TECHNICAL DISCUSSIONS

ACCREDITATION OF HOSPITALS AND MEDICAL EDUCATION INSTITUTIONS—CHALLENGES AND FUTURE DIRECTIONS

A. HOSPITALS
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EXECUTIVE SUMMARY

Hospital accreditation is gaining prominence due to globalization efforts and especially trading in health services. It will eventually become a tool for international categorization and recognition of hospitals. This challenge calls for immediate reform of the role hospitals should play as a component of the national health system. While making use of accreditation as an incentive to improve capacity of national hospitals to provide quality care, countries and WHO need to work together to ensure that accreditation is protecting the national health system. It is important that countries introduce their own standards for accreditation based on the best interests of their health system in order to safeguard primary health care principles of universality, equity, quality, efficiency and sustainability.

In collaboration with Member States, WHO/EMRO has developed hospital accreditation guidelines which are based on these principles and which are intended to strengthen the steering role of the national health authority. The guidelines reflect a hospital accreditation model that is appropriate for the Region and flexible enough to allow for adaptation at national level. There are specific features in the regional accreditation model which differ from other accreditation approaches and that are intended to help make the hospital accountable to the national health system. One of these is the comprehensive scope of the model, which includes promotive, preventive and curative standards wherever relevant. The model also entails a stepwise approach to accreditation, starting with a basic level, to be required for all hospitals, to a more sophisticated level. Establishing national accreditation systems according to the regional guidelines will help to ensure that hospitals, whether public or private, national or expatriate, play their expected roles in national health systems.

Strategies for WHO and Member States should aim at fostering national accreditation initiatives and providing guidance for national accreditation efforts to ensure that accreditation systems are developed in a way that upholds the principles of health for all. Such strategies include encouraging national debate to reach consensus on accreditation, adapting the regional guidelines at country level and establishing a regional advisory group to guide countries in addressing accreditation issues.
1. INTRODUCTION

1.1 Quality improvement and accreditation

Health systems currently operate within an environment of rapid social, economic and technological change. Such changes are expected to continue for the foreseeable future as a result of restructured economic and social policies, globalization of markets and enhanced worldwide communication. Many of the health systems currently in place have neglected evaluation of the quality of individual and systematic institutional care in the past, giving rise to an unnecessary increase in costs. National health systems are coming under increasing scrutiny with a view to cost containment and quality improvement, often as a direct or indirect result of health sector reform.

Accreditation can be the single most important approach for improving the quality of health care structures. In an accreditation system, institutional resources are evaluated periodically to ensure quality of services on the basis of previously accepted standards. Standards may be minimal, defining the bottom level or base, or more detailed and demanding. Accreditation is not an end in itself, but rather a means to improve quality. The accreditation movement is gaining prominence due to globalization and especially the global expansion of trade in health services. It will eventually become a tool for international categorization and recognition of hospitals. When implemented appropriately, accreditation can strengthen the fundamental leadership and steering role of national health authorities.

1.2 Hospitals and health system reform

The common understanding of hospital accreditation is that it is a means to improve and ensure quality. In a wider sense it can contribute to reforming the health sector. Hospitals are an integral part of health systems; by harmonizing standards in hospitals in line with other institutions and levels of care, continuity of care is improved and the health care network strengthened.

- Hospitals account for 40%–70% of the national health budget. Efficiency in hospitals is demanded by all stakeholders.
- Hospitals dominate health systems and are important symbols for the public and for decision-makers in most countries of the Region.
- Hospitals play a crucial role in health care delivery and are labour intensive. On average, hospitals employ half the physicians and two-thirds of the nurses in a country.
- Although hospitals are large fixed assets and difficult to change, hospital treatment patterns are changing due to changing technology and demands. Hospitals are being ‘re-engineered’ to cope with challenges of high cost and increase demand. Accreditation is an opportunity for better reengineering of hospitals.
Accreditation of hospitals is a way to enhance standardization of care and exchange of expertise worldwide.

Pressures are intensifying to make hospitals more accountable to national health policies. Accreditation is a way to ensure that hospitals contribute to national health systems as set by health planners.

Specific goals of hospital accreditation are usually determined by the type of national health system and its policies. The most important objectives include enhancing health systems, promoting continuous quality improvement, informing decision-making and ensuring accountability to national health policies (Box 1).

### Box 1. Objectives of hospital accreditation

**Enhanced health systems**: integrating and involving hospitals as an active component of the health care network.

**Continuous quality improvement**: using the accreditation process to bring about changes in practice that will improve the quality of care for patients.

**Informed decision-making**: providing data on the quality of health care that various stakeholders, policy-makers, managers, clinicians and the public can use to guide their decisions.

**Improved accountability and regulation**: making health care organizations accountable to statutory or other agencies, such as professional bodies, government, patient groups and society at large, and regulating their behaviours to protect the interests of patients and other stakeholders.

1.3 The role of WHO in regional accreditation initiatives

In countries where health care is left to market forces, accreditation is a requirement to be competitive in the health care business. This is not the case in most countries of the Eastern Mediterranean Region, where it is the ministries of health who are taking the lead in efforts at quality improvement, as a natural evolution of concern expressed by health planners and providers and the users of health services. National health systems in the Region need protection from possible adverse effects of globalization treaties and agreements which influence trading of health services. There is danger that important global trade treaties will create a competitive environment with a focus on clinical sophistication at the expense of affordable, cost-effective public health investments. As the leading international agency for health, WHO has a role to play in promoting a model of accreditation that is oriented towards primary health care and that contributes to national health systems development.

There is great diversity of hospitals in the Region, often even within the same country. Prominent public and private medical centres exist in the Region that are comparable to the most
advanced in any other region. However, in many of these hospitals there are also services that do not meet a minimum level of quality. A number of government, semi-private and private health institutions in the Region are currently seeking recognized accreditation systems in order to cope with heightened demands for quality in health care service delivery. Many countries, including Jordan, Kuwait, Oman and Saudi Arabia, have established national committees to study requirements for accreditation; others, such as Egypt and Morocco, are piloting national accreditation programmes. Private hospitals are also active in pursuing accreditation and ISO certification.

In recent years, the Regional Office has held a number of intercountry meetings and consultations on quality improvement in response to requests for technical assistance from Member States. An expert group meeting on hospital accreditation was convened in Cairo, Egypt, from 23 to 26 September 2002 to advise on the implementation, at the national level, of hospital accreditation systems. In collaboration with Member States, the Regional Office has developed a hospital accreditation model that is appropriate for the Region and that is flexible enough to allow for adaptation at country level. Using this model, a draft manual on hospital accreditation has been developed that includes guidelines for countries in establishing national accreditation programmes and standards and indicators to assist national accreditation bodies in formulating their own evaluation tools.

The regional guidelines on accreditation are meant to protect national health systems from being overwhelmed or marginalized by international health trading companies and investments. Establishing national accreditation systems according to these guidelines will help to ensure that hospitals, whether public or private, national or expatriate, play their expected roles in national health systems. The guidelines promote a stepwise accreditation model that is comprehensive and system-oriented and that safeguards the principles of health for all. This approach differs from the business-oriented accreditation models found in many industrialized countries.

2. THE EMRO MODEL OF HOSPITAL ACCREDITATION

2.1 Major features

- Nationally owned. Hospital accreditation is a system of ongoing consensus, rationalization and hospital organization. National ownership is crucial, both to lay the foundation and to maintain, from the beginning, a high degree of integrity and accountability of the national accreditation system. Of great importance is the creation of the national accreditation body, which must be apolitical and multi-representational. This entity is responsible for administration and policy-making of the accreditation system at the national level. It should set national standards for accreditation, adapt the WHO guidelines for accreditation, identify and train the surveyors, conduct and monitor the site surveys and make the decisions related to the awarding and maintaining of accreditation.
Multi-institutional. The national accreditation body is multi-institutional and includes the most prominent and active players in the public and private sectors of the national health system. Representation from the Ministry of Health is also essential because of the Ministry’s authority and ability to transfer resources as necessary in the accreditation process.

Comprehensive. The hospital is not an isolated facility but an integral part of the health system. The EMRO accreditation model focuses on the holistic role and functions of the hospital in a national health system, whether the hospital is public or private. The scope of the model includes the clinical, preventive, promotive and educational functions of hospitals. The guidelines focus not only on the quality of clinical care but also on the quality of relation and functions with community and other components of national health services, such as referral services and training of the health workforce.

Incremental. The model includes increasingly complex standards for each hospital service, from an initial “threshold” to more sophisticated levels. These standards represent the expected level of desired care, practice, or methods defined by national experts or professional associations. In each situation, the initial standard is the required minimum limit of quality. No hospital should be below this level after a specified period of time. When the standard for the basic level is met, the next step is to reach the second and third levels, progressively. This promotes an environment of continuous improvement, because there will always be standards of higher complexity to pursue.

Integrated. A hospital is not comprised of independent or isolated services. Hospital structures and processes are integrated in such a way that poor functioning in one component interferes throughout and in the final result. For this reason it is necessary that all of a hospital’s services, from the laundry to the operating room, reach at least the basic level standard for the hospital to be accredited. An isolated service or unit is not accredited, even if it is fully equipped and of exceptional quality. A hospital “is” or “is not” accredited as a whole, indivisible unit.

2.2 Levels, standards and performance indicators

The regional accreditation guidelines recommend the use of levels of standards of accreditation of increasingly complexity. In order to attain an advanced level of quality for a specified hospital service, the standards for lower levels should first be satisfied. Accreditation by levels is based on certain specific principles. For example, Level 1 should require the observation of basic quality of care compatible with institutional resources. The services, units, or sectors have responsible certified personnel that observe formal safety requirements and have appropriate infrastructure to implement activities within the corresponding rules and regulations. For Level 2, in addition to Level 1 standards, there should be evidence of organizational planning of care in relation to documentation, training, control, and decisions making based on information and the internal audit. Services, units, or sectors have documented process and procedure manuals, that are up-to-date and available, as well as clinical protocols and basic statistics; continuous
education programmes are offered for the improvement of processes, sentinel events, and evidence of integration with other hospital services. For Level 3, in addition to Level 2 standards, there should be evidence of institutional policies for continued improvement in terms of structures, processes, procedures, technology upgrades, and outcomes or impacts. The services, units, or sectors have measurement systems for client satisfaction; integration with the institutional quality and productivity programme; evidence of improvement cycles; data information systems and indicators that allow service evaluation; and community impact. The standards are statements of expectation that define the structures, processes and results that must be firmly established in a hospital so that it may provide quality care. For example, standard of structure refers to equipment, physical area, support services and personnel; standard of process includes admission, nursing procedures, medical procedures, operational manuals, norms, routines and flows; and standard of outcomes covers mortality, morbidity, readmissions, complications, infections and client satisfaction (accessibility, information, personnel, and facilities). All these standards require evidence of performance (or qualitative indicators) that are simple, inexpensive and easy to observe by the surveyors.

To determine the level agreed upon for each standard, the evaluation should begin at the lower levels until reaching a level where the requirements are not completely satisfied. For example, in a hospital which has different sophistication levels among its services, some of the services may rank at level three or four, but other services and departments may rank at level one. This hospital would be accredited at the first level as long as some services do not exceed the first level.

In the draft manual, qualitative indicators, or evidence of performance, are described for each standard and designed to ascertain the degree to which measures prescribed by standards are carried out and their effect on patient care. The data collection process for observing qualitative indicators is designed to be as simple as possible. The results should offer information useful to those in decision-making or managerial positions to help them make necessary changes.

The evidence of performance of standards is not assessed through a generic checklist. Hospitals are unique entities, each with its own tradition, culture and history. The surveyors will establish a tailor-made model of assessment for each hospital, defining how, when and what will be assessed first; this flexibility cannot exist in a rigid checklist. Accreditation is still a very subjective way of assessment. For this reason, highly competent surveyors must be selected. A sample of standards and qualitative indicators, or evidence of performance, from the draft accreditation manual are included as Annex 1.

3. CHALLENGES IN IMPLEMENTING HOSPITAL ACCREDITATION

Institutionalizing improved quality of care through accreditation requires more than a technical approach. Failure to change the behaviour and attitudes of people and organizations is the commonest cause of ineffective quality initiatives. Sustained improvements often require a change in attitude and acquisition of a sense of ownership with regard to the quality of services
provided by an organization. Many supporting initiatives are required to integrate accreditation into the structure and function of an organization. A mix of challenges are faced in hospital accreditation. The challenges in setting and measuring against standards are mostly technical; the challenges in making appropriate change are social and managerial.

- Strengthening legal support. Executive orders, laws and regulations of the Ministry of Health and continuous implementation of such regulations are important support for accreditation programmes. In general, law enforcement is weak in many countries of the Region.

- Establishing a multi-institutional and independent national accreditation body. This entity is vital for the accreditation process; however, its establishment requires consensus among the different actors in the public and private health sectors towards a common goal. Without a national accreditation body, multiple accreditation entities may appear and compete among one another, each setting different standards and priorities. This can affect the entire accreditation process negatively. Uniformity of standards is essential for the accreditation process; such uniformity can only be ensured through establishment of a single national accreditation body.

- Ensuring participation of the private and insurance sectors. The role of public or private social security and private health insurance is vital in implementation of hospital accreditation. The relationships between the different health care providers and purchasers need to be delineated, and the Ministry of Health should coordinate with private insurance companies to determine the best models for provision and financing of health services. Unfortunately, many countries do not have a process to tie national accreditation to provision of hospital services.

- Ensuring use of minimum standards. In general, professional medical associations always strive to establish optimum standards. However, when starting to implement an accreditation process, it is important to establish minimum standards for hospital services. Very few hospitals, in the short term, are able to meet optimum standards. Therefore, efforts are needed to convince hospitals to carry out the accreditation process, gradually ensuring the meeting of optimum standards.

- Ensuring application of standards to all hospital services. Approval of particular units or isolated programmes has been supported by some groups. A hospital may have a good programme in place to control infections or clinical laboratory, but this does not always ensure that other services meet minimum standards for accreditation.

- Basing accreditation on consensus rather than numerical scoring. Use of a total numerical score as the basis for accrediting a hospital may mask certain areas with potentially serious problems. Rather than assigning a score, at the end of the accreditation visit the surveyors should agree by consensus whether the hospital is or is not accredited, or whether some time is required to correct deficiencies (partial accreditation).
• Differentiating between licensing and accreditation. Some countries do not have national systems for licensing hospitals or issuing initial permits for construction or renovation of health facilities. Such systems are generally administered by municipal authorities and almost always deal only with observable structural features. Accreditation should not be used as a tool for licensing. However, licensing is a prerequisite for accreditation.

• Ensuring sustainability of a national accreditation programme. Although accreditation may be voluntary on the part of hospitals, these institutions must have some incentive for accepting the accreditation process. In the United States, the vast majority of hospitals survive as a result of patients covered by Medicare, a social security programme for the elderly. For a hospital to be contracted under Medicare, it must have prior accreditation from the National Accreditation Commission. Similar incentives for sustainability of this process will be required in countries of the Region.

• Clarifying the role of surveyors. The accreditation process must always be viewed as a permanent educational activity for hospital staff; never as a bureaucratic inspection or critical audit in search of victims. The basic role of surveyors is that of specialized consultants helping the hospital to overcome its managerial or technical difficulties. Assessment teams generally include a physician recognized for his/her skills, a nurse with far-reaching experience in hospitals, and an administrator with a solid background in hospitals.

4. STRATEGIES FOR DEVELOPING HOSPITAL ACCREDITATION IN THE REGION

Strategies should aim at fostering national accreditation initiatives and providing guidance for national accreditation efforts to ensure that accreditation systems are developed in a way that upholds the principles of health for all. The following strategies may be implemented by Member States in collaboration with WHO.

• Raising awareness at national level and encouraging debate by interested stakeholders to develop consensus on launching hospital accreditation.

• Strengthening hospital inspection units and improving administrative procedures in ministries of health in preparation for launching accreditation.

• Establishing national hospital registers with detailed profiles of individual hospitals.

• Studying efforts and experiences in hospital accreditation in the Region and exchanging experiences through a network of interested institutions and experts.

• Collaborating with regional and international bodies (e.g. Gulf Cooperation Council) for advocacy of hospital accreditation.
- Participating in annual international forums (e.g. meetings of the International Society for Quality in Health Care) to update knowledge on hospital accreditation and share experiences with others.
- Designating an expert advisory group on hospital accreditation in the Region to provide objective guidance to national authorities in addressing accreditation issues.
- Reviewing periodically and documenting progress in implementing hospital accreditation in the Region.
- Applying, after adaptation, the suggested steps for implementing hospital accreditation at national and local (hospital) levels (Box 2).

**Box 2. Steps for implementing accreditation at national and local (hospital) level**

**At national level:**
1. Orient the national authorities within the Ministry of Health and other stockholders on the concept, methodology, benefits and expected outcomes of accreditation.
2. Launch the accreditation process by establishing an “ad hoc” national accreditation committee (NAC) by the Ministry of Health.
3. Present the accreditation manual to the national ad hoc committee.
4. Initiate contact with national leadership by the national ad hoc committee.
5. Review and adapt the draft manual by the national ad hoc committee.
6. Hold first national seminar on hospital accreditation, “Validation of standards and evidence of performance (qualitative indicators)”. 
7. Identify available resources and existing ongoing activities on accreditation and quality improvement throughout the country by the ad hoc national committee.
8. Select public and private, large and small hospitals as pilots.
9. Hold second national seminar on hospital accreditation, “Presentation of the accreditation process in pilot hospitals”.
10. Establish a permanent multi-institutional National Accreditation Commission representing health care providers, independent or semi-governmental organizations, universities, insurance companies and/or community representatives.
11. Reformulate some standards and indicators based on pilot study.
12. Hold initial formal surveyor training.

**At local (hospital) level:**
1. Initiate contact with hospital authorities.
2. Form the hospital accreditation committee.
3. Train staff on concepts of accreditation; present the manual to hospital governing bodies.
4. Communicate the standards to those who must use them.
5. Carry out self-evaluation, based on proposed standards for services.
6. Design the situation profile.
7. Implement a plan of action to improve the areas that do not reach the minimum level standards.
8. Conduct problem solving and process improvement.
9. Train staff and monitor the plan of action.
10. Report to the hospital authorities.
5. CONCLUSIONS

A number of government, semi-private and private health institutions in the Region are seeking a recognized accreditation system in order to cope with the newly emerging competitive environment of health care service delivery. Many countries have looked to WHO for technical support in their efforts to develop hospital accreditation programmes. In response, the Regional Office has convened an intercountry consultative meeting on hospital accreditation, engaged a critical mass of regional resource people and developed, in collaboration with countries, a hospital accreditation model that is appropriate for the Region and that is flexible enough to allow for adaptation at national level. Accreditation should encourage every serious effort for improvement. It should not be restricted to sophisticated hospitals with advanced technology, but is intended for all hospitals so that they may contribute to better performance of national health systems.

6. RECOMMENDATIONS

To Member States

1. Plan and conduct an intensive awareness-raising campaign to promote concepts of quality improvement and accreditation with a view to securing political commitment for hospital accreditation.

2. Adapt the regional accreditation guidelines, if necessary, and use them to develop national plans for accreditation and quality improvement.

3. Share accreditation experiences with WHO/EMRO, including progress achieved and constraints faced, and refer to WHO/EMRO for relevant technical support.

To WHO/EMRO

4. Circulate the draft accreditation manual to all countries of the Region.

5. Provide technical support to countries in the development of action plans for implementing accreditation programmes.

6. Enhance partnership with regional (such as the GCC) and international organizations to expedite implementation of accreditation programmes in the Region.

8. Develop an expert advisory panel on hospital accreditation in the Region to provide national authorities with objective guidance in establishing accreditation programmes. The mandate of the advisory panel would be to help ensure that national accreditation systems are competent to: monitor and evaluate adherence to national health system policy and responsiveness to current and future challenges; monitor and evaluate quality performance of health organizations/facilities on various levels; cover managerial and clinical aspects; enhance the learning environment and quality improvement culture in organizations; and establish a national framework to take full responsibility for the accreditation initiative.
SAMPLE OF STANDARDS AND QUALITATIVE INDICATORS FROM THE DRAFT ACCREDITATION MANUAL

I. Organization of medical care

4. Emergency service

Level 1: It has a physician on active duty 24 hours a day, functioning with the exclusive use of a site and nurses dedicated to the service, with radiological, pharmacy, laboratory and blood bank support. It has written standards, protocols, guidelines and posters available for the most prevailing diseases.

The office of personnel should be requested to provide the list of physicians and nurses assigned to the sector and their distribution to provide adequate coverage 24 hours a day seven days a week. Confirmation should be obtained of the record of the registration of all the physicians. The site designated for emergency service should not be utilized for other tasks and should have the elements necessary for fulfilling its function: stretchers, instruments for sutures and dressings, and drugs for emergencies.

Level 2: It has the following specialties on call: clinical medicine, general surgery, obstetrics and gynaecology, and paediatrics. It has a resuscitation unit, served by personnel of the emergency service. For specialized hospitals, relevant specialists should be available on call.

The list of professionals with these specialties for every day of the week should be requested. There should be verification that list exists and is available in the service. The resuscitation unit is an area designated for the resuscitation of patients at imminent risk of death; it has the staff and instruments to allow the immediate survival of the patient until he can be moved to the intensive care service. The resuscitation unit should have appropriate drugs and disposable materials, a defibrillator, an electrocardiograph, and an internal pacemaker; it will have, in addition to oxygen, compressed air and an aspirator.

Level 3: Professionals representing at least three of the basic specialties are on active duty 24 hours a day.

There should be verification of the list of corresponding professionals and their distribution and also that they have facilities for night-time rest in rooms that are not utilized for patients. A haemodynamic monitor and a respirator should be available.

Editorial note: Standards of each level of satisfaction have a small instructive highlighted for the evaluator and the evaluated. These are evidence of performance or qualitative indicators of the standard (in italics). The detailed instructions should be further developed for the evaluation committees of each country.
Level 4: It has professionals representing at least two additional specialties on call 24 hours a day, with access to the equipment of the corresponding service.

There should be verification of the list of corresponding professionals and their distribution and also that there are keys for the respective services in the general key cabinet and that they are accessible to the night shift. It should be verified that the telephone numbers recorded allow rapid contact with the specialists on call. Educational levels are essential at this level.