

# What are the arrangement options for the accreditation of health service providers in LMICs?

March 2012

This rapid response was prepared by the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative.

## Key messages

- Accreditation may be used at the national level both as an external assessment of health services and as a tool for organizational development
- Four models of accreditation identified from the literature include:
  - Traditional Accreditation Model
  - Focused Accreditation Model
  - Outcome-based Accreditation
  - Other Approaches like ISO certification
- The effectiveness, affordability and sustainability of an accreditation programme depends on many variable factors, especially the health care environment of the country involved



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## Who requested this rapid response?

This document was prepared in response to a specific question from a policy maker in Uganda.

## ! This rapid response includes:

- Key findings from research
- Considerations about the relevance of this research for health system decisions in Uganda

## X Not included:

- Policy or practice related recommendations
- Detailed descriptions

## What is SURE Rapid Response Service?

SURE Rapid Responses address the needs of policymakers and managers for research evidence that has been appraised and contextualised in a matter of hours or days, if it is going to be of value to them. The Responses address questions about arrangements for organising, financing and governing health systems, and strategies for implementing changes.

## What is SURE?

SURE – Supporting the Use of Research Evidence (SURE) for policy in African health systems - is a collaborative project that builds on and supports the Evidence-Informed Policy Network (EVIPNet) in Africa and the Regional East African Community Health (REACH) Policy Initiative (see back page). SURE is funded by the European Commission's 7th Framework Programme.

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## Glossary

of terms used in this report:

[www.evipnet.org/sure/rr/glossary](http://www.evipnet.org/sure/rr/glossary)

# Background

National accreditation systems are defined as programs that, at a national level, aim to provide accreditation services to primary care, community services, hospitals or networks (1, 2). They include statutory and voluntary bodies that offer organizational development through external assessment of health services by means of published service standards.

Accreditation may be used at the national level not only as an external assessment of health services but also as a tool for organizational development. Note that for this purpose, single-specialty or local programs, accreditation of training, and accreditation of ISO certification are not included. However in those countries where accreditation is mandated nationally but is provided at regional level, regional programs would be included.

Programs that carry out the accreditation exercise may be independent or not, of government influence. However, reviews of regulation of the health sectors in low-income countries invariably conclude that the state's ability to monitor and ensure quality is very weak (3).

Accreditation continues to become popular in many countries at the expense of the failures of licensing. Licensing is essentially different from accreditation in that, among others, it is a legal requirement for all facilities, while accreditation is based on voluntary opt-in; licensing systems are often financed and run by governments, while accreditation is usually financed from the fees from facilities, and licensing is based on minimum input-based standards, often little more than health and safety standards, whilst accreditation encourages higher level achievement in inputs, processes and even outcomes (3). Therefore accreditation is attractive and has immediate appeal in countries struggling to maintain systems of effective licensing of health care providers because it is voluntary; it places the obligation on facilities to raise standards and is financed by health providers, thereby encouraging competition in raising standards. The downside to it though is that it can be complex to establish and costly to administer; it also places a burden of cost on providers that is not affordable (3). Despite this accreditation is recommended for all health systems; accredited facilities have been reported to outperform other facilities in several reports although a causal link between accreditation and quality has not yet been clearly established (3). The outperformance may however be partly explained by the fact that this being voluntary for the providers, it will tend to be the better, more proactive, facilities that are more likely to seek accreditation, and these being

proactive it is assumed these would probably have improved over time anyway, with or without accreditation.

There is a paucity of information on the arrangements for accreditation in different low and middle income countries; it is therefore hoped that the new surveys commissioned by the International Society for Quality in Health Care (ISQua) in 2010-2011 will fill the information gaps (4). However in the year 2000, the World Health Organization carried out a survey of known national accreditation programs in its member states to look at the different arrangements they had for their health service providers (5). From the review it was clear that demands for accreditation are increasing worldwide and that they are also changing rapidly, increasingly taking into account the public agenda. The survey noted the number of accreditation programs around the world to have doubled every five years between 1990 and 2000. This paper is based on some of the findings of this survey. It also relies on evidence and information from a USAID and Republic of South Africa report on International Health Care Accreditation models and Country experience prepared in 2010 (4). The paper will also present additional information in form of case studies from countries within the region like Kenya, Zambia and South Africa (4, 6, 7).

### How this Response was prepared

After clarifying the question being asked, we searched for local or national evidence from Uganda and countries of similar context and other relevant research. The methods used by the SURE Rapid Response Service to find, select and assess research evidence are described here:

[www.evipnet.org/sure/rr/methods](http://www.evipnet.org/sure/rr/methods)

## Summary of findings

From a review of several literature, four commonly utilized models for health care accreditation are revealed (4):

### a) **Traditional Accreditation Model:**

Under this model, a variety of standards including structural, process, outcome, and others are developed for the health care facilities, both at the departmental level as well as with a number of quality assurance processes. The focus under this model is on inputs and processes. This model could be easily adapted in low income countries as most standards for service delivery have already been fairly well developed. However, many facilities may not be able to meet the inputs/process standards and significant investment in education, training, and development of personnel and facilities would need to be implemented to ensure that these standards can be met.

### b) **Focused Accreditation Model:**

Under this model, the focus of accreditation is initially limited to a few key high risk/high prioritized areas; for example, surgical theatres, accident and emergency units, laboratories, child health services, and related departments and services. A good example of this is the World Health Organisation (WHO) programme on “Baby Friendly” Hospitals as well as the “Adolescent-Friendly” Clinic Initiative in South Africa (See Appendix I).

**c) Outcome-based Accreditation:**

Under this model, health outcomes are used as a measure to assess the quality of care provided by a facility. However, outcomes are not only determined by the quality of care but by also type of patients admitted, say in terms of stage of disease, to the facility. The facilities use continuous quality improvement (CQI) tools and approaches to improve the health outcomes through changes in the processes of delivering care.

**d) Other Approaches:**

There are a few other approaches for accreditation of health care facilities available internationally (e.g., ISO 9001:2000). The International Organisation for Standardisation (ISO) is by far the largest standards/certification type organisation, but ISO has limited application in health care as compared to business and industry sectors. Another model is a “hybrid” approach that utilizes some of the traditional model components, but utilizes primarily the ISO 9001:2000 standards as the major component for hospital accreditation. Table 1 below outlines some of the advantages and disadvantages of each of the various accreditation models.

**Table 1. Comparison of various Models**

<b>Model</b>	<b>Strengths/Advantages/ Incentives</b>	<b>Weaknesses/Disadvantages/ Consequences</b>
<b>Traditional</b>	<ul style="list-style-type: none"> <li>• Well developed over 50 years in 30+ countries with thousands of successful facilities being accredited.</li> <li>• Standards and results are usually in the public domain - more transparency</li> <li>• Standards exist for every department and function</li> <li>• Application of principles will increase levels of continuous quality improvement over the long term</li> </ul>	<ul style="list-style-type: none"> <li>• High expense to develop, implement, and operate</li> <li>• Can be over-developed and become too complex and too costly to operate</li> <li>• Needs a critical mass of the number of facilities to be optimally implemented</li> <li>• Long development time with two years to do first surveys and five years to become organisationally and financially sustainable</li> <li>• Government must be committed to long term development and implementation with focus on results over many years</li> <li>• May need donor assisted funding to get it designed and developed</li> </ul>

<b>Focused</b>	<ul style="list-style-type: none"> <li>• Focus on high priority areas</li> <li>• Lower expense than traditional model to develop and to operate</li> <li>• Good experiences in many countries over many years with good results</li> <li>• Can be developed and implemented quickly as compared to traditional method</li> </ul>	<ul style="list-style-type: none"> <li>• Limited number of applications available and does not cover the whole organisation nor the total continuous quality improvement process</li> </ul>
<b>ISO 9000: 2001</b>	<ul style="list-style-type: none"> <li>• Well-developed international organisation (ISO)</li> <li>• Well-developed standards in non-clinical areas like housekeeping, maintenance, dietary, laundry, etc.</li> <li>• Large international organisation for support, backup and education</li> </ul>	<ul style="list-style-type: none"> <li>• Has proven successful in limited number of facilities as compared to traditional model</li> <li>• Certification Programme and not an Accreditation Programme</li> <li>• Standards and results not in the public domain means less transparency and no knowledge of how many facilities are using the standards</li> <li>• Only one clinical department (Laboratory) has ISO developed standards and not well developed in most of the clinical departments; Development costs are high at the beginning but less to maintain over the long term</li> </ul>
<b>Hybrid ISO</b>	<ul style="list-style-type: none"> <li>• Lower cost than traditional model</li> <li>• New accreditation model with new ideas and approaches</li> </ul>	<ul style="list-style-type: none"> <li>• Still unproven and still being fully tested internationally</li> <li>• Actual cost not known</li> </ul>

The survey carried out by the World Health Organisation revealed several factors that characterize the different arrangements of accreditation programs all over the world.

These include the following:

- Consideration for public agenda or public views
- Transparency
- Cost and benefits
- Expenditure and Income
- Legal frameworks
- Relation to government
- Public access to standards
- Program coverage
- Revision of standards
- Public access to reports

Public agenda: A third of all programs were enabled by national legislation, particularly since the late 1990s. Voluntary accreditation is becoming statutory and most new programs are government-sponsored.

Transparency: The move towards statutory and governmental endorsement mentioned above is associated with a move towards more and more free access by the public to the standards, processes and findings of accreditation. This enhances accountability from the providers and from the accrediting program.

Costs and benefits: with the new arrangements, more valuable evidence should be available about the costs and benefits of accreditation to governments, communities and providers. Such data will be increasingly crucial to governments and funding agencies when making investment decisions.

Income: The majority (60%) of the national accreditation programs surveyed was supported by fees from either the accreditation process or associated activities such as training and workshops; 23% relied mainly on government grants. Some new programs had different and quite conditional arrangements; For example that in the Slovak Republic, began with development funding from government for 2–5 years, with a view to becoming organizationally and financially independent over that period of time.

Legal framework: results from the survey suggested that only one-third of programs were enabled by legislation and that most of that legislation appeared in the late 1990s. Most programs were not based on any national legislation; notably accreditation of all health services was compulsory by law only in France and Italy.

Relationship to government (this is in terms of their management, funding or recognition): half of the programs were funded, partially funded or managed directly by government; the more long established programs tended to be independent of government. Most programs established in the past five years were sponsored by government. It was also clear that accreditation is increasingly used by governments as a means of regulation and public accountability, rather than for voluntary self-development of the concerned providers.

Program coverage: this refers to *whether programs focus on primary (community, general practice), secondary (hospital), or tertiary care (referral, academic centers)*. Accreditation traditionally developed in hospitals and then moved outwards towards community services and networks of preventive and curative services. The shifting of emphasis towards primary care may reflect a move to population-based medicine that is reinforced, particularly in developing countries, and this is in fact more popular with the development partners. In contrast, several programs focused

initially on academic and tertiary centers. The long established programs generally began with standards and surveys that reflected management units. They used that experience to develop their repertoire and to make the challenging transition to client-focused accreditation. Some countries extend these accreditation services to social services and to the private sector too.

Public access to standards: some programs make the general content and intent of the standards available, but without detailed criteria for assessment and scoring. Some programs sell their standards only as part of a development package; for example, Malaysia includes a one-day on-site training program while Canada incorporates the standards and program materials in the initial application package fee. Just under one-quarter of programs in the survey provided standards free to the public; these programs were typically government-sponsored, except for those in the Netherlands and Switzerland. About half of the programs sell their standards and a further half of these are sold at “little or no cost”.

Revision of standards: two-thirds of programs that gave a date use standards that have been approved within the past two years. Some 40% of programs use standards that are five years old. On average across all respondent programs, standards are revised every 4.5 years; in programs less than 15 years old, the average is about 2 years.

Public access to reports: two-thirds of programs do not provide full reports to the public. Programs providing free reports also give public access to their standards at little or no cost and, with the exception of Australia (QIC), are government-sponsored.

Other issues arising:

Shifting focus: Standards and assessments are increasingly focusing on integrated pathways, following patients and disease processes (horizontally) rather than management units (vertically).

Gestation: it takes about two years for most new programs to prepare for their first survey and even longer before they are self-sufficient.

Year of origin: the beginnings of some developments can easily be identified – for example, in terms of initial project funding – but others were a gradual fusion of research, vision and opportunity that were more difficult to date precisely. However findings from the survey showed that in 32 years before 1990, five of the responding programs in the survey became operational and the number of programs doubled in 1990–95, and more than doubled again in the following five years; the length of time for programs to develop is variable, ranging from 0 to 15 years with an average of 3.5

years: typically, the development phase lasts two years but the variation is not clearly associated with factors such as funding, external support or political will. Some programs had the benefit of growing out of an existing organization. This survey did not seek to collect data that might correlate speed of development with the amount or duration of start-up funding, but it does show that a new program is unlikely to become self-sufficient in less than three years – the period for which many such schemes are initially funded.

Country of inspiration: Nearly three-quarters of programs acknowledge that standards were influenced by a specific external model, which they studied and it fit in their context. Most (87%) specified that influence was shared between the United States and Canada (one-third each) and Australia (one-quarter). Japan's standards had no reference to an external model.

## **Country cases within the region**

Quality assurance initiatives in Africa and other developing regions of the world are increasingly a focus of discussion (4). It is noted that increasing numbers of developing countries have been introducing quality assurance programs into their health care system since the early 1990s. Though countries have adopted diverse methodologies and approaches, they all have consistently brought about policy changes which impact on the way services are organized and delivered.

One group of countries (mostly from Latin America) emphasizes a more formal and structured approach to QA and is pursuing accreditation for health facilities and licensing of providers. Another group emphasizes the development and implementation of standards as a way to improve quality of health services. A third group has placed initial emphasis on quality deficiencies in specific health programs on health facilities with primary attention on improving health care delivery processes. And so it is clear that programs must be tailored to meet specific national circumstances, meaning that accreditation cannot be imported from elsewhere without modification; that standards need to be developed in relation to existing conditions; and improvement objectives need to recognize existing resource constraints. Three examples of accreditation arrangements are given in Appendix 1; these are from Kenya, Zambia and South Africa.



## **Other Key issues in setting up an Accreditation Programme (8)**

The experiences of other countries show that accreditation has been a valuable technology for quality improvement. But the effectiveness of an accreditation programme, as well as its affordability and sustainability, depends ultimately on many variable factors, in particular the health care environment of the country or organisation involved. It also depends on the kind of programme concerned and how it is implemented. International experience has also shown that setting up accreditation as an extension of licensing or combined with a licensing programme has not been effective and has failed in a number of countries.

In the ISQua Accreditation Toolkit , these variables are addressed under four principal headings: Policy, Organization, Methods and Resources. Details of this are provided in Appendix II.

## **Conclusion**

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There are several models of accreditation of health service providers that can be adopted by a low and middle income country and these include the traditional accreditation model, focused accreditation model, outcome-based accreditation model and other approaches like using ISO certification. Within these models several factors are adopted according to the setting for example how much of the public agenda is considered, or the relation to the government or what scope the program will cover. Whatever the choice made is and whatever modifications are put in place, the effectiveness of the programme, its affordability and sustainability will depend on several factors but especially the health care environment it is serving and is a part of.

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### Conflicts of interest

None known.

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Regional East African Community  
Health Policy Initiative

The Regional East African Community Health-Policy Initiative (REACH) links health researchers with policy-makers and other vital research-users. It supports, stimulates and harmonizes evidence-informed policymaking processes in East Africa. There are designated Country Nodes within each of the five EAC Partner States. [www.eac.int/health](http://www.eac.int/health)



The Evidence-Informed Policy Network (EVIPNet) promotes the use of health research in policymaking. Focusing on low and middle-income countries, EVIPNet promotes partnerships at the country level between policymakers, researchers and civil society in order to facilitate policy development and implementation through the use of the best scientific evidence available. [www.evipnet.org](http://www.evipnet.org)

## Appendices

### Appendix 1

#### Kenya

The National Health Sector Strategic Plan II (NHSSPII 2005-2010) in Kenya outlined the review of the Public Health Act including the issue of accreditation, among other things, for the assurance of quality and standards. The two line ministries, that is, the Ministry of Medical Services and Ministry of Public Health and Sanitation also prioritized accreditation in their respective strategic plans, by planning for re-categorization and accreditation of health facilities in line with the Kenya Essential Package for Health (KEPH) to guide the identification of inputs required within the context of the existing KEPH Norms and Standards (MoMS Strategic Plan 2008-2012, MOPHS Strategic Plan 2008-2012).

The Ministry of Medical Services (MOMS) further outlined the development of a hospital accreditation policy as one of its 2012 goals, envisaging development of a Health Facilities Accreditation Framework, establishing and operationalizing a Hospital Accreditation Commission (HAC) and development of a star system policy to stimulate competitiveness in service delivery, together with development of updated standards, and procedures for hospital quality assurance.

Before these recent arrangements however, there have been attempts at streamlining the accreditation process in Kenya. In 2004-2005, the Department of Standards & Regulatory Services (DSRS) initiated the development of the Centre for Quality in Health Care (CQH) which was an independent and autonomous not-for-profit company. Its mandate was to provide quality management training, accreditation of health care organizations, research monitoring and evaluation, and Health Technology Assessments in the East African region, among others. It was to be a member of the International Society for Quality in Healthcare (ISQua) and had a partnership arrangement with the Council for Health Services Accreditation in Southern Africa (Cohsasa) and Joint Commission International. However, due to a number of reasons, this body collapsed.

In the mean time accreditation of health services has been limited to the small scale accreditation activities carried out by the National Hospital Insurance Fund (NHIF) and Kenya National Accreditation Services (KENAS). The NHIF is the only state owned insurance whose core function is to collect contributions from all salaried Kenyans or volunteers and pay hospital benefits out of the contributions to members. It accredits public, faith-based and private health facilities which have in-patient capacity in order to attend to the needs of the Fund's members. It is worth to note that the outpatient services are not accredited which serve the majority of the population especially the poor and the rural and remote areas.

Due to the context in which this accreditation operates nearly all the public facilities from the level of Sub-district facilities and above are accredited as a matter of routine though not necessarily meeting the accreditation criteria. In addition apart from diminished rebates, there are no regulatory mechanisms to ensure that health facilities not meeting the accreditation standards outlined by NHIF are penalized. In addition, private and faith based facilities can opt out of the accreditation and therefore there is no influence on the quality of care they offer.

KENAS is a newly formed government accrediting organ accrediting laboratories on voluntary basis; there are no mechanisms to ensure that all laboratories are accredited and their quality is regulated. Therefore Kenya's efforts to review and develop a comprehensive accreditation system that addresses the quality aspects of the health services providers including, hospitals, clinics, health centers laboratories and pharmacies which is governed by a legal framework to ensure that only the accredited facilities are allowed to operate, is a welcome idea.

## **Zambia**

The Government of Zambia launched a national hospital accreditation program in 1997 in a bid to address documented problems in its hospitals. This program defined 35 standards of good hospital practice, grouped into seven functional categories. External review teams used these to measure the compliance of participating hospitals in several surveys, judging the hospitals to be either compliant, partially compliant, or non-compliant in each category. The plan for the government was to phase 20 hospitals into the program each year, with the goal of using the survey results, including progress towards better performance, to stimulate the hospitals to comply with the standards and provide better care. Despite some promising results, the program was phased out after several years due to changing priorities and termination of funding.

The program was evaluated though and the evaluation investigated whether the accreditation program improved hospital practices and patient outcomes. The findings generally suggested that the accreditation program had a positive impact, but the evidence was not irrefutable because the study had several methodological problems. Furthermore, many accreditation standards were not evidenced-based and were not causally linked to outcomes or important process standards. Because changes in research indicators probably come several years after changes in accreditation scores, the measurement of research indicators may have been too soon to demonstrate gains in accreditation standards. Also, while compliance scores went up, they were still relatively very low. Still, hospital managers thought the program had merit, saying the feedback motivated them to improve, which they did if possible. However, they added that they were unable to take actions that required funds, which they normally did not have, or required expertise that was not available.

## **South Africa**

In 2010, South Africa proposed the establishment of an independent Office of Standards Compliance (OSC). It was proposed that this would handle accreditation of institutions and that it would audit 25% of health establishments annually to assess if they comply with core standards for quality, with a view to accrediting those that met the standards. The initiative was to be financed by the government. In this proposal, which also included the proposed national health insurance (NHI) plan, it was suggested that accreditation of health providers would be compulsory and a prerequisite for contracting with the NHI authority (NHIA).

*(However the definition of accreditation as used in the proposed NHI here extends beyond the traditional use of accreditation in so far as regulating quality; it extends to a type of licensing*

*mechanism for health facilities and providers eligible to provide healthcare services under the NHI system. This is a significant departure from global definitions of accreditation)*

South Africa is not new to accreditation; aside from these recent efforts, South Africa began to institute accreditation in the mid-1990s; By 2004, four institutions were providing accreditation services in the country. The non-profit Council for Health Services Accreditation of Southern Africa (COHSASA) was the only private accrediting institution. Government institutions were the Council for Medical Schemes operating at national level, the Department of Health of Gauteng Province, and the LoveLife National Adolescent Friendly Clinic Initiative (NAFCI). COHSASA had since 2000 designed both administrative and healthcare delivery standards. It offered accreditation services to hospitals, sub-acute care facilities, home healthcare services, psychiatric facilities/ programs, primary clinics, and general practitioners. It would visit facilities seeking accreditation and guide management toward successful program completion. (Some respondents saw potential conflict of interest in this dual role.) It provides both baseline and later assessments and awards both provisional and final accreditation, both with limited terms.

**The Council for Medical Schemes (CMS)**, headquartered in Hatfield, Pretoria, was created by federal statute to provide regulatory supervision of private health financing through medical schemes, a massive and important industry that encompasses all managed care organizations. CMS has created standards for accreditation of medical aid scheme administrators and managed care organizations (MCOs). It also registers brokerage firms. CMS has improved the compliance of schemes, administrators, and MCOs with relevant laws and has developed its own standards and regulations, such as patients' rights charters, to improve care.

**A Directorate of Quality Assurance** was established by the Gauteng Provincial Department of Health for the overall management of its program to accredit public facilities. The directorate offices are in Johannesburg. The directorate sets standards and trains facilitators and facility-based multidisciplinary quality assurance teams to conduct self-assessments and prepare monthly reports. The standards cover certain areas, such as: (1) inpatient units (e.g., record keeping, prevention of pressure sores); (2) outpatients units (reception and information, waiting times, patient safety); (3) pharmacies (equipment, waiting times, reception, patients' rights); and (4) hospital management (patient information, complaints system, public participation, monitoring of absenteeism).

Accreditation peer review teams measure compliance with standards as part of a two-phase process.

**LoveLife** is a five-year, national adolescent reproductive health program aimed to reduce high-risk behaviors among people aged 15 to 24 years. One of its components is NAFCI, which was introduced in 1999 as a nationwide quality improvement program to encourage public health clinics to become more adolescent friendly. NAFCI is implemented through provincially based coordinators who work closely with all categories of clinic-based staff and department of health managers to ensure compliance with NAFCI standards. LoveLife partners with the Reproductive Health Unit (RHU) of the University of Witwatersrand to operate the accreditation program.

NAFCI has developed a recognition system where clinics are assessed according to NAFCI standards and criteria. Clinics are awarded bronze, silver, or gold (good, better, and best, respectively) depending on how well they meet the standards. There is no direct chargeable cost to the clinics as the program is fully funded. The initiative has received enormous support from both the national and provincial departments of health.

## **Appendix 2**

Taken from the Introductory Section of the ISQua Toolkit 2004, these four key issues are discussed in more depth in a Section IX of this paper.

### **Policy:**

- What is the purpose of the proposed programme?
- 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 programme be governed?
- How would it ensure compatibility with associated regulatory and independent agencies?

### **Methods:**

- How will standards be made valid?
- Who will develop standards?
- 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 programme?
- What does it cost to set it up?

Outlined above are examples of the key questions and issues that need to be clearly reviewed and discussed before a country moves into a decision making process with regard to selection of an accreditation programme.