestimated resource is the time needed to plan, design, build and deliver a sustainable new accreditation program (see also 5.7.6 Sources of funding: developmental, operational). The pace at which this can be done is limited largely by factors outside the control of the program, notably by the prevailing culture and prevailing attitudes towards leadership, innovation, improvement, team-working and transparency.

In practice, the development stages which may overlap, are:

- policy decision to develop accreditation and define scope;
- appraisal of options on existing models and their adaptation;
- formation of agency structure;
- development of standards and assessment process;
- surveyor selection and training;
- pilot testing and education;
- revision of standards and methods;
- first “live” surveys;
- first accreditation decisions.

In response to surveys in 2000 and 2002, several programs reported the year in which they were first identified as a project, and the year in which they carried out their first accreditation survey. Table 28 shows that most programs took at least two years to make their first survey, and would need much longer to build sufficient capacity to survey and reach accreditation decisions on the majority of hospitals in that country.

Both the Dutch and the French national programs for accreditation grew out of existing agencies. NIAZ developed in 1999 from the PACE pilot project for hospital standards, which began in 1989. ANAES was created in 1997 from the existing ANDEM, which had been developing and evaluating clinical practice guidelines since 1990. By November 2002, ANAES had surveyed over 600, and reached an accreditation decision on 300, of the 3000 healthcare organisations in France – about 10% coverage after five years of the accreditation program. NIAZ reached the same coverage in three years¹ and Zambia in 2 years.

Table 27: Years in Development

	Project start	First “live” survey	Surveys completed first year	Years to first survey
Argentina	1994	1996	3	3
Bulgaria	2000	2001	80	1
Czech Rep.	1995	1997	2	2
France	1997	1999	9	2
Germany	1997	2001		4
Ireland	1999	2002		3
Italy (Marche)	1997	2001		4
Japan	1995	1997		2
Malaysia	1995	1999	3	4
Netherlands	(1989)	1999	4	10
Poland	1996	1998	23*	2
Portugal	1999	2000	4*	1
Switzerland	1994	1998	12*	4
Thailand	1997	1999	10	2
Zambia	1997	1999	8	2

* completed in second year of surveys

In Zambia, this first cycle, including accreditation decisions, was achieved in just under four years. The component stages are shown in Figure 2.

Figure 2 Chronology of Major Milestones in the Development of the Zambian Hospital Accreditation Program, 1997-2000⁴⁵

Year	1997				1998				1999				2000			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1	Recognising need to improve quality and choosing accreditation to address need															
		x	x	x												
2	Choosing the appropriate accreditation configuration and adapting it to the country															
			x	x												
3	Setting up the formal structure to advise, operate, and manage the accreditation program															
			x	x	x	x	x	x								
4	Developing and testing standards, and agreeing on the survey process															
			x	x	x	x	x	x								
5	Recruiting, hiring, and training surveyors															
							x	x	x	x	x	x	x	x	x	x
6	Conducting educational campaigns and surveys															
							x	x	x	x	x	x	x	x	x	x
7	Refining rules, policies, and procedures for accreditation															
								x	x	x	x	x	x	x	x	x
8	Developing the accreditation database format															
									x	x	x	x	x			
9	Conducting accreditation decision surveys															
									x	x	x	x	x	x	x	x
10	Interpreting survey data and making accreditation decisions															
									x	x	x	x	x	x	x	x

5.5.1 Option appraisal

In Ireland, an Accreditation Steering Group (including representatives from the ministry) was established in November 1998. It set up a Management Group to evaluate a number of existing major accreditation schemes (including schemes from USA, Canada, UK, Australia) for applicability to the Irish health system. The Group then drafted a framework for development of an Irish Accreditation Scheme, an associated work-plan, and an invitation for proposals from international programs to assist. By this process, the Canadian Council on Health Services Accreditation (CCHSA) was selected as preferred provider³⁶.

5.5.2 Formation of agency structure

In Ireland, a Central Project Team was then appointed to implement the work-plan, which included:

- Developing standards, with the support of hospitals;
- Developing non-standards components of the scheme;
- Assisting in the establishment of the accrediting body, with the Steering Group;
- Surveyor recruitment and training;
- Developing a detailed plan for roll-out of the Scheme.

5.5.3 Development of standards and assessment process

Continuing the Irish story, each of the teaching hospitals participating in the development contributed by appointing an Accreditation Project Manager. His role was to support the Central Project Team by leading part of the standards development, commenting on other outputs, and preparing for accreditation. Each hospital also set up the following:

- A multidisciplinary steering group to oversee input to the initiative;
- Standards development working groups;
- An accreditation preparatory group.

The start-up, from formation of the steering group to first draft standards, was completed in 14 months, which was acknowledged to be a “Tight timeframe, and a high demand on human resources”. This would not have been possible had the standards been developed locally, rather than imported from Canada. They also needed to make only relatively minor local adaptations, and had direct technical assistance from the Canadian Council.

Table 28: Standards Development Process (Ireland)

CCHSA templates	2000	January
Preliminary standards developed		March-April
Preliminary standards for cross consideration		May
Draft standards		May
Pilot self assessment		May-July
Pilot peer review		August
Final draft standards		November
International validation of all standards		November
Final standards	2001	January

5.5.4 Surveyor selection and training

Training cannot begin until standards and procedures are available – if necessary, in draft form. In established programs, training is provided by existing surveyors and staff. New programs generally use expertise from other countries, at least for initial training. The German KTQ program began training surveyors two years before the first “live” surveys.

5.5.5 Pilot testing and education

Even with substantial external technical help in preparation, it is essential to test the draft standards, assessment processes and surveyors. This usually reveals concerns about the preparation of staff, organisations and surveyors, the interpretation of standards, the on-site scheduling, and the difficulty which surveyors have in writing self-explanatory reports for the accrediting body.

“A COHSASA facilitator is appointed to work with a participating hospital for a period of 9 to 18 months for first-time entrants, depending on how far the hospital is from meeting the standards, and 3 to 6 months for second-time entrants, depending on the need of the hospital”¹. South Africa

If organisations are to have a fair chance to prepare for the first pilot survey, they need to have the standards made available at least six months in advance – unless, of course, they were directly involved in the original drafting (as in Ireland). When the pilot tests are completed, the process of revising standards, procedures and guidance documents begins again.

“Reasons for the delay in conducting the educational surveys included logistical challenges of arranging transportation to distant locations, scheduling conflicts among surveyors, surveyor attrition, and insufficient or erratic funding... One year was expected to elapse between a hospital’s educational survey and its formal accreditation survey. The average time for the first eight hospitals to receive the full accreditation survey has been close to 1 year, although written communication of results from educational surveys also took 1 year... Unfortunately, the lack of a ZHAC secretariat and bureaucratic inefficiencies delayed the communication of results to hospitals” Zambia

5.5.6 The continuing cycle

Once awarded or denied accreditation, organisations are expected to follow a pathway defined by the accreditation body. This may be a “focus” survey of specific issues to be made within a few months, submission of action plans to respond to specific recommendations (or evidence of their fulfilment), statistical reporting, mid-term review, or full accreditation. Even the latter award is usually contingent on the organisation acting on recommendations made at the first survey.

“In the facilitated accreditation program, designed to help public hospitals to reach accreditation standards, the usual time from induction to formal self-assessment is 18 months, to external survey is 21 months, and to accreditation decision is 24 months.” South Africa

Until the system is well tested, and the stability of the program and of the participating organisations is clear, the accrediting body is likely to favour shorter awards. The length of this cycle, and the rate of entry to (or loss from) the program, projects the future survey workload.

5.6 Costs to participating institutions

5.6.1 Reaching compliance with standards

In general, mature accreditation programs do not specify comprehensive standards of structure (eg norms of staffing, funding, equipment). They do, however, expect participants to deploy sufficient skills and facilities to deliver their function, to work “within resources available” and to “use hospitals well”.

“One benefit of the external quality assessment process was that quality improvements could be made with little or no extra funding. Services focused on developing policies, procedures, integrated work systems, multidisciplinary team work, client-centred care, knowledge and skill building plus communication and consultation...Such processes incurred little, or no, financial cost to the services. The key resources required to achieve a change in these structures and processes was staff time and/or the cost of an external person to facilitate the process” Mahaffey³⁴

In developing countries, accreditation may act primarily as a vehicle for generally “taking stock”, and for developing greater equality of structure and access, where the health care system has wide regional and social divisions. In this case, the health system must be able to mobilise resources in order to respond appropriately to the priorities objectively demonstrated through the accreditation process.

“The research team discovered one looming difficulty: hospitals were expecting more than just to know their status (accredited or not accredited). Other expectations included: funding to correct deficiencies in areas where standards were not met, increases in education and training programs, new equipment, and even money for construction...Interviews with hospital staff members suggest that they had difficulties achieving infection control and QA standards without external capacity building. Environment of care required some financial outlays, such as for the purchase of fire extinguishers, which many hospitals could not afford” Zambia

5.6.2 Preparation time

The greatest cost to institutions occurs in the preparation stage. In Canada, for example, this is estimated to be four times the cost of the external survey process. Much of the preparation is focused on bringing policies, procedures and quality systems up to commonly accepted standards across the organisation.

“To be truly successful quality improvement processes require time and effort from everyone. However in many situations the majority of the work is carried out by a few committed staff members. From the case studies it can be seen that a staff position dedicated to quality improvement was, or was considered to be, a favourable way for the service to reach the required standard.

One National Health Service Trust (in Northern Ireland) delegated a nurse/manager to implement the quality improvement processes necessary to prepare for the external assessment. At the end of the preparation, and external assessment phase of the process, it was necessary for her to take leave because of strain and exhaustion.” Mahaffey

5.6.3 External facilitators

“The assistance of an independent facilitator to prepare for the external quality assessment can be extremely valuable. In three different services (in Australia, New Zealand and South Africa) a facilitator worked with the service to interpret the standards, explain the process plus provide advice and guidance on policies, protocol and procedure development.”³⁴

Much of the preparation for institutional accreditation is done by independent consultants whose exact costs are hard to identify – though they are considered a high burden by the “accreditees”.

5.6.4 Survey fees

Some programs (e.g. UK, HQS and South Africa COHSASA) consider and price “facilitation” as an integral part of the accreditation process. Others make a point of differentiating between consultancy (including general education and development) and training, which is specific to the accreditation standards and assessment process. Some programs also include all documentation and direct survey costs (eg surveyor travel and accommodation) into a single-price package per survey. Others aim to smooth the cyclical costs by running a subscription program.

In 2000, the Australian ACHS charged \$3400 for annual program membership. In Canada, a small organisation with a budget of less than \$3million would pay an annual fee of \$685 plus a survey fee, based on \$1500 per surveyor day. In New Zealand there is no separate charge for surveys, but an annual subscription of \$3200 is charged which includes education, guidance, standards, tools, survey and mid-term progress visits.

5.6.5 Responding to survey recommendations

In most programs, the majority of report recommendations after the external survey are about improving systems and organisation. They are less concerned with increasing resources. Arguably, the costs of preparing for external survey and for implementing organisational improvements should be regarded as the costs of good management rather than the cost of the external assessment. Few studies have systematically analysed costs to institutions, but these were included in the joint study in South Africa and Zambia (by COHSASA and JCI)¹.

5.7 Program budget requirements

Countries need help to identify package ingredients, and to recognise the ongoing costs and the implications for scheduling. Most new programs take at least two years to prepare for their first survey; even longer before they are sustainable, and longer still (if ever) before they are self-financing.

In short, political and financial support needs to be consistent beyond the term in office of most health ministers and many governments.

“While USAID/Zambia supported the program in its early years, personnel changes at USAID led to a realignment of priorities. No other donor has stepped in to assist, and because the government contribution was limited, the program is now stalled. A key program deficiency was that it never developed a plan for financial viability.” Zambia

5.7.1 Key variables

Although the number of health care organisations in the country may be a key determinant of program costs, it is the policy decisions about the configuration, development and operation of the program, which have greater impact.

Program configuration

- Single national program, or multiple sub-national programs?
- Limited priority focus (eg polyclinics) or entire health system?
- To supplement existing external assessments or to replace them?
- To inspect and regulate, or to teach and develop?

Development

- Standards off the peg or made to measure?
- Thoroughness of system design and testing.
- Cost of specialist expertise.

Operation

- Surveyor payment, workload, wastage;
- Length and depth of surveys;
- Length of survey cycle;
- Efficiency of scheduling, transport, survey logistics etc;
- Investment in communications, publicity, information;
- Efficiency of report-handling, accreditation adjudication.

5.7.2 Program development expenditure

Some of the most detailed available information comes from a published study of the Zambian national hospital accreditation program⁴⁵

“Even though fewer than one in five hospitals has completed the accreditation cycle, questions of short-term funding and long-term sustainability have already arisen. The research team estimated that the program costs nearly US\$10 000 per hospital for a full accreditation cycle, not including any technical assistance or resources to the hospital (see Table 31). Since this includes start-up costs and external consultancies, it would be expected that the cost per hospital would decrease in subsequent cycles to about US\$7000”.

Table 28: Estimated Costs of the Zambia Hospital Accreditation Program for a Complete Cycle 1997-2000

	External Assistance, US\$ (USAID)	Zambian expenditures, US\$ (CBoH)	Program funds still required, US\$	Estimated totalcost, US\$
Advocacy to stakeholders	11230	500		11730
Capacity building (and study tour)	66700	2500		69200
Training of trainers	72100	3750		75850
Standards development and testing	72880	3250		76130
Training of surveyors	23190	300		23490
Accreditation Council	69050	6100		75150
Educational campaigns	8000	2000		10000
Surveys and feedback	92450		251550	344000
Independent infrastructure for Accreditation Council			97300	97300
Data entry	1080		2930	4010
Total estimated cost	416675	18400	351780	786860
Per hospital estimated cost				9960

5.7.3 Profiling budgets

Although a sustainable program is constantly under development, the start-up costs may last 3-5 years before a tested and valued product is sufficiently marketable to begin recovering some operational costs from customers. Whether they want to buy in, and whether they can afford to, depends on the incentives and sanctions, and on the existing operating budgets.

During the first year, the program may manage with a small core staff, several working groups and low overheads. But costs expand rapidly with the addition of external consultants, surveyor training, document production and the direct costs of field testing. At the next stage, when the initial development is completed and the program is ready to offer accreditation, it may face another challenge. The faster the rate of uptake, the faster the program must invest to build capacity. Funding should be profiled to reflect growth, not divided into equal annual tranches.

The French national agency ANAES was set up in 1997, completed 19 surveys in 1999, 165 in 2001 and is aiming for a “steady state” of over 700 hospital surveys per year.

5.7.4 Program operational expenditure

The reported expenditure of some national programs is shown in Table 33. Given the variation in the scope, activity, employment costs and stage of development in these programs, no simple formula can be derived from these figures. But they do illustrate the scale of costs, activity and personnel involved.

Table 30: Accreditation Programs Reporting 1999 Data

	Year first survey	Expenditure 1999, \$000	Number of surveys 1999	Number of surveyors 1999
Canada	1958	9500	328	350
Australia (ACHS)	1974	2750	272	374
Netherlands*	1999	251	NA	50
New Zealand	1989	500	50	70
UK (HAP)*	1990	225	19	41
UK (HQS)*	1990	2945	86	450
USA (NCQA)	1991	22000	352	200
Switzerland*	1998	135	15	38
South Africa	1994	539	92	82
Japan**	1997	2600	189	464
Malaysia	1999	20	3	22
France*	1999	12000	164	439
Poland*	1998	70	25	28
Portugal*	2000	210	4	36
Ireland	2002	295	0	0
Thailand	1999	500	10	20
Bulgaria*	2001	176	80	401

* data for 2001

** data for 2000

5.7.5 Principal budget headings

In larger, well-established programs, such as the Canadian CCHSA, typical budget headings, include:

- Indirect costs of the operational infrastructure of the Council (allocated per operating budget of accredee):
 - education (surveyor, organisation);
 - research and development (existing, new programs, standards);
 - corporate costs (information technology, finance, human resources, communications, marketing, translation, legal, infrastructure).
- Direct survey costs (team travel, accommodation, internal costs of processing the accreditation survey).
- Income: services, publications, teaching.

5.7.6 Sources of funding: developmental, operational

Thirty programs gave information on their main sources of income in 1999. The majority (60%) were supported by fees from either the accreditation process or from associated activities, such as training and workshops; 23% relied mainly on governmental grants.

Table 35: Who is the Customer? Who Pays?

Government pays	
“Not all programs will charge true cost recovery fees. Many hospitals cannot afford to pay. It is more economic and efficient for the government to give the money directly to the accreditation program.”	International adviser
“The program is directly funded by government; only accredited facilities can obtain contracts from the National Health Service”	Italy
“A fully independent program would find it hard to pay development costs, which are expensive; even if it can generate some funding it would need partial backup, especially in developing countries which have a newborn healthcare quality system.”	Indonesia
Cost sharing and transition	
“Direct government funding is anticipated for a period of three to four years. By years 4 and 5, the combined income from membership fees, external peer review assessment and charges for other services, is planned to cover at least 75% of the Agency’s actual costs.”	Bosnia FBiH
“Most successful programs eventually require the health care organizations seeking accreditation to pay for the services associated with achieving this recognition, such as the on-site survey costs, education, and publications.”	Zambia
“The continued subsidies from the government for accreditation in developing countries may be necessary to reduce financial burden to health facilities.”	Thailand
“Development funding for accreditation should be jointly financed by all interested parties - government, sickness funds, commerce”	Czech Republic
“The program is financed until 2005 by the Health Sector Reform Project, funded by the World Bank, USAID grant and some income from accreditation services. It is planned to transfer to full self-financing at the expense of users of operation services by 2005.”	Kyrgyz Republic
Health care organisations pay	
“The accreditation criteria are freely available, however not free of charge. The financing of the national accreditation body depends on selling booklets etc.”	Germany
“The program is not financed by the government; the problem is that state health facilities are not able to pay accreditation services at full cost.”	Kyrgyzstan
“It is better that the candidate organization pays for this service. That allows them to act as real clients”	Spain

6 Conclusions

As stated at the beginning, this toolkit aims to highlight some of the questions which need to be addressed before deciding on, and implementing, an accreditation program. Detailed answers must be specific to the values, policies and organisations of individual countries.

Some general principles may be proposed to address the ten challenges listed in the Introduction.

6.1 Clarity of purpose

- Define the values and objectives which initially prompted consideration of a new program.
- Describe how these relate to plans for health reform in general, and to the national quality strategy in particular.
- If there is no national quality strategy, start with the experience of others¹.

6.2 Appropriate technology

- Map the scope of existing mechanisms for external quality assessment, to identify gaps and overlaps.
- Consider a range of options for integrating, extending or supplementing these mechanisms (eg licensing, certification, accreditation) and assess their suitability in the national context.

6.3 Quality culture

- Define the principal stakeholders who would use, or help to provide, an accreditation program eg patients, professions, insurers. Involve them in early discussion.
- Demonstrate transparency; make policies and proposals freely accessible.
- Assess the capacity of prevailing attitudes among the public, professions, providers and politicians, to adapt to independent assessment of the performance of health care organisations.
- Define and encourage voluntary self-regulation and public accountability.
- Do not underestimate the importance of a willing environment, or the time needed to develop it.

6.4 Motivation

- Create rewards for organisations which gain voluntary accreditation, e.g. eligibility for training status, preferential reimbursement by health insurance, public recognition, exemption from statutory inspection.
- Design the program to be an external catalyst for internal change.
- Encourage employers to second staff for training and work as voluntary peer group surveyors, promoting it as part of their personal professional development.
- Keep coercion and sanctions as a last resort.

6.5 Independence

- Keep the accreditation agency far enough from government to be credibly independent.
- Establish a governing body which is representative of the principal stakeholders, but is dominated by none of them.
- Provide enabling legislation, if necessary, to authorise the functions of the agency.

6.6 Scope of responsibility

- Define and prioritise the agency's terms of reference in relation to the overall strategy for quality.
- Aim for a single national agency for all institutions, both public and private.
- Start with core standards and accreditation for single institutions, e.g. acute hospitals, polyclinics, health centres. Then aim for more specialised services, e.g. long-term care, mental health, followed by the linkages between them, e.g. preventive health, health networks.

6.7 Clear relationships

- Define the related organisations with which the agency should work, on what issues it should work, and how.
- Define the procedures for exchange of information between organisations (public and private), consistent with rules for data protection and for public information.

6.8 Objectivity and probity

- Design and publish procedures for the contracting, facilitation, assessment, reporting and accreditation decisions. These procedures should promote confidence and avoid improper influence by any individuals or factions.

6.9 Sustainable resourcing

- Make projections of human and financial resources, based on realistic assumptions of the volume and scope of activities during the development phase, and on the rate of uptake and cost-sharing in the operational phase.
- Expect full core funding to be needed for 3-5 years before tapering towards funding from income generation (if any).

6.10 External technical assistance

- Download the ALPHA principles and standards from www.isqua.org as a template for program policy, design and operation.
- Identify agencies in other countries which are prepared to share their experience of accreditation in situations similar to yours.

Appendix 1: Self-Assessment Tool – Key Factors in Accreditation

Policy, values and culture	Yes ?	No ?
1. The aim of the accreditation program (AP) is to promote and document improvement in the performance of health services; it is not primarily to reduce costs or close facilities.		
2. The views of stakeholders on the role of accreditation in the national plans for quality improvement will be sought in advance by formal public consultation.		
3. Participation in the AP will be voluntary.		
4. The national government will recognise, endorse and promote uptake of the accreditation program.		
5. The policy and management of the AP will remain consistent, regardless of changes in government.		
6. Accredited organisations will automatically be assumed to be (re)licensed.		
7. Doctors are organised and willing to accept corporate responsibility for the quality of their clinical practice.		
8. There is representation on the accrediting body of the major leading health care professional organisations within the country.		
Organisation and structure		
1. Statutory licensing and registration of individuals and organisations against minimal standards of structure and safety, will be clearly demarcated from accreditation, and managed by a separate agency.		
2. Statutory regulations and inspectorates ensure the safety of public, patients and staff with respect to radiation, fire, hygiene, medicines and devices.		
3. There is an identified quality unit, and a named officer, responsible for coordination of government initiatives within the MoH.		
4. There is a national resource centre for collecting and developing clinical practice guidelines.		
5. There is a national centre for the collation and dissemination of comprehensive comparative information on health system performance.		
6. There is a national information and resource centre for quality improvement methods.		
7. There is a professional organisation and mechanism to control registration of medical practitioners at national level.		
8. There is a professional organisation and mechanism to control registration of nurses at national level.		
9. There are active quality improvement structures identified within each self-regulating clinical profession and specialty.		
10. There is designated leadership, accountability, supervision, monitoring and communication of quality at sub-district, district, regional and national levels.		
11. There is a national external quality assurance system for clinical laboratories.		
12. There is a national society for quality in health care.		
13. The functions of the AP will be defined by national law.		
14. The AP will be managed nationally, and not delegated to regional or local administrative authorities.		
15. The AP will not be managed directly by the Ministry of Health, government agencies (eg public health institute), ISO accreditation service, or health insurance funds.		
16. The AP will be governed by a Board which represents professional, public and governmental interests but is dominated by none of them		
	Yes ?	No

Methodology

1. Policy-makers have agreed written definitions of the different functions, structures and operations of accreditation and licensing, both of individuals and of organisations.		
2. The AP will be required to comply with ALPHA principles and standards.		
3. Public and private health insurers and funding agencies will provide financial incentives for facilities to encourage participation in the AP.		
4. Achievement of accreditation will be a condition of recognition of clinical training posts		
5. Final decisions on accreditation awards will be made on published criteria through a defined process; they will not be made by individual surveyors or program staff.		
6. The standards and criteria used for accreditation assessment will be derived from documented evidence of what has been shown to be effective by research or experience in health care.		
7. The scope and duration of accreditation awarded to individual facilities will be freely accessible to the public.		
8. The accreditation standards will be freely accessible to the public.		

Resources

1. The AP will be guaranteed core funding for development, profiled over time and according to agreed expenditure and earned income.		
2. Initial funding from whatever source (government, development banks, donor agencies or charities) will not exceed sustainable continuing income from program operation and subsidies.		
3. Development funding will be realistically budgeted for five years, or a year after break-even, whichever is first.		
4. The AP will be authorised to recoup operating costs from users of accreditation services.		
5. The AP will have access to aggregated data which are routinely reported to the MoH by health care providers.		
6. Health facilities will provide staff with accurate, complete and timely data by which clinical and organisational performance can be measured.		
7. Personnel will be trained to evaluate and improve the performance of their own work and of their health care organisation.		
8. Directors of hospital and health services will have formal training in health service management		

Appendix 2: accreditation program websites

Argentina: Instituto Técnico para la Acreditación de Establecimientos de Salud	www.itaes.org.ar
Australia: Australian Council on Healthcare Standards	www.achs.org.au
Australia: Australian General Practice Accreditation	www.agpal.com.au
Australia: Quality Improvement Council	www.qic.latrobe.edu.au
Brazil: Consórcio Brasileiro de Acreditação	www.cbacred.org.br
Brazil: National Accreditation Organization	www.ona.org.br
Canada: Canadian Council on Health Services Accreditation	www.cchsa.ca
Czech Republic: Centrum pro kvalitu ve zdravotnictví	www.szu.cz/cekz/
Denmark: KISS (Kvalitet i Sønderjyllands Sundhedsvæsen)	www.kissprojekt.dk
Finland: Sosiaali- ja terveydenhuollon palvelujärjestelmän kehittämishjelma, auditointi ja laaduntunustus	www.efektia.fi
France: Agence Nationale d'Accréditation et d'Evaluation en Santé	www.anaes.fr
Germany: KTQ (Kooperation für Transparenz und Qualität im Krankenhaus)	www.ktq.de
Ireland: Major Academic Teaching Hospitals (MATHs) Accreditation Project:	www.accredithhealth-ireland.ie
Italy (Emilio-Romana): Accreditamento Istituzionale Regione Emilia-Romagna	www.regione.emilia-romagna.it/agenziasan
Italy (Marche): Programma di accreditamento istituzionale. Regione Marche	www.ars.marche.it
Japan: Hospital Accreditation Program	www.jcqh.or.jp/
Malaysia: Malaysian Healthcare Accreditation Program	www.msghealth.com
New Zealand: Quality Health New Zealand	www.qualityhealth.org.nz
Latvia: Arstniecibas iestazu atbilstibas novertesana	www.vsmta.lv
Netherlands: Nederlands Instituut voor Accreditatie van Ziekenhuizen	www.niaz.nl
Poland: Program Akredytacji Szpitali (Hospital Accreditation Program)	www.cmj.org.pl
Portugal: Instituto da Qualidade em Saude (Health Quality Service)	www.iqs.pt
Slovakia: Centrum pre kvalitu a akredit-ciu v zdravotnictve	www.health.gov.sk/starostlivost/centrum/
South Africa: Council on Health Service Accreditation of Southern Africa	www.cohsasa.co.za
Spain: Acreditacion FAD/JCI	www.fadq.org
Switzerland: Akkreditierung VQG	www.vqg.ch
Thailand: Institute of Hospital Quality Improvement and Accreditation	www.hsri.or.th/ha/index.htm
UK: Healthcare Accreditation Program	www.caspe.co.uk/hap
UK: Health Quality Service	www.hqs.org.uk
UK: Clinical Standards Board, Scotland	www.clinicalstandards.org
USA: Joint Commission on Accreditation of Health Care Organizations	www.jcaho.org
USA: Joint Commission International	www.jcinc.com
USA: National Committee for Quality Assurance	www.ncqa.org

Appendix 3: Glossary of terms (ALPHA)

Accreditation

A public recognition of the achievement of accreditation standards by a healthcare organisation, demonstrated through an independent external peer assessment of that organisation's level of performance in relation to the standards.

Accreditation body

The organization responsible for the accreditation program and the granting of accreditation status

Access

Ability of clients or potential clients to obtain required or available services when needed within an appropriate time.

Accountability

Responsibility and requirement to answer for tasks or activities. This responsibility may not be delegated and must be transparent.

Appropriateness

The degree to which service is consistent with a client's expressed requirements and is provided in accordance with current best practice.

Assessment

Process by which the characteristics and needs of clients, groups or situations are evaluated or determined so that they can be addressed. The assessment forms the basis of a plan for services or action.

Audit

A systematic independent examination and review to determine whether actual activities and results comply with planned arrangements

Benchmarking

Comparing the results of organizations' evaluations to the results of other interventions, programs, or organizations, and examining processes against those of others recognised as excellent, as a means of making improvements.

Best practice

An approach that has been shown to produce superior results, selected by a systematic process, and judged as exemplary, or demonstrated as successful. It is then adapted to fit a particular organization.

Business objectives

The steps needing to be taken to achieve the goals of the organization, including action plans indicating who, what, why, when, and how goals will be achieved.

Business plan

The current action plan for achieving organization goals, capacities, abilities, resources, assets, and strengths of groups or individuals to deal with situations and meet their needs.

Clients

Individuals or organizations being served by the organization.

Community

Collectivity of individuals, families, groups and organizations that interact with one another, cooperate in common activities, solve mutual concerns, usually in a geographic locality or environment.

Competence

Guarantee that an individual's knowledge and skills are appropriate to the service provided and assurance that the knowledge and skill levels are regularly evaluated.

Complaint

Expression of a problem, an issue, or dissatisfaction with services that may be verbal or in writing.

Complementary

Services or components that fit with each other, or supplement one another, to form more complete services.

Confidentiality

Guaranteed limits on the use and distribution of information collected from individuals or organizations.

Consent

Voluntary agreement or approval given by a client.

Continuity

The provision of coordinated services within and across programs and organizations, and over time.

Contract

Formal agreement that stipulates the terms and conditions for services that are obtained from, or provided to, another organization. The contract and the contracted services are monitored and coordinated by the organization and comply with the standards of the government and the organization.

Coordination

The process of working together effectively with collaboration among providers, organizations and services in and outside the organization to avoid duplication, gaps, or breaks.

Credentialling

The process of assessing and attesting to an individual's knowledge, skills, and competence and their compliance with specific requirements.

Criteria

Specific steps to be taken, or activities to be done, to reach a decision or a standard.

Cultural appropriateness

The design and delivery of services consistent with the cultural values of clients who use them.

Culture

A shared system of values, beliefs and behaviours.

Customers

The patients/clients of a client organization. Internal customers/staff of the organization.

Data

Unorganised facts from which information can be generated.

Document control system

A planned system for controlling the release, change, and use of important documents within the organization, particularly policies and procedures. The system requires each document to have a unique identification, to show dates of issue and updates and authorisation. Issue of documents in the organization is controlled and all copies of all documents are readily traceable and obtainable.

Education

Systematic instruction and learning activities to develop or bring about change in knowledge, attitudes, values or skills.

Effectiveness

The degree to which services, interventions or actions are provided in accordance with current best practice in order to meet goals and achieve optimal results.

Efficiency

The degree to which resources are brought together to achieve results with minimal waste, re-work and effort.

Ethics

Standards of conduct that are morally correct.

Evaluation

Assessment of the degree of success in meeting the goals and expected results (outcomes) of the organization, services, programs or clients.

Evidence

Data and information used to made decisions. Evidence can be derived from research, experiential learning, indicator data, and evaluations. Evidence is used in a systematic way to evaluate options and make decisions.

Follow-up

Processes and actions taken after a service has been completed.

Goals

Broad statements that describe the outcomes an organization is seeking and provide direction for day-to-day decisions and activities. The goals support the mission of the organization.

Governance

The function of determining the organization's direction, setting objectives and developing policy to guide the organization in achieving its mission, and monitoring the achievement of those objectives and the implementation of policy.

Governing body

Individuals, group or agency with ultimate authority and accountability for the overall strategic directions and modes of operation of the organization. Also known as the council, board, board of commissioners, etc.

Guidelines

Principles guiding or directing action.

Health professionals

Medical, nursing or allied health professional staff who provide clinical treatment and care to clients, having membership of the appropriate professional body and, where required, having completed and maintained registration or certification from a statutory authority.

Human resources

The personnel requirements of the organization.

Incidents

Events that are unusual, unexpected, may have an element of risk, or that may have a negative effect on clients, groups, staff, or the organization.

Indicator

Performance measurement tool, screen or flag that is used as a guide to monitor, evaluate, and improve the quality of services Indicators relate to structure, process, and outcomes.

Information

Data that is organised, interpreted and used. Information may be in written, audio, video or photograph form.

Information systems

Systems for planning, organising, analysing and controlling data and information, including both computer-based and manual systems.

Leadership

Ability to provide direction and cope with change. It involves establishing a vision, developing strategies for producing the changes needed to implement the vision; aligning people; and motivating and inspiring people to overcome obstacles.

Licensure

Process by which a government authority grants permission to an individual practitioner or healthcare organization to operate or to engage in an occupation or profession.

Linkages

Connections, contacts and working relationships established with others.

Management

Setting targets or goals for the fixture through planning and budgeting, establishing processes for achieving those targets and allocating resources to accomplish those plans Ensuring that plans are achieved by organising, staffing, controlling and problem-solving.

Mission

A broad written statement in which the organization states what it does and why it exists. The mission sets apart one organization from another.

Need

Physical, mental, emotional, social or spiritual requirement for well-being. Needs may or may not be perceived or expressed by those in need. They must be distinguished from demands, which are expressed desires, not necessarily needs

Objective

A target that must be reached if the organization is to achieve its goals It is the translation of the goals into specific, concrete terms against which results can be measured.

Organization

Comprises all sites/ locations under the governance of, and accountable to, the governing body/owner(s).

Operational plan

The design of strategies, which includes the processes, actions and resources to achieve the goals and objectives of the organization.

Orientation

The process by which staff become familiar with all aspects of the work environment and their responsibilities

Partners

The organizations that the organization works and collaborates with to provide complementary services

Partnerships

Formal or informal working relationships between organizations where services may be developed and provided jointly, or shared.

Peer assessment

A process whereby the performance of an organization, individuals or groups are evaluated by members of similar organizations or the same profession or discipline and status as those delivering the services

Performance review

The continuous process by which a manager appraisal and a staff member review the staff member's performance, set performance goals, and evaluate progress towards these goals

Personnel record

Collection of information about a staff member covering personnel issues such as leave, references, performance appraisals, qualifications, registration, and employment terms

Philosophy

A statement of principles and beliefs made by the organization by which it is managed and delivers services

Policies

Written statements which act as guidelines and reflect the position and values of the organization on a given subject.

Procedures

Written sorts of instructions conveying the approved and recommended steps for a particular act or series of acts

Processes

Series of interrelated activities and communications which accomplish services

Qualified

Having the credentials for, being professionally and legally prepared and authorised to perform specific acts

Qualitative

Data and information expressed with descriptions and narratives, a method that investigates the experience of users through observation, interviews

Quality

The degree of excellence, extent to which an organization meets clients' needs and exceeds their expectations

Quality activities

Activities which measure performance, identify opportunities for improvement in the delivery of services, and include action and follow-up.

Quality assessment

Planned and systematic collection and analysis of data about a service, usually focused on service content and delivery specifications and client outcomes.

Quality control

The monitoring of output to check if it conforms to specifications or requirements and action taken to rectify the output. It ensures safety, transfer of accurate information, accuracy of procedures and reproducibility.

Quality improvement

Ongoing response to quality assessment data about a service in ways that improve the processes by which services are provided to clients

Quality plan

The current action plan for meeting service quality requirements.

Quality project

A timebound quality improvement plan for an identified service or area.

Quantitative

Data and information that is expressed in numbers and statistics, a method that investigates phenomena with measures.

Recruitment and selection

Processes used to attract, choose and appoint qualified staff and surveyors .

Reliability

Extent to which results are consistent through repeated measures by different measurers, or at different times by the same measurer, when what is measured has not changed in the interval between measurements.

Research

Contribution to an existing body of knowledge through investigation, aimed at the discovery and interpretation of facts

Results (Outcomes)

The consequences of a service.

Rights

Something that can be claimed as justly, fairly, legally, or morally one's own. A formal description of the services that clients can expect and demand from an organization.

Risk

Chance or possibility of danger, loss or injury. This can relate to the health and well-being of staff and the public, property, reputation, environment, organizational functioning, financial stability, market share and other things of value.

Risk management

A systematic process of identifying, assessing and taking action to prevent or manage clinical, administrative, property and, occupational health and safety risks in the organization.

Safety

The degree to which the potential risk and unintended results are avoided or minimised.

Scope

The range and type of services offered by the organization and any conditions or limits to service coverage.

Services

Products of the organization delivered to clients, or units of the organization that deliver products to clients.

Staff

Employees of the organization.

Stakeholder

Individuals, organizations or groups that have an interest of share in services.

Standard

A desired and achievable level of performance against which actual performance is measured.

Strategic plan

A formalised plan that establishes the organization's overall goals, and that seeks to position the organization in terms of its environment.

Survey

External peer assessment which measures the performance of the organization against an agreed set of standards.

Surveyor

External peer reviewer, assessor of organizational performance against agreed standards.

Validity

Extent to which a measure truly measures only what it is intended to measure.

Values

Principles, beliefs or statements of philosophy that guide behaviour and that may involve social or ethical issues.

Vision

Description of what the organization would like to be.

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